PROMOTING MEDICATION SAFETY FOR OLDER ADULTS BY IMPLEMENTING A MEDICATION DISCHARGE PLAN: FROM THEORY TO PRACTICE

CSHP-WEBINAR
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La Chaire pharmaceutique Michel-Saucier en santé et vieillissement

PRESENTERS PERSONAL DISCLOSURE

1) Presenter's Name: **Yannick Villeneuve**

-I have no current or past relationships with commercial entities.
-I have received no speaker's fee for this learning activity.

Current Employee of CIUSSS du Centre-Sud-de-l'Île-de-Montréal

2) Presenter's Name: **Louise Papillon-Ferland**

I have the following relationships with commercial interests (in past 2 years):

- **Funding (Grants)** Michel Saucier Pharmaceutical Chair in Health and Aging; Les Alliés de la Faculté de pharmacie (Université de Montréal); Inven-T (Université de Montréal)
- **Speaker (Conference fee) :** Association des pharmaciens en établissements de santé du Québec; Association professionnelle des pharmaciens salariés du Québec; McGill (Department of Family Medicine/ Faculty of Medicine and Health Science); Pharmascience; Académie Brunet-Coutu; Fédération des Médecins specialistes du Québec
- **Other:** Current Employee of CIUSSS du Centre-Sud-de-l'Île-de-Montréal and University of Montreal

I have received no speaker's fee for this learning activity

COMMERCIAL DISCLOSURE

- This program has received financial support from the Michel Saucier Pharmaceutical Chair in Health and Aging in the form of:
  - Funding of the practical guide (e.g., translation, graphic design and linguistic revision)
  - Funding for promotional materials
- This program has received financial support from the Faculty of Pharmacy of the Université de Montréal in the form of:
  - Funding to meet with a statistician to plan the method section of the Delphi.
- This program has received in-kind support from the Direction de l'enseignement universitaire et de la recherche of the CCSMTL in the form of:
  - Logistical and promotional support

PRESENTATION OBJECTIVES

- Explain the context and medication-related issues at hospital discharge;
- Describe the guiding principles to design a Medication Discharge Plan (MDP);
- Summarize considerations related to the format and transmission of an MDP;
- Discuss the implementation of an MDP in clinical practice.

BACKGROUND – RISKS AT HOSPITAL DISCHARGE

- The transition care period can be a major cause of adverse drug events (ADEs) in older adults.
- In the PRIME study
  - ADEs following hospital discharge occurred in 37% of older adults
    - More than half were potentially preventable

Parekh N, et al. Br J Clin Pharmacol. 2018. ACSQHC. Safety Issues at Transitions of Care. 2017.

BACKGROUND - DEFINITIONS

- Medication reconciliation (MedRec)
  - Main objective is to identify and resolve medication discrepancies
- Discharge summary (DS)
  - Summarizes the main events of the patient's hospital stay
  - Drug information is often limited to
    - Drug list
    - Medication changes
    - To a lesser extent, the reasons for medication changes

BACKGROUND - LIMITS

- So MedRec and DS have their limits
  - To ensure coordination and continuity of patient drug therapy
  - Relevant information on drug therapy is either not included or incomplete.

BACKGROUND – MEDICATION DISCHARGE PLAN (MDP)

- An MDP is an opportunity to foster effective communication about medications between the hospital and the primary care team.
  - Highlighting medication-related issues encountered during the hospital stay
- Managing medication-related issues
  - This aspect distinguishes the MDP from the DS or MedRec.

BACKGROUND - MDP

- Either in the literature and in clinical practice, there are discrepancies concerning the MDP
  - Contents
  - Format
  - Mode of transmission to the next care provider
- A practical guide has been developed
  - Facilitating the design and implementation of an MDP for older adults discharged from hospital

Villeneuve Y et al. RSAP 2021
LeBlanc VC et al. Explor Res Clin Soc Pharm. 2021.
Xuan S et al. Med Care. 2021.

RESEARCH PROJECT

Promoting medication safety for older adults upon hospital discharge: Guiding principles for a medication discharge plan

Fang Hao Zhang[1,2,3] | Justine Lauzon[1,2,4] | Jérémy Payette[1,2,5] | Fanny Courtemanche[3] | Louise Papillon-Ferland[3,6,7] | Faranak Firoozi[3,6] | Suzanne Gilbert[6] | Justin P. Turner[6,7,8] | Yannick Villeneuve[3,6]

Objectives

- Create guiding principles for the development of a standardized MDP.
- Identify the guiding principles deemed essential for a short-version MDP.
- Develop a practical guide to help implement the MDP, including patient prioritization, format and mode of transmission of the MDP.

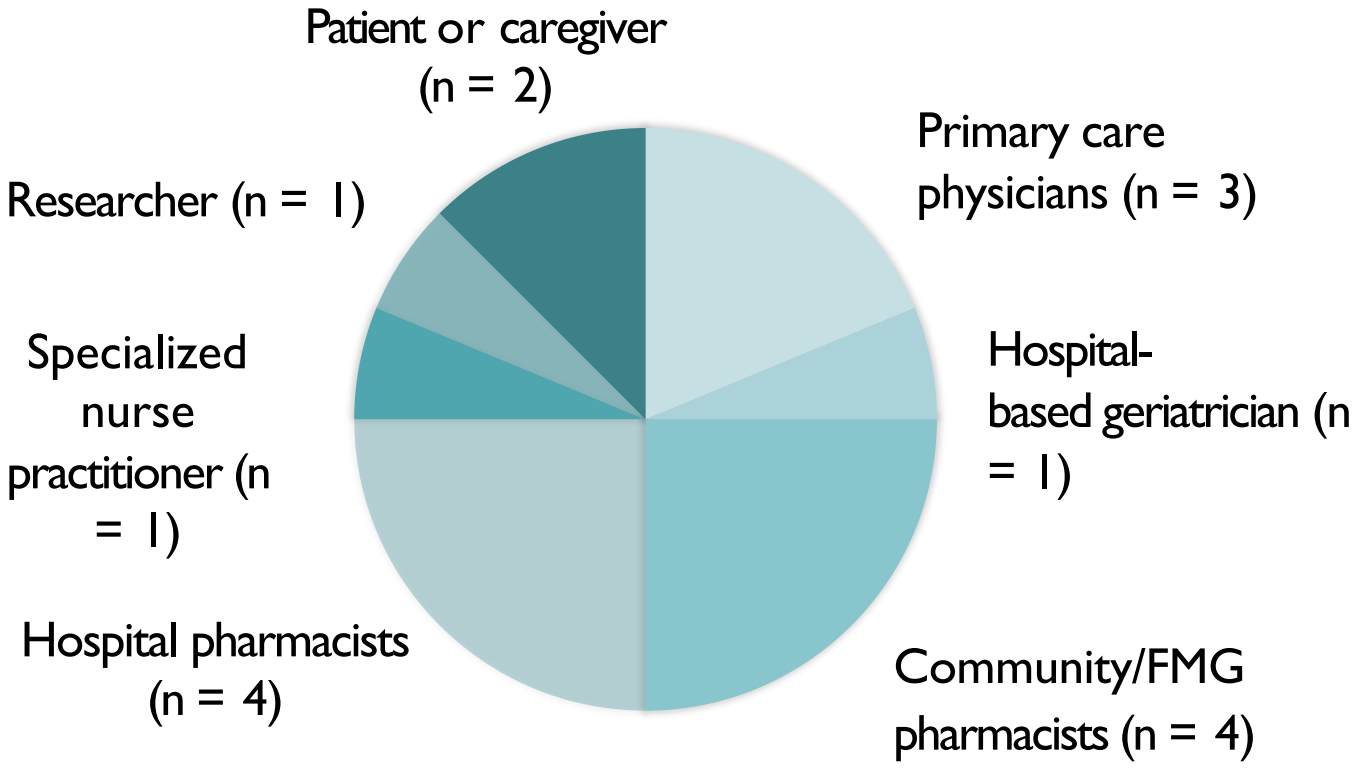
Methodology

- Modified Delphi process - Participants selected in Quebec (n = 16)
- Initial guiding principles were developped from a literature review and the clinical experience of our research team.
- Vote on the relevance, clarity and feasibility of each guiding principle (using a 9-point Likert scale)
  - Consensus: 70% voted 7 or more for relevance and clarity
  - Comments were collected to modify guiding principles if necessary
  - Vote on guiding principles deemed essential
- Selection of patient prioritization criteria
- Questionnaire on format and mode of transmission
- Practical guide development

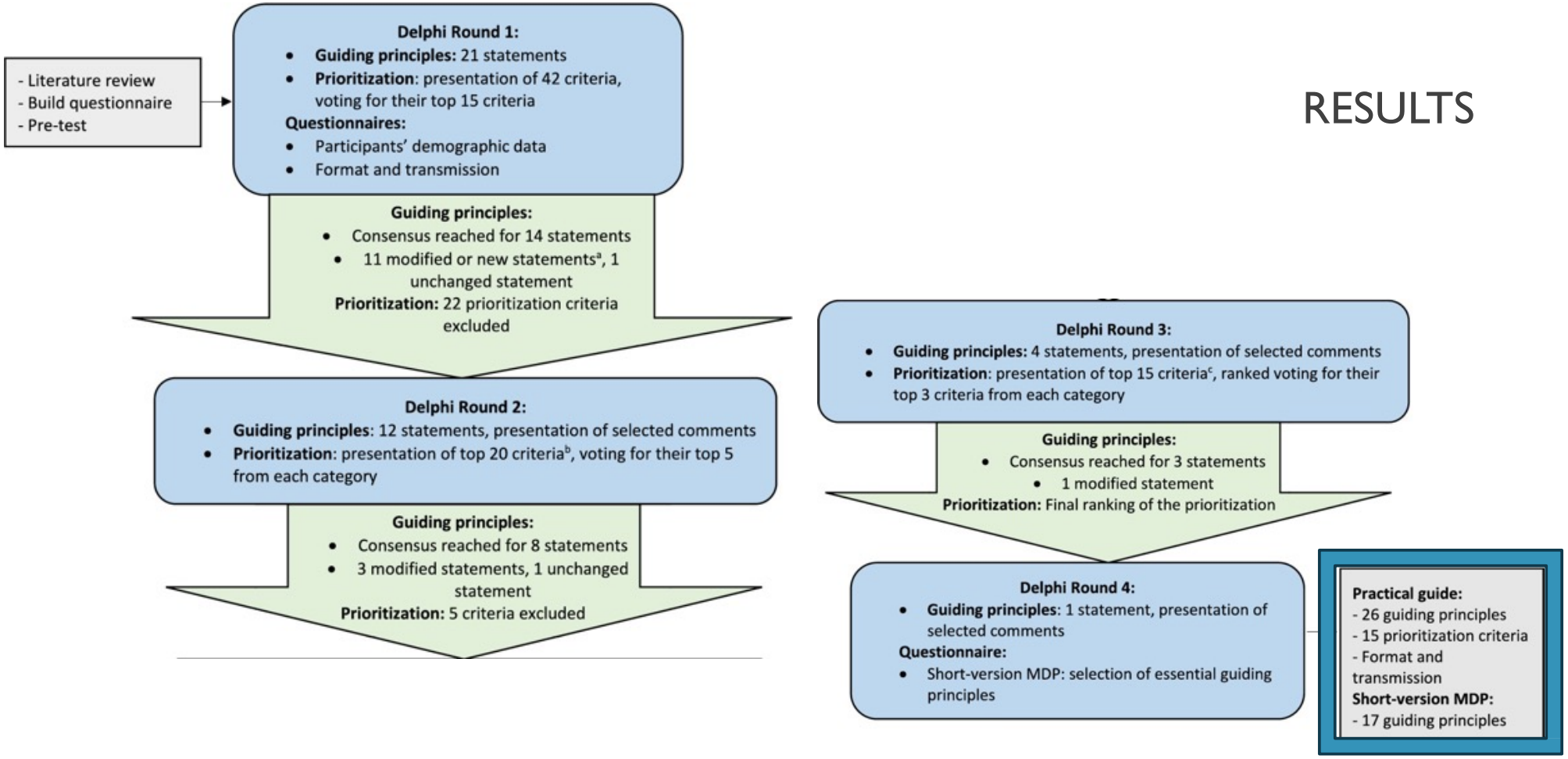
Zhang FH, Lauzon J,Payette J,Courtemanche F,Papillon-Ferland L, Firoozi F,Gilbert S,Turner JP,Villeneuve Y. Promoting medication safety for older adults upon hospital discharge: Guiding principles for a medication discharge plan. Br J Clin Pharmacol. 2024 Aug 18. doi: 10.1111/bcp.16216.

RESULTS

N = 16 participants

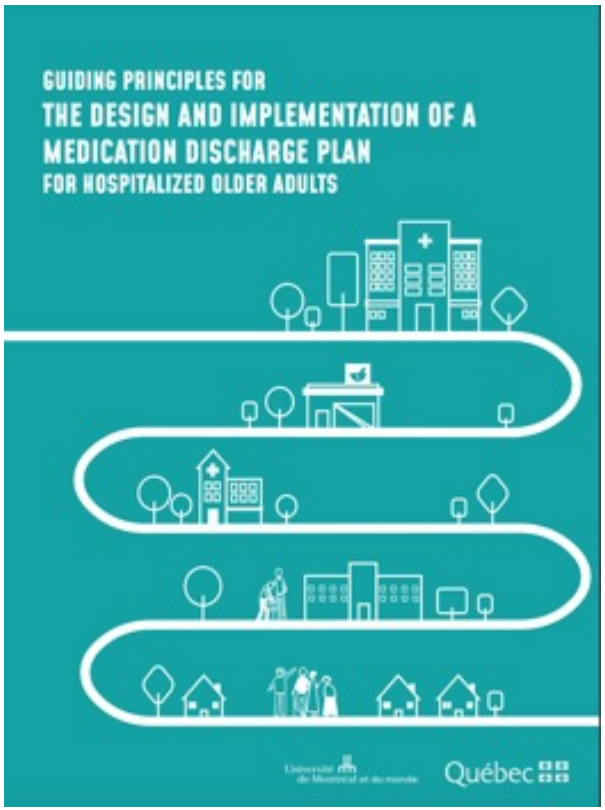


RESULTS



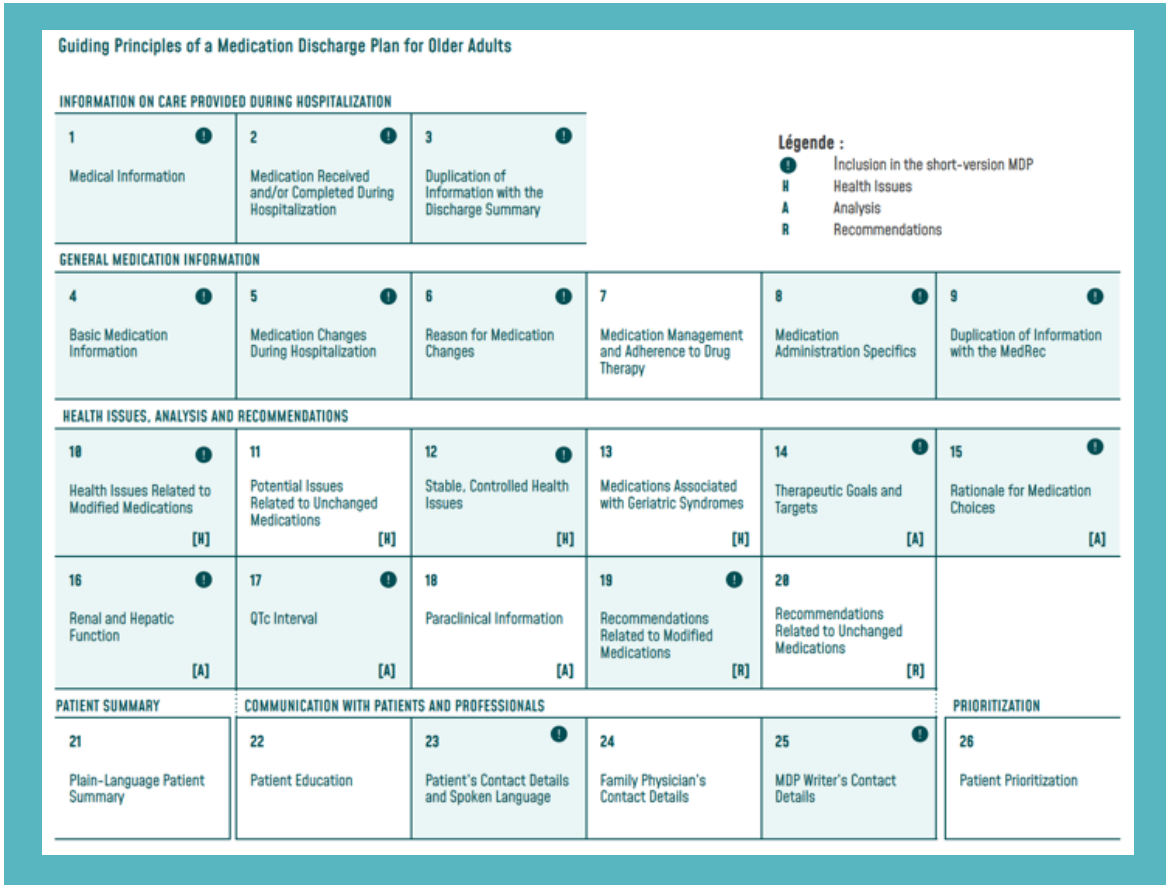
GUIDE FOR MDP DESIGN AND IMPLEMENTATION

- Available at :
- https://iugm.ca/fr/guide-transition-medication



GUIDE SECTIONS: THE 26 GUIDING PRINCIPLES

1. Information on care provided during hospitalization
2. General medication information
3. Health issues, analysis and recommendations
4. Plain-Language patient summary
5. Communication
6. Prioritization



1. INFORMATION ON CARE PROVIDED DURING HOSPITALIZATION

1: Medical information

- Reason for admission
- Primary and secondary diagnoses
- Past medical history
- Patient length of stay
- Scheduled post-discharge medical follow-ups

2: Medication received and/or completed during hospitalization

- Which therefore do not appear on the discharge prescription...
- Focus on information that could influence the management of outpatient drug therapy.

1. INFORMATION ON CARE PROVIDED DURING HOSPITALIZATION

- Reasons for admission and other information often not available for primary care
- Rx: Examples of useful information - Patient received...
  - Ceftriaxone 2 g IV x 5 days (from X to X)
  - Iron sucrose 300 mg IV x 3 doses
  - Pamidronate 60 mg IV administered on...

MEDICATION DISCHARGE PLAN

Reason for admission:	Refer to the discharge summary.
Primary diagnosis and other active diagnoses:	Refer to the discharge summary.
Medical history:	Refer to the discharge summary.

Medication received and/or completed during hospitalization:
Refer to the discharge summary. **Complete if necessary, for example: antibiotic treatments, intravenous iron, history of failed treatment attempts.**

1. INFORMATION ON CARE PROVIDED DURING HOSPITALIZATION

3: Duplication of information with discharge summary

- Avoid duplication: MDP should be transmitted with a copy of the discharge summary when available.
- Specify info #1 and #2 IF :
  - Incomplete or missing on DS
  - DS not available within a reasonable time

Practical tip = Favor sending the discharge summary.

But may be necessary until availability in shared electronic health record ...

2. GENERAL MEDICATION INFORMATION

4: Basic medication information

- Information influencing the choice of medication:
  - Allergies and drug intolerances that occurred previously or during hospitalization (and reactions if known)
  - Patient's current weight and height (and dates of measurements)
- Method of medicine packaging (vials or pillbox)
- Contact details for the patient's community pharmacy

5: Medication changes during hospitalization

- List of changes made to the patient's medication during hospitalization:
  - Drugs added or discontinued and changes in dose or dosage

9: Duplication with the Med Rec

- Avoid duplication: MDP should be transmitted with a copy of the MedRec
- Clarify/complete info #4 to #8 IF :
  - Incomplete or missing in the MedRec

2 . GENERAL MEDICATION INFORMATION (CONTINUED)

Key = Send the MedRec at the same time.
Do not duplicate information!

But adapt to the realities of each setting. Who will or will not receive the MedRec in practice?

2 . GENERAL MEDICATION INFORMATION

6: Reason for medication changes

- Reason for medication changes during hospitalization:
  - Indication for new medication or reason for discontinuation
  - Duration of treatment (if known)

- Examples of useful information:
  - Citalopram trial - not tolerated (hyponatremia)
  - Candesartan discontinued re: hyperkalemia
  - Risperidone started for severe agitation 2^{e} delirium
  - Double antiplatelet therapy x 1 year (then ASA only)
- Avoid unnecessary implicit information (e.g.: Sennosides started for constipation)

Indications and reasons for medication changes (addition, discontinuation, dose or dosage change, specific treatment duration):
Refer to the medication reconciliation.

2. GENERAL MEDICATION INFORMATION

7: Medication management and adherence

- Adherence: patient often well known from primary care team, but may fluctuate (e.g. delirium in resolution)
  - Cause of non-adherence identified ?? (visual impairment, cognition, $, ...)
- Information on management is essential, especially for non-autonomous patients or if shared management
  - Independent for pills but insulin managed by son
  - Successful self-medication trial in dispill

8: Specific precautions for medication administration

- Supplementary details regarding medication administration:
  - Tube feeding or dysphagia (ex: post-stroke)
  - Crushed tablets or opened capsules

Conversely, avoid mentioning what is already well known to the primary care team.

Medication management, administration and adherence to drug therapy:
Examples: Responsible individual's name for medication administration, tablets must be split/crushed, self-medication trial during hospitalization, potential factors that may influence adherence (e.g., cognitive or visual impairment).

3.1. TYPES OF HEALTH ISSUES TO BE ADDRESSED

10 : Health issues related to modified medications

- Choose the right health problems for a **relevant and succinct** MDP
- Address health issues related to medications **modified, started or discontinued** during hospitalization

11 : Potential issues related to unchanged medications

- Address health issues related to medications that have not been modified during hospitalization ... BUT for which a **potential problem could be the subject of future intervention.**
  - **Avoid multiple concomitant changes in geriatrics...** We can't fix everything during admission, depending on the length of stay!
  - Ex: Benzodiazepine deprescribing suggested but initiation of tapering was not appropriate in hospital

3.1. TYPES OF HEALTH ISSUES TO BE ADDRESSED

12 : Stable and controlled health issues

- In general, **DO NOT discuss** stable, well-controlled health problems whose medication has not been modified during the hospital stay.
- Less relevant and less efficient to deal with stable health issues (with unmodified treatment)
  - → The primary care team often knows even more about these problems than the hospital staff!

13 : Medications associated with geriatric syndromes

- Address medications potentially associated with geriatric syndromes:
  - Cognitive impairment, delirium, falls, denutrition/weight loss, urinary incontinence, etc.

3.2 ANALYSIS

14 : Therapeutic objectives and targets

- **Patient-specific** therapeutic goals and targets, when applicable

15 : Rationale for medication choices

- **Concise justification** of prescribed or recommended pharmacological treatments that are **not considered standard practice**

Health issue(s)	Analysis and recommendation(s)
Health issue and associated medication(s)	SOA: **Specify therapeutic goals when relevant**
	P: **Target the involved professional when relevant**
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Health issue and associated medication(s)	SOA: **Specify therapeutic goals when relevant**
	P: **Target the involved professional when relevant**

3.2 ANALYSIS

- Targets and therapeutic objectives: Mention those adapted to the patient rather than the generally accepted targets.
  - Taking into account the patient's overall condition, frailty and preferences
    - Ex: Be able to go alone to the residence dining room
    - Ex: BP < 140/90 mmHg without orthostatic hypotension
  - Primary care team sometimes better suited to establish them
- Concise justification of treatments
  - When the situation is complex or atypical
    - Ex: High-dose antidepressant for refractory depression
  - Avoid standard information
    - Ex: Metformin started as first-line treatment for type 2 diabetes

3.2 ANALYSIS

16 : Renal and hepatic function

- Estimation of renal function (GFR)
- Severity of cirrhosis (Child-Pugh classification) if applicable

17 : QTc interval

18 : Paraclinical information

- QTc interval IF this information is **deemed relevant**
- **Relevant** exam results (e.g. laboratory tests, medical imaging) performed during hospitalization and **related to medication**

- Laboratories and imaging :
  - Do not duplicate information available in provincial/national EHR... But relevant to highlight a particular result (Close follow-up recommended)
  - Specify relevant information **not found** in provincial EHR (e.g. gastroscopy)
  - Consider if patient refused access to his/her provincial EHR (if patient agrees)

3.3 RECOMMENDATIONS

19 : Recommendations related to modified medications

- Include pharmacological recommendations
  - For health issues related to medications modified, initiated or discontinued during hospitalization.
  - With associated efficacy and safety monitoring

20 : Recommendations related to unchanged medications

- For whom a **potential problem** has been identified during hospitalization.

Prioritize if multiple suggestions !

Health issue(s)	Analysis and recommendation(s)
Health issue and associated medication(s)	SOA: **Specify therapeutic goals when relevant**
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3.3 RECOMMENDATIONS

- Allows to add follow-up information for drugs related to problems that are **still active.**
- Give priority to...
  - Reassessment required within a **short timeframe (risk or instability)**
  - Specify follow-up time
  - Medium- or long-term follow-up less essential to mention
    - Primary care professionals are generally in a position to determine these routine follow-ups and the appropriate timing.
- For potential problems :
  - Ex: Four-month weaning plan not started during hospitalization for patient at risk of falling
  - Consider as suggestions > recommendations (Respect autonomy of primary care team)
  - In some cases, it may be appropriate to raise a problem without precise recommendations (especially if the information available to the hospital is incomplete).

4. PLAIN-LANGUAGE PATIENT SUMMARY

21: Plain-language patient summary

> The MDP should include a section for the patient summarizing in layman's terms relevant information about medication changes that have occurred during hospitalization as well as pharmacological recommendations.

- 40-80% of medical information communicated by professionals is immediately forgotten...
  - Written support required!
- Older adults reported that access to medical notes helped them remember the care plan and why medications were prescribed.
  - < 5% worried or confused by reading these notes
- Tip: If hospitalization is long and complex, target what is most relevant
- If moderate to severe cognitive impairment: Refer to caregiver

Naughton CA. Pharmacy (Basel). 2018;6(1). doi: 10.3390/pharmacy6010018 35.
DesRoches CM et al. J Am Geriatr Soc. 2021;69(12):3497-506.

5 : COMMUNICATION WITH PATIENTS AND PROFESSIONALS

22 : Patient education

- Patient education during hospitalization
- **Format** of information transmitted (written and/or verbal)

23 : Patient's contact details and spoken language

- In the event that the patient is taken on by a **new pharmacy or care team**
- Specify language if neither French nor English

24 : Family physician/NP's contact details

- Family doctor or NP responsible for the **medical follow-up related to the patient's drug therapy**.
- FMG pharmacist if known/involved

25 : MDP writer's contact details

- Name and contact details of the writer**(s).**

MDP - SHORT VERSION

- What to prioritize if resources or time are limited?
- 17 of the 25 guiding principles (including 3 automatic ones)

Guiding Principles of a Medication Discharge Plan for Older Adults

INFORMATION ON CARE PROVIDED DURING HOSPITALIZATION

1 ! Medical Information	2 ! Medication Received and/or Completed During Hospitalization	3 ! Duplication of Information with the Discharge Summary

Légende :
! Inclusion in the short-version MDP
H Health Issues
A Analysis
R Recommendations

GENERAL MEDICATION INFORMATION

4 ! Basic Medication Information	5 ! Medication Changes During Hospitalization	6 ! Reason for Medication Changes	7 Medication Management and Adherence to Drug Therapy	8 ! Medication Administration Specifics	9 ! Duplication of Information with the MedRec

HEALTH ISSUES, ANALYSIS AND RECOMMENDATIONS

10 ! Health Issues Related to Modified Medications [H]	11 Potential Issues Related to Unchanged Medications [H]	12 ! Stable, Controlled Health Issues [H]	13 Medications Associated with Geriatric Syndromes [H]	14 ! Therapeutic Goals and Targets [A]	15 ! Rationale for Medication Choices [A]
16 ! Renal and Hepatic Function [A]	17 ! QTc Interval [A]	18 Paraclinical Information [A]	19 ! Recommendations Related to Modified Medications [R]	20 Recommendations Related to Unchanged Medications [R]	

PATIENT SUMMARY	COMMUNICATION WITH PATIENTS AND PROFESSIONALS				PRIORITIZATION
21 Plain-Language Patient Summary	22 Patient Education	23 ! Patient's Contact Details and Spoken Language	24 Family Physician's Contact Details	25 ! MDP Writer's Contact Details	26 Patient Prioritization

26: PATIENT PRIORITIZATION

When prioritizing patients for the writing of an MDP, it is recommended to consider both medication-related and non-medication-related criteria. Priority should be given to patients who meet both types of criteria.

Figure 1: Prioritization Criteria to Identify Patients Who May Benefit Most from an MDP When Human Resources Are Limited

Non-medication-related criteria	Medication-related criteria
• Hospitalized in the last 30 days, or 2 hospitalizations in the last 6 months • Multiple concurrent medical conditions (≥ 4 comorbidities) • Major neurocognitive disorder • Frailty[a] • Fall-related admission • Delirium during hospital stay • Socially isolated (living alone and without social support) • Loss of autonomy	• Hospitalization related to adverse drug reactions • High-risk polypharmacy (≥ 10 medications[b] with ≥ 1 high-risk medication[c]) • Use of potentially inappropriate medications[d] • Complex medication regimen[e] • History of non-adherence to medication in a patient who manages their own medication • Medication with variable, increasing or decreasing dose • Polypharmacy (≥ 15 medications[b])

FORMAT - MDP

- The MDP can be presented in various formats:
  - As a separate document, distinct from other records
  - Integrated into the MedRec at discharge
  - Integrated into the DS in collaboration with the medical team
  - Integrated into different documents based on the specifc requirements of your practice and care setting
- Aim not to exceed 2 pages
- Writing the MDP is not restricted to the pharmacist
  - Encourage collaborative work with the medical team

REMEMBER!
Advocate for a precise and concise MDP, tailored to the patient's condition and needs.

TRANSMISSION - MDP

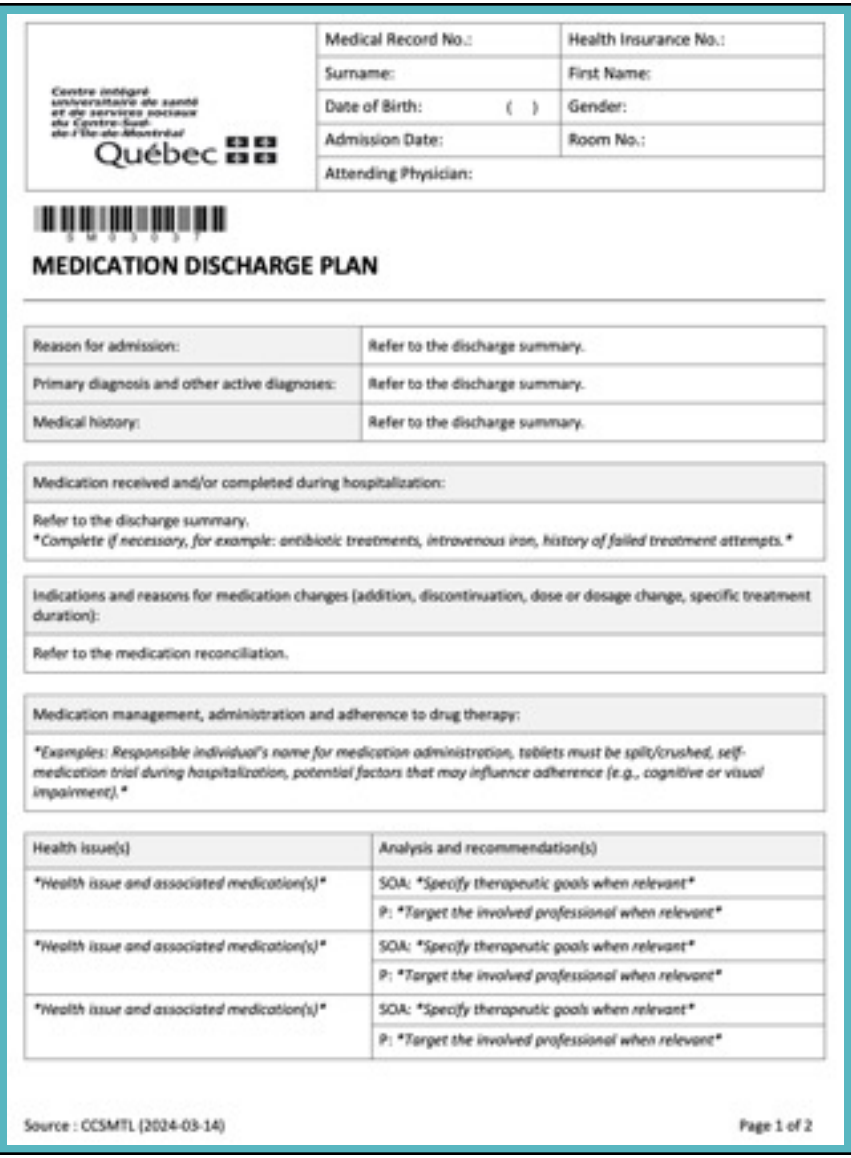
- Many professionals are involved in the transition of care and should have access to the MDP
  - Physician, community pharmacist, FMG pharmacist, specialized nurse practitioner, specialist physician and next healthcare team in the event of an inter-institutional transfer
  - The patient or caregiver should be given a copy
- Confirm the patient's agreement before its transmission, unless it is already covered by a general agreement for care upon hospital admission
- Email (if secure), fax, using the patient or caregiver as an intermediary, and ultimately, whenever possible, a secure shared electronic platform
- The MDP should be sent at the time of discharge, otherwise within 24 to 48 hours.

DEVELOPING A TEMPLATE-MDP

- Group discussion about each guiding principle (GP) based on the specifc requirements of your practice and care setting
  - Decide where each GP should be found
    - MedRec (e.g., reason for medication changes)
    - DS (e.g., reason for admission and medical history)
    - MDP (most of the others GPs)
- Develop a template-MDP by integrating the preceding reflection

IMPLEMENTING AN MDP

EXAMPLE OF A TEMPLATE-MDP



Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal
Québec

	Medical Record No.:	Health Insurance No.:
	Surname:	First Name:
	Date of Birth: ( )	Gender:
	Admission Date:	Room No.:
	Attending Physician:	

MEDICATION DISCHARGE PLAN

Reason for admission:	Refer to the discharge summary.
Primary diagnosis and other active diagnoses:	Refer to the discharge summary.
Medical history:	Refer to the discharge summary.

Medication received and/or completed during hospitalization:
Refer to the discharge summary. **Complete if necessary, for example: antibiotic treatments, intravenous iron, history of failed treatment attempts.**

Indications and reasons for medication changes (addition, discontinuation, dose or dosage change, specific treatment duration):
Refer to the medication reconciliation.

Medication management, administration and adherence to drug therapy:
Examples: Responsible individual's name for medication administration, tablets must be split/crushed, self-medication trial during hospitalization, potential factors that may influence adherence (e.g., cognitive or visual impairment).

Health issue(s)	Analysis and recommendation(s)
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Source : CCSMTL (2024-03-14)

Page 1 of 2

IMPLEMENTING AN MDP

EXAMPLE OF A TEMPLATE-MDP

Medical Record No.: _____ Surname: _____ First Name: _____

Additional relevant information:
Examples: Severity of cirrhosis according to the Child-Pugh classification, relevant laboratory tests/medical imaging, QTc interval, patient education provided, spoken language (when relevant).

Summary for the patient or caregiver:
Summarize in layman's terms the points deemed relevant (e.g., certain medication changes that occurred during hospitalization, certain pharmacological recommendations).

Contact information:		
Contact person:	(*Relationship to patient*)	Contact information:
Family physician or SNP:		Contact information:

[1]SNP: Specialized Nurse Practitioner

Prepared by:
Surname and first name (in block letters): License No.:
Job title:
Signature: Date:

Contact information:

In collaboration with:
Surname and first name (in block letters): License No.:
Job title:
Signature: Date:

This document is complementary to the medication reconciliation (if available) and the discharge summary (if available). Refer to these documents for more information.

Source : CCSMTL (2024-03-14) Page 2 of 2

MDP

EXAMPLE #1

- The DS mentioned that the clonazepam withdrawal has been planned but the MDP had more details.
- The familly physician and the community pharmacist have been targeted for follow-ups.

MEDICATION DISCHARGE PLAN

Reason for admission:	Refer to the discharge summary.
Primary diagnosis and other active diagnoses:	Refer to the discharge summary.
Medical history:	Refer to the discharge summary.

Medication received and/or completed during hospitalization:
Refer to the discharge summary.

Indications and reasons for medication changes (addition, discontinuation, dose or dosage change, specific treatment duration):
Refer to the medication reconciliation.

Medication management, administration and adherence to drug therapy:
Blister pack. She is independent to manage her medication. Adherent to her drug therapy.

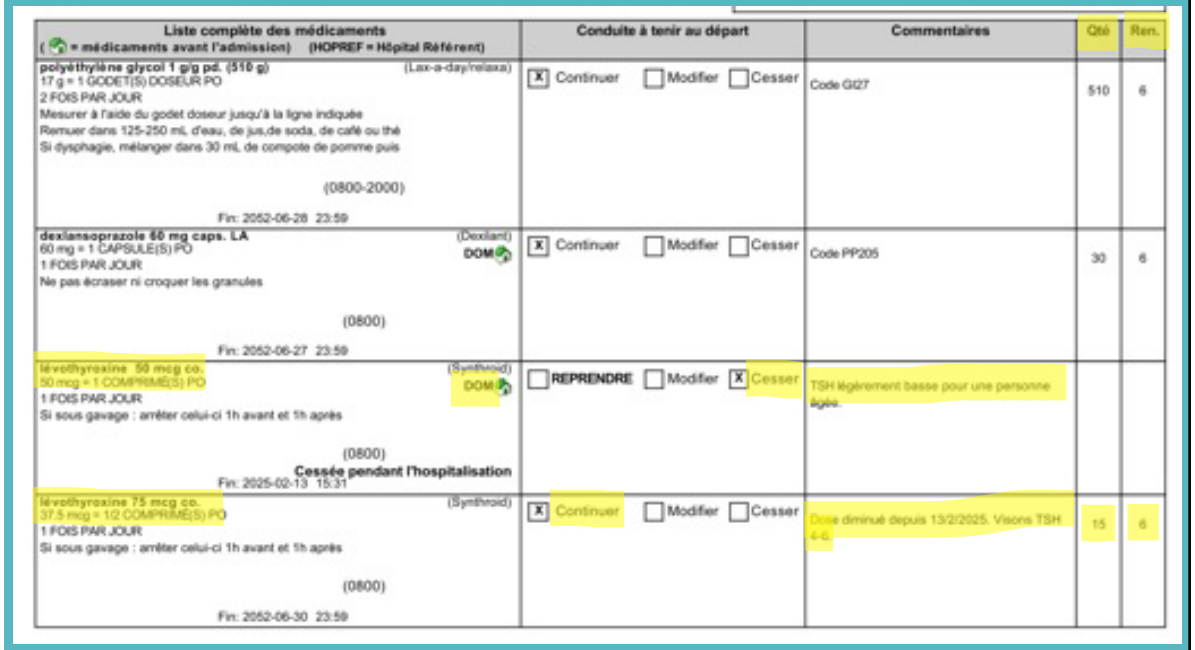
Health issue(s)	Analysis and recommendation(s)
Anxiety-depression -Mirtazapine 30 mg bedtime -Clonazepam 0,125 mg morning + 0.25 mg noon. Withdrawal started on February 2nd. See MedRec for details. Medication history -Clonazepam 0.25 mg bid at home -Aripiprazole 2 mg die. Very short-term trial at home (intolerance). Suggested by gerontospychiatrist to potentiate drug therapy.	SOA: Patient had cognitive complaints and morning fatigue. No clear symptoms of depression or anxiety. Weaning off clonazepam seemed possible. If anxiety increases, another antipsychotic may be tried. Quetiapine could be a good choice. Start with short-acting to facilitate titration, but then XR to promote tolerance and adherence.
	P: 1) Family physician: -If clonazepam withdrawal causes persistent anxiety, consider quetiapine unless psychiatry advises otherwise. Short-acting initially but XR thereafter. 2) Community pharmacist or family physician: - Follow up clonazepam withdrawal evolution to slow down withdrawal if necessary.

MDP

EXAMPLE #1

-MedRec

- Explanation in the comment box why levothyroxine has been decreased
- Levothyroxine has not been addressed in the MDP



Liste complète des médicaments (= médicaments avant l'admission) (HOPREF = Hôpital Référent)	Conduite à tenir au départ	Commentaires	Qté	Ren.
polyéthylène glycol 1 g/g pd. (510 g) (Lax-a-day/relaxa) 17 g = 1 GODET(S) DOSEUR PO 2 FOIS PAR JOUR Mesurer à l'aide du godet doseur jusqu'à la ligne indiquée Remuer dans 125-250 ml, d'eau, de jus,de soda, de café ou thé Si dysphagie, mélanger dans 30 ml, de compote de pomme puis (0800-2000) Fin: 2052-06-28 23:59	[X] Continuer [ ] Modifier [ ] Cesser	Code GI27	510	6
dexlansoprazole 60 mg caps. LA (Dexilant) DOM 60 mg = 1 CAPSULE(S) PO 1 FOIS PAR JOUR Ne pas écraser ni croquer les granules (0800) Fin: 2052-06-27 23:59	[X] Continuer [ ] Modifier [ ] Cesser	Code PP205	30	6
lévothyroxine 50 mcg co. (Synthroid) DOM 50 mcg = 1 COMPRIMÉ(S) PO 1 FOIS PAR JOUR Si sous gavage : arrêter celui-ci 1h avant et 1h après (0800) **Cessée pendant l'hospitalisation** Fin: 2025-02-13 15:31	[ ] REPRENDRE [ ] Modifier [X] Cesser	TSH légèrement basse pour une personne âgée.		
lévothyroxine 75 mcg co. (Synthroid) 37.5 mcg = 1/2 COMPRIMÉ(S) PO 1 FOIS PAR JOUR Si sous gavage : arrêter celui-ci 1h avant et 1h après (0800) Fin: 2052-06-30 23:59	[X] Continuer [ ] Modifier [ ] Cesser	Dose diminué depuis 13/2/2025. Visons TSH 4-6.	15	6

MDP

EXAMPLE #1

Additional relevant information:
Patient education on medication has been done at discharge. The patient agrees to transmit this document (MDP) and the discharge summary to the community pharmacy and the family physician.

Summary for the patient or caregiver:
Ms. XX, here is a summary of the medication changes during your stay: -We began tapering off your clonazepam gradually. We've asked the pharmacy to put it in your blister pack to facilitate gradual tapering. If you become more anxious during tapering, you may wish to discuss this with your family physician or pharmacist, as it is possible to slow down tapering if necessary. You may also want to consider a substitute molecule if your anxiety is too intense. -Dicyclomine has been discontinued as it is not effective and may cause side effects. -Acetaminophen has been added to your blister pack given your back/neck pain. -Diclofénac gel has also been added for your pain if needed. -Levothyroxine has been decreased considering the blood test. Follow-up will be done by your family doctor.

Contact information:	
Contact person: XX (Daughter)	Contact information: XX
Family physician or SNP: XX	Contact information: XX

*SNP: Specialized Nurse Practitioner

Prepared by:
Surname and first name (in block letters): XX License No.: XX
Job title: Pharmacist
Signature: XX Date: XX

Contact information: XX

MDP

EXAMPLE #2

-ASA indication was unclear, but it was preferred to let GP reassess in case information were missing.

-In this case the family physician was targeted but in another case it could be a specialist physician.

MEDICATION DISCHARGE PLAN

Reason for admission:	Refer to the discharge summary.
Primary diagnosis and other active diagnoses:	Refer to the discharge summary.
Medical history:	Refer to the discharge summary.

Medication received and/or completed during hospitalization:
Refer to the discharge summary.

Indications and reasons for medication changes (addition, discontinuation, dose or dosage change, specific treatment duration):
Refer to the medication reconciliation.

Medication management, administration and adherence to drug therapy:
She will manage her medication in vials as before. She has been offered a blister pack but refused. She seems independent when it comes to managing her medication, but follow-up may be needed temporarily when she returns home.

Health issue(s)	Analysis and recommendation(s)
Indication? -ASA 80 mg die	SOA: Acetylsalicylic acid (ASA) appears to be prescribed for primary prevention. History of uterine bleeding. Ferritin is low. Risks and benefits to be assessed. Patient not aware of ASA indication.
	P: Family physician: -Reassess indication/relevance ASA.

Additional relevant information:
Patient education on medication has been done at discharge. A reminder as needed, as she may have forgotten. The patient agrees to transmit this document (MDP) and the discharge summary to the community pharmacy and the family physician.

MDP

EXAMPLE #2

Summary for the patient or caregiver:
In summary, here are the changes of your medication: -Bisoprolol decreased -Has been stopped: hydrochlorothiazide, celecoxib, turmeric (natural product) -Addition of vitamin D -Addition of vitamin B12 (stop buying over the counter) Moreover, ASA should be reassessed (risks versus benefits) with your family doctor.

Contact information:	
Contact person: XX	Contact information: XX
Family physician or SNP: XX	Contact information: XX

*SNP: Specialized Nurse Practitioner

Prepared by:
Surname and first name (in block letters): XX License No.: XX
Job title: Pharmacist
Signature: XX Date: XX

Contact information: XX

FACILITATORS FOR THE IMPLEMENTATION OF NEW PHARMACY PRACTICES

- Training and skills development
- Organizational support
- Motivation and acknowledgement
- Using champions of change
- Adapting work processes

Auta A, et al. Int J Clin Pharm. 2015.
Haines ST, et al. J Am Coll Clin Pharm. 2022.
https://publications.msss.gouv.qc.ca/msss/fichiers/2023/23-516-04W.pdf

MDP IMPLEMENTATION - HOW TO GET THERE

- Try to have a student to support implementation and follow-ups
- Discussion with doctors
  - How do they see their collaboration
  - Where is the DS currently being drafted?
    - Avoid duplication or discrepancies
- Discussion with nurse/clerk
  - Explanation of the new document
  - Where to file it?
  - Who to transmit it to?
  - How to communicate instructions related to the transmission of the MDP?

MDP IMPLEMENTATION - HOW TO GET THERE

- Process established at IUGM for the MDP
  - We have access to the directory of DS currently being drafted.
  - The MDP currently being drafted is filed in the same directory as the DS.
  - The physician is notified when the pharmacist plans to do a MDP.
  - Patient/caregiver consent obtained by pharmacist and documented in the MDP
    - Don't forget to present the MDP to the patient, especially as this information concerns him or her.
  - The completed MDP is filed in the patient's record in the same section as the DS.
  - The pharmacist prescribes in the patient's record to whom the MDP should be transmitted
  - A copy of the MDP will be placed in the patient's package at discharge, and the original will be kept in the patient's record.
  - Submit the MedRec and DS with each MDP transmission

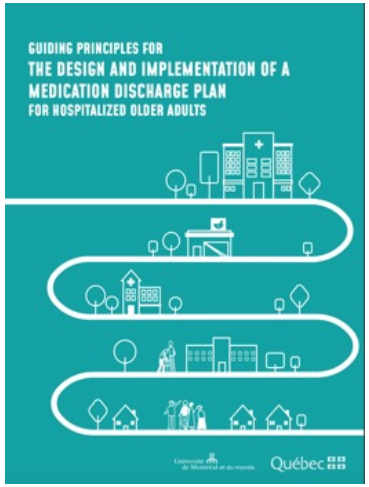
MDP IMPLEMENTATION - HOW TO GET THERE

- Discussion with pharmacists
  - Initial MDP training
  - During implementation, present MDPs to exchange, influence and motivate each other
  - Finding solutions to the challenges you face
- Elements for motivation
  - Keep it simple at first
  - It's better to communicate 1-3 key elements than to be too exhaustive
  - Trust yourself to target the right patients/problems
  - Primary care staff generally know their patients
    - You can name a potential problem without a precise plan
    - Simple problems don't need to be addressed
  - Don't wait at discharge to start preparing the MDP or target the issues to be addressed

MDP IMPLEMENTATION - HOW TO GET THERE

- Try to do audits to feed discussions at follow-up meetings
  - DS: Duplicating or conflicting information?
  - MDP:
    - Examples: number, sections filled, type of problems
  - Transmission: Is it faxed?
- Verify the perception of physicians and nurses/clerks during implementation
- Modify if necessary
  - The Template-MDP
  - The process

CONCLUSION



- The purpose of the MDP is to promote the coordination and continuity of the patient's drug therapy during the transition of care.
- The guiding principles of the practical guide have been developed to streamline the design and implementation of the MDP
- Developing your MDP
  - Adapt it to your setting
  - Keep it simple at first
  - Provide support and follow-ups after implementation

Have you developed an MDP?

Share it with us so we can publish it on our website!

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