BPMH Training Tips

Definitions:

BPMH: Best Possible Medication Historyis a history created using 1) a systematic process of interviewing the patient/family; and 2) a review of at least one other reliable source of information to obtain and verify all of a patient's medication use (prescribed and non-prescribed).

Medication reconciliation: a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.

Sources: Ideally, as many sources as possible should be used. At least 2 must be used.

1. Patient:
   * The patient is the most important source (assuming patient clarity).
   * Try to attain all your information and identify discrepancies so you can create targeted questions for the patient.
   * Follow the ISMP drug questionnaire to ask open questions and ensure all meds are covered
   * Remember patients may not be taking meds as prescribed, so ask HOW they take it.
2. Family
   * See above
3. MAR
   * If patient is transferred from a facility with a MAR, it may be the only source used.
   * Check administrations to see if regular meds are on hold.
   * Pay attention to dosing size (ex: 10mg tab) vs actual dose (ex: 20mg daily) as this is a common source of error.
4. ODB profile (Connecting Ontario)
   * Useful tool for finding patient’s medications and pharmacy. Also helpful as a double check to make sure no meds are missed.
   * Does not give instructions (only amount and day supply)
   * Medications will only show if covered by the Ontario Drug Benefit (Patient <25yo or >65 yo and medication must be on ODB formulary). As such, not all medications will show up on this list.
   * Insurance will typically only cover 3 months-worth of medications, so all regularly used medications should be in this time frame.
   * However, the time frame should be extended to 6 months to see all possible medications. This will include most PRN medications or medications that patients are non-compliant with.
5. Pharmacy
   * Usually the most efficient source. Call the pharmacy and speak with a technician/pharmacy team. Ask for a 6 month patient history and they will fax the meds to you.
   * Again, most common meds are filled within 3 months and meds filled 3-6 months should be questioned. After 6 months the patient very likely is not taking them.
6. Med vials/blister
   * If patients bring in their own meds/vials, you must still ask the patient if they are using them. Many times they will bring whatever is in the med drawer.
   * Check fill dates, as old bottles/blisters (>3-6 months) should be questioned.
   * Always ask if there are other meds, as it is common to miss an inhaler/patch
7. Patient med list
   * Med lists are commonly not updated.
   * Go through the list with the patient to ensure no changes and that they are taking them as appropriate.
8. Physician list from office
   * They do not contain up to date information on all meds or instructions
   * Meds previously prescribed by that physician will show up, even those that have been discontinued. This puts the patient at risk of receiving medications that may harm them.
   * Any meds prescribed by a specialist or other facility will not show up

Suggested Process (if possible):

1. Attain pharmacy/pharmacies from Connecting Ontario. Ask patient for permission to call their pharmacy
2. Call pharmacy and ask for a med history fax. Tend to other duties while waiting for the fax.
3. Look over fax without recording yet. Gather any questions you want to approach the patient with.
4. Compare pharmacy list with other sources available (ex: med list, physician list) and gather more questions for the patient.
5. Go through ISMP interview guide with the patient. Ask any questions you’ve gathered.
6. Enter meds in EMR

FAQ:

1. If the patient takes a med differently than prescribed, what do I record?
   1. Record how the patient actually takes the medication and also indicate in the EMR afterwards how it was actually prescribed so the physician is aware.
2. What if I am not sure of the current dosage, frequency ect. What if I am not sure if they are actually taking a med?
   1. Try to attain information from another source. If all sources exhausted, please write “Pharmacy to clarify” and it will be seen by pharmacy.
3. What if their pharmacy is closed?
   1. Try to get a med history through other sources (Ex: family, Connecting Ontario). Document if there are meds you are unsure of with “Pharmacy to clarify”
4. What if 2 sources have conflicting information?
   1. Go with what makes more sense. In general, MARs are the most reliable, then patients (if they are good historians), then pharmacy lists, then patient med lists.
5. Do we enter medications they use seldomly (ex: advil about every 6 months for headaches)
   1. No, only enter medications patients use on a regular basis. It is usually a judgement call on the writer, as a migraine medication (ex: sumatriptan PRN used about once per month) would likely be included.