Title: Medication Reconciliation for Outpatients	**Policy No.:** F 4.51 **Pages:** 6
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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 and when sharing care. The purpose of this document is to outline the Medication Reconciliation policy and procedures at CAMH for outpatients.

2.0 Persons Affected

This policy applies to all outpatient physicians, nurse practitioners, pharmacists, nurses, and clinic CAMH personnel.

3.0 Policy

This policy applies to all CAMH outpatient services. While medication reconciliation is encouraged for all outpatient clients/patients, it is required for selected individuals at high risk of potential adverse drug events based on specified prescription criteria as listed in Section 6.1, below. Any outpatient client/patient prescribed one of the specified medications by a CAMH prescriber should have medication reconciliation completed at time of first prescription, regularly during their outpatient care (at least every 6 months), and when discharged from the clinic.

4.0 Definitions

Best Possible Medication History (BPMH): A BPMH is a complete medication list created using 1) a systematic process of interviewing the client/patient, family and/or caregiver(s); and 2) a review of at least one other reliable source of information to obtain and verify a client/patient's current medication use (prescribed

and non-prescribed). Complete documentation includes drug name, dosage, route, frequency, and adherence. (ISMP)

Medication Reconciliation: Medication reconciliation is a formal process in which healthcare providers work together with clients/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 client/patient is taking (i.e., a BPMH) 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 client/patient. (ISMP)

5.0 Responsibilities

5.1 Medication reconciliation is a shared responsibility that involves multiple health care providers, as well as the client/patient and caregiver(s).

5.1.1 Prescribers: Outpatient prescribers identify clients/patients who meet the selection criteria for medication reconciliation as listed in Section 6.0, below. Prescribers are responsible for determining and documenting a BPMH, communicating what medications should be continued, discontinued or modified, and resolve any discrepancies. Prescribers should communicate the list of current medications to the client/patient and/or caregiver(s). In addition, any discrepancies identified should be communicated to the client/patient, caregiver and any other relevant health care provider involved in their care, as appropriate.

5.1.2 Pharmacists: Outpatient pharmacists may assist with all aspects of medication reconciliation. Requests for assistance by outpatient teams will be accommodated whenever feasible.

5.1.3 Nurses: Outpatient nurses are responsible for facilitating the medication reconciliation process as needed. This can include educating the client/patient and caregiver(s) about the process and its importance. Nurses may also determine and document the BPMH.

5.1.4 Clinic CAMH personnel: Other outpatient clinic CAMH personnel may assist in gathering medication records, for example, from community pharmacies and ConnectingOntario for use by prescribers, pharmacists or nurses in determining the BPMH.

6.0 Procedures

6.1 Type of Outpatient Visits Requiring Medication Reconciliation

6.1.1 Required for each I-CARE encounter in which a client/patient is prescribed any of the following medications by a CAMH clinician:

- **C**lozapine;
- **L**ithium;
- **O**pioids;
- **P**henytoin;
- **I**M Depot Antipsychotics;
- **C**arbamazepine.

6.2 Type of Clinical Scenarios Where Medication Reconciliation Could Be Considered

6.2.1 Frequent hospitalizations (3 or more per year).
6.2.2 Known medication non-adherence.
6.2.3 Sensitivities to medications.
6.2.4 Apparent therapeutic resistance to multiple medications.
6.2.5 Prescribed 4 or more psychotropic medications.
6.2.6 Taking 7 or more medications in total.
6.2.7 Taking medication outlined in Section 6.1.1, above, prescribed by non-CAMH clinician.

6.3 How Frequently to Conduct Medication Reconciliation Where Required (Section 6.1)

6.3.1 At time of first prescription for medications outlined in Section 6.1.1, above.
6.3.2 Every 6 months at least.
6.3.3 Upon discharge from the outpatient clinic.
6.3.4 For transfers between CAMH outpatient clinics, the receiving clinic should complete medication reconciliation.

6.4 Medication Reconciliation Process – Outpatient Prescribers

6.4.1 Compile the BPMH

6.4.1.1 Using multiple sources of information (e.g., community pharmacy medication profile, client/patient interview, medications brought in by clients/patients).
6.4.1.2 Referring eligible clients/patients for a MedsCheck at their regular pharmacy, which can help facilitate this process.

6.4.1.3 Including all medications (e.g., psychiatric and medical, prescription and non-prescription).

6.4.1.4 Resolving discrepancies amongst conflicting information.

6.4.2 Record the BPMH, in the “Document Medications by History” section of I-CARE, including the sources used and client/patient adherence information.

6.4.2.1 If the “Document Medication by History” section is already populated with medication information, the prescriber must review, confirm, adjust and complete the list to ensure it reflects a current BPMH.

6.4.3 Perform reconciliation using the electronic ‘Reconciliation’ function and select ‘Outpatient’

6.4.3.1 Indicate “Continue” (for medications prescribed at CAMH to be continued), “Prescription” (for medications to be continued and generate an outpatient prescription), ‘Acknowledge’ (for medications prescribed outside of CAMH), or 'STOP'.

6.4.3.2 An action for each BPMH medication is required to complete medication reconciliation.

6.4.4 Document discrepancies, actions taken to resolve discrepancies, and reasons for changing or stopping medications.

6.4.5 Communicate BPMH, discrepancies and changes to the client/patient and caregiver(s), and other health care providers, as appropriate each time medication reconciliation is completed.

6.4.6 An ‘Outpatient Medication Summary’ should be generated as soon as possible after completing medication reconciliation and given to the client/patient and caregiver(s) each time medication reconciliation is completed. After 2 weeks, a new medication reconciliation is required before generating the document.

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

F 4.7 Discharge Medication
F 4.46 Medication Reconciliation for Inpatients
PC 2.4.7 Discharge of an Inpatient

8.2 Other Resources

Best Possible Medication History
Document Medications by History
Medication List Review and Maintenance (Video)
Medication Reconciliation for Outpatients
Medication Reconciliation in Outpatient Clinics (Video)
Outpatient Medication Summary Document

9.0 Review/Revision History

Date	Revision No.	Revision Type (minor edit, moderate revision, complete revision)	Reference Section(s)
March 2014	1.0	New Policy	• N/A. Not implemented.
March 2015	2.0	Moderate	• Version 1.0 not implemented. Refined type of visits where medication reconciliation required.
November 2018	3.0	Moderate	• Changed requirements for clients/patients requiring medication reconciliation and clarified roles.

Date	Revision No.	Revision Type (minor edit, moderate revision, complete revision)	Reference Section(s)
May 2020	4.0	Moderate	• Clarified requirements for clients/patients requiring medication reconciliation and included use of Outpatient Medication Summary document. • For consistency changed term “clinic staff” to “clinic CAMH personnel”. • For consistency, changed client to client/patient.