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Medication Reconciliation Policy

1. Introduction

1.1. Description

Medication Reconciliation is a formal, systematic process in which health care professionals partner with patients, residents and clients to ensure accurate and complete transfer of medication information at interfaces of care.

The purpose of this policy is to reduce adverse events due to medications by implementing structured medication reconciliation processes at transitions of care.

1.2. Scope

This is a joint policy between Vancouver Coastal Health (VCH) and Providence Health Care (PHC).

- **Acute Care:** all admitted patients.
- **Emergency Department:** all admitted patients.
- **Emergency Department/Urgent Care Centers:** *Non admitted patients* identified at risk for an adverse drug event (ADE).
- **Perioperative Services and Invasive Procedures:** *Outpatients* identified at risk for an ADE[1].
- **Residential Care:** all admitted and re admitted residents.
- **Home Health; Community Based Mental Health; Substance Misuse (Addictions)**; **Ambulatory Care; Ambulatory Systemic Cancer Therapy:** all clients for whom medication management is a *significant component of care*.

1.3. Exceptions

- Neonates
- Internal transfers that do not result in level of care changes and/or the re-ordering of medications
- Discharges against medical advice

[1] Planning for this ROP is under review by the VCH/PHC Medication Reconciliation Steering Committee

2. Policy

2.1. Medication Reconciliation Policy

Prescribers will reconcile patient/resident/client medications at transitions of care utilizing the Best Possible Medication History (BPMH) with involvement of the patient/resident/client and family and/or care provider (as appropriate).

Medication orders written at admission, transfer, and/or discharge will include the list of medications taken prior to the transition and instructions regarding each medication following the transition.

2.2. Acute Care

2.2.1. Admission

Prescribers will reconcile patient medications at admission utilizing the BPMH *within 24 hours of admission.* Medication orders written at admission will include a complete list of all medications taken prior to admission including instructions regarding their disposition.

2.2.2. Admission from Another Facility

The primary goal is to "consider not only what the patient was receiving at the sending facility, but also medications they were taking at home that may be appropriate to continue, restart, discontinue, or modify."

If the patient's length of stay at the sending facility has been 90 days or more (and based on clinical assessment by the prescriber), the current medication list may be considered the BPMH.

2.2.3. Transfer

Internal transfer is an interface of care associated with a change in the patient's level of care where medication orders have to be rewritten and may include: transfer to and from an ICU or Critical Care Unit; pre and post-operative transfers.

Medication Reconciliation at transfer requires the prescriber to review all medication taken prior to admission (BPMH); current medications (Medication Administration Record (MAR)) to create new transfer medication orders.

2.2.4. Discharge Home

Medication reconciliation for discharge home requires the prescriber to compare the patient's BPMH at admission with their current inpatient medications to create a Best Possible Medication Discharge Plan (BPMDP). This plan consists of clear communication to the patient and subsequent caregivers of the medications that

the patient should take after discharge relative to the medications they were taking prior to admission and should include:

- The medications taken prior to admission which are to be continued unchanged;
- The medications taken prior to admission which are to be continued at a different dose;
- The medications taken prior to admission which are to be stopped;
- The medications started in hospital which are to be continued (at the same or different doses);
- New medications that are to be started at discharge; and
- The indication for each medication to be taken after discharge.

Using a consistent, structured, transparent process to create a BPMDP helps to ensure that all changes are intentional and that discrepancies are resolved prior to discharge.

Additional considerations in developing the BPMDP include sorting out any formulary substitutions that occurred during hospitalization, formulary restrictions of the patient's insurance plan at discharge and identifying which medications will require prescriptions as the patient may have a sufficient supply of some medications at home.

This information is shared with patient, family and/or caregiver, pharmacy, General Practitioner, any appropriate specialist and, any appropriate program/service e.g. Community Based Mental Health (copy retained on the chart).

2.2.5. Discharge to Another Facility (External Transfer)

The goal of medication reconciliation during the site to site transfer process (discharge from one facility and an admission to another facility) is for the sending facility to provide the receiving facility with all the patient's medication information obtained since admission.

2.2.6. Emergency Department/Urgent Care (Non-admitted Patient)

In partnership with clients, families,or caregivers (as appropriate), medication reconciliation is initiated for clients with a decision to admit and *a target group of clients without a decision to admit who are at risk for potential adverse drug events.*

Organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit. Trial(s) in progress utilizing a Clinical Decision Rule developed by Dr. Corinne Hohl.

2.2.7. Perioperative Services and Invasive Procedures: Outpatients Only

In partnership with clients, famililes or cargivers, medication reconciliation is initiated for a *target group of outpatients who may be at risk for potential adverse drug events* (organizational policy specifies when medication reconciliation is initiated for outpatient clients).

The criteria for a target group of outpatients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented (*under review.*)

2.3. Residential Care

2.3.1. Admission from Home

Prescribers will reconcile the resident's medications at admission utilizing the BPMH. Medication orders written at admission will include a complete list of all medications taken prior to admission including instructions regarding their disposition.

2.3.2. Admission from Another Facility or Readmission

For a new admission from another facility, if the resident's length of stay has been 90 days or more (and based on clinical assessment by the prescriber), the current medication list may be considered the BPMH.

For a new admission from a facility, the primary goal is to "consider not only what the resident was receiving at the sending facility, but also medications they were taking at home that may be appropriate to continue, restart, discontinue, or modify."

For re admission, the prescriber uses current medication orders and previous BPMH to generate new admission orders. At the same time any discrepancies are reconciled and documented.

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2.3.3. Discharge Home

See 2.2.4 Acute Care: Discharge Home.

2.3.4. Discharge to Another Facility

See 2.2.5 Acute Care: Discharge to Another Facility (External Transfer).

2.4. Home and Community Care; Community Based Mental Health

2.4.1. Admission

The team will create a BPMH on the first visit (ideally), at the next available opportunity and/or within 90 days.

The prescriber resolves discrepancies with the client and/or communicates to the most responsible prescriber (MRP) i.e. GP, if the client has more than one primary care provider. Education is provided to the client and family regarding the importance of sharing the client's medication list with all those involved in their care.

For long term clients with no original BPMH, the team will perform during the next visit; every six months and/or as necessary based on clinical assessment.

2.4.2. End of Service

Discharge to Self-Care

The team will update the client's medication list and provide to the client and/or family (or primary care provider as appropriate) along with clear information about any changes.

The team educates the client and family to share the complete medication list with health care providers within the client's circle of care.

Discharge to Facility e.g. Hospice

The most recently updated medication list using the PARIS Discharge Report is provided to the receiving care provider, facility and community pharmacy as appropriate.

2.5. Substance Misuse (Addictions)

2.5.1. Admission

The team creates a BPMH at the beginning of service. The team tracks and communicates information regarding any changes to client medications.

2.5.2. End of Service

The team provides the client and care providers (as appropriate) with a copy of the client's updated medication list.

2.6. Ambulatory Care; Ambulatory Systemic Cancer Therapy

2.6.1. Admission

The team creates a BPMH in consultation with the client, family, and/or care provider prior to or during the initial ambulatory care visit. The team identifies, documents, and communicates medication discrepancies to the client's most responsible prescriber and maintains a current medication list in the client record.

During or prior to subsequent ambulatory care visits, the team compares the BPMH with the current medication list and identifies and documents any medication discrepancies. The frequency is determined by the prescriber and team based on client treatment needs and clinical assessment.

2.6.2. End of Service

The team provides the client and next care provider and/or most responsible prescriber as appropriate, with a complete list of medications the client should be taking.

2.7. Primary Care (High Priority)

TBD

2.8. Responsibilities

While medication reconciliation is the responsibility of the prescriber; obtaining the BPMH is an interdisciplinary team responsibility. The BPMH may be obtained by:

- Registered Nurse (RN), Registered Psychiatric Nurse (RPN) , Midwife, Nurse Practitioner (NP) - Basic Skill;
- Pharmacist;
- Physician;
- Licensed Practical Nurse (LPN) with additional education (VCH only); or
- Regulated Pharmacy Technician (advanced orientation).

Medication Reconciliation will be documented on appropriate VCH/PHC forms and/or within the patient's electronic health record (e.g. Cerner, PARIS, etc.) whichever is applicable.

2.9. Compliance

2.9.1. Acute: (Admission VCH)

VCH

- **Quality of the BPMH process:** The quality audits look at the section where the medication history is verified with the patient and/or family/care provider prior to reconciling and creating admission orders. Trained auditors select a sample of charts every fiscal period and examine the completeness of the BPMH process. Specifically, this involves auditors comparing the list of medications reported against those checked off as reviewed and verified with the patient and/or family/care provider. Results are posted quarterly on the Quality and Patient Safety portal.
- **Utilization of the Medication Reconciliation forms** to write admission orders (all acute sites and all programs). Data are obtained from the Discharge Abstract Database with reporting/posting to Quality and Patient Safety portal by Decision Support.

PHC

- **Utilization of the Medication Reconciliation forms** to write admission orders - data are obtained from the Discharge Abstract Database with reporting with reporting/posting to PHC Commitment to Excellence portal by Decision Support.

2.9.2. Tertiary/Sub Acute Mental Health

VCH/PHC

- Data are submitted to VCH Quality and Patient Safety.
- Results are posted on the VCH Quality and Patient Safety intranet portal every fiscal period.

2.9.3. Residential Care: (Admission/Re Admission)

VCH

- The data are collected by pharmacists and/or operational staff for directly funded residential care facilities.
- Results are posted on the VCH Quality and Patient Safety intranet portal every fiscal period.

PHC

- MedRec data are submitted to Decision Support.
- Results are posted on the VCH Quality and Patient Safety intranet portal every fiscal period.

2.9.4. Home Health, Community Based Mental Health:

In progress

2.9.5. Substance Misuse (Addictions); Ambulatory Care; Ambulatory Systemic Cancer Therapy

TBD

3. Supporting Documents and References

3.1. Related Policies

- Clinical Practice Guideline: How to Complete an Admission Medication Reconciliation Order/Record/Prescription Form Utilizing a Best Possible Medication History

3.2. Standards/Guidelines/Forms

- Best Possible Medication History – Top Ten Tips and Interview Guide 2013 (VCH.0265)

Medication Reconciliation Orders have been adapted for each Community of Care (CoC) and PHC.

- Community Health Medication Reconciliation Record (pre-populated with information from *PharmaNet and manual)
- Discharge Medication Orders (DMO)
- Medication Reconciliation Orders Form (prepopulated with information from *PharmaNet and manual)
- Medication Reconciliation Peri-operative Orders Form (prepopulated with information from *PharmaNet and manual)
- Medication Reconciliation Prescription (*PharmaNet)
- Moving in Medication Orders (PHC only)
- Transfer Medication Orders (TMO)

PharmaNet populated MedRec forms:

- A summary of the patient/resident/client PharmaNet medication information for the last six months prints directly onto the "Medication Reconciliation Order/ Record/Prescription" form. This provides the clinician gathering the medication history with a record of the last time a prescription for a particular drug product was dispensed for the patient/resident/client during this time period.
- Staff should print the PharmaNet form even if a patient/resident/client has not had any medications dispensed in the last six months- this form contains space to enter non PharmaNet medications.

NOTE:

- ***PharmaNet does NOT include*** samples, non-prescription medications (i.e. over the counter, herbals, etc.), BC Cancer Agency intravenous medications or BC Centre for Excellence (HIV) medications. In addition, it does not indicate which drugs have been discontinued or whether administration instructions have been changed since filled. It does not include prescriptions that may have been provided to the patient/resident/client but not yet filled/dispensed.
- Manual or non PharmaNet MedRec forms:
  - ❖ These forms are used for patients that have no Personal Healthcare Number (PHN) and are from out of the province/country, etc.

3.3. Definitions

"**BPMDP**" means Best Possible Medication Discharge Plan.

"**BPMH**" means Best Possible Medication History. A BPMH is created using 1) a systematic process of interviewing the patient/family and 2) a review of at least one other reliable source of information to obtain and verify all of a patient's medication use (prescribed and non-prescribed). Complete documentation includes drug name, dosage, route and frequency. The Best Possible Medication History (BPMH) is the cornerstone of the medication reconciliation process.

"**Client**" means any person receiving care or services from VCH or PHC and includes patients and residents.

"**CoC**" means Community of Care.

"**DMO**" means Discharge Medication Orders.

"**MAR**" means Medication Administration Record.

"**MedRec**" means medication reconciliation.

"**MRP**" means most responsible prescriber.

"**PHC**" means Providence Health Care Society.

"**Prescriber**" includes Physicians, Nurse Practitioners, Midwives, and/or Pharmacists.

"**TMO**" means Transfer Medication Orders.

"**VCH**" means Vancouver Coastal Health.

3.4. References

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3.5. Keywords

Medication Reconciliation, MedRec, Best Possible Medication History, Best Possible Medication Discharge Plan

3.6. Questions

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