MEDICATION RECONCILIATION POLICY

Summary of Changes

	NEW	Previous
BC Cancer	21-APRL-2023	BC Cancer Agency Medication Reconciliation Policy – December 2012

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.

The purpose of this policy is to:

- Describe the guiding principles around Medication Reconciliation and Best Possible Medication History (BPMH) across BC Cancer;
- 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

- This policy applies to all BC Cancer Regional Centres.
- This Policy 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 reconcile medication and resolve/communicate discrepancies, including:
  - Registered Nurses; Licensed Practical Nurses
  - Pharmacists;
  - Pharmacy Technicians;
  - Providers; and
  - Other DHCPs who come into contact with information about patients' medication history.

2. Policy

2.1. Medication Reconciliation Frequency

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. (see Appendix A: BC Cancer Risk Assessment Tool - Ambulatory Care Medication Reconciliation at Transition)
- For Inpatient Care at the Vancouver Centre, Medication Reconciliation occurs on admission and discharge to the inpatient unit.

2.2. General Principles

- Collection and verification of the Best Possible Medication History (BPMH) must be completed prior to Medication Reconciliation.
- Providers must reconcile patient medication at Transitions in Care utilizing the BPMH with involvement of the patient, family/caregiver(s), and other Designated Health Care Professionals (DHCPs) as appropriate with the patient's consent.
- Medication reconciliation is an **ongoing process**. Medication orders written at transitions of care must consider the list of medications taken prior to the transition and include any instructions regarding each medication following the transition.
- Medication reconciliation processes are defined, as applicable.
- Medication reconciliation will be documented on appropriate BC Cancer forms and/or within the patient/client's paper or electronic health record (e.g. Cerner), whichever is applicable.

3. Responsibilities and Compliance

3.1. Responsibilities

All health care providers are responsible for obtaining and communicating the Best Possible Medication History and documenting and resolving any medication discrepancies.

Designated Health Care Professionals (DHCPs):

All DHCPs will:

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

DHCPs 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:
  i. The patient/client and/or
  ii. The substitute decision maker, guardian, or representative, if applicable
  iii. Other providers of DHCPs that are receiving the patient/client.

Most Responsible Provider:
Medication Reconciliation is the responsibility of the most responsible provider for the patient

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.

Providers:
Reconcile medication documented in the BPMH and resolve/communicate discrepancies with other providers as appropriate.

Practice under terms consistent with their scope and practice, and/or Medical Staff Rules and Regulations, with appropriate education, and according to their organizational directive(s).

3.2. Compliance

Monthly compliance audit results will be completed by the regional BC Cancer centres, compiled by the Director, Quality and Safety and communicated by the Director, Quality and Safety to each regional leadership team at their Regional Operations Quality Committee. Compliance results will also be communicated at Quality Council monthly.

4. Related Documents

VPP CST Medication Reconciliation Policy

BC Cancer Advance Care Planning Procedure

Medication Reconciliation PowerPoint

BPMH Interview guide March 3, 2023

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

BC Cancer Medication Reconciliation Audit Tool

5. Definitions

Admission: Refers to the process of accepting a person into a hospital, clinic, 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 MRP 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: 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: Refers to the Provider who has overall responsibility for the patient's care at BC Cancer.

Patient: Refers to patient, client/patient, 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 client/patient's 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 client/patient's experience a change in team membership or location: admission, handover, transfer, and discharge" (Qmentum ROP Handbook 2018, page 29).

6. References

Accreditation Canada. Required Organizational Practices (Current Version) www.accreditation.ca Canadian Patient Safety Institute and Institute for Safe Medication Practices Canada (2011).

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

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. www.ismp-canada.org/medrec/

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 (MedicationReconciliation). Institute for Healthcare Improvement. www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx

Health Standards Organization. 2017. Accreditation Canada Required Organization Practices 2017 Handbook.V3.

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

Health Standards Organization. 2020. Accreditation Canada Required Organizational Practices 2020 Handbook Qmentum.

Institute for Safe Medication Practice. Best Patient Medication Discharge History (BPMDP)

Patient Interview Guide. 2011. McGraw-Hill Concise Dictionary of Modern Medicine. 2002.

7. Appendices

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

Appendix B: BC Cancer Medication Reconciliation Audit Tool

Appendix A: 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 B: BC Cancer Medication Reconciliation Audit Tool

Note: For CST Cerner live sites, audits verify completion of the Ambulatory Medication Reconciliation.

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 the 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 Compliance Rate:

****Last page of document****

First Issued:	28-DEC-2012		
Approving Body:	Quality Council		
Final Sign Off:	**Name**	**Title**	**Date Signed**
	Hamze Jomaa Dr. Elaine Wai	Director – Quality & Safety Medical Oncologist; Chair, MAC	11-APRIL-2023 21-APRIL-2023
Developed By:	**Name**	**Dept.**	**HO**
	Medication Reconciliation Working Group		PHSA-BC Cancer
Owner(s):	Director, Quality & Safety		
Posted Date:	23-APRIL-2023		
Version:	3.0		
Revision:	**Name of Reviser**	**Description**	**Date**
	Mary-Lou Hurley	Revisions as per updated process of Medication Reconciliation on Transition	15-MARCH-2019
	Ruby Gidda	Added Frequency of Med Rec, general principles, and added content to Responsibilities section.	27-FEB-2023