Title: Medication Reconciliation for Inpatients	**Policy No.:** F 4.46
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1.0 Purpose

Medication Reconciliation is widely recognized as an important client/patient safety initiative by both *Safer Healthcare Now!* in Canada, and the World Health Organization. It is an Accreditation Canada Required Organizational Practice. Medication Reconciliation is designed to prevent adverse drug events by eliminating discrepancies in client/patient medication information during periods of transitions in care. The purpose of this document is to outline the Medication Reconciliation policy and procedure for inpatients.

2.0 Persons Affected

This policy applies to all inpatient prescribers (including physicians and nurse practitioners), pharmacists, nurses, team members responsible for discharge planning and Central Registration CAMH personnel.

3.0 Policy

Inpatients at CAMH will have a structured Medication Reconciliation process followed to inform client/patient care at times of transitions in care. This applies to clients/patients registered in the Emergency Department (ED) longer than 24 hours, all clients/patients upon admission to an inpatient unit, at times of internal transfers between units, and at discharge.

4.0 Definitions

Best Possible Medication History (BPMH): A BPMH is 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). Complete documentation includes drug name, dosage, route and frequency. The BPMH is more comprehensive than a routine primary medication history which is often a quick preliminary medication history which may not include multiple sources of information. (ISMP)

Medication Reconciliation: Medication reconciliation is 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. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking (known as a BPMH – see above definition) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient. (ISMP)

5.0 Responsibilities

Medication reconciliation is a shared responsibility which involves multiple healthcare providers, as well as the client/patient or family.

5.1 Prescribers

5.1.1 **At admission to an inpatient unit or for clients/patients in the ED longer than 24 hours**, determine and document the BPMH, and document decisions on whether each medication will be ordered or not.

5.1.2 **At transfer between inpatient units**, the responsible prescriber(s) on the receiving unit must make a decision for each medication currently ordered for the client/patient.

5.1.3 **At discharge**, reconcile current inpatient medication orders and the home medications as documented in the BPMH from admission to establish the complete list of the client/patient's medications upon discharge.

5.2 Pharmacists

5.2.1 **At admission**, follow up on the initial BPMH for each client/patient for any needed clarifications or changes, and document the final BPMH.

5.2.2 **At transfer between inpatient units**, review the client/patient's current medication regimen, including the prescriber's transfer medication reconciliation decisions.

5.2.3 **At discharge,** in collaboration with the prescriber, prepare a complete list of the client/patient's medications upon discharge, to work with the discharge team member and client/patient regarding to whom the medication list information should be communicated (e.g., community pharmacy, family doctor, community psychiatrist) in addition to the

client/patient and caregiver(s), if appropriate, and to facilitate this communication.

5.2.4 Provide assistance with the completion of the medication reconciliation process at any phase, including entering orders and seeking co-signature where required.

5.3 Nurses

5.3.1 **At admission**, facilitate the medication reconciliation process as needed (e.g., educating the client/patient and/or caregivers about the process and its importance).

5.3.2 **At transfer between inpatient units**, nurses on the receiving unit shall review the client/patient's ordered medications and to follow-up with the prescriber or pharmacist for clarification of any issues, if needed.

5.3.3 **At discharge,** facilitate communication about the discharge plans for clients/patients and work with physicians and pharmacists to ensure the discharge medication list is prepared, communicated and disseminated appropriately.

5.4 Team Member Responsible for Discharge Planning

5.4.1 Ensure the Estimated Discharge Date (EDD) in I-CARE is kept updated.

5.4.2 **At discharge**, communicate discharge plans to the unit pharmacist, and work with the pharmacist and client/patient to determine whom the discharge medication list should be communicated (e.g., community pharmacy, family doctor, community psychiatrist) in addition to the client/patient, and to facilitate the dissemination.

6.0 Procedures

6.1 Arrivals via the Emergency Department

6.1.1 Central Registration CAMH personnel

6.1.1.1 Retrieves the Ontario Drug Benefit (ODB) Drug Profile Viewer report for client/patient, and sends it to the unit printer where it will be placed in the paper chart after use. The Drug Profile Viewer will then be scanned into the electronic health record according to the most current scanning policies and procedures.

6.1.2 Physician or Pharmacist
- 6.1.2.1 Compiles the initial BPMH
  - 6.1.2.1.1 Using multiple sources of information (e.g., ODB Drug Profile Viewer, ConnectingOntario, community pharmacy list, client/patient's medication vials, client/patient interview, caregiver interview).
  - 6.1.2.1.2 Includes all medications (e.g., psychiatric and medical, prescription and non-prescription).
- 6.1.2.2 Records the BPMH, including sources used, on the "Document Medications by History" list in I-CARE.

For clients/patients with decision to admit or those registered in the ED for 24 hours or longer:

6.1.3 Prescriber
- 6.1.3.1 Uses the I-CARE admission reconciliation function to indicate 'Stop' or 'Continue' for each BPMH medication. For BPMH medications to be continued, the prescriber completes the medication order entry process, making any adjustments to the regimen as needed at this time.
- 6.1.3.2 For BPMH medications that are stopped or changed upon admission, the reason for these decisions must be documented in the 'Compliance' tab area for that medication.

6.1.4 Pharmacist on Duty
- 6.1.4.1 Confirms admission medication orders were placed using the medication reconciliation process.
- 6.1.4.2 Verifies the orders as per usual process.

For ED clients/patients transferred to an inpatient unit:

6.1.5 Receiving Unit
- 6.1.5.1 Ensures medication reconciliation on admission is completed.
- 6.1.5.2 Pharmacist follows-up on the BPMH to ensure completeness and further reconciles medications as needed in communication with the prescriber. This may include entering orders and seeking co-signature where required.

6.2 Direct Admissions

6.2.1 Central Registration CAMH personnel

6.2.1.1 Retrieves the Ontario Drug Benefit (ODB) Drug Profile Viewer report for client/patient, and sends it to the unit printer.

6.2.2 Admitting Prescriber

6.2.2.1 Compiles the initial BPMH

6.2.2.1.1 Using multiple sources of information (e.g., ODB Drug Profile Viewer, ConnectingOntario, community pharmacy list, client/patient's medication vials, client/patient interview, caregiver interview).

6.2.2.1.2 Includes all medications (e.g., psychiatric and medical, prescription and non-prescription)

6.2.2.2 Records the BPMH, including sources used, on the 'Document Medications by History' list in I-CARE.

6.2.2.3 Uses the I-CARE admission reconciliation function to indicate 'Stop' or 'Continue' for each BPMH medication. For BPMH medications to be continued, the prescriber completes the medication order entry process, making any adjustments to the regimen as needed at this time.

6.2.2.4 For BPMH medications that are stopped or changed upon admission, the reason for these decisions must be documented in the 'Compliance' tab area for that medication.

6.2.3 Pharmacist on Duty

6.2.3.1 Confirms admission medication orders were placed using the medication reconciliation process.

6.2.3.2 Verifies the orders as per usual process.

6.2.4 Receiving Unit Pharmacist

6.2.4.1 Follows-up on the BPMH to ensure completeness and further reconciles medications as needed in communication with the prescriber. This may include entering orders and seeking co-signature where required.

6.3 Transfer Between Inpatient Units

6.3.1 Receiving Unit Prescriber

6.3.1.1 Uses the I-CARE transfer medication reconciliation function to indicate 'Stop' or 'Continue' for each current inpatient medication.

6.3.1.2 If changes are needed for a current medication the changes are made according to usual procedures.
NOTE: Medication orders cannot be modified in the transfer medication reconciliation function.

6.3.1.3 BPMH medications also appear on the transfer list. The prescriber can take this opportunity to review any home medications that were not continued on admission to order them at this point if desired.

6.3.2 Receiving Unit Nurse

6.3.2.1 Reviews the client/patient's ordered medications and follows-up with the prescriber or pharmacist for clarification of any issues, if needed.

6.3.3 Pharmacist

6.3.3.1 Reviews the client/patient's current medication regimen, including the prescriber's transfer medication reconciliation decisions. Pharmacists may assist in completing medication reconciliation at transfer, including entering orders and seeking co-signature where required.

6.4 Planned Discharges from Inpatient Units

6.4.1 Team Member Responsible for Discharge Planning

6.4.1.1 Keeps the Estimated Discharge Date in I-CARE updated, and informs unit pharmacist of client/patient's discharge date.

6.4.1.2 Coordinates with the client/patient regarding to whom medication information should be communicated (e.g., community pharmacy, family doctor, community psychiatrist), and facilitates the communication.

6.4.2 Discharge Prescriber

6.4.2.1 Prepares a complete list of the client/patient's medications upon discharge using the discharge medication reconciliation function in I-CARE.

6.4.3 Unit Pharmacist

6.4.3.1 Once medication reconciliation at discharge has been completed by the prescriber, the pharmacist will complete the discharge medication planning PowerForm. The medication information will then autopopulate into the medication section of the Patient Oriented Discharge Summary (PODS) with a customized medication grid.

6.4.3.2 The Community Pharmacy Medication Summary (CPMS) also autopopulates following completion of discharge medication reconciliation. The CPMS indicates changes to the client/patient's medications compared to admission, and provides a list of the final discharge medications. The pharmacist will review the information to ensure accuracy and add any relevant additional notes. The CPMS can be faxed directly from I-CARE to the community pharmacy that the client/patient intends to use.

6.4.3.3 The pharmacist will conduct a medication education session with the client/patient to review their discharge medication plan.

6.5 Unplanned or Short-Notice Discharges from Inpatient Units

6.5.1 Team Member

6.5.1.1 Informs unit pharmacist of client/patient pending or complete discharge.

6.5.1.2 Coordinates with client/patient, if possible and appropriate, regarding to whom their medication list should be communicated once prepared.

6.5.2 Discharge Prescriber

6.5.2.1 Completes discharge medication reconciliation in I-CARE if possible and appropriate to the circumstances.

6.5.3 Unit Pharmacist

6.5.3.1 If medication reconciliation at discharge has been completed the pharmacist can complete the discharge medication planning PowerForm to populate the PODS, if possible and appropriate to the circumstances. If the discharge medication planning form cannot be completed by the pharmacist, the PODS will populate with a list of the discharge medications as per the medication reconciliation completed by the prescriber. If medication reconciliation has not been completed, the medication section of the PODS will indicated 'Please follow-up with your physician or pharmacist'.

6.5.3.2 If discharge medication reconciliation has been completed and the circumstance allows, the pharmacist can review and send the CPMS to the community pharmacy.

7.0 References

Institute of Safe Medication Practices. Medication Reconciliation. Available at: https://www.ismp-canada.org/medrec/

World Health Organization. (2009). High 5's project. Available at: https://www.high5s.org/bin/view/Main/WebHome

8.0 Links/Related Documents

8.1 Related Policies and Procedures

PC 2.4.7 Discharge of an Inpatient
F 4.7 Discharge Medication

8.2 Other Resources

How To: Best Possible Medication History
How To: Inpatient Medication Reconciliation
Medication Reconciliation on Discharge (Video)

9.0 Review/Revision History

Date	Revision No.	Revision Type (minor edit, moderate revision, complete revision)	Reference Section(s)
January 2008	1.0	New policy	• N/A.

Date	Revision No.	Revision Type (minor edit, moderate revision, complete revision)	Reference Section(s)
May 2011	2.0	Complete Revision	• All sections.
March 2013	3.0	Moderate	• Updated to include medication reconciliation at discharge.
May 2014	4.0	Moderate	• Updated to reflect changes post I-CARE implementation.
March 2015	5.0	Moderate	• Updated to reflect non-admitted ED client/patients.
February 2017	5.1	Minor	• Updated for clarity regarding pharmacist ordering.
February 2019	6.0	Moderate	• Updated to reflect new discharge medication communication tools (PODS and CPMS) and to remove non-admitted ED clients/patients.
June 2021	7.0	Moderate	• Updated to reflect removal of inpatient status (EAU) for ED clients/patients. • Updated medication reconciliation to initiate for patients registered in the ED for longer than 24 hours.