Provincial Health Services Authority

MEDICATION RECONCILIATION PROCEDURE

Summary of Changes

	NEW	Previous
BC Cancer	Best Possible Medication History-Interview/Verification Guide added to Appendix	

1. Introduction

1.1. Focus

Medication Reconciliation is an inter-professional team function and ongoing process. Reducing medication adverse events is best accomplished by defining structured medication reconciliation principles and processes at Transitions in Care.

At BC Cancer, Medication Reconciliation is conducted in partnership with Patients and Families to ensure that the Medication Reconciliation documentation reflects the current use of medications and is utilized to communicate accurate and complete information about patients' medications across care transitions.

- The purpose of this procedure is to outline the steps involved during a new patient's Admission to BC Cancer ambulatory care programs, at a minimum of one point of transition including completion of care provided by BC Cancer, providers should apply a **risk assessment approach**, working with team members to identify client groups that are at most risk and likely to benefit from medication reconciliation, and at transition periods, and at Discharge.

***Note: Monthly compliance results will be completed by the regional BC Cancer centres and communicated at Quality Council and the Regional Operations Quality committee monthly.**

1.2. Health Organization Site Applicability

This is a provincial procedure that applies to all Regional BC Cancer Centres.

1.3. Practice Level

This document applies to all health care professionals and Staff that assist with forms, obtain and communicate Best Possible Medication History (BMPH), document, verify and resolve any medication discrepancies. This includes:

- Most Responsible Provider and Designated Health Care Professionals including:
  - Pharmacists and Pharmacy Technicians
  - Patient Care Aide, Health Unit Clerk, Registered Nurse, Licensed Practical Nurse
- Health Information Management (HIM)

1.4. Definitions

Admission: Refers to the process of accepting a person into a hospital, clinic (ambulatory), program, and service or treatment facility as an active patient.

Best Possible Medication History (BPMH): A medication history created using a systematic process of interviewing the patient/family/care provider and reviewing at least one other reliable source of information to obtain and verify all of the patient's medications (including prescription, non- prescription, traditional, holistic, herbal, vitamins and supplements). The BPMH includes the drug names, dosages, routes, and frequencies. It captures the patient's actual medication use, which may differ from their list of prescribed medications.

Designated Health Care Professionals (DHCP) Note: VPP Definition:

Refers to both Regulated Health Care Professionals (RHCP) and Approved Non-regulated Health Care Professionals (ANHCP).

a. Regulated Health Care Professionals: Professionals regulated by regulatory colleges under the Health Professions Act (e.g. Physicians, Midwives, Pharmacists, Nurses, and Dietitians). For complete list see BC Ministry of Health Professional Regulation.
b. Approved Non-regulated Health Care Professionals: non-regulated professionals (including students) designated through the health organizations approval process (e.g. Medical Imaging Technologists, Cardiology Technologists, Respiratory Therapists).
c. Students in Designated Health Care Professions.

Discharge: The transition point at which the Provider decides, in consultation with the patient and family that the patient will no longer be followed at BC Cancer, and all care will be transferred back to the Primary Care Provider. This can be documented as a discharge.

Family is defined by the patient. When the patient is unable to define family the patient's substitute decision maker or legal body provides the definition. Family members are the people who provide the primary physical, psychological, or emotional support for the patient. Family is not necessarily blood relatives. Family members are encouraged to be involved and supportive of the patient and integral to the overall well-being of the patient

Medication Reconciliation: Is a structured, shared process whereby healthcare professionals:

i. Identify and resolve discrepancies between best possible medication history (BPMH) and medications ordered at transition points;

ii. Engage and partner with patients, families, or caregivers (as appropriate) with, at least, one other source of information to generate the BPMH (Accreditation Canada, 2016).

iii. Document and communicate accurate up-to-date information about patient medications to the patient and their next service provider, as appropriate.

Most Responsible Provider (MRP): Refers to the Provider who has overall responsibility for the patient's care at BC Cancer.

Patient: Refers to patient, client, resident or person in receipt of healthcare.

Provider: Refers to Physicians, Nurse Practitioners, Pharmacists, Provider students (within their scope of practice), Dentists, and Registered Midwives.

Staff – Employee of BC Cancer who performs the designated steps. Employees include Health Unit Clerks, Patient Care Aides, Registered Nurses, Licensed Practical Nurses, Health Information Management (HIM) Staff, and Designated Health Care Professionals.

Transitions in Care: A set of actions designed to ensure the safe and effective coordination and continuity of care as clients experience a change in health status, care needs, health-care providers or location (within, between, or across settings). Accreditation Canada requires communication of patient information "where clients experience a change in team membership or location: admission, handover, transfer, and discharge" (Qmentum ROP Handbook 2018, page 29).

1.5. Need to Know

- Medication Reconciliation is the responsibility of the most responsible Provider for the patient or the current provider that is seeing the patient at their visit.
- The BC Cancer team provides the patient and the next care provider (i.e. Primary Care Provider or MRP, pharmacy, or home services) with the complete list of medications that have been managed by the team and that the patient should be taking following the end of service.

Ambulatory Care Medication Reconciliation occurs:

- On Admission of patients to BC Cancer at their initial ambulatory care visit.
- At a minimum of one point of transition including completion of care provided by BC Cancer.
- Providers should apply a **risk assessment approach**, working with team members to identify client groups that are at most risk and likely to benefit from medication reconciliation

- The transition point at which the MRP decides, in consultation with the patient and family that the patient will no longer be followed at BC Cancer, and all ongoing care responsibilities will be transferred back to the Primary Care Provider. This will be documented as a Discharge.
- All patient populations at BC Cancer will be evaluated as to whether or not they are required to complete medication reconciliation at transitions. Clinical judgement by a patient's health care provider may outweigh this risk assessment tool and medication reconciliation should at this time be performed if deemed necessary to reduce the risk of potential adverse drug events. Refer to **Appendix 1.**

Inpatient Medication Reconciliation occurs:

- For Inpatient Care at the Vancouver Centre, Medication Reconciliation occurs on Admission and Discharge to the inpatient unit.

1.6. Equipment and Supplies

- Ambulatory Care Medication Reconciliation Form
- Primary Care Medication Reconciliation Communication Form
- Conduct BPMH using Pharmanet

2. Procedure

2.1. Steps and Rationale

2.1.1 Patient Admission

For CST Cerner live site, click here to navigate to site 2.2 Site Specific Practices

#	Action	Role
1.	Medication Reconciliation is retrieved and placed on the new patient chart.	Health Information Management (HIM) staff
2.	Transport chart to appropriate location within each regional centre. The chart will then go to chart preparation. Place the document on the patient paper chart.	HIM Staff HUC
3.	Upon receiving chart, book appointment to complete BPMH prior to initial physician appointment (this step not at all regional centres and this step should not delay initial appointment)	HUC/Nursing/Pharmacy
4.	Provide the patient with a Medication Reconciliation form when they check in for their NP appointment.	HUC/Patient Care Aide

	Patient reviews the medication list and completes their portion of the Medication Reconciliation form.	
5	Once the patient completes the Medication Reconciliation form, place it on the patient chart for the physician.	Nurse/patient care aide
6.	Upon patient arrival to BC Cancer, complete the BPMH with the patient, collaboratively completing their portions of the form.	DHCP
7.	Review and complete and sign the Medication Reconciliation form. Address any discrepancies with the patient. Provides chart to HUC and requests pharmacy consult if necessary.	Provider
8.	Consider if a pharmacy consult should occur. A pharmacy consult is recommended for complex medication situations: a. More than 7 medications b. Targeted drugs c. Anti-retrovirals d. Anti-inflammatories e. Anti-epileptics f. Anticoagulants g. CYP3A4 drugs (inducers or inhibitors) Call Pharmacy if a consult is required and provide: • Name • BC Cancer ID Number • Urgency (if indicated)	Provider/DHCP
9.	HUC will receive the chart, including the medication reconciliation form Process the orders and fax the completed Medication Reconciliation form to CAIS at 1-604-708-2003.	HUC
10.	Review patient's medications. Re-scan the Med Rec form if there are changes made. **NOTE:** If Med Rec not yet matched in CAIS, contact HIM for urgent addition to CAIS	Pharmacy
	SUBSEQUENT VISITS (Quality Improvement Pilot Project taking place at 3 Regional Centres in Team Based Care (TBC) (Abbotsford, Surrey, and Victoria)	
11.	During or prior to subsequent ambulatory care visits on a 3-month interval, for active systemic therapy patients, the team reviews the Best Possible Medication History (BPMH) with the current medication list and identifies and documents any medication discrepancies. **(QI Pilot Project at 3 Regional Centres in TBC)** Changes/discrepancies are flagged to the Physician.	DHCP

	This applies to all BC Cancer Regional Centre for Medical Oncology only.	
12.	Review chart and if patient has not been seen for 3 months, place medication reconciliation form on chart.	Chart Prep HUC
13.	Book appointment prior to subsequent provider appointment for BPMH (this step not at all regional centres and this step should not delay subsequent appointment) ***This step applies to virtual appointments***	HUC/Nursing/Pharmacy
14.	**Complete BPMH** a. If there are no discrepancies, inform physician and place BPMH on the chart for provider to review b. If there are discrepancies, Place BPMH on chart and flag for the provider. c. Provider, follow the below steps to complete medication reconciliation.	DHCP
15.	**Refer to steps 7-10 above**	
	HOLD: CERNER sites: CST Build in progress	ON HOLD

2.1.2 Transition or Patient Leaving Against Medical Advice

Click here for Patient Transition in Care or a Patient Leaving against Medical Advice

2.1.3 Discharge

#	Action	Role
1.	a) Book DHCP in ACU prior to the patient's next visit with the provider **Rationale:** This will permit time for the DHCP to complete the Best Possible Medication History. The appointment time is provided to the patient as per standard process	Health Unit Clerk (HUC)
	b) If patient is identified for discharge just at the time of ACU clinic visit, Provider will notify care team immediately pre-clinic; write order and give order to HUC. The care team in clinic will print the Medication Reconciliation form and provide to the Provider to complete. Inform patient to wait in the waiting room. Provide the patient a copy of their medication reconciliation form before leaving	Provider/DHCP/HUC
2.	Indicate chart prep as an activity to ensure that a medication reconciliation form is available at the next visit. This will remind physician of potential discharge at next visit.	Health Unit Clerk

3.	Inform the patient of appointment time prior to physician appointment to complete their medication reconciliation form.	Health Unit Clerk
4.	Prepare chart for patient's clinic visit and print and add the Ambulatory Care Medication Reconciliation form to patient chart.	Health Unit Clerk
5.	Upon patient arrival to ACU, complete the Best Possible Medication History with the patient, collaboratively completing portions of the form.	Designated Health Care Provider (DHCP)
6.	Review and complete the Medication Reconciliation form. This includes reviewing the form for accuracy and completeness, completing any remaining discrepancies with the patient, discusses plan of care, dating and signing the form. For medications prescribed by a BC Cancer provider, the physician will indicate whether the medication should be continued, modified, or discontinued.	Provider

Refer to steps 7-9 for medication discrepancies. If no medication discrepancies, continue to step 10.

*****Refer to procedure below (I, II, III) for circumstances where the patient is not to be discharged, leaves against direction, or being transitioned to another team member or facility.**

I. **If the patient is not to be discharged**, the physician will notify the patient that this important information will be kept on file and reviewed again at a later day.
II. **If the patient leaves against direction**, Inform patient to wait in the waiting room to enable the Nurse/HUC can provide the patient a copy of their medication reconciliation form before leaving (Provider/Nurse). Mail copy to the patient.
III. **If the patient is being transitioned to another team member or facility or palliative care**: the Ambulatory Care Medication Reconciliation form is provided to the team member or returned to the facility along with the patient chart.

7.	Fax the Primary Care Medication Reconciliation Communication Form to the GP/NP together with the Ambulatory Care Medication Reconciliation form.	Health Unit Clerk
8.	Give Medication Reconciliation form, prescriptions and chart to HUC Photocopy Ambulatory Care Medication Reconciliation form and give copy to patient.	Provider Health Unit Clerk
9.	Review, complete and sign the Medication Reconciliation form.	Provider

No Medication Discrepancies: Continue to step 10.

10.	Inform patient to wait in the waiting room to enable the Nurse/HUC can provide the patient a copy of their medication reconciliation form before leaving.	Provider/DHCP
11.	HUC receives the chart, prescriptions, Primary Care Medication Reconciliation Communication form, and discharge order.	HUC
12.	Process the orders including providing a copy of the Medication Reconciliation form to the patient who should be in the waiting room.	Health Unit Clerk
13.	Fax and scan Medication Reconciliation form to CAIS	HUC/ACU Clerk/HIM
14.	Dictate the summary to the primary care provider using pertinent Medication Reconciliation standard centre specific discharge template as part of the discharge summary dictation OR Fax copy of medication reconciliation to GP or Provide patient with a copy	Provider HUC

2.2. Site Specific Practices: CST Cerner Live Sites

In CST Cerner, it is the physician responsibility to complete the Ambulatory Medication Reconciliation for patients during:

- Admission to ambulatory care
- Transfer of Care
- Discharge from BC Cancer

In CST Cerner, it is the physician's responsibility to complete the Inpatient Medication Reconciliation for patients during:

- Admission
- Transfer of Care
- Discharge from BC Cancer

To support Ambulatory Medication Reconciliation, DHCPs follow the CST Cerner Help Ambulatory Medication Reconciliation Overview.

a. Note: the "BPMH" linked topic outlines the **nursing** component – it is included at the start/overview of the help topic
b. The rest of the linked help topic outlines the **provider steps**
c. **Note regarding the nursing BPMH piece:** The last sub-topic in the help is "Finish Documenting the BPMH: (1) Click **Document History**  at the bottom-right of the page." Nurses must do this in order for "**Reconciliation Status** will change to complete, indicated by a **green check mark**. "

2.3. Documentation

Medication reconciliation will be documented on the appropriate BC Cancer forms and/or within the patient/client's paper or electronic health record (e.g. Cerner), whichever is applicable (Medication Reconciliation Policy)

Please refer to VPP Medication Reconciliation Policy for documentation inclusion requirements and documenting in Cerner.

2.4. Patient/Client Education

Patient and family education on Medication Reconciliation is provided in the "Patient Safety is # 1" Handbook. Patients and families are essential to the accurate completion of the Medication Reconciliation process and will be given information by the healthcare provider at each transition point when medication reconciliation is performed.

3. Related Documents and References

3.1. Related Documents

VPP Medication Reconciliation Policy

BC Cancer Advanced Care Planning Policy

Medication Reconciliation PowerPoint

BPMH Interview guide March 3, 2023

3.2. References

Accreditation Canada. Required Organizational Practices (2017). www.accreditation.ca

Ambulatory Medication Reconciliation Overview. (2021). CST Cerner Help. http://cstcernerhelp.healthcarebc.ca/#t=Patient_Chart%2FMedications%2FMedRec%2FAmbulatory_Medication_Reconciliation.htm&rhsearch=reconciliation&rhsyns=%20

Canadian Patient Safety Institute and Institute for Safe Medication Practices Canada (2011). Medication Reconciliation in Acute Care: Getting Started Kit. Safer Healthcare Now! www.patientsafetyinstitute.ca/en/toolsResources/Pages/Med-Rec-resources-getting-started-kit.aspx.

Institute for Safe Medication Practices Canada. (2012). Medication Reconciliation (MedRec). Institute for Safe Medication Practices Canada. www.ismp-canada.org/medrec/

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Institute for Healthcare Improvement. (2012). How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation). Institute for Healthcare Improvement. www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx

Health Standards Organization. 2018. Accreditation Canada Required Organizational Practices 2018

Handbook Qmentum.

Overview of Medication Reconciliation. (2019). CST Cerner Help. http://cstcernerhelp.healthcarebc.ca/#t=Patient_Chart%2FMedications%2FMedRec%2FOverview_of_Medication_Reconciliation.htm&rhsearch=reconciliation%20ambulatory&rhsyns=%20&rhhlterm=reconciliation%20ambulatory

4. Appendices

Appendix 1: BC Cancer Risk Assessment Tool - Ambulatory Care Medication Reconciliation at Transition

Appendix 2: Medication Reconciliation Audit Tool

Appendix 1: BC Cancer Risk Assessment Tool - Ambulatory Care Medication Reconciliation at Transition

*Medication Reconciliation is conducted in partnership with clients and families where the client is at risk of potential adverse drug events. Organizational policy determines which **type** of ambulatory care visits require medication reconciliation, and **how often** medication reconciliation is repeated. Organizations should apply a **risk assessment approach**, working with team members to identify client groups that are at most risk and likely to benefit from medication reconciliation (Except modified from Accreditation Canada-Required Organizational Practice).*

All patient populations at BC Cancer will be evaluated as to whether or not they are required to complete Medication Reconciliation at Transition as per the BC Cancer Policy/Procedure. Clinical judgement by a patient's health care provider may outweigh this risk assessment tool and medication reconciliation should at this time be performed if deemed necessary to reduce the risk of potential adverse drug events.

Risk Assessment Question	Response	Response
Is the care provided to the patient population in the ambulatory clinic highly dependent on medication management? (for example commencing or ongoing systemic therapy, will leave the appointment with a prescription or advice regarding a change in medication)	YES	NO
Is the patient taking systemic corticosteroids, opiates requiring a triplicate prescription, anti-convulsants (seizure medications), benzodiazepines or anti-coagulants that has been initiated or altered by care at BC Cancer	YES (To **any** component of the question-**even if it is just one component, it is a yes**)	NO

If there is one YES response to the questions, then this patient will require medication reconciliation at transition as per the BC Cancer Policy/Procedure.

Appendix 2: Medication Reconciliation Audit Tool

Measurement	Chart #1	Chart #2	Chart #3	Chart #4	Chart #5	Chart #6	Chart #7	Chart #8	Chart #9	Chart #10
Is the form in chart										
Does the list of medications include the medication, name, dose, route and frequency										
Is verified section completed by nurse , physician, or pharmacist										
Is the form signed by a physician										

Key: √ = Yes X = No

Total # of forms in chart:

Total # of forms with the list that includes the medication name, dose, route and frequency:

Total # of charts with verified section completed:

Total # of charts signed by a physician:

Total Medication Reconciliation on Discharge from BC Cancer from BC Cancer Compliance Rate:

Appendix 3: Best Possible Medication History- Interview/Verification Guide

Introduction

- PharmaNet provides a list of patient's medications called a profile. To ensure it is accurate and complete, it is important to verify each medication and update the list as of the current date.

Does the patient have any current or new medication allergies?

- If yes, what is the effect of the medication?

Information gathering

- **In person:** 'Did you bring your medication list or your pill bottles with you?'
- **By telephone:** 'Do you have your medication list or pill bottles in front of you?'
- Go through each medication separately on the PharmaNet profile ***verify- using guide below:***
  - Clarify how each medication is taken. This may be different from how it is ordered.
  - 'Are there any medications that you have but you are not taking?' or taking PRN?
  - 'Are you taking any medication that is prescribed for someone else?'
  - 'Do you have a pharmacy you normally go to (name and location)?'
  - 'Do you get your medications from more than one pharmacy?'

Over the Counter (OTC) Medications

- Are there any medications being taken where a prescription is not required?
- Are they taking any medications that could be purchased without a doctor's prescription?' (I.e. Acetaminophen, antihistamines, etc.)

Vitamins/Mineral Supplements

- Do they take any vitamins or minerals? (I.e. multivitamin, iron, calcium, etc.)
- Do they take any supplements? (I.e. glucosamine, St John's Wort, etc.)

Eye/Ear/Nose drops/sprays

- Do they use any eye/ear drops or nose sprays?

Patches/Creams/Ointments/Inhalers/Injectables/Samples

- Do they use any inhalers or take injectable medication?
- Do they use any medicated patches, creams or ointments?
- Did their doctor give them any medication samples to try?

Antibiotics

- Have they been prescribed any antibiotics *in the past 3 months*?

Conclusion of the interview

- Provide answers to any questions the patient may have.

Requirements for Medication Verification

- Name of medication (generic/trade)
- Route of administration
- Name of prescriber
- Date ordered
- Frequency of administration
- Dosage and strength
- Indication

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