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Scope of Practice Review for Dieticians

I would like to express my concern over the proposed expansion to the Scope of Practice for Dieticians. While I wholeheartedly agree dieticians are “valued members of interprofessional health care teams using their expertise to integrate nutrition care into health promotion and disease prevention and management for patients” their training and expertise does not include the complex process of prescribing and dispensing medications. “Registered Dieticians are the health professionals who are uniquely trained to provide expertise on food and nutrition”. Prescribing and dispensing medications requires a different skill set with an extensive education in biochemistry, organic chemistry, pharmacokinetics and pharmacodynamics. It is not simply a matter of understanding the disease and knowing which medication is used to treat the disease. The complex process of drug absorption, distribution, metabolism and clearance in addition to the chemical interaction between medications in the body requires years of study to ensure patients achieve the desired health outcome from these complex chemicals.

Insulin, oral hypoglycemic medications and total parenteral nutrition are considered high risk/high alert medications along with oncology agents and dialysis solutions. Medication Safety recommendations resulting from root cause analysis of sentinel events has determined these agents bear a heightened risk of causing significant patient harm when they are used in error. Oncology agents and dialysis solutions require prescribing and dispensing by Specialist Physicians and Pharmacists to ensure safe use. I do not believe it would be in the patient’s best interest to have these high risk/high alert drugs prescribed and dispensed by the same non-physician health care practitioner.

Finally, the Safer Health Care Now initiative “Medication Reconciliation” is the process designed to prevent medication errors at patient transition points such as entering and leaving hospital, and all other points along the health care continuum. It is the process of creating the most complete and accurate Best Possible Medication History (BPMH) of all home medication for the patient. The addition of another health care practitioner to the list of regulated healthcare practitioners with the controlled act of dispensing will only further complicate the difficult process of obtaining the Best Possible Medication History.

While I understand the request by Dieticians to expand their scope of practice in an attempt to further enhance the care of their patients, I do not support the request for the reasons outlined above,

Thank you for providing the opportunity to comment.

Respectfully submitted,
H. B, B.Sc.PhM, R.Ph

The 10 SHN interventions

- AMI - Acute Myocardial Infarction
- CLI - Central-line associated Bloodstream Infections
- Falls - Falls Collaborative in Long-term care
- MedRec - Medication Reconciliation (Acute-care)
- MedRec - Medication Reconciliation (Long-term care)
- MRSA - Antibiotic-resistant organisms (AROs)/Methicillin-resistant *Staphylococcus aureus*
- RRT - Rapid Response Teams
- SSI - Surgical Site Infections
- VAP - Ventilator-associated Pneumonia
- VTE - Venous thromboembolism

Goal

The goal of medication reconciliation in Long Term Care (LTC) is to reduce the potential for adverse drug events (ADEs) and patient harm by identifying and resolving discrepancies and improving documentation in drug regimens at care transitions such as

Background

Incomplete or inaccurate medication information is a critical issue reflected in a growing number of LTC studies. A 2007 survey of continuing care nurses and pharmacists in Alberta found:

- 75% of the time medication information was NOT legible and complete
- 90% of the time information was NOT available to tell if the prescribed medications were appropriate for the resident's diagnoses.
- 40% of the time medication information DID NOT arrive the same day as the resident's admission.¹

In a 2004 study by Boockvar the incidence of ADEs caused by medication changes at transfer between facilities was 20%. ADEs due to medication changes occurred most often upon transfer from the hospital back to the LTC facility. Incomplete or inaccurate communication between facilities was identified as a potential factor in these occurrences. Their recommendation was to implement medication reconciliation, at the time of admission back to the long-term care facility.²

A 2006 study by Boockvar, found that the possibility of having a discrepancy related adverse drug event was less likely in the group of residents who had medication reconciliation performed by a pharmacist with physician communication upon transfer from acute care to long-term care compared with the group that did not.³

In Phase 1 of the *Safer Healthcare Now!* campaign acute care medication reconciliation teams made significant improvements in reducing discrepancies and preventing potential errors. Expanding implementation of medication reconciliation to long-term care and community care organizations in Phase 2 will further help to close communication gaps in medication information transfer thus improving resident safety across the continuum of care.

Intervention

Medication Reconciliation in long-term care is a formal process of:

1. At admission, obtaining a complete and accurate list of each resident's current and pre-admission medications - including name, dosage, frequency and route (BPMH).
2. Using the BPMH to create admission orders or comparing the list against the resident's admission orders, identifying and bringing any discrepancies to the attention of the prescriber for resolution.
3. Any resulting changes in orders are documented and communicated to the relevant providers of care and resident or family member wherever possible.

Intervention Measures

The Core Measures are:

1. **Mean number of UNDOCUMENTED INTENTIONAL Discrepancies (Documentation Accuracy)**
Target: Reduce baseline in area of focus by 75%.
2. **Mean number of UNINTENTIONAL Discrepancies (Medication Error)**
Target: Reduce baseline in area of focus by 75%.
3. **Percentage of Residents Reconciled upon admission**
Target: 100% of residents reconciled upon admission.

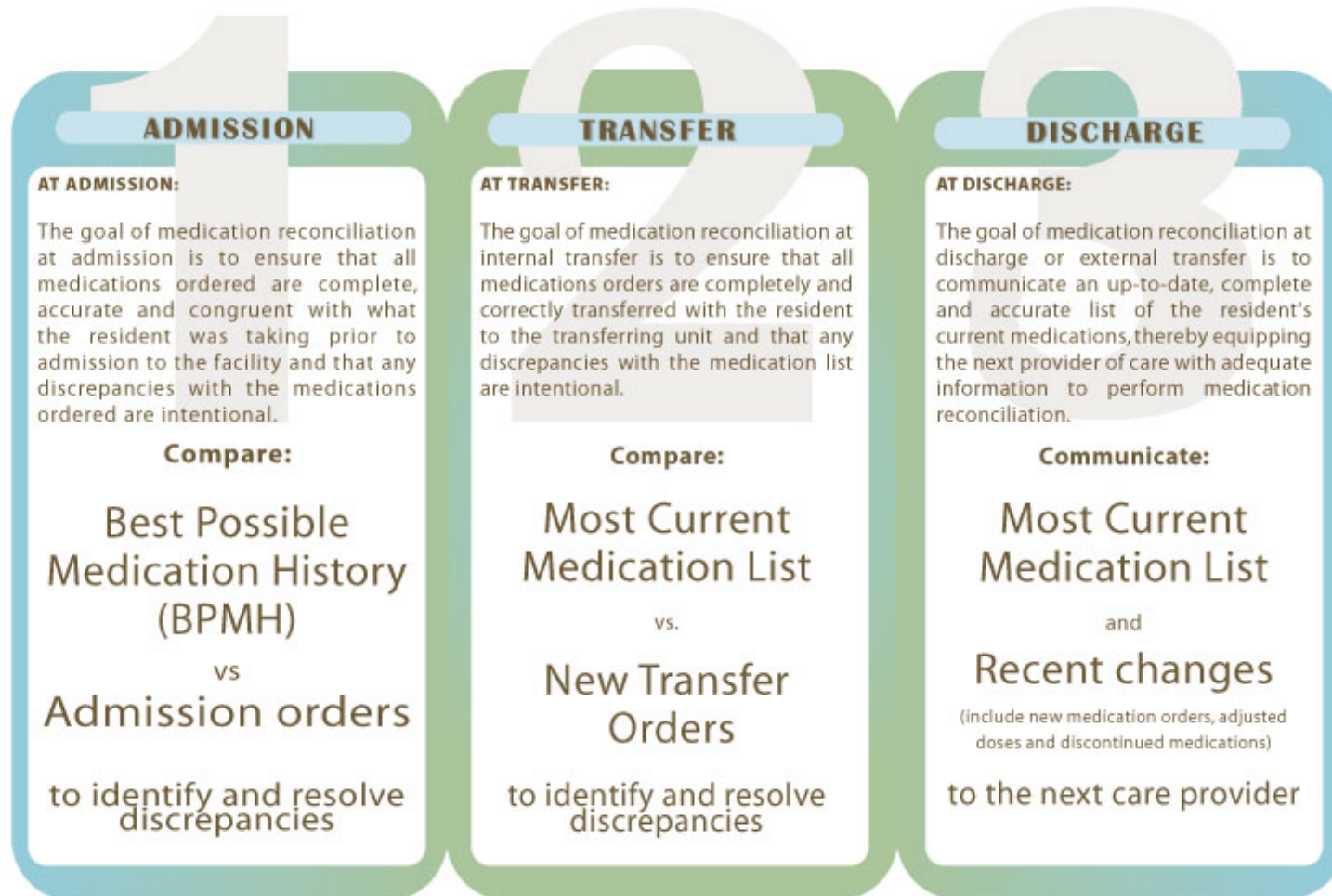
¹ Earnshaw, K et. al. Perspectives of Alberta Nurses and Pharmacists on Medication Information Received. July 29, 2007

² Boockvar K, Fishman E, Kyriacou CK, et al. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and Long-term care facilities. Arch Intern Med. 2004;164:545-550

³ Boockvar K et. Al. Medication Reconciliation for Reducing Drug-Discrepancy Adverse events *Am J Geriatr Pharmacother.* 2006;4:236-243

MEDICATION RECONCILIATION

From Admission to Discharge in Long-Term Care



The 10 SHN interventions

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Goal

Prevent adverse drug events (ADEs) by implementing a medication reconciliation process upon admission, transfer and discharge.

Background

- ADEs occur frequently. Communication problems between healthcare professionals in different care settings are a significant factor. A 2004 Canadian study found drug and fluid-related events were the second most common type of procedure or event related to adverse events.¹
- In a Canadian investigation, Forster et al. found that 23% of hospitalized patients discharged from an internal medicine service experienced an adverse event; of the 23%, 72% were ADEs.²
- Chart reviews reveal over half of all hospital medication errors occur at the interfaces of care.³
- A Canadian study by Cornish and colleagues found that 53.6% of the study population had at least one unintended discrepancy, of which 38.6% were judged to have the potential to cause moderate to severe discomfort or clinical deterioration. Most discrepancies (46.4%) included the omission of a regularly used medication.⁴

Medication reconciliation is a process designed to prevent medication errors at patient transition points. It includes:

- Creating the most complete and accurate list or Best Possible Medication History (BPMH) of all home medications for each patient.
- Using that list when writing medication orders.
- Comparing the list against the physician's admission, transfer, and/or discharge orders; identifying and bringing any discrepancies to the attention of the physician; and, if appropriate, making changes to the orders ensuring the changes are documented.

Accreditation Canada includes medication reconciliation as part of its required organizational practices which includes:

- Reconciling the clients' medications upon admission to the organization, with the involvement of the patient/client.
- Reconciling medications with the patient/client at referral or transfer and communicating the clients' medications to the next provider at referral or transfer to another setting, service, service provider or level of care within or outside the organization.⁵

¹ Baker GR, Norton PG. The Canadian Adverse Events Study: the incidence of adverse events among hospitalized patients in Canada. *Can Med Assoc J.* 2004; 170(11):1678-1686.

² Forster AJ, Clark HD, Menard A, Dupuis N, Chernish R, et al., Adverse events among medical patients after discharge from hospital. *Can Med Assoc J.* 2004; 170(3):345-349

³ Rozich JD, Resar RK. Medication Safety: One organization's approach to the challenge. *J Clin Outcomes Manage.* 2001;8(10):27-34. 4

⁴ Cornish PL, Knowles SR, Marchesano R, Tam V, Shadowitz S, Juurlink DN, Etchells EE. Unintended medication discrepancies at the time of hospital admission. *Arch Intern Med.* 2005;165:424-429.

⁵ Accreditation Canada. Required Organizational Practices. Accessed July 2008. Available at: <http://www.accreditation-canada.ca/default.aspx?page=355&cat=30>

Intervention Measures

The core measures are:

Admission and Transfer:

1. Mean # of UNDOCUMENTED INTENTIONAL Discrepancies [Documentation Accuracy]
Target: Reduce baseline in area of focus by 75%
2. Mean # of UNINTENTIONAL Discrepancies [Medication Error]
Target: Reduce baseline in area of focus by 75%

Discharge:

1. Percentage of patients reconciled at discharge with a Best Possible Medication Discharge Plan (BPMDP)
Target: 100% of all eligible patients

Note: A BPMDP is created by using the BPMH and the 24-hour medication administration record (MAR) as references. It evaluates and accounts for: new medications started in hospital, discontinued medications, adjusted medications, unchanged medications that are to be continued, medications held in hospital, formulary adjustments made in hospital, new medications started upon discharge and additional comments as appropriate - e.g., status of herbals or medications to be taken at the patient's discretion.

Success Stories:

- Kwan et al. conducted randomized controlled trial with 464 surgical patients at the University Health Network in Toronto, Ontario. They demonstrated that multidisciplinary medication reconciliation (pharmacists, nurses and physicians partnering with the patient) in a preadmission clinic resulted in a 50% reduction in the number of patients with discrepancies linked to home medications. Furthermore, the collaborative intervention also resulted in more than halving the number of patients with discrepancies with the potential to cause possible or probable harm compared to standard of care (29.9% vs. 12.9%).⁶
- A multidisciplinary team at the Royal Jubilee Hospital (Vancouver Island Health Authority) developed a sustained practice medication reconciliation model in a surgical pre-admission clinic serving four surgical wards. During a 6 month review of 615 patients with 3570 medications reconciled, the team estimated 591 potential discrepancies were avoided with the intervention.
- Pincher Creek Hospital, within the Chinook Health Region, has implemented a system to ensure the community pharmacy was contacted for a current medication list. To date, 90% of complex medical clients are admitted with a current medication history.
- New evidence is emerging on a continual basis.

⁶ Kwan Y, Fernandes OA, Nagge JJ, Wong GG, Huh J, Hurn DA, et al. Pharmacist medication assessments in a surgical preadmission clinic. *Arch Intern Med* 2007;167:1034-1040.

MEDICATION RECONCILIATION

From Admission to Discharge

1 ADMISSION

AT ADMISSION:

The goal of admission medication reconciliation is to ensure there is a conscious decision on the part of the patient's prescriber to continue, discontinue or modify the medication regime that a patient has been taking at home.

Compare:

Best Possible Medication History (BPMH)

vs.

Admission Medication Orders (AMO)

to identify and resolve discrepancies

2 TRANSFER

AT TRANSFER:

The goal of transfer medication reconciliation is to consider not only what the patient was receiving on the transferring unit but also any medications they were taking at home that may be appropriate to continue, restart, discontinue or modify.

Compare:

Best Possible Medication History (BPMH)

and the

Transferring Unit Medication Administration Record (MAR)

vs.

Transfer Orders

to identify and resolve discrepancies

3 DISCHARGE

AT DISCHARGE:

The goal of discharge medication reconciliation is to reconcile the medications the patient is taking prior to admission and those initiated in hospital, with the medications they should be taking post-discharge to ensure all changes are intentional and that discrepancies are resolved prior to discharge.

Compare:

Best Possible Medication History (BPMH)

and the

Last 24 hour Medication Administration Record (MAR)

plus

New medications started upon discharge

to identify and resolve discrepancies and prepare the **Best Possible Medication Discharge Plan (BPMDP)**

Adapted from Barnsteiner, J. H. (2005). Medication Reconciliation. *American Journal of Nursing*, 3(suppl), 31-36. Created by the Institute for Safe Medication Practices Canada (ISMP Canada) for the Safer Healthcare Now! campaign.