BC CANCER ABBOTSFORD MEDICATION RECONCILIATION AT DISCHARGE (AMBULATORY CARE) PROCEDURE

Summary of Changes

	NEW	Previous
BC Cancer	Ambulatory Care Discharge Medication Reconciliation Procedure	Medication Reconciliation Policy & Procedure Ambulatory Care Medication Reconciliation Directive

1. Introduction

1.1 Focus

Medication Reconciliation is the responsibility of the most responsible prescriber for the patient. Obtaining and communicating the Best Possible Medication History (BPMH) and documenting and resolving any medication discrepancies are the responsibility of all healthcare professionals.

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.

1.2 . Health Organization Site Applicability

This procedure applies to BC Cancer Abbotsford Centre.

1.3 . Practice Level

This policy applies to all health care professionals who obtain, communicate BPMH, document and resolve any medication discrepancies.

1.4 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.

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

Staff – Employee of BC Cancer who performs the designated steps. Employees include Health Unit Clerks, Patient Care Aides, Registered Nurses, Licensed Practical Nurse, HIM Staff and/or Oncologists/Nurse Practitioner

Patient – Refers to patient, family or care provider.

Discharge – The transition point at which the care provider decides, in consultation with the patient and family, that they will no longer be receiving care at BC Cancer.

1.5 Equipment and Supplies

- Ambulatory Care Medication Reconciliation Form
- Discharge Summary Templates

2. Steps and Rationale

2.1 Decision made by oncologist to potentially discharge patient at the next follow up appointment. Oncologist will write "Med-Rec at next visit" on order sheet. **Health Unit Clerk** (HUC) to book RN in ACU with **ACMEDREC** CAIS code in CAIS 15 minutes prior to the patient's next appointment to do a BPMH.

2.2 **HUC** to indicate on chart prep as activity and flag to remind oncologist of potential discharge at next visit.

2.3 As **HUC** prepares chart for patient's clinic visit they will print and add the Ambulatory Care Medication Reconciliation form to patient chart.

2.4 **HUC** in chart prep will phone the patient and request them to arrive 15 minutes prior to their scheduled appointment time.

2.5 Medication Reconciliation form is provided to patient by **patient care aide (PCA) or licensed practical nurse (LPN)** as they are waiting for their appointment. Patient reviews the medication list and completes their portion of the Medication Reconciliation form.

2.6 If patient is identified for discharge just at the time of ACU clinic visit, oncologist will notify care team (**RN, PCA, LPN, HUC**) immediately pre-clinic; write order and give order to **HUC**. **HUC** in clinic will print the Ambulatory Care Medication Reconciliation form and give to **PCA/LPN**.

2.7 Medication Reconciliation form is provided to patient by **PCA/LPN** as they are waiting for their appointment. Patient reviews the medication list and completes their portion of the Medication Reconciliation form.

2.8 **PCA/LPN** receives form back from patient, attaches form to chart, and alerts clinic **RN**. **PCA/LPN** escorts patient to clinic room for appointment.

2.9 Clinic **RN** will review responses with patient as needed, complete verification column, and help patient and family to complete the form as required. **RN** returns the chart to physician to complete the reconciliation

2.10 During clinic appointment and before completing orders, **physician** reviews and signs the Ambulatory Care Medication Reconciliation form and discusses plan of care. For medications prescribed by the BC Cancer physician, the physician will indicate whether the medication should be continued, modified, or discontinued. Should the patient not be discharged the physician will notify the patient that this important information will be kept on file and reviewed again at a later day. **Physician/NP** informs patient to wait in waiting room so **HUC** can provide the patient a copy of their medication reconciliation form.

2.11 **Physician/NP** gives the Ambulatory Medication Reconciliation form, prescriptions, Primary Care Medication Reconciliation Communication Form (if discrepancies) and discharge order to **HUC**. **If discrepancies**, HUC faxes the Primary Care Medication Reconciliation Communication Form to the GP/NP together with the Ambulatory Care Medication Reconciliation form. Physician/NP gives Medication Reconciliation form, prescriptions and chart to health unit clerk who photocopies Ambulatory Care Medication Reconciliation form and gives copy to patient. If the patient is being transitioned to another facility or palliative care the Ambulatory Care Medication Reconciliation form is returned to the facility along with the patient chart.

2.12 HUC faxes the Ambulatory Care Medication Reconciliation form to Health Information Management (HIM). **HIM** scans Ambulatory Care Medication Reconciliation form into CAIS.

2.13 When physician/NP is dictating the discharge summary they will add in the pertinent Medication Reconciliation standard discharge template as part of the discharge summary dictation.

3. Patient/Client Education

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

4. 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/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/

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

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

5. Appendices

Appendix A: Ambulatory Care Medication Reconciliation Form

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BC Cancer Agency CARE & RESEARCH

Birthdate: Gender:
PHN:

Ambulatory Care Medication Reconciliation
(Page 1 of 7)
Printed on: 2019 Feb 21 11:38

Official Use Only:

Date:	Physician Signature:	Printed Name and College ID:

Dear Patient:
Please review the list of medications in Section A and Section B.
Under column Patient's Use: please indicate "yes" if the information is correct and "no" if the information is incorrect.
Your healthcare provider will discuss this information with you during your appointment.

Section A Current Medications	Patient's Use	Official Use Only	
		Verification	Reconciliation
	☐ Yes ☐ No	☐ As listed and managed by other provider	
		☐ As listed ☐ Unable to verify ☐ Discontinued ☐ Different than listed	☐ Continue verified dose ☐ Hold for evaluation ☐ Discontinue ☐ Managed by other provider
	☐ Yes ☐ No	☐ As listed and managed by other provider	
		☐ As listed ☐ Unable to verify ☐ Discontinued ☐ Different than listed	☐ Continue verified dose ☐ Hold for evaluation ☐ Discontinue ☐ Managed by other provider
	☐ Yes ☐ No	☐ As listed and managed by other provider	
		☐ As listed ☐ Unable to verify ☐ Discontinued ☐ Different than listed	☐ Continue verified dose ☐ Hold for evaluation ☐ Discontinue ☐ Managed by other provider
	☐ Yes ☐ No	☐ As listed and managed by other provider	
		☐ As listed ☐ Unable to verify ☐ Discontinued ☐ Different than listed	☐ Continue verified dose ☐ Hold for evaluation ☐ Discontinue ☐ Managed by other provider

THIS FORM DOES NOT ACT AS A PRESCRIPTION

Requested by: kthanda2 BC01400120 BCCA-Fraser Valley Cancer Ctr

APPENDIX B: Discharge Summary Letters

Med Rec due to new or changed medication/cancer therapy:

Dear Dr. _____,

Re: Medication Reconciliation upon discharge from BC Cancer

Our mutual patient _____ will not have further active treatment at BC Cancer and I am discharging him/her to your care. Given this transition in care, I have reviewed M _____'s Pharmacare list of currently prescribed medications and asked him/her to indicate which are currently being taken. I have asked M_____ to take this medication reconciliation document to you and review at an appointment soon. Some of these are supportive care medications that I have recommended or prescribed so I wish to ensure you are aware of current doses. M _____ is not discharged on any cancer related medications. I have detailed plans for follow-up and transfer of care in my discharge note. Sincerely,

Dr. _____

No changes to current medications or cancer medications:

Dear Dr. _____,

Re: Medication Reconciliation upon discharge from BC Cancer

M _____ has completed all active treatment at BC Cancer and I am discharging him/her to your care. BC Cancer has not made any changes to his/her medications during treatment. I have not prescribed any cancer medication upon discharge.

I have detailed plans for follow-up care in my discharge note.

Sincerely,

Dr. _____

First Issued:	November 2018		
Approving Body:	BC Cancer Abbotsford Regional Senior Operations Committee		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	Dr. Muhammad Zulfiqar Ruby Gidda	Regional Medical Director Acting Senior Director	November 2018 November 2018
Developed By:	**Name**	**Dept.**	**HO**
	Ruby Gidda	Operations	
Owner(s):	Senior Operations		
Posted Date:			
Version:			
Revision:	**Name of Reviser**	**Description**	**Date**
	Ruby Gidda		04-08-2019