Medication Reconciliation: Admission PROCEDURE

Summary of Changes

	NEW	Previous
BC Cancer-Kelowna	NEW	

1. Introduction:

1.1 Purpose

Medication Reconciliation is conducted in partnership with patients and families to ensure that medication reconciliation documentation reflects the current use of medications (including over the counter and herbal remedies). It is utilized to communicate accurate and complete information about patients' medications across care transitions at BC Cancer.

1.2 Scope

Medication Reconciliation is the responsibility of the most responsible provider for the patient. Obtaining and communicating the Best Possible Medication History (BPMH) and documenting and resolving any medication discrepancies (verification) is the responsibility of all health care professionals.

2. Procedure

This procedure will apply to all patient populations, and will occur at the following identified transitions:

- New patient admission

NEW PATIENT ADMISSION

Role	Action
Chart Prep Clerk	**1.** Adds the following form to the patient chart: • Excelleris Ambulatory Care Medication Reconciliation (See Appendix A) •
Patient	**1.** Reviews/modifies medications listed on Excelleris • Section A – confirms current medications • Section B – adds medications taken in last 180 days, but are no longer current • Section C – adds medications not noted in Section A
Nurse	**1.** Reviews patient entries on Excelleris to verify BPMH, using BPMH Interview Guide (see Appendix C)
	• Completes Excelleris "Verification" column • Completes Excelleris "Reconciliation" column as able • Communicates any discrepancies to Provider • Documents completion of BPMH and any interventions **2.** Completes Nursing portion of Medication Reconciliation Audit
***for MOVI appts, the Nurse will call the patient in advance to complete Excelleris Sections A-C, Verification, and Reconciliation, and can sign the top portion of Excelleris on the physician's behalf after discussion with the physician**	
Provider	**1.** Reviews Excelleris "Reconciliation" column and completes any remaining discrepancies with patient **2.** Consults with pharmacy for any medications unable to verify/reconcile **3.** Dates and signs top of Excelleris **4.** Completes Provider portion of Medication Reconciliation Audit

Ambulatory Care Clerk	**1.** Reviews/confirms Excelleris is complete (obtains missing information from Nurse or Provider as necessary) **2.** Uploads completed Excelleris into CAIS

3. Responsibilities and Compliance a. Responsibilities and Compliance

Clinical providers (Medical and Nurse Practitioners), Registered Nurse s, and Clinical Pharmacists are to understand , comply and follow this procedure for BPMH, and medication reconciliation upon admission

4. Related Documents

5. Definitions

Medication Reconciliation – a formal process in which the healthcare providers work together with patients, families and care providers to generate a Best Possible Medication History, identify and resolve medication discrepancies, and communicate a complete and accurate list of medications.

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, nonprescription, 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.

Prescriber – healthcare professional who is able to prescribe medications as part of their scope of practice (e.g. physician, nurse practitioner).

Healthcare professional – Refers to physician, pharmacist, nurse, or nurse practitioner.

Staff – Employee of BC Cancer who performs the designated steps.

Patient – Refers to patient, family or care provider.

Discharge – The transition point at which the Radiation Oncologist (RO) or Medical Oncologist (MO)

decides, in consultation with the patient and family, that they will no longer be seeing this patient.

This may be documented as Discharge

6. **References**

Accreditation Canada. Required Organizational Practices (2017). www.accreditation.ca 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/MedRec-resources-getting-startedkit.aspx.

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

Institute for Safe Medication Practices Canada. (2012). *Medication Reconciliation (MedRec).* Institute for Safe

Medication Practices Canada. www.ismp-canada.org/medrec/
Institute for Safe Medication Practices Canada. (2011). *Optimizing Medication Safety at Care*

Transitions - Creating a National Challenge. Institute for Safe Medication Practices – Canada. www.ismpcanada.org/download/MedRec/MedRec_National_summitreport_Feb_2011_EN.pdf

7. **Appendices**

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First Issued:	13-MAR-2019		
Approving Body:	BC Cancer- Kelowna- Senior Clinical Operations		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	John Larmet	Senior Director- Regional Clinical Operations	13-MAR-2019
Developed By:	**Name**	**Dept.**	**HO**
	Frances Dewolff	Clerical	BC Cancer
	Andrea Knox	Professional Practice Nursing	BC Cancer
Owner(s):	Mike Darud, Manager Clinical Services		BC Cancer
Posted Date:	13-MAR-2019		
Version:	1		
Revision:	**Name of Reviser**	**Description**	**Date**
			DD-MMM-YYYY