MEDICATION RECONCILIATION POLICY

Summary of Changes

	NEW	Previous
All Sites	BPMH documented in acute and ambulatory care using CERNER EHR as Document Meds by History	
	Med Rec on transfer surgical workflow	
VCH		
PHC		
PHSA		

Contents

1. Introduction

Medication reconciliation is an interprofessional team function and ongoing process. Reducing medication adverse events is best accomplished by defining structured **medication reconciliation** principles and processes at **transitions in care.**

1.1 Purpose

The purpose of this Policy is to:

- Describe the rules and principles around medication reconciliation and **best possible medication history (BPMH)**;
- Outline the responsibilities of those identified as in scope for adhering to the Policy; and
- Identify who is responsible for monitoring compliance and potential outcomes for non-compliance with the Policy.

1.2 Scope

a. This Policy applies to **acute care**, **long term care**, **outpatient**, and owned-and-operated **primary care** settings across Vancouver Coastal Health (VCH), Providence Health Care (PHC) and Provincial Health Services Authority (PHSA). It applies to all **Designated Health Care Professionals (DHCP)** authorized to participate in the collection, communication, verification and documentation of the BPMH, and/or to identify and document medication discrepancies, document and communicate medication changes, and/or to reconcile medication and resolve/communicate discrepancies, including:
   - Registered Nurses; Registered Psychiatric Nurses, Licensed Practical Nurses
   - Pharmacists;
   - Pharmacy Technicians;
   - **Providers**; and
   - Other DHCPs who come into contact with information about patients' medication history.

b. This Policy only applies to **neonates/newborns** during the encounter of birth when there are medications to reconcile at care transitions.

2. Medication Reconciliation

2.1 General Principles

a. Collection and verification of the BPMH must be completed prior to **Medication Reconciliation.**

b. Providers must reconcile patient medication at transitions in care utilizing the BPMH with involvement of the patient, family/caregiver(s), and other DHCPs as appropriate with the patient's consent.

c. The **Most Responsible Provider (MRP)** must ensure medication reconciliation is completed and may seek input from other providers as needed, to facilitate communication and understanding at care transitions.

d. Each organization must determine the role of the MRP on the basis of who is the most appropriate provider to oversee the overall plan of care for the patient.

e. Medication Reconciliation is an ongoing process. Medication orders written at admission, Transfer, and/or discharge must consider the list of medications taken prior to the transition and include any instructions regarding each medication following the transition.

2.2 Best Possible Medication History Documentation

a. The **BPMH** must document all medication that the patient takes, including prescribed and not prescribed, and how the patient takes it. If this is different from how the medication was prescribed, then the discrepancies between the prescription instructions and the patient's actual use must also be documented.
b. **When using the Cerner electronic health record:** documentation of the BPMH must include at a minimum all medication that is actively being taken in the home/community, including:
    1. Active treatment protocols, such as cancer treatments in progress;
    2. Intermittent medication (refers to medication prescribed on defined cycle [e.g. every three weeks] for one or more doses [e.g. depot injections, chemotherapy]);
    3. The following "No Longer Taking" medications:
        i. Medications that are temporarily on hold; and
        ii. Medications that the patient has stopped taking on their own without provider direction.

Exception: The BPMH documented in Cerner excludes any medication administered as in-clinic orders (i.e. IV chemotherapy, other in-clinic PowerPlans) at VCH/PHC/PHSA clinics that document those orders in Cerner.

2.3 Acute Care

2.3.1 Admission

a. At a minimum the admitting provider must reconcile medications for all admitted in-patients utilizing the BPMH within 24 hours of admission.
Exceptions
    i. When medication cannot be verified due to patient condition and/or lack of family/caregiver support the timeline can be extended to the earliest opportunity, up to transfer out of Critical Care.
    ii. For surgical in-patient procedures refer to 2.3.4.

2.3.2 Admission from another Healthcare Facility

a. If the patient has been sent from another healthcare facility that maintains a current, complete medication list (e.g. the Medication Administration Record (MAR) or list of discharge medication), such as Long Term Care or other hospital, the current medication list from the sending healthcare facility must be considered as the primary source of medication information. Secondary sources of information should include medication taken prior to admission to the sending facility.
b. If the patient's length of stay at the sending healthcare facility has been 90 days or more, the current medication list (i.e. the MAR) is considered the BPMH.
c. If a current, complete medication list is not maintained by the sending facility, the BPMH should consider all other reliable sources of medication information, as available.

2.3.3 Transfers

a. Medication reconciliation at Transfer requires the provider to review all medication taken prior to admission (i.e. the BPMH) as well as current medication to create new transfer medication orders.

b. At a minimum, medication reconciliation must be performed for transfers into and out of critical care/high acuity*, and post-operatively

Exceptions:

i. When there is no change in service level.
ii. Adult ICU/Critical Care patients when going to or returning from the operating room
iii. Minor procedures that do not result in changes to medication therapy, level of care or other care transitions, including:
   a. Central venous catheter insertion
   b. Intrathecal catheter insertion
   c. Pacemaker insertion
   d. Hemodialysis and peritoneal access
   e. Scope procedure through a natural orifice.
   f. Other minor procedures fitting the above criteria, as identified by the HO.

c. For transfers into and out of critical care/***high acuity,** medication reconciliation must be performed by a critical care provider.

**** High Acuity** unit where the provider is part of the critical care team.*

d. For postoperative transfers, see 2.3.4.b

2.3.4 Perioperative Medication Reconciliation

a. BPMH and medication reconciliation is required at admission for in-patient surgical procedures:
   i. If the BPMH has been collected prior to the patient presenting for surgery (e.g.at the Pre-Admission Clinic or surgeon's office) then the BPMH must be re-verified at admission for surgery.
   ii. If the BPMH has not been collected prior to the patient presenting for emergent surgery, then it must be collected at the first appropriate opportunity of a patient's encounter (e.g. the Emergency Department or post-operatively).

Note: Same-day care and other out-patient invasive procedures are not considered in-patient encounters - refer to Section 2.5

b. At a minimum, transfer medication reconciliation (or admission medication reconciliation if not done) must be performed post-operatively -
   i. **When using the electronic health record**: medication reconciliation must be signed off before the patient goes to Post Anesthetic Care Unit (PACU) or at the earliest appropriate opportunity after the patient leaves the operating room, before any medication administration tasks, as orders remain active in the system during the surgery unless explicitly discontinued by the provider.
   ii. **When using the paper based health record**: before the patient is sent to the in-patient unit.

Exceptions:

Minor procedures: see 2.3.3.b

2.3.5 Discharge

2.3.5.1 Discharge Home

a. Medication reconciliation for discharge home requires the provider compare the patient's BPMH at admission with their current inpatient medication to create a **medication discharge plan**. This plan consists of accurate and up to date written communication to be given to the patient, **family** and

subsequent caregivers of the prescription and non-prescription medication that the patient should take after discharge relative to the medication they were taking prior to admission and should include:

i. The medication taken prior to admission that is to be continued unchanged.
ii. The medication taken prior to admission that is to be continued differently (e.g. dose/frequency).
iii. The medication taken prior to admission that is to be stopped.
iv. The medication started in hospital that is to be continued (at the same or different doses).
v. New medication that is to be started at discharge.
vi. Prescriptions required before the patient goes home.
vii. The indication for each medication to be taken after discharge.
viii. Formulary substitutions and special authority medication need to be considered

Exception: For sites that cannot produce a medication discharge plan the patient must receive at a minimum medication discharge instructions.

2.3.5.2 Discharge to another Facility

a. When the patient is discharged to another facility the medication discharge plan must be sent to the receiving facility, as well as the patient and family as appropriate.

Exception: For sites that cannot produce a medication discharge plan the sending facility must send at a minimum the current MAR to the receiving facility. If the patient has been at the sending facility for more than 90 days the receiving facility can use the MAR as the BPMH.

2.4 Long Term Care

2.4.1 Admission

a. At a minimum the admitting provider will reconcile medication at admission utilizing the BPMH within 5 days of the arrival of the patient.
b. For admissions from another facility - See 2.3.2 Acute Care: Admission from Another Facility**.**

2.4.2. Discharge Home

See 2.3.5.1 Acute Care: Discharge Home

2.4.3. Discharge to another Facility

See 2.3.5.2 Acute Care: Discharge to Another Facility

2.5 Outpatient Settings

2.5.1 Admission

a. When medication management is a significant component of care (as determined by clinical area policy or guideline), the team creates a BPMH in consultation with the patient, family, and/or care provider prior to or during the initial visit, or as the patient condition allows. The team identifies, documents, and communicates medication discrepancies to the patient's MRP, the patient, family, and/or caregiver and maintains a current medication list in the client record.

b. For programs that prescribe medication, the provider resolves and/or communicates medication reconciliation discrepancies with the patient, family/caregiver (as appropriate), prescribing provider(s) and patient's primary care provider in the community.
c. During or prior to subsequent visits, the team reviews the BPMH or the current medication list and identifies and documents any medication discrepancies. The frequency is determined by each program based on patient population, treatment needs, and clinical assessment. BPMH should be reviewed at a minimum annually or at next visit if less frequent, and when there are changes to medications.

2.5.2. End of Service Discharge

a. The team provides the patient and a member of the next care team (i.e. Primary Care Provider or MRP, pharmacy, or home services) with the complete list of medication that has been managed by the team that the patient should be taking following the end of service.
b. If the patient is in a **Shared Care Model** ongoing responsibility for medication reconciliation lies with the prescribing community primary care provider.

2.6 Primary Care (VCH owned-and-operated clinics)

a. When prescribing medications, the team verifies the client's list of medications (the BPMH, which can be documented in the Usual Medications screen in Profile EMR), in partnership with the client, family and other providers as appropriate, and updates the medication list as needed.
b. The team makes all reasonable efforts to respond promptly to requests for completion of medication reconciliation by other care teams.

3. Responsibilities and Compliance

3.1 Responsibilities

3.1.1 Designated Health Care Professionals

All DHCPs will:

- Practice within their designated scope; and
- Communicate any part of the medication history collected to the DCHP documenting the BPMH.

DCHPs whose scope includes collection, verification and documentation of the BPMH will:

- Identify and document medication discrepancies.
- Document and communicate medication changes, inclusive of rationale, to:
  - The patient and/or
  - The substitute decision maker, guardian, or representative if applicable
  - Other providers or DCHPs that are receiving the patient.

3.1.2 Providers

All Providers will:

- Reconcile medication documented in the BPMH and resolve/communicate discrepancies with other providers as appropriate.
- Practice under terms consistent with their scope of practice, and/or Medical Staff Rules and Regulations, with appropriate education, and according to their organizational directive(s).

3.1.3 Unit/Clinic/Program and its Leadership

The Unit/Clinic/Program and its leadership will:

- Define the process for authorized healthcare professionals to fulfill the appropriate requirements for BPMH and medication reconciliation as applicable in their areas.
- Define which out-patient Settings (including Ambulatory Cancer Care; Ambulatory Care; BC Mental Health and Substance Use Services; Community Based Mental Health; Community Based Services/Outreach; Community Based Substance Use Services; Home Health) have medication as a significant component of care, for which BPMH and MedRec are required
- For the applicable outpatient settings as above, define the target patient/client groups for BPMH and medication reconciliation.

3.2 Compliance

Compliance with this Policy is expected. Anyone noting a violation of the Policy may support others to locate and understand the Policy and/or advise leadership of the need for education and support regarding the Policy. After education and support is offered, and the person remains non-compliant, the HO may remove the person from their workplace position (job) up to and including termination of employment or privileges within the organization.

4 Related Documents

4.1. Related Standards / Guidelines / Forms

- Medication Reconciliation procedure BC Children's and Women's
- Medication Reconciliation at Admission (Ambulatory Care) Procedure BC Cancer Abbotsford
- Medication Reconciliation for New Patient Admission (Ambulatory Care) Procedure BC Cancer Vancouver
- Medication Reconciliation for New Patient Admission (Ambulatory Care) Procedure BC Cancer Victoria
- Medication Reconciliation at Discharge (Ambulatory Care) Procedure BC Cancer Victoria
- Medication Reconciliation for Clinics: BCMHSUS FPH CCR-619C
- Medication Reconciliation for Hospital: BCMHSUS FPH CCR-619H
- VCH-PHC Medication Reconciliation Guideline

4.2 Related Policies

- Orders Management Policy
- Medication Administration Policy

5. Definitions

Acute Care refers to all admitted inpatients in hospitals, Emergency Departments, Forensic Psychiatric Hospital, Tertiary/Subacute Mental Health and Substance Use Services and In-Patient Rehabilitation.

Admission refers to the process of accepting a person into a hospital, clinic, program, and service or treatment facility as an active patient.

Ambulatory care refers to any form of medical care—including diagnosis, observation, treatment, rehabilitation, which is provided on an outpatient basis (i.e. does not require an admission to hospital).

Best Possible Medication History (BPMH) is 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 medication. The BPMH includes the drug names, dosages, routes, frequencies, compliance, and last dose taken.

Designated Health Care Professionals (DHCP): 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 refers to process of ending service including the release of a patient from an inpatient facility to another facility or home or completing treatment in an outpatient/community program or service.

Electronic Health Record (EHR) refers to the CST Cerner electronic health record.

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.

Intermittent medication refers to medication that are prescribed on a defined cycle (e.g. every three weeks) for one or more doses (e.g. depot injections, chemotherapy).

Long Term Care refers to all admitted and re-admitted residents of owned and operated long term care facilities

Medication Discharge Plan – is a generic term for what the Institute of Safe Medication Practices refers to as the Best Possible Medication Discharge Plan (BPMDP).

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 communication up-to-date information about patient medications to the patient and their next service provider, as appropriate; and

Medication - including prescription, non-prescription, samples, investigational, clinical trial drugs, traditional, holistic, herbal, vitamins and supplements).

Most Responsible Provider refers to the Provider who has overall responsibility for the patient's care.

Neonate/Newborn - newborn is more of a 'lay' term and neonate more of a 'medical' term for a child under 28 days of age.

Outpatient Settings refers to all patients for whom medication management is a significant component of care in Ambulatory Cancer Care; Ambulatory Care; BC Mental Health and Substance Use Services; Community Based Mental Health; Community Based Services/Outreach; Community Based Substance Use Services; Home Health.

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

Perioperative services and invasive procedures refers to the provision of invasive procedures (e.g., diagnostic, interventional, and endoscopic procedures) in a hospital. Procedures may take place in a traditional operating room, cardiac catheterization suites, endoscopy suites, radiology departments, or other areas where operative or invasive procedures may be performed. This standard does not apply to dental procedures or to minor dermatological procedures, including the removal of benign moles and cysts, nevi, seborrheic keratoses, fibroepithelial polyps, hemangiomas, and neurofibromata.

Primary Care is a service at the entry to the health care system that addresses diagnosis, ongoing treatment and management of health conditions as well as health promotion, disease and injury prevention, and referral to health care specialists. It includes the following principles: a regular provider or setting of care; the provider or team take overall responsibility for the ongoing care of patients; and the coordination and integration of care across all elements of the health care system such as other physicians, providers or settings. Primary care services can be delivered by one practitioner, such as a family physician's office, or a group, team, or network of primary care providers and can be co-located, or delivered in a number of sites

Provider refers to Physicians, Dentists, Pharmacists, Registered Midwife, Registered Nurse Practitioner and Provider students, within their scope of practice.

Shared Care Model refers to initiatives to facilitate collaboration between hospital and community-based physicians, and GPs and Specialists, with the goal of providing a coordinated health care experience (Shared Care BC 2018).

Transfer is an interface of care associated with a change in the patient's level of care (e.g. transfer to and from an ICU or Critical Care Unit; pre and post-operative transfers) or service environment where the same encounter/visit continues.

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).

6. References

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