WHAT PATIENTS AND MEMBERS TOLD US ABOUT PATIENT CARE

A REPORT OF SURVEYS CONDUCTED IN THE FALL OF 2017
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Executive Summary

CSHP’s Excellence in Hospital Pharmacy program is a multi-year program designed to foster excellence and innovation in patient care. It supports hospital pharmacy teams in their provision of exceptional patient care, which in turn should result in improved patient health outcomes.

Patients are our focus.

Excellence is founded on three priority themes: Patient-Centred Care, Best Practice, and Communication and Collaboration.

In November 2017, the Excellence program surveyed patients and CSHP members to learn how the Excellence themes are presently being reflected in the care being provided to patients by hospital pharmacy teams.

This report outlines the survey results by respondents (patients and CSHP members) and is divided into sections according to the Excellence themes.

Highlights of what we heard:

- Patients told us that they want to be included in decisions around their medications and their care. They would like the hospital pharmacy team to provide additional education about their medications.

- Forty-seven per cent (47% or 103/217) of member respondents chose “The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient’s goals”, as a top priority.

- Twenty-nine per cent (29% or 57/196) of member respondents reported developing pharmaceutical care plans for greater than 75% of patients; however, only 5% (4/80) report having achieved this target at an organizational level.

- Fifty-seven per cent (114/199) of member respondents reported working in an advanced practice role.

Survey results suggest that there is a need to focus on engaging the hospital pharmacy team in achieving a better understanding of the information and services that patients want and the means by which patients wish to receive that communication.

Based on these findings, the Excellence program will next suggest step-wise, realistic and ideal targets for Excellence priority theme measures. In addition, the program will provide practice recommendations and develop tools and services to assist members in achieving these goals.

“Patients need to be part of the plan. Expectations, life style, economics are all important factors around whether a plan will work. Sometimes what we, in health care, perceive as the most important may not matter at all to the client (patient) and family.”
Introduction

About Excellence

Patients are our focus.

CSHP’s Excellence in Hospital Pharmacy program unites CSHP members through engagement in 15 measures, 6 principles, 3 themes and one reason: improving patient health outcomes.

Three Themes:

1. Patient-Centred Care
   - The pharmacy team views patients as valuable, effective partners in shared decision-making.
   - The pharmacy team listens to, understands, and respects the patient’s story about experiences and expectations that will affect the use of medications.

2. Best Practice
   - The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient’s goals.
   - The pharmacy department implements risk-reduction strategies to improve the safety of the medication-use system.

3. Communication and Collaboration
   - The pharmacist develops and assesses the pharmacy care plan in collaboration with other members of the health care team.
   - The pharmacist communicates the plan of care to the professionals who will assume responsibility for care of the patient at care transitions.

Six Principles and Fifteen (15) Measures:

Listens: The pharmacy team listens to, understands, and respects the patient’s story about experiences and expectations that will affect the use of medications.
   - Extent of patient-reported communication with the pharmacy team.
   - Extent of patient-reported satisfaction with their interactions with the pharmacy team.

Cares: The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient’s goals.
   - Proportion of patients for whom a pharmacist has developed and initiated a pharmacy care plan. (cpKPI1)
   - Proportion of patients who receive education from a pharmacist about their disease(s) and medication(s) during their hospital stay. (cpKPI2)
   - Proportion of patients who receive medication education from a pharmacist at discharge. (cpKPI3)
   - Extent of patient-reported involvement in care decisions.
**Implements:** The pharmacy department implements risk-reduction strategies to improve the safety of the medication-use system.
- Implementation of medication system-risk reduction strategies.
- Evaluation of the impact of medication system risk-reduction strategies.

**Collaborates:** The pharmacist develops and assesses the pharmacy care plan in collaboration with other members of the health care team.
- Proportion of patients who receive comprehensive direct patient care from a pharmacist working in collaboration with the health care team. (cpKPI\(^1\))
- Proportion of patients for whom a pharmacist participates in interprofessional patient care rounds to improve medication management. (cpKPI\(^2\))
- Proportion of pharmacists whose practice includes advanced practice roles.

**Communicates:** The pharmacist communicates the plan of care to the professionals who will assume responsibility for care of the patient at care transitions.
- Proportion of patients whose plan at transition of care is communicated to the appropriate health care provider.
- Proportion of patients who receive documented medication reconciliation at discharge (as well as resolution of identified discrepancies), performed by a pharmacist. (cpKPI\(^3\))

**Values:** The pharmacy team views patients as valuable, effective partners in shared decision-making.
- Presence of patient experience advisors participating on at least one pharmacy committee.
- Implementation of tools for staff and leadership that include expectations regarding patient-centred care.

**The Survey**

In November 2017, the CSHP *Excellence* program surveyed patients and CSHP members to evaluate how *Excellence* themes are presently being reflected in the care being provided to patients by hospital pharmacy teams. CSHP invited members to participate in an online survey (using Simple Survey) – we reached out to members by utilizing the CSHP eBulletin and by way of e-announcements. The patient survey was distributed with assistance from pharmacy leaders across Canada who circulated the survey to respective patient experience advisor groups. As well, CSHP reached out to various national patient groups. Both surveys were open for approximately one month.

The online survey produced 54\(^1\) responses from patients (or their caregiver) and 368 responses from CSHP members. This report outlines the survey results by category of respondent and is divided into sections based on *Excellence* themes.

All responses are included in this report. This is in recognition of the value the *Excellence* program places on the input of patients and CSHP members. It represents as well, an effort to respect all responses and determine relevant future action to successfully address needs. The body of the report provides summary information: additional (sub-group) analysis can be provided upon request. All requests for additional information about the survey should be submitted to CSHP.

\(^1\) The figures presented herein (# of patient and member respondents) are slightly different than what was presented in the survey report infographic due to the timing that responses were received.
Section 1: What Patients Told Us

Introduction

We received 54 patient and caregiver responses.

In general, patients told us the importance of feeling included in decisions around their medications and their care. Patients would like the hospital pharmacy team to provide additional education about their medications.

Analysis of qualitative data from the survey suggests that patients would like to receive more information and education about the following:

- Medication education at the time of hospital discharge (e.g., what is new, what has been changed)
- Medication side effects – detailed information about what to expect and when to be concerned
- Whom to contact if they experience side effects
- Reason for taking the medication
- Contraindications to taking a medication
- Brand names and generic names of their medications
- Drug interactions with natural health products and supplements
- Additional written educational materials

Overall, while two-thirds (18/26) of the patients who interacted with the hospital pharmacy team were satisfied with the interactions they had, fully half of the surveyed patients were never counselled about their medications.

Respondents identified themselves as either a patient or as a family member/caregiver, and provided their province/territory of residence. The breakdown is as follows:

<table>
<thead>
<tr>
<th>Location of Care</th>
<th>Role not identified</th>
<th>Family member or other caregiver</th>
<th>Patient</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td>1</td>
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<tr>
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<td>2</td>
</tr>
<tr>
<td>Quebec</td>
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<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>4</td>
<td>15</td>
<td>35</td>
<td>54</td>
</tr>
</tbody>
</table>

“The patient is the focal point of care and one should understand the patients’ view of what they are on, what they expect and what their desire is to accept or change.”
Excellence Theme 1: Patient-Centred Care

1. The last time you stayed in the hospital or had an appointment at a hospital clinic, do you remember talking with a member of the hospital pharmacy team about your health and medications?

Although the number of respondents is small (53), these results likely reflect the general experience of patients and the overall availability of hospital pharmacy team members in the direct patient care setting. As documented in the member survey comments, many hospitals do not have pharmacists in all clinical practice areas and as so it is not surprising that less than half (41% or 22/53) of patients surveyed recall speaking with a hospital pharmacy team member during their last hospital encounter. Another point to consider is that although there is a low percentage of patients who were uncertain (4% or 2/53) about whether they spoke with a hospital pharmacy team member, there may be opportunities to improve on this measure by increasing patient awareness of the hospital pharmacy team’s role, particularly for activities performed during transitions of care such as medication reconciliation and education.
2. If yes (patients remembered talking with a member of the team), were you satisfied with the conversations you shared with members of the hospital pharmacy team?

This is a positive result showing that the hospital pharmacy team is meeting patient expectations in the majority of cases. Seventeen of the 25 patients (68%), were satisfied with their interaction with the hospital pharmacy team. An important next step may include validating this measure by asking patients to define specific expectations related to the hospital pharmacy team interactions. This could confirm that the activities and interventions provided by the hospital pharmacy team are meeting patient expectations. Patient comments suggest that there are a variety of reasons why they are not satisfied with the hospital pharmacy team conversations.

“The pharmacist understood our query and made sure we got our answer. It was about which medications we were to avoid versus which were OK to take.”

3. Did the hospital pharmacy team treat you with courtesy and respect?
This measure is an important parameter to ensuring patient satisfaction and making patients feel like equal partners in care. The result is encouraging (with none reporting a negative experience). This measure is also a promising predictor of success for members’ goals to implement patient advisors on pharmacy committees and tools for staff that include expectations regarding patient-centred care.

Excellence Theme 2: Best Practice

1. During your hospital stay or appointment, were you involved in decisions about any of your medications – those prescribed at the time or those you were taking before your admission or appointment?

Almost half (44% or 21/47) of the surveyed patients thought that they were never involved in decisions about their medications and an additional 28% (13/47) reported only sometimes being involved. This result clearly indicates a gap in patient engagement in decision-making related to medications, which evidence suggests is a core component to achieving medication adherence.²
2. Before starting any new medication, did a hospital pharmacist tell you what the medication was for and describe possible side effects in a way you could understand?

Half of the surveyed patients (23/46) indicated that a pharmacist never counselled them before starting a new medication. This is a significant area for improvement.

“Introduce yourself as a hospital pharmacist. Show a clear understanding how my current and new medications would work together. Explain how to carefully use my new medication.”

3. When you left the hospital or clinic, did you have a clear understanding about all of your prescribed medications, including those you were taking before you came to the hospital?

More than half (59% or 27/46) of the responses indicated that the patient (or caregiver) had a clear understanding of their medications at discharge. Although this question does not specify the involvement of a hospital pharmacy team member in medication education at discharge, it is an encouraging result. Data from the Canadian Institute for Health Information (CIHI) suggests that 1 in 11 patients are re-admitted to hospital within one month of
discharge costing the health care system in Canada over 1.8 million dollars annually. A significant proportion of these readmissions are related to medication errors.

Given the response to question 2 (above) further evaluation to identify the hospital pharmacy team involvement in medication education/review on discharge is warranted.

“Clearer directions about what medication to continue to take after discharge in light of any new prescriptions given at discharge. Though the pharmacist was an active part of the team, we did not see her for this prior to discharge.”

Excellence Theme 3: Communication and Collaboration

1. During your hospital visit, did you feel that there was good communication about your medications between the hospital pharmacy team, doctors, and nurses?

These results suggest that 67% (33/49) of respondents could not say there was good communication between health care providers. Although these results may not be generalized across all practice areas, understanding that a patient’s experience when he or she receives health care is integral to improving patient-centred care and health outcomes, there may also reflect a lack of integration of the patient and caregiver as members of the health care team. A shared decision-making model may offer the patient an opportunity to observe and understand interdisciplinary collaboration and communication.
2. After you left the hospital, did you feel that there was good communication about your medications between the hospital pharmacy team, doctors, nurses, and your local pharmacy?

The results were tied between good (32% or 16/50) and poor (32% or 16/50) communication. Again, with the understanding that the patient may not be completely aware of existing interprofessional communication, the results speak to the need for patients to experience or witness good communication, which they will perceive as a part of patient-centred care resulting in a positive patient experience. Effective communication at discharge or transition of care is vital to ensure patient safety. Evidence suggests that up to 23% of hospital discharged patients experience at least one adverse event following discharge with 72% being adverse drug events. This risk has prompted a multi-incident analysis of medication incidents associated with hospital discharge by the Institute for Safe Medication Practices Canada utilizing data from the Community Pharmacy Incident Reporting Program (April 2010-Dec 2014).
Section 2: What CSHP Members Told Us

Introduction

We received 368 responses from members (Members and individual Supporters) of CSHP.

CSHP members told us:

- These are their top 2 principles of Excellence:
  1. “The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient’s goals” (Chosen by 47% [103/217] respondents)
  2. “The pharmacist develops and assesses the pharmacy care plan in collaboration with other members of the health care team” (Chosen by 43% [92/214] respondents).

- A minority of staff member respondents (28%) said that more than 50% of patients under their care receive education about their diseases/medications during their hospital visit (56/197 respondents) or at discharge (55/196 respondents).

- The majority of respondents (57% or 114/199) reported working in an advanced practice role.

- Sixty-eight per cent (68% or 54/79) of management staff said their organization has evaluated the impact of medication system risk reduction strategies.

- Only 27% per cent (21/78) of management staff indicated that more than 50% of patients at their organization receive comprehensive direct patient care from a pharmacist working in collaboration with a health care team.

In some areas, we asked similar, related questions to both staff pharmacists and pharmacy management, with some interesting results. They include:

- Staff pharmacists tended to rank the percentage of patients for whom they provide bundled services as higher versus the responses from pharmacy management. This makes sense, as staff pharmacists would be reporting on their individual experiences, whereas pharmacy managers would be reporting on their entire department or organization.

- Forty-eight per cent (48% or 77/162) of staff pharmacists were unsure if patient experience advisors were present on pharmacy committees, versus only 7% (5/71) of pharmacy managers and clinical coordinators. This suggests a need to better educate staff pharmacists about the role and availability of patient experience advisors.

- Twenty-nine per cent (29% or 57/196) of staff respondents currently report developing pharmaceutical care plans for greater than 75% of patients; however, only 5% (4/80) report achieving this target at the management level. This suggests that there is a desire to provide these services, but a lack of resources is preventing further uptake.
For the survey, respondents identified themselves by province/territory, title, facility type, bed size and years of experience. Selected demographic information follows:

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<th>Province/Territory</th>
<th>Percentage</th>
<th>Count</th>
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</tr>
<tr>
<td>Alberta</td>
<td>17%</td>
<td>61</td>
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<td>Saskatchewan</td>
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<tr>
<td>Manitoba</td>
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<td>16</td>
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<tr>
<td>Nova Scotia</td>
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<td>Prince Edward Island</td>
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<td>9</td>
</tr>
<tr>
<td>Newfoundland and Labrador</td>
<td>5%</td>
<td>20</td>
</tr>
<tr>
<td>Northwest Territories</td>
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<td>2</td>
</tr>
<tr>
<td>Did not disclose</td>
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</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td><strong>100%</strong></td>
<td><strong>368</strong></td>
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<table>
<thead>
<tr>
<th>Position</th>
<th>Percentage</th>
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<td>Management</td>
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<tr>
<td>Director</td>
<td>8%</td>
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<tr>
<td>Manager of Pharmacy</td>
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<tr>
<td>Clinical Coordinator</td>
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<td>53</td>
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<tr>
<td><strong>Total Management</strong></td>
<td><strong>32%</strong></td>
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</tr>
<tr>
<td>Staff</td>
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<tr>
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<tr>
<td>Pharmacy Resident</td>
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<td>3</td>
</tr>
<tr>
<td>Pharmacy Student</td>
<td>1%</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td><strong>67%</strong></td>
<td><strong>247</strong></td>
</tr>
<tr>
<td>Did not disclose</td>
<td>1%</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total Respondents</strong></td>
<td><strong>100%</strong></td>
<td><strong>368</strong></td>
</tr>
</tbody>
</table>

“I think our key role is the provision of patient-centred pharmaceutical care in collaboration with the patient and the health care team.”
Excellence Theme 1: Patient-Centred Care

1. Does your pharmacy department have patient experience advisors on at least one pharmacy committee, working group or team?

![Staff/Management Responses Chart]

These results represent a reasonable reflection of the current early level of patient engagement in a planning or decision-making capacity on hospital pharmacy committees and working groups, whereby 28% (66/238) said they have a patient experience advisor. This result may be related to the complexity of navigating hospital policy prior to engaging patients in quality improvement work. The work that is being done to enable patients to become equal partners in the health care team is still emerging.

CSHP members ranked this principle #5 of six priorities.

The pharmacy team listens to, understands, and respects the patient’s story about experiences and expectations that will affect the use of medications. (Chosen by 30% [64/213] of respondents as their first or second choice.)
2. Has your pharmacy department implemented tools for pharmacy staff and leadership that include expectations regarding patient-centred care?

This survey result suggests that there is room for growth and development in setting standards related to patient engagement in hospital pharmacy practice. As well, there is a high level of staff who are unclear (38% or 90/237) on the existence of tools that support increasing awareness of the importance of patient-centered care culture, environment or practices. In addition, the majority that responded ‘unsure’ are those who practice in large facilities (> 500 beds). This suggests that there is a gap in the knowledge exchanged between pharmacists and management.

CSHP members ranked this principle #4 of six priorities.

The pharmacy team views patients as valuable, effective partners in shared decision-making. (Chosen by 31% [66/211] of respondents as their first or second choice.)
Excellence Theme 2: Best Practice

1. a) For what proportion of patients under your care have you developed and initiated a pharmaceutical care plan (PCP)?

![Staff Responses Graph]

Results suggest that pharmacy staff are not developing pharmaceutical care plans (PCPs) for the majority of patients under their care. Only 27% (22/80) of management reported that PCPs were being developed by

1. b) What is the proportion of patients at your organization for whom pharmacists have developed and initiated a pharmaceutical care plan?

![Management Responses Graph]
pharmacists for the majority of their patients. The low score may reflect a lack of extensive clinical pharmacist coverage at many hospitals in Canada.

Fifty-four (54% or 106/196) of staff respondents (representing facilities of all sizes, small and large) report that less than 50% of patients in their facility have a PCP plan initiated and developed by a pharmacist, and 5% (4/80) of management respondents report that none of their patients has had a PCP.

At the majority of organizations, less than half of patients receive a pharmacist-developed and initiated PCP. Pharmaceutical care plans are one of the eight (8) national cpKPIs\(^1\) established to advance clinical pharmacy practice. They are a valuable tool in improving patient care; however, they are a multi-step process and require ongoing follow-up. (The pharmacist is required to establish goals of therapy, make appropriate interventions, and evaluate outcomes to resolve drug therapy problems.)

**CSHP members ranked this principle #1 of six priorities.**

The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient’s goals. (Chosen by 47% [103/217] of respondents as their first or second choice.)

> “Ensuring patient involvement in care plan development and monitoring is essential to pharmacy practice.”

2. a) What proportion of patients under your care receive education from a pharmacist about their diseases(s) and medication(s) during their hospital visit?

![Staff Responses](chart.png)

<table>
<thead>
<tr>
<th># of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
</tr>
<tr>
<td>1−25%</td>
</tr>
<tr>
<td>26−50%</td>
</tr>
<tr>
<td>51−75%</td>
</tr>
<tr>
<td>76−100%</td>
</tr>
</tbody>
</table>
2. b) What is the proportion of patients in your organization who receive education from a pharmacist about their diseases(s) and medication(s) during their hospital visit?

![Management Responses](image)

Qualitative data taken from the patient survey suggests that patients would like more education about medication indications and side effects. (See patient results, theme 2, question 1). Pharmacists can play an important role in improving patients’ understanding of their medications during their hospital stay.

At the organizational level, very few patients are receiving education about their medications from a pharmacist during their hospital stay; 86% (86/80) of management respondents (representing facilities of all sizes, small and large) say they have only been able to provide in-hospital education about patients’ disease(s) and medication(s) to less than 50% of patients. Of hospitals with more than 200 beds, 14% (20/147) of staff respondents reported that between 76 and 100% of their patients receive education about their disease(s) or medication(s) during their hospital stay.

This is an ideal role for the hospital pharmacy team to play. Qualitative data from the patient survey suggests that patients wish to be more involved in care decisions. Providing patient education at the time of the medication change, rather than waiting until the time of discharge, could result in the patient being more involved in their care and improve the patient’s understanding of their medications. Response rates to this question may suggest a lack of pharmacy resources for inpatient units, and/or that other clinical pharmacy activities are being prioritized over patient education during hospital visits.

“At this point in time, our resources on the distribution side outweigh our clinical resources which naturally leads to a focus on distribution activities.”
3. **a)** What proportion of patients under your care receive medication education from a pharmacist at discharge?

**Results** suggest that less than half of patients are receiving medication education from a pharmacist at discharge. Seventy-two per cent (141/196) of staff respondents say that less than 50% of patients under their care receive medication education from a pharmacist at discharge. It should be noted that other health care professionals, such as nurses and physicians, are involved with medication reconciliation at discharge and therefore may also be involved with medication education at discharge.

**Staff Responses**

<table>
<thead>
<tr>
<th># of patients</th>
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<th>1–25%</th>
<th>26–50%</th>
<th>51–75%</th>
<th>76–100%</th>
</tr>
</thead>
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**Management Responses**

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<th># of patients</th>
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<th>1–25%</th>
<th>26–50%</th>
<th>51–75%</th>
<th>76–100%</th>
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<tbody>
<tr>
<td>Total count</td>
<td>78</td>
<td>6</td>
<td>47</td>
<td>17</td>
<td>6</td>
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</table>
Qualitative data from the patient survey suggests that patients would like to know about changes to their medications at the time of discharge. Because discharge from hospital usually brings multiple changes to a patient’s medication regimen, pharmacists should be providing medication education to patients at discharge. Providing discharge medication counseling as part of the patient care bundle – including medication reconciliation, attending patient care rounds, identifying and resolving drug related issues – has been shown to improve the quality of medication use and reduce 3-month readmission rates for certain patient groups admitted to internal and family medicine teams.4

The majority of management respondents (about 90% or 70/78), say that less than half of patients are receiving education from a pharmacist about their disease(s) and medication(s), both during their hospital stay and at discharge. A national strategy to improve the provision of patient education from the hospital pharmacy team may help to address this.

“Right now the patients in my clinical area are not receiving pharmacist education (maybe only 1%). I think we need to be proactively developing these care plans to monitor patients and educate them more appropriately. I think this should be done in collaboration with community pharmacists and other health care professionals at transitions of care...a known time that patients are at high risk for errors/incidents.”

4. Considering the extent of your whole organization, has your pharmacy department evaluated the impact of medication system risk reduction strategies?

Survey results suggest that over half of hospital pharmacy management have evaluated the impact of medication system risk reduction strategies. The majority of those who indicated that their department does not evaluate the impact of medication system risk reduction strategies, are those in larger facilities of >500 beds (24%). Sixty-eight (68% or 54/79) of respondents who reported that their hospital pharmacy department has evaluated the impact of medication management risk reduction strategies were from hospitals of greater than 200 beds.

These are encouraging results, indicating that most hospital pharmacy departments are using medication system risk reduction strategies, and they are engaging in quality improvement activities by evaluating processes at their organization.
CSHP members ranked this principle #3 of six priorities.

The pharmacy department implements risk-reduction strategies to improve the safety of the medication-use system. (Chosen by 33% [71/218] of respondents as their first or second choice.)

“Robotic medication preparation, tallman lettering, drug interaction checker and special labelling for high alert drugs.”

5. Considering the extent of your whole organization, has your pharmacy department evaluated the impact of patient care risk reduction strategies?

![Management Responses](chart.png)

Fewer hospital pharmacy managers indicated that their department was evaluating the impact of patient care risk reduction strategies (60% or 45/75) versus medication system risk reduction strategies, and 16% (12/75) said they were not evaluating these strategies. Nearly a quarter of the 75 hospital pharmacy managers who responded (24% or 18/75) were unsure if their department was evaluating the impact of such strategies, such as de-prescribing, falls prevention, antimicrobial stewardship.

Where these patient care risk reduction strategies may involve other stakeholders besides hospital pharmacy, evaluation of the initiatives would not be the sole responsibility of the hospital pharmacy department. This may account for the increased number of “unsure” responses as opposed to the same number in the question on medication system risk reduction strategies, which would fall almost exclusively under the hospital pharmacy department’s responsibilities.

“De-prescribing, antimicrobial stewardship program and falls prevention.”
Excellence Theme 3: Communication and Collaboration

1. a) What is the proportion of patients under your care who receive comprehensive direct patient care from a pharmacist working in collaboration with the health care team?

![Staff Responses Diagram](image)

- None: 21
- 1–25%: 32
- 26–50%: 23
- 51–75%: 25
- 76–100%: 91

1. b) What is the proportion of patients at your organization who receive comprehensive direct patient care from a pharmacist working in collaboration with a health care team?

![Management Responses Diagram](image)

- None: 7
- 1–25%: 28
- 26–50%: 22
- 51–75%: 15
- 76–100%: 6
Less than 50% of patients receive comprehensive direct patient care from a pharmacist. Sub-group analysis indicates that 47% (91/192) of respondents who identified as a pharmacist provide patients with comprehensive direct patient care in collaboration with the health care team to 76-100% of their patients.

Management reports that only 8% (6/78) of patients in their organization receive comprehensive direct patient care from a pharmacist working in collaboration with a health care team.

“My organization has increased pharmacist staffing in high risk patient populations (as a patient care risk reduction strategy).”

2. a) For what proportion of patients under your care do you participate in interprofessional patient care rounds to improve medication management?

<table>
<thead>
<tr>
<th># of patients</th>
<th>None</th>
<th>1−25%</th>
<th>26−50%</th>
<th>51−75%</th>
<th>76−100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
<td>24</td>
<td>25</td>
<td>22</td>
<td>27</td>
<td>100</td>
</tr>
</tbody>
</table>
2. b) What is the proportion of patients at your organization whom a pharmacist participates in interprofessional care rounds to improve medication management?

![Management Responses](image)

The results indicate that 51% (100/198) of staff are participating in interprofessional patient care rounds to improve medication management for greater than 75% of patients under their care. However, only 8% (8/79) of management responses reported having staff pharmacists participating in interprofessional patient care rounds for greater than 75% of their patients.

CSHP members ranked this principle #2 of six priorities.

The pharmacist develops and assesses the pharmacy care plan in collaboration with other members of the health care team. (Chosen by 43% (92/214) of respondents as their first or second choice.)

"Pharmacists need to be given protected time to round with the team to showcase our value. Pharmacists should be present during patient care rounds to get a more holistic picture of patients as the care plan is being developed."
3. Overall, is your work characterized by **advance practice roles/activities**?

![Staff Responses](chart)

3. Overall, is your work characterized by **advance practice roles/activities**?

4. If yes, are you practicing to full scope as per your provincial regulations?

![Staff Responses](chart)

4. If yes, are you practicing to full scope as per your provincial regulations?

A breakdown of the same information above, provided by staff years of work experience is as follows (details are included whereby the total may include a hospital pharmacy technician/assistant):

<table>
<thead>
<tr>
<th>Experience</th>
<th>Yes, fully</th>
<th>Yes, partially</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 + years</td>
<td>29</td>
<td>36</td>
<td>24 (includes 1 technician)</td>
</tr>
<tr>
<td>5–10 years</td>
<td>14</td>
<td>19 (includes 2 technicians)</td>
<td>17 (includes 1 technician)</td>
</tr>
<tr>
<td>1–2 years</td>
<td>7</td>
<td>18</td>
<td>3</td>
</tr>
</tbody>
</table>
Similar to work characterized by advanced practice, we see a downward trend in members practicing to full provincial scope as years of experience increases. Optimizing the roles of health care providers can improve patients’ access to care and maximize the efficiency of the health care system.

5. For what proportion of patients under your care are you involved in the transfer of information to other health care providers at care transitions?

<table>
<thead>
<tr>
<th># of patients</th>
<th>None</th>
<th>1–25%</th>
<th>26–50%</th>
<th>51–75%</th>
<th>76–100%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23</td>
<td>70</td>
<td>34</td>
<td>39</td>
<td>32</td>
</tr>
</tbody>
</table>

Results suggest that the majority of respondents communicate with other health care providers at care transitions for only a small number of their patients. The majority of staff pharmacists (88% or 175/198) have reported being involved in the transfer of information to other health care providers at care transitions.

Thirty-six per cent (36%) of pharmacists who had at least 5 years of experience transferred information to other health care providers at transitions for 1–25% of their patients. Only 11% of pharmacists with 10 or more years of experience did not transfer information to other health care providers at transitions.

Pharmacists can play a vital role in bridging the transfer of care to ensure medication needs are communicated and any alterations, additions, or omissions are highlighted to the necessary professionals. Regular involvement by pharmacists in the transfer of information provides an opportunity to reduce errors commonly seen in the transition between settings.

CSHP members ranked this principle #6 of six priorities.

The pharmacist communicates the plan of care to the professionals who will assume responsibility for the care of the patient at care transitions. (Chosen by 19% [41/222] of respondents as their first or second choice.)

“Transfer of accountability – if not communicated, much of the benefit of the hospitalization could be wasted. Pharmacists must be considered essential team members in the care of patients.”
6. a) What proportion of patients under your care receive documented medication reconciliation at discharge (as well as resolution of identified discrepancies), performed by a pharmacist?

![Staff Responses Chart]

<table>
<thead>
<tr>
<th># of patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>57</td>
</tr>
<tr>
<td>1–25%</td>
<td>50</td>
</tr>
<tr>
<td>26–50%</td>
<td>27</td>
</tr>
<tr>
<td>51–75%</td>
<td>23</td>
</tr>
<tr>
<td>76–100%</td>
<td>40</td>
</tr>
</tbody>
</table>

6. b) What is the proportion of patients at your organization who receive documented medication reconciliation at discharge (as well as resolution of identified discrepancies), performed by a pharmacist?

![Management Responses Chart]

<table>
<thead>
<tr>
<th># of patients</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>17</td>
</tr>
<tr>
<td>1–25%</td>
<td>36</td>
</tr>
<tr>
<td>26–50%</td>
<td>15</td>
</tr>
<tr>
<td>51–75%</td>
<td>8</td>
</tr>
<tr>
<td>76–100%</td>
<td>4</td>
</tr>
</tbody>
</table>

Results suggest that the majority of pharmacists are not consistently involved in medication reconciliation on discharge for patients under their care. Only 32% (63/197) of pharmacists provide documented medication reconciliation at discharge to more than 50% of their patients, while 29% (57/197) of pharmacists provide no documented medication reconciliation at discharge. Thirty-five per cent (14/40) of staff pharmacist respondents...
who work in a hospital of greater than 500 beds reported that they provide medication reconciliation at discharge for between 76 and 100% of their patients.

Medication reconciliation on discharge is one of the eight national cpKPIs\(^1\) established to advance clinical pharmacy practice. It provides a focus for patient care towards activities that will have positive impacts on patient outcomes. Providing medication reconciliation on discharge for inpatients under their care is a fundamental activity for pharmacists involved in clinical services.

At the organizational level, results suggest that the majority of medication reconciliation on discharge is provided by health care providers other than pharmacists, with only 15% (12/80) of management respondents reporting that medication reconciliation on discharge by pharmacists for the majority of patients. The responses to this question may also reflect a lack of extensive coverage of clinical pharmacy services for inpatient programs. While other health care providers can effectively provide medication reconciliation at discharge, pharmacists have the optimal expertise to perform this activity where they are involved in clinical inpatient services.

“If we don’t view and engage the patient as a valued member of the health care team, they are less likely to understand their medical condition(s) and medication(s) and this could increase the risk of errors and noncompliance.”

Conclusion and Next Steps

Patients told us that for the most part, they felt that they were treated with courtesy and respect by members of the hospital pharmacy team and many said they were satisfied with the conversations they had with members of the team. Patients want to be included more often in decisions around their medications and their care (only a minority said they were) and would like the hospital pharmacy team to provide more education about their medications, especially what the medication was for, and the possible side effects.

CSHP members told us what they wanted their top 2 priorities to be. Below is a chart of the principles ranked in order by the number of respondents that selected the principle as choice 1 or choice 2.

<table>
<thead>
<tr>
<th>Top Priorities</th>
<th>Ranking</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pharmacist provides proactive patient-centred care to develop a pharmacy care plan that reflects the patient’s goals.</td>
<td>#1</td>
<td>103/217</td>
</tr>
<tr>
<td>The pharmacist develops and assesses the pharmacy care plan in collaboration with other members of the healthcare team.</td>
<td>#2</td>
<td>92/214</td>
</tr>
<tr>
<td>The pharmacy department implements risk-reduction strategies to improve the safety of the medication-use system.</td>
<td>#3</td>
<td>71/218</td>
</tr>
<tr>
<td>The pharmacy team views patients as valuable, effective partners in shared decision-making.</td>
<td>#4</td>
<td>66/211</td>
</tr>
<tr>
<td>The pharmacy team listens to, understands, and respects the patient’s story about experiences and expectations that will affect the use of medications.</td>
<td>#5</td>
<td>64/213</td>
</tr>
<tr>
<td>The pharmacist communicates the plan of care to the professionals who will assume responsibility for care of the patient at care transitions.</td>
<td>#6</td>
<td>41/222</td>
</tr>
</tbody>
</table>
Other member responses:

4. A minority of staff members (28% or 56/197) said that more than 50% of patients under their care receive education about their disease(s)/medication(s) during their hospital visits or at discharge.

5. Sixty-eight per cent (68% or 54/79) of management respondents said their organization has evaluated the impact of medication system risk reduction strategies.

6. Only 27% (21/78) of management indicated that more than 50% of patients at their organization receive comprehensive direct patient care from a pharmacist working in collaboration with a health care team.

7. The majority of respondents (57% or 114/199) reported working in an advanced practice roles or activities. This is encouraging for the profession going forward, but there is still room for improvement.

Differences noted in the results obtained from staff pharmacists and pharmacy management included:

8. Overall, staff respondents tended to report providing services that comprise the eight cpKPIs\(^1\) (e.g., medication reconciliation, pharmaceutical care plan, medication education) for a higher percentage of patients versus pharmacy managers. This makes sense, as staff members would be reporting on their individual experience, whereas pharmacy managers would be reporting for a department or an organization.

- Only 29% (57/196) of staff respondents currently report developing pharmaceutical care plans for greater than 75% of patients. This drops to 5% (4/80) at the management level. This suggests that there is a desire to provide these services, but there are a lack of resources preventing further uptake.

- Forty-eight per cent (48% or 77/162) of staff pharmacists were unsure if patient experience advisors were present on pharmacy committees, versus only 7% (5/71) of pharmacy managers and clinical coordinators. This suggests a need to better educate staff pharmacists about patient experience advisors.

Based on these findings, the Excellence program will suggest step-wise, realistic and ideal targets for Excellence priority theme measures. In addition, the program will develop tools and services to assist members in achieving these goals.

“There is often a gap in engaging patients as partners in care or it is treated as a second thought in many practice areas. Respecting the experience and expectations of the patient helps the hospital pharmacy team to prioritize and streamline care strategies and ultimately impacts medication adherence which contributes to sustainable changes in patient and community health and wellness.”

Notes


3. Canadian Institute for Health Information (CIHI), 2016
Glossary

### Advanced practice roles/activities
May include the following:
- Prescribing/adapting medication orders
- Ordering diagnostic tests
- Administering diagnostic tests
- Administering injections
- Conducting physical assessment of patient, e.g., obtaining vital signs (blood pressure, pulse, blood glucose, etc.)

### Caregiver
An individual who may be a family member or any unrelated person who provides ongoing health-related care and support to another person in need.

### Comprehensive direct patient care bundle
A bundle of inter-related patient care services associated with improving meaningful patient outcomes, such as reducing hospital re-admissions. This bundle of services includes:
- Medication reconciliation on admission
- Pharmaceutical care plan and/or resolution of drug therapy problems
- Pharmacist’s participation in inter-professional care rounds
- Patient education (during hospital stay and/or at discharge)

Medication reconciliation at discharge

### Expectations regarding patient-centred care
“Expectations” regarding patient-centred care would include any criteria or operating/implementation principles within a tool, which talk about the patient at the centre of care.

### Hospital pharmacist
A person licensed to prepare, compound, and dispense drugs upon written order (prescription) from a licensed practitioner such as a physician, dentist, or advanced practice nurse. A pharmacist is a health care professional who cooperates with, consults, and advises the licensed practitioner concerning drugs, as appropriate.

### Hospital pharmacy team
The group pharmacy personnel who work together for a common goal. Such a group may include pharmacists, pharmacy technicians/assistants, pharmacy students, and pharmacy management, and others.

### Management
Any member of the hospital pharmacy team at the managerial and/or director level.

<table>
<thead>
<tr>
<th><strong>Medication reconciliation</strong></th>
<th>A formal process to ensure that accurate and comprehensive medication information is communicated consistently across transitions of care.</th>
</tr>
</thead>
</table>
| **Medication system risk reduction strategies** | Strategies to reduce the risks associated with the medication system. Such strategies may include the following:  
  - Bar coding medications  
  - Automated dispensing cabinets  
  - Robotic medication preparation or dispensing |
| **Patient education** | Education that is specific to a disease or drug and is provided in an interactive manner (e.g., face-to-face, via telephone or video) to either the patient or the patient’s agent (e.g., parent, guardian). |
| **Patient experience advisors** | Patient representatives on pharmacy department councils and committees who ensure that the patient’s perspective is considered in decision-making. |
| **Patient safety risk reduction strategies** | Strategies to reduce the risks patient are exposed to while they receive care (or awaiting care). Such strategies may include the following:  
  - Hospital pharmacy reduction strategies  
  - Recommendations from the “Choosing Wisely Canada” campaign  
  - De-prescribing  
  - Falls prevention  
  - Antimicrobial stewardship program  
  - Opioid administration and monitoring program  
  - Advanced practice roles/activities  
  - Comprehensive direct patient care bundle  
  - Health care team approach to delivering care  
  - Medication system risk reduction strategies  
  - Patient education  
  - Patient experience advisors  
  - Patient-centred care  
  - Pharmaceutical care plan |
| **Pharmaceutical care plan** | A treatment plan that involves a practitioner assuming responsibility for a patient’s drug-related needs. It involves the completion of all steps in the patient care process, specifically:  
  - Assessment of the patient (e.g., medical problems and drug therapies, which can lead to the identification of drug therapy problems)  
  - Development of a care plan  
  - Follow-up evaluations |
| **Staff** | Any hospital pharmacy team member that is not at the managerial or director level. |
What Patients and Members Told Us about Patient Care: A Report of Surveys Conducted in the Fall of 2017

Published by the Canadian Society of Hospital Pharmacists (CSHP), Ottawa, Ontario. 2018

Suggested citation:


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