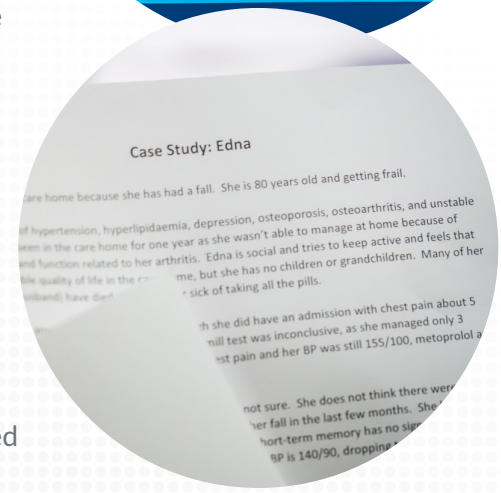
# Overview of the Shared Care Polypharmacy Risk Reduction Initiative – Acute Care

**The main goal of the Shared Care Polypharmacy Risk Reduction (PPhRR) initiative, focused on the elderly, is to support physicians to work with other health professionals, patients/residents and families, to develop the best medication plans for each patient/resident under their care.**

The following are ***steps previously taken to prototype work for PPhRR in acute care*** to improve the approach to medication management for patients transitioning to and from acute care and the community:


1. Engaged the local Division of Family Practice, linking to community physicians.
2. Engaged key physicians who would be interested.
3. Engaged with operational leaders of pharmacy and hospital ward care (usually nursing), whose staff may become involved, and then chose a 'unit' to prototype the improvement work.
4. Established a 'working group' (including people associated with the 'target unit, where possible) involving physicians, pharmacist(s), nursing, a community-Division of Family Practice rep and community pharmacist.
5. Mapped the patient medication journey from the emergency room to acute care, at discharge, and then back into the community. Staff from the target unit were included in the mapping.
6. Based upon the mapping, the working group identified a few key improvement ideas to start developing and testing through a quality improvement approach.
7. The work was carried out over a number of months with the support of a coordinator. The working group met over that time to steer the work.
8. Provided education sessions to physicians involved at the unit level, related to PPhRR, as well as information on improvements being developed and tested.
9. Solidified key improvements and developed a sustainability plan for the target unit. A spread plan for the hospital was also developed for presentation to the local hospital Patient Medication Safety and Quality Committee.

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**Note:** The work at Royal Inland hospital in Kamloops (Thompson Division of Family Practice), was conducted more generally with physicians and a specific unit was not chosen. However, the approach was generally the same, including starting with mapping and then testing improvement ideas.

## KEY LESSONS LEARNED INCLUDED:

- While there is an awareness of the potential adverse effects of medications, especially for patients with complex health conditions and/or frailty, there is a **lack of a standard, coordinated approach to address this issue**, where such an approach would include both medication reconciliation and a meaningful medication review.

- **Inter-disciplinary team members often had an incomplete understanding of what the other acute care health care providers were doing or could be doing** to support development of an effective medication management plan.

- While there is an awareness of the need to provide adequate information at the time of discharge and transition of the patient back into the community, there is a **lack of a standard, coordinated approach to support follow-up** by patient/family and the community physician, pharmacist and other health care providers involved.

## COMMON IMPROVEMENT PROCESSES WORKED ON:

- **Connecting admission medication reconciliation with discharge medication reconciliation** to produce the final discharge medication prescription.

- **Conducting a medication review very close to discharge** to build into the final discharge medication prescription.

- **More clearly identifying physician responsibility for generating/signing off on the final discharge medication prescription**, while providing support to the physicians from clinical pharmacists (when available) and unit clerks.

- **More clearly identifying and supporting how nursing would be involved in supporting the medication plan**, particularly through supporting patient/family education, in conjunction with clinical pharmacy.

- **Reviewing and improving the discharge medication forms for communication back into the community**, especially as part of the discharge medication reconciliation approach, and ensuring that the final discharge medication prescription (including indications and reasons for medication changes), would be sent to the family physician and the community pharmacy.