Best Possible Medication Discharge Plan (BPMDP) Counselling Student Guide[1,2,3]

Note: The template provided here serves as a general guide for use but the practice educator can amend this at any time to better suit the practice environment and patient population. As approaches and resources may vary, students should always discuss their approach with the practice educator on site prior to conducting BPMDP counselling session for the first time while on practicum.

Pre-counselling Preparation

- ✓ Confirm the patient's discharge time with your practice educator and/or the physician to ensure you have adequate time for medication reconciliation and discharge counselling. This is important; as patients are eager to leave hospital once they find out they are being discharged.
- ✓ Try to schedule the counselling session as soon as the discharge date is known and medications are confirmed and at a time the patient's family/caregiver is available (if they wish to be present)
- ✓ Ensure discharge prescriptions have been prepared and confirmed with the physician, if not already done so, and that any noted discrepancies, or drug therapy problems such as medications with no appropriate indications or medical conditions with no medications have been resolved.
- ✓ Confirm that all Pharmacare (including First Nations Health Benefits Plan, Plan W), private drug plan, and special authority requests have been completed (if applicable).
- ✓ Prepare patient friendly medication list, date it, and review it with the practice educator. Once verified by practice educator, provide it to the patient/caregiver at the beginning of the BPMDP counselling session.

Counselling Session

- ✓ When reviewing the medication list with the patient and/or caregiver:
  - Review and counsel the patient on each of the discharge medications +/- devices: the purpose of each medication, how it works, onset of action, dose, timing, intended duration, adverse drug reaction's (ADR's) of all medications (with emphasis on any new medications and their intended duration).
  - Ensure you communicate the changes, particularly the changes to the home regimens the patient was on prior to hospital admission so they can make adjustments accordingly i.e. for each medication indicate the following, if applicable:
    - Medications that have CHANGED in hospital
    - Medications that are NO LONGER REQUIRED on discharge
    - Medications that are to CONTINUE on discharge
    - Medications that are NEW and to be taken on discharge
  - Counsel patient on when to seek medical care.
  - Ensure counselling on all other miscellaneous points have been completed (e.g. non-drug measures).
  - Identify any barriers to non-adherence and offer solutions, e.g. discuss blister packages/dosettes with patient and if this is something they want, document this on prescriptions that are being sent to community pharmacy.
    - To assess adherence, consider asking patient how often he/she forgets to take medications in a given week
    - Assess visual impairment, dexterity
- ✓ Ensure outpatient lab requisition is prepared and forwarded to patient (if applicable and not already done by others).
- ✓ Discuss future steps patient must take (e.g. follow-up with physician in a timely manner, which tests will be needed, etc.).
- ✓ Ask patient to return all discontinued medications to his/her own pharmacy to minimize any risk of confusion.

Summary

- ✓ Assess the patient's/caregiver's understanding by having him/her summarize the counselling points and/or demonstrate how to use the devices, if applicable.
- ✓ Summarize the main points and then ask patient/caregiver if he/she has any questions.
- ✓ Advise patient/caregiver to keep the medication list on him/her at all times and share with his/her family physician, specialist(s) or dentist at every appointment.
- ✓ Ask the patient about his/her preferred pharmacy and have the discharge prescription faxed there.
  - Advise patient/caregiver to use ONE community pharmacy to fill all prescriptions.

---

[1] Adapted with permission from the LMPS (SPH, SMH, VGH) EEF's Mutually Beneficial Activity Checklists (with contributions from Dr. M. Leung and her directed studies students March 2016)

[2] Adapted with permission from ISMP Canada. Reference: Canadian Patient Safety Institute and ISMP Canada (2017). Medication Reconciliation in Acute Care Getting Started Kit, version 4. Retrieved March 15, 2017 from: https://www.ismp-canada.org/medrec/

[3] ISMP Canada (2015). Hospital to Home – Facilitating Medication Safety at Transitions: A Toolkit for Healthcare Providers.

©Copyright 2018 UBC Faculty of Pharmaceutical Sciences, Office of Experiential Education. All Rights Reserved.

- For critical medications that should not be interrupted, call the community pharmacy to ensure they have supplies on hand.

✓ Thank patient/caregiver.

Post-Counselling

✓ Under the guidance and supervision of practice educator document service provided in the chart.

✓ If possible and where appropriate, prepare communication to GP and/or community pharmacist and provide them with a name and number to contact about any inquiries.

- Notify them of all changes that were made and document:
    - All NEW medications, including indication, intended duration and Pharmacare/non-Pharmacare special authority approval
    - All medications that are to be CONTINUED (or reassessed by GP for continuation)
    - Medications that have been switched or CHANGED (e.g. dose/frequency changes)
    - Medications that have been DISCONTINUED (include prior-to-admission medications that should be discontinued and those that were started in hospital and no longer needed)
    - Discharge monitoring plan and follow up

✓ Be available to respond to questions from patients/caregivers and/or community partners if needed.

©Copyright 2018 UBC Faculty of Pharmaceutical Sciences, Office of Experiential Education. All Rights Reserved.