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

Summary of Changes

	NEW	Previous
BC Cancer	Ambulatory Care Discharge Medication Reconciliation Procedure	

1. Introduction

1.1 Focus

To ensure a Medication Reconciliation process occurs at important transition points in the patient's care. Medication Reconciliation is the responsibility of the most responsible provider for the patient. Obtaining and communicating the Best Possible Medication History (BPMH), documenting and resolving any medication discrepancies (verification) 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.

The BC Cancer team provides the patient and the next care provider (i.e. Primary Care Provider or MRP, pharmacy, or home services) with the complete list of medications that have been managed by the team and that the patient should be taking following the end of service.

1.2. Health Organization Site Applicability

This procedure applies to BC Cancer Kelowna Centre.

1.3. Standard and Applicable Patient Visits

This procedure will apply to patient populations and transitions as defined in the BC Cancer Standard for Medication Reconciliation at Discharge.

1.4. Practice Level

This policy applies to all health care professionals and staffs that assist with forms, obtain and communicate BPMH, document, verify and resolve any medication discrepancies.

1.5 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. Health care providers document and communicate up-to-date information about patient medications to the patient and their next service provider, as appropriate

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.

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

Provider refers to Physicians, Nurse Practitioners, Pharmacists, Provider students (within their scope of practice), Dentists, and Registered Midwives.

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

Healthcare professional – Refers to physician, nurse, nurse practitioner or pharmacist. Includes all **Designated Health Care Professionals (DHCP)** authorized to prescribe, transcribe or receive orders or administer medication for patient specific care under terms consistent with their scope of practice, and/or Medical Staff Rules and Regulations, and according to HO policy.

Staff – Employee of BC Cancer who performs the designated steps. Employees include Health Unit Clerks, Patient Care Aides, Licensed Practical Nurses, HIM Staff, and Designated Health Care Professionals.

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 the patient will no longer be followed at BC Cancer, and all care will occur via the Primary Care Provider. This can be documented as a discharge.

1.6 Equipment and Supplies

- Ambulatory Care Medication Reconciliation Form
- BC Cancer Doctor's orders sheet and transfer summary

2. Steps and Rationale

2.1 Physician identifies that patient will be discharged from BC Cancer – Kelowna at the time of or during the Ambulatory Clinic appointment.

2.2 Physician instructs patient to wait in the exam room. An order to discharge from BC Cancer is written on the Doctor's order sheet and communicated to the clinic nurse.

2.3 Clinic Nurse will print off and complete the BPMH with patient. The nurse will instruct the patient to check in with the clerk for their copy prior to leaving and bring the completed BPMH out to the physician.

2.4 The physician will review the BPMH and complete and sign off on the medication reconciliation. For medications prescribed by the BC Cancer physician, the physician will indicate whether the medication should be continued, modified, or discontinued.

2.5 The physician brings the completed ambulatory medication reconciliation form out to the clerk. The clerk will photocopy the medication reconciliation form a give a copy to the patient.

2.6 The clerk will fax the Ambulatory Care Medication Reconciliation form to Health Information Management (HIM). **HIM** scans Ambulatory Care Medication Reconciliation form into CAIS.

2.7 When **physician** is dictating the transfer summary they will add in the pertinent Medication Reconciliation standard discharge template communication 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.

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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

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