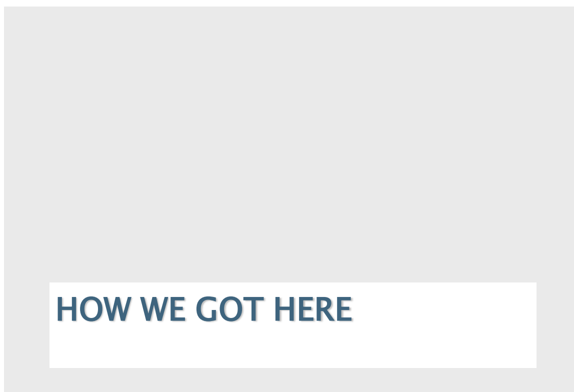
Agenda

- How We Got Here
  - Our history and context
- How We Did it
  - Our Approach
- What was the secret sauce
  - Our key success factors
- What advice do we have for others
  - Our thoughts



How We Got Here

Who we are
- LHSC is a multi-site acute care teaching hospital
- Over 900 beds
- Regional academic programs including renal, cancer, neonatology and pediatrics, transplant, emergency, medicine, surgery, cardiology, CNS, mental health

How We Got Here

- 2005-2007 CAPHC Initiative/ Psychiatry pilot
  - Limited success due to:
    - Limited to each specific area
    - Relied on one individual in each area
    - No policy, no procedure
    - Dealt with admission only
- 2008-2009 Another attempt with new nursing leader sponsored by pharmacy; expanded ineffectively to several areas
  - Limited success due to:
    - Small team with unrealized depth/scope/challenges including active and vocal opposition by physicians and pharmacists
    - Insufficient pharmacy resources to support the process that was designed
    - BPMH Admission Form could not be used as order form

How We Got Here

- October 2010 – new CEO appointed
- Key mandates
  - Quality
  - Culture
  - Performance
- Culture and operational diagnostic conducted
- Calls to action on infection and access commissioned
- Winter 2011 – Corporate Leadership Reorganization
- Preparation for accreditation cycle began

HOW WE DID IT

How We Did It

- New executive appointed responsible for pharmacy
- Plan for pharmacy services developed including immediate recruitment of Director to fill a year long vacancy
- Assessed current medication reconciliation plan and learnings from other efforts
- Medication reconciliation leader took on new role and new DoP and executive recruited a new leader

How We Did It

- Implementation Phases
  - Phase 1: Sub Acute Medicine / Palliative Care October 2011
  - Phase 2: Ortho Surgery – University Hospital Nov 28, 2011
  - Phase 3a: All of University Hospital Feb 29, 2012
  - Phase 3b: All of Victoria Hospital May 30, 2012
- Team Included
  - Project Leader, Project Manager, VP Medical, VP Pharmacy, Clinical Informatics, Forms, Medical Affairs, Decision Support, Physicians and Residents, Nursing Educators, Nursing Professional Practice, Pharmacy Student, Communications, Health Records

How We Did It

- Communication & Education
  - Clear, consistent key messages from core team
  - Kickoff sessions
    - New forms, new process
  - Unit Specific Working Group Meetings
  - Educational sessions to Medical Leaders, Staff, Residents, Students
  - Corporate Communication
    - E-cast, The PAGE, weekly e-mail tips, CEO messages
  - Support
    - Phone, pager, e-mail contact to core team

WHAT WAS THE SECRET SAUCE?

Key Learnings From Past Efforts

- Lack of a well defined plan and a defined future state
- Lack of formal policy, procedures
- Medication Reconciliation was not an ROP for Accreditation and therefore viewed as optional
- Lack of an inter-disciplinary focus and approach
- Lack of corporate executive administrative and medical sponsors
- Insufficient engagement of physicians

Using Influence

Others

- Appreciative inquiry and a spirit of quality improvement
  - Leaders, staff and physicians understood the fact that the process and tools would change based on their feedback as the project progressed
  - Naysayers asked:
    - "What would it take to make this happen"
    - "What will you do to make it happen"
    - "*Will you help us – this is what we need from you*"
- A track record of success is needed
  - Medical leaders were more receptive due to highly successful pharmacy run campaign to eliminate abbreviations

Others

- Connecting the implementation at every stage with quality –
  - "med rec will improve patient safety"
  - Make the conversation and experience contagious
- Be truthful
  - "Med rec will add work to your day – but its about patient safety and we will be electronic within two years so it's temporary!"
- Recognize key informal leaders and bring them on the team
- Timing is everything

WHAT ADVICE DO WE HAVE FOR OTHERS?

What Advice Do We Have For Others?

- Make it mandatory – you absolutely must have clear and visible senior leadership support.
- Leadership support must include a plan of what to do if staff don't comply – have the courage to say "no – we're doing it this way".
- A respected physician lead is important!
- Make it about quality…even though this is an ROP… we are doing it to keep our patients safe. Only play the "ROP Card" when all your influencing techniques have failed… this is not an option.
- Select the correct formal, executive, tactical as well as informal leaders and change agents.
- Follow up with units early and often… Even though you feel you conducted great education sessions, without a doubt… the first day, the staff members working won't know what med rec is!
- Resist the urge to allow multiple customization of forms.

SO, HOW ARE WE DOING?

So how are we doing?

- Anecdotal data
  - CCAC and Community Pharmacists – “clearer communication to community providers”
  - Residents, Physicians – “process is easy and makes discharges consistent”
  - Pharmacists
- Data is trending upwards in terms of compliance to using forms/process in all areas of the hospital
- Medication Reconciliation Sustainability Team active
  - Continuous Quality Improvement
  - Answering day-to-day questions and solve problems that may arise
- Transitioning to eMedRec

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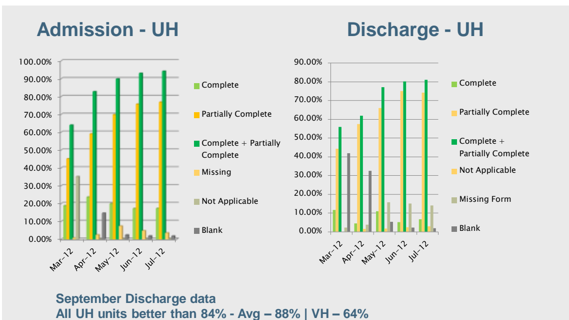
So how are we doing?



September Discharge data
All UH units better than 84% - Avg – 88% | VH – 64%

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ADDITIONAL SLIDES

Structural / Motivation

- **Executive administrative and medical leadership**
  - Vice President for Pharmacy and Medical Affairs key executive sponsors
  - Provide visible leadership and remove roadblock
  - Judicious use of CEO's influence within the broader organization
  - Project lead with significant organizational credibility specifically selected
  - Aligning goals of portfolios with the desired outcomes
  - Medication Reconciliation was not optional – it is a required organizational practice

Social / Motivation

- **Front line medical, pharmacy and nursing medication reconciliation evangelists**
  - Key front line spokespeople
  - MD telling the story of how errors impacted his practice
  - Pharmacist providing the content expertise and system knowledge to make it easier to participate
  - Key front line nurses from nursing practice to influence others
  - In specific areas, champions designated and physician leaders played role to make sure it happened

Social / Ability

- **Aligned resources from various disciplines**
  - Ensure forms management responds quickly
  - Aligned all nursing educators with this purpose
  - Aligned pharmacy resources
  - Ensured full participation from medical leaders at the Medical Advisory Committee
  - Aligned health records for audits

Structural / Ability

- **Disciplined project management**
  - Seasoned project manager embedded in the project
  - Project management discipline