AK0800 – Medication Reconciliation

1.0 PURPOSE

To appropriately and consistently apply the Medication Reconciliation process to improve the quality and safety of care for all Interior Health (IH) Clients across clinical service areas and satisfy Accreditation Canada Required Organizational Practices (ROPs) and associated tests of compliance.

2.0 DEFINITIONS

TERM	DEFINITION
Adverse Drug Event	An injury from a medication or lack of an intended medication. Includes adverse drug reactions and harm from medication incidents.
Best Possible Medication History (BPMH)	A history that lists all the medications a Client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, supplements, street drugs - including the dose, frequency, route of administration, and strength. Creating a verified BPMH involves interviewing the Client, family, or caregivers, and consulting at least one other source of information such as the Client's previous health record, or a community pharmacist to verify what the client is taking. The verified BPMH is an important reference tool for reconciling medications at care transitions (e.g. admission, transfer, and discharge). A verified BPMH is generated and is used to identify and resolve unintentional medication discrepancies and undocumented intentional medication discrepancies and generate admission, transfer, and discharge medication orders that can serve as an up-to-date and accurate list of medications that can be communicated to the patient and next care provider at the time of a care transition. It is an important and cost-effective quality and safety initiative that can reduce adverse drug events (e.g., omissions, duplications, incorrect orders).
Client	Refers to a patient, person-in-care or person receiving care within an IH Emergency Department; Inpatient Services; Ambulatory Services; Home and Community Services; and Long-term Care Services.
Intentional Discrepancy	When there is a difference noted between the medication regimens the Client was actually taking based on the verified BPMH and the prescribed medication orders at a care transition. The prescriber has made an intentional choice to add, change or discontinue a medication. Best practice is for this to be clearly documented, as undocumented intentional discrepancies can lead to confusion and care inefficiencies.

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TERM	DEFINITION
Medication Reconciliation (MedRec)	A formal systematic process where the interprofessional care team (e.g., physicians, nurses, pharmacists, pharmacy technicians, or other allied health professional) work together with Clients, families and other care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care (e.g. admission, transfer, and discharge).
Most Responsible Practitioner (MRP)	The Practitioner who accepts the overall responsibility for a Client's management and coordination of care at any given time.
PharmaNet	A province-wide network that links all B.C. pharmacies to a central set of data systems where all prescriptions dispensed are entered. PharmaNet is administered by the B.C. Ministry of Health (MoH) and the College of Pharmacists of B.C. and was developed to improve prescription safety.
Practitioner	The physicians, dentists, midwives and nurse practitioners who have been granted privileges by the IH Board to practice in IH owned and operated facilities and programs.
Unintentional Discrepancy	When there is a difference noted between the medication regimens the Client was actually taking based on the verified BPMH and the prescribed medication orders at a care transition. The prescriber has unintentionally added, changed, or omitted a medication.

3.0 POLICY

3.1 This policy applies to Emergency Department; Inpatient Services; Ambulatory Services; Home and Community Services; and Long-Term Care Services.

3.2 This policy includes all IH staff who have a shared responsibility to participate in obtaining and verifying medication histories and identifying and reconciling medication discrepancies during prescribing (when required) at care transitions (e.g. admission, transfer, and discharge). Staff participation includes but is not limited to: all members of the medical staff, nurses, pharmacists, pharmacy technicians, and allied health care professionals.

3.3 Medication reconciliation will be completed and documented for: emergency department Clients with a decision to admit; inpatient Clients at admission, transfer, and discharge; long-term care Clients at admission, transfer and discharge; home and community care service Clients at the beginning and end of service; and ambulatory service Clients at initial and subsequent visits (with frequency established) where medication management is a major component of care.

3.4 Clinical decision support tools (CDSTs) such as clinical practice standards, process algorithms, and clinical tools (e.g. pre-printed orders, electronic order sets, and medication calendars, etc.) will be developed as needed. The principles of the Policy will be adhered to in the absence of a CDST.

3.5 The Medication Reconciliation Steering Committee will lead the organizational plan to sustain medication reconciliation.

3.6 Team members (including practitioners and clients) who are responsible for medication reconciliation will be provided with relevant education that will be documented in the Medication Reconciliation Steering Committee meeting minutes.

3.7 Quality planning, control, and improvement measures will be used to monitor compliance with medication reconciliation process and improvements will be made when required. These will be documented in the Medication Reconciliation Steering Committee meeting minutes.

4.0 PROCEDURES

4.1 In a given clinical service area where MedRec is required to be performed for a Client, an appropriate interprofessional team member (e.g. practitioner, nurse, pharmacist, pharmacy technician, or other allied health professional) will follow the processes and use the tools provided to list all the medications the Client is taking including prescription, non-prescription, traditional, holistic, herbal, vitamins, supplements, street drugs. The medication list should include the dose, frequency, route of administration, and strength.

4.2 An appropriate interprofessional team member (e.g. practitioner, nurse, pharmacist, pharmacy technician, or other allied health professional) is responsible for creating a verified BPMH by interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, or a community pharmacist to verify what the client is taking.

4.3 The MRP (or designate) will follow the processes and use the tools provided to identify and reconcile medication discrepancies and generate admission, transfer, or discharge medication orders. Document the reasons for Intentional Discrepancies in the Client's health record. Medications orders generated by the MRP (or appropriate designate) serve as an up-to-date and accurate list of medications that can be communicated to the Client and/or next care provider at the time of a care transition.

4.4 At admission, the MRP (or designate) will review the verified BPMH and determine which medications are appropriate to restart, continue, modify, discontinue, or discontinue and reassess at transfer or discharge. Document the reasons for Intentional Discrepancies in the Client's health record.

4.5 At transfer, the MRP (or designate) will review both the current medications and the verified BPMH of home medications to determine which medications are appropriate to

restart, continue, modify, discontinue, or discontinue and reassess at transfer or discharge. Document the reasons for Intentional Discrepancies in the Client's health record.

4.6 At the end of service or discharge, the MRP (or designate) will review both the current medications and the verified BPMH of home medications to determine which medications are appropriate to restart, continue, modify, or discontinue. Document the reasons for Intentional Discrepancies in the Client's health record.

4.7 At the end of service or discharge, an appropriate interprofessional team member (e.g. practitioner, nurse, or pharmacist) is responsible for providing the Client with an up-to-date and accurate list of medications and information about their medications in a format and language they can easily understand. This medication list should also be provided to the Client's community providers (e.g. community MRP, nurse practitioner, community pharmacist, home care provider).

5.0 REFERENCES

Clinical Decision Support Tools

http://insidenet.interiorhealth.ca/Clinical/MedMgmt/Pages/MedRec.aspx

- Medication reconciliation to prevent adverse drug events. Boston (MA). Institute for Healthcare Improvement (IHI) © Jan 2019, [cited 2019 June 10]. Available from: http://www.ihi.org/Topics/ADEsMedicationReconciliation/Pages/default.aspx
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