Medication Management Medication Reconciliation on Discharge in Rural FHT

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Atikokan, ON FHT
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AFHTO Medication Management Workshop

Atikokan, Ontario

- Population 2753 in 2016
- Median age 49; many seniors
- Canoe capital of Canada Quetico
- 200 km SW of Thunder Bay

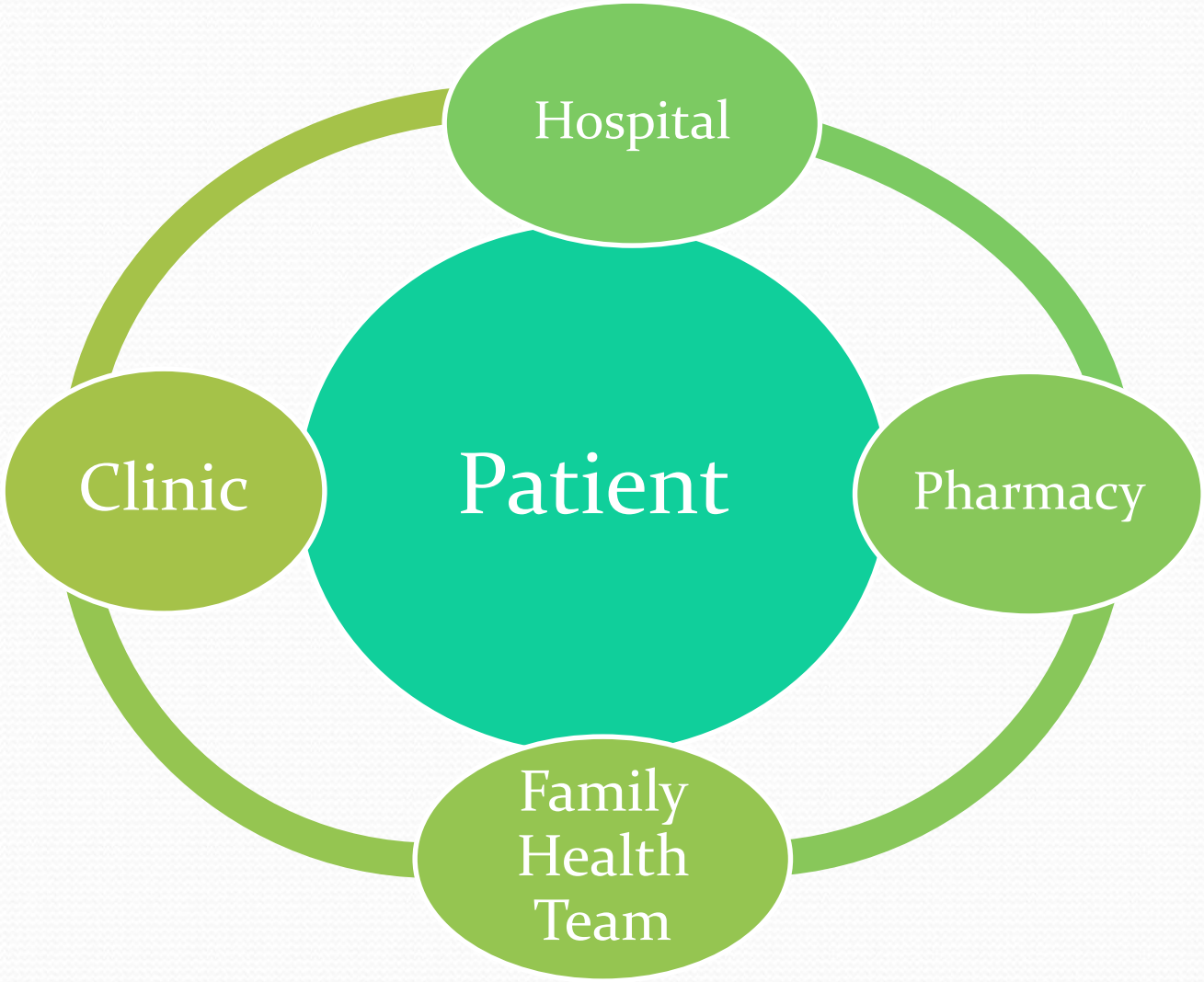
Atikokan Family Health Team

"Working together to help our community be healthy"

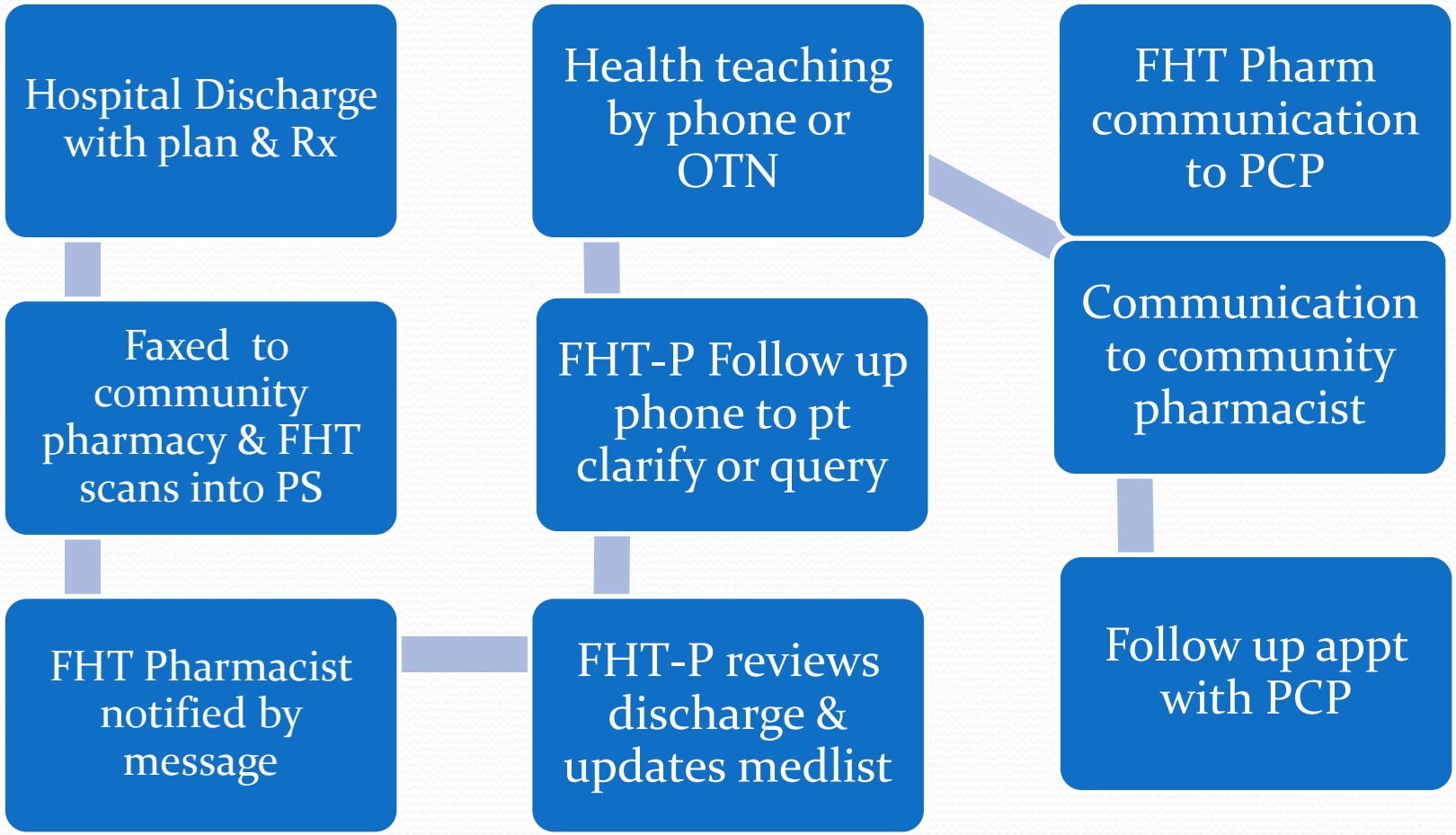
Atikokan FHT staff

- 3 administrative staff
- 4 nurses (2 RN, 2 RPN)
- 1 mental health worker
- 0.2 nurse practitioner under NWLHIN
- 1 nurse practitioner
- 0.45 dietician
- 0.2 pharmacist

Points of Medication Reconciliation



Hospital Discharge Medication Reconciliation



Medication Management

Medication management involves patient-centered care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams.

Canadian Pharmacists Association

5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS

when you see your doctor, nurse, or pharmacist.

1. CHANGES?

Have any medications been added, stopped or changed, and why?

2. CONTINUE?

What medications do I need to keep taking, and why?

3. PROPER USE?

How do I take my medications, and for how long?

4. MONITOR?

How will I know if my medication is working, and what side effects do I watch for?

5. FOLLOW-UP?

Do I need any tests and when do I book my next visit?

Keep your medication record up to date.

Remember to include:

- ✓ drug allergies
- ✓ vitamins and minerals
- ✓ herbal/natural products
- ✓ all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

ismp

cpsi icsp

Attikokan Family Health Team

Canadian Pharmacists Association / Association des pharmaciens du Canada

SafeMedicationUse.ca

Medication Management – Medication Schedule – Client Copy

Name: Penny Sillen DOB March 8, 1954 Address 123 Winding Way

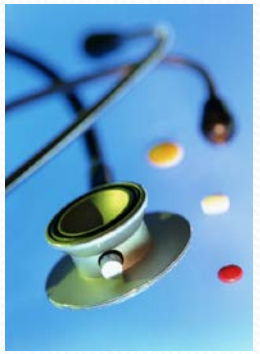
Date: November 27, 2014 Allergies: sulfa = rash

Adverse reactions: upset stomach with codeine

Comments:

Drug name	dose	route	reason	Morning 	Lunch 	Supper 	Bed 	Comments
EC ASA	81 mg	mouth	heart	x				Prevents stroke and heart attack
Ramipril (Altace)	5 mg	mouth	Blood pressure				x	Started Nov 21, 2014; monitor any new cough
Zopiclone (Imovane)	7.5 mg	mouth	Sleep				x	Only as needed; may halve tablet
Vitamin D	1000 units	mouth	Bones		x			Over the counter
Lantus Long acting insulin	16 units	inject	Diabetes				x	Adjust to target morning glucometer 5 – 7.

Medication management



- Pharmacist communicates issues to prescriber MD or NP, target before post discharge follow up appointment where suggestions or medication issues can be reviewed and considered with physical exam & reassessment.

Resources needed

- 0.2 Pharmacist (remote or not)
- OTN where pharmacist not on site
- Nursing or family involvement for select individuals due to OTN & pt limitation
- Community partner collaboration
  - hospital, local pharmacy, FHT

QIP - annual report in progress

Number of patients discharge medication reconciliation (77 to date)

Number of patients discharged from hospital (81)

QIP challenge discharge med rec

- Capturing discharges from hospitals outside of Atikokan community
  - Thunder Bay
  - Fort Frances
  - Other parts of Ontario or out of province

- Local community pharmacist faxes FHT pharmacist a copy of any hospital discharge from outside Atikokan and FHT pharmacist adds to emr & completes reconciliation process

IMPACT

- Health Literacy
- Empower individual patients
- Therapeutic relationship
- Communication & collaboration
- Patient Safety

Case example

- MN is a 75 yo woman with hx osteopenia, GERD, hypertension, IBS.
- Discharged from hospital with diverticulitis query abcess on ciprofloxacin and metronidazole x 10 days.
- Home medications to continue per hospital are pantoprazole 40 mg daily

  losartan 50 mg po daily

  calcium 500 mg po daily

  EC ASA 81 mg po daily

Medication List Update per follow up phone call to MN

- Hydrocortisone cream (outdated)
- Eucerin cream (outdated)
- Steroid nasal spray daily (now as needed)
- Lax a Day regularly (now as needed)
- Low dose ASA was started 4 – 6 months ago on recommendation of chiropractor for a procedure to prevent clot
- Unsure of vitamin D dose in calcium supplement product
- Allergies verified; remote allergy to penicillin low risk

MN Medication Management

- Discussed to hold calcium until ciprofloxacin course completed (drug interaction)
- Query need for low dose ASA – message MD
- Query clarify vitamin D dose to ensure at least 1000 units per day – message MD

- Inquire about tolerability and adherence to new medicines; pt denies any upset stomach from antibiotics and states she uses a dosette for adherence.

MN Medication Management

- MD follow up post discharge visit:
  - confirms chiropractic care completed and risk benefit to discontinue low dose ASA
  - MD communicates recommendation at least 1000 units per day of vitamin D

- FHT-P updates EMR medication profile with follow up phone call to patient.

Discussion

- Medication reconciliation at discharge provides medication management opportunities :
  - encourage individual patient health literacy with respect to medications.
  - ensure communication and collaboration of care within interdisciplinary team.