AK0800 – Medication Reconciliation

Interior Health would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, Syilx, and Tŝilhqot'in Nations, where we live, learn, collaborate and work together.

Interior Health recognizes that diversity in the workplace shapes values, attitudes, expectations, perception of self and others and in turn impacts behaviors in the workplace. The dimensions of a diverse workplace includes the protected characteristics under the human rights code of: race, color, ancestry, place of origin, political belief, religion, marital status, family status, physical disability, mental disability, sex, sexual orientation, gender identity or expression, age, criminal or summary conviction unrelated to employment.

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) Persons across clinical service areas and satisfy Accreditation Canada Required Organizational Practices (ROPs).

2.0 DEFINITIONS

TERM	DEFINITION
Best Possible Medication History (BPMH):	*A comprehensive medication history collected by a trained Interprofessional Team Member which includes a thorough history of all regular medications (prescribed and non-prescribed) that a Person is actually taking, using a number of different sources of information. The BPMH is different and more comprehensive than a routine primary medication history. The BPMH is an important reference tool for reconciling medications at care transitions (e.g. admission, transfer, and discharge).*
Intentional Discrepancy:	*When there is a difference noted between the medication regimens the Person was actually taking based on the 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.*
Interprofessional Team Member	*The Practitioners, nurses, pharmacists, pharmacy technicians, or other allied health professionals involved in the Persons care.*
Medication Reconciliation (MedRec)	*A formal systematic process where the Interprofessional Team Member work together with the Persons, families, and other care providers to ensure accurate and*

TERM	DEFINITION
	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 Person's management and coordination of care at any given time.*
Person	*An individual with whom a health or social service provider has established a therapeutic relationship for the purpose of partnering for health. Replaces the terms "patient", "client," and "resident" that are used across health and social service organizations.*
PharmaNet	*British Columbia's provincial repository of medication dispensing from community pharmacies. Authorized Interprofessional Team Members can access PharmaNet to view medication dispensing records. PharmaNet is not inclusive of sample medications, medication adjustments that do not require a new prescription, several antiviral and cancer care medications, and any non- prescription medications that a Person could be taking. PharmaNet lists may contribute to, but do not replace the BPMH.*
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. They collaborate in the responsibility for management and coordination of care at any given time.*
Unintentional Discrepancy	*When there is a difference noted between the medication regimens the Person was actually taking based on the 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 As defined by Accreditation Canada's Required Organizational Practices this policy applies to service areas where medication management is a major component of care including:

- Acute Care (Inpatient) Services including: Cancer Care Services, Critical Care Services, Hospital Based Psychiatry Services, Obstetric Services, Perioperative Services and Invasive Procedures, Rehabilitation Services;
- Tertiary Mental Health Services;
- Ambulatory Care Services including: various Ambulatory Care Services, Primary Care, Cancer Care Services;
- Emergency Department;

- Home and Community Care Services including: Home Care Services,
- Community Mental Health and Substance Use (MHSU) Services; and
- Long-term Care Services.

3.2 This policy applies to all members of the IH interdisciplinary team who have a shared responsibility in obtaining and verifying medication histories, reconciling medication discrepancies during prescribing (when required) at care transitions and when new medication orders are required.

3.3 The MedRec Steering Committee leads the organizational plan to sustain MedRec in accordance with the Accreditation Canada Required Organizational Practice: MedRec is a Strategic Priority.

3.4 Service Areas will:

3.4.1 Complete and document medication reconciliation following the service areas standardized processes for:

- Acute Care (Inpatient) and Tertiary Mental Health Services Persons at admission, transfer, and discharge;
- Ambulatory Care Service Persons at initial and subsequent visits (with frequency established) and end of service;
- Emergency Department Persons with a decision to admit;
- Home and Community Care Services Persons at initial and subsequent visits (with frequency established);
- Community MHSU Services Persons at admission, transition of care and discharge/end of service;
- Long-term Care Persons at admission, transfer, and discharge.

3.4.2 Develop Clinical decision support tools (CDST) as needed.

3.4.3 Provide relevant education to Persons and the Interprofessional Team Members who are responsible for MedRec.

3.4.4 Each service area monitors compliance with MedRec process and makes improvements when required.

4.0 PROCEDURES

4.1 To complete the required MedRec a trained Interprofessional Team Member follows the service areas' standardized processes and tools to perform a BPMH for the person. The BPMH involves:

4.1.1 The Person and/or family/caregiver medication interview wherever possible.

4.1.2 Include drug name, dose, frequency, and route of medication the Person is currently taking, even though it may be different from what was actually prescribed.

4.1.3 Include any traditional, holistic, herbal, vitamins, and supplements along with dose, frequency, and route that the Person is taking.

4.1.4 Verify each medication (prescription and non-prescription) with more than one source of information (i.e. Person, family/caregiver, blister pack, personal medication list, medication profile from other facilities, inspection of medication vials, PharmaNet and/or a community pharmacist).

4.2 When the BPMH process has identified discrepancies between what the Person has originally been prescribed and what they are actually taking, they will be resolved in partnership with Persons and families/caregiver and the appropriate MRP. Actions taken to resolve the medication discrepancies are documented as per the service areas standardized processes and tools.

4.3 The MRP (or designate) follows the service areas MedRec standardized processes and tools provided to identify and reconcile intentional and unintentional medication discrepancies and generate medication orders. Document reasons for discrepancies in the Person's health record. Medications orders generated by the MRP (or designate) serve as an up-to-date and accurate list of medications. Communicate discrepancies to the Person and/or next care provider at the time of a care transition.

4.3.1 At admission: review and compare the BPMH to the Persons current medication needs. Determine which medications are appropriate to continue, modify, discontinue, or discontinue and reassess at transfer or discharge. Communicate decisions and generate admission orders as required.

4.3.2 At transfer: review and compare both the Persons current medications and the BPMH completed at admission to determine which medications are appropriate to restart, continue, modify, discontinue, or discontinue and reassess at transfer or discharge. Communicate decisions and generate transfer orders as required.

4.3.3 At the end of service or discharge: review and compare both the Persons current medications and the BPMH completed at admission to determine which medications are appropriate to restart, continue, modify, or discontinue. Communicate decisions and generate medication prescriptions as required.

4.4 At the end of service or discharge, an appropriate Interprofessional Team Member is responsible for providing the Person with an up-to-date and accurate list of medications and information about their medications in a format and language they can easily understand. Provide this medication list to the Person's community providers (e.g. community MRP, nurse practitioner, community pharmacist, home care provider).

5.0 REFERENCES

1. Interior Health Medication Reconciliation Toolkits:
   - Medication Reconciliation Community MHSU Toolkit
   - Medication Reconciliation Acute Toolkit
   - Medication Reconciliation Outpatient Medical Oncology Toolkit
   - Medication Reconciliation CDM HH PHC Toolkit
   - Medication Reconciliation Long Term Care Toolkit

2. Assessing accuracy of an electronic provincial medication repository. Price et al. BMC Medical Informatics and Decision Making 2012, 12:42. Available from: BMC Medical Informatics and Decision Making
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6. Accreditation Canada Required Organizational Practices 2022 Handbook © Health Standards Organization 2022. Available from: ROP Handbook
7. Accreditation Canada QMentum Standards Leadership © Health Standards Organization 2021. Available from: Qmentum Program Standards Leadership