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| **Medication Reconciliation** | |
| Developed By: | Approved By:  Safe Medication Committee – September 5, 2013 |
| Date of Origin: | Review or Revision Date: |

## Policy Statement

All patients admitted to Listowel or Wingham Hospitals will have had their medications reviewed following the medication reconciliation process.

Medication Reconciliation is intended to prevent adverse drug events (ADE’s) at all interfaces of care, for all patients. A Canadian study found that at admission 54% of studied patients had at least one unintended discrepancy, with the most common discrepancy (46%) being omission of a regular medication (Safer Healthcare Now! 2011). At transfer and discharge, unintentional discrepancies have been shown to lead to discomfort, clinical deterioration, and preventable adverse events (Safer Healthcare Now, 2011).

Medication Reconciliation is defined as a formal process in which healthcare providers work with patients, families and care providers to ensure an accurate, comprehensive list of each patient’s current home medications including name, dosage, frequency and route and comparing the physician’s admission, transfer and/or discharge orders to that list.

Discrepancies are brought to the attention of the prescriber and if appropriate changes are made to the orders. Any resulting changes on orders are documented and communicated consistently across transitions of care (ref: Safer Healthcare Now!, 2011).C

## Responsibilities

The following personnel must work together and use a realistic approach to compile the most complete medication list reasonably possible in the circumstances. In this context, “complete” includes all that an institution is told or knows and requires reasonable effort to seek out correct information.

* Pharmacist-review medications(drug, dose, frequency & route) Verify physicians orders
* Pharmacy Technicians-review medications
* Physicians-review BPMH and order appropriate medications
* Nursing-review BPMH and notify physician of any discrepancies
* Patient/Family/Caregiver-provide medications or a list of medications

## Equipment

Computer with current BPMH entered

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| Cross  References |  |
| Key Words |  |

## Procedure

**Definitions**

**Adverse Drug Event (ADE):** An injury from a medicine or lack of an intended medicine. Includes adverse drug reactions and harm from medication incidents, including preventable allergic reactions (i.e. an undocumented, known allergy).

**Best Possible Medication History (BPMH):** A medication 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. The medication history also includes a listing of allergies and associated reactions

**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. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking 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.

**Intentional Discrepancies:** The prescriber has made an intentional choice to add, change or discontinue a medication and their choice is clearly documented. This is considered to be ‘best practice’ in medication reconciliation.

**Undocumented Intentional Discrepancies:** The prescriber has made an intentional choice to add, change or discontinue a medication but this choice is not clearly documented.

Undocumented intentional discrepancies are a failure to document. They are not medication errors and do not usually represent a serious threat to patient safety. *Undocumented intentional discrepancies* may however lead to confusion, require extra work and may lead to medication errors. They can be reduced by standardizing the method for documenting admission medication orders. *Undocumented intentional discrepancies* represent 25 –

75% of all discrepancies.

**Unintentional Discrepancy:** The prescriber unintentionally changed, added or omitted a medication the patient was taking prior to admission. Unintentional discrepancies are potential medication errors than can lead to ADEs. They can be reduced by ensuring good training of nurses/prescribers/pharmacists at obtaining in-depth medication histories and by wisely involving clinical pharmacists to identify and reconcile these discrepancies. In institutions without access to clinical pharmacists, reconciliation of discrepancies

can be assigned to other healthcare professionals.

## References

|  |  |
| --- | --- |
| Cross  References |  |
| Key Words |  |

1. Safer HealthCare Now! (2011). How-to-Guide: Medication Reconciliation in Acute Care – Getting Started

APPENDICES

|  |  |
| --- | --- |
| Cross  References |  |
| Key Words |  |

Patient Admitted?

**No**

Discharge

**Yes**

BPMH

Completed ***Within 24 hours of admission*.**

BPMH initiated in ER for ER admits whenever possible, and by the MRN on the Inpatient unit for direct admits

* BPMH
* 2 sources of information when possible

***MRN*** on in-patient unit reviews orders and signs them off electronically

***Authorized Prescriber*** Completes admission medication reconciliation power form within 24

hours of admission.

Patient’s medications at organization?

**No Yes**

***Pharmacist will verify medication orders within a reasonable amount of time***

Request that meds are

brought in

Once list is obtained send meds home if possible, or store as per unit guidelines

Discrepancies noted on orders?

**No Yes**

Reconciliation Complete

***Pharmacy Team*** Notify Authorized Prescriber of any discrepancies and documents resolution

**No**

Patient ready

for discharge?

Continue plan of care

Return Patient’s medications brought in. Request permission to discard discontinued medication

**Yes**

***Documents***

* Discharge order
* Completes discharge medication reconciliation power form
* EMR medication profile (office document if needed)

***Authorized Prescriber***

**Compares:**

Both Home and Hospital medications present on the discharge medication reconciliation power form

**Provides:**

* Discharge medication plan for the patient (includes prescription)

Reconciliation Complete

***MRN***

* Verifies orders
* Contacts the prescriber for clarification where discrepancies exists
* Provides education to the patient and/or SDM on medication

Patient transfer to different service?

**No**

Continue plan of care

**Yes**

***MRN*** on receiving unit verifies orders

***Authorized Prescriber* completes a facility to facility discharge powerform**

Discrepancy noted

***Pharmacist verifies orders within a reasonable amount of time***

**No Yes**

Reconciliation Complete

***Pharmacy Team*** Notify Authorized Prescriber of any discrepancies and documents resolution



**Yes**

Patient attending pre- admission clinics?

**No**

***Follow*** Medication Reconciliation Process: Admitted Patients

***Pre-Admission Clinic Visit*** BPMH completed by Pre- admit clinic nurse during Pre-admit visits



***Day of Admission***

* Admitting nurse verifies the BPMH obtained at pre-admission clinic with patient and makes changes as needed as well as completes compliance

***Follow***

Medication Reconciliation Process Admitted Patients

***Follow***

Medication Reconciliation Process at Discharge



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**Yes**

Patient attending pre- admission clinics?

**No**

***Day of Surgical Procedure***

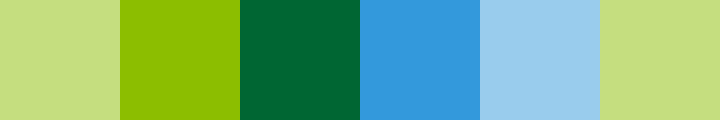
* Admitting nurse completes the BPMH

***Pre-Admission Clinic Visit*** BPMH completed by Pre- admit clinic nurse during Pre-admit visits

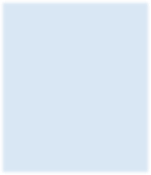
***Day of Surgical Procedure***

* Admitting nurse verifies the BPMH obtained at pre-admission clinic with patient and documents any changes along with compliance

# Logo - no tag lineMedication Reconciliation Process Oncology



Outpatient Chemo



Subsequent Visits

\* MRN Reviews the BPMH at each visit and makes the necessary changes

Authorized Prescriber Compares: Best Possible

Medication History (BPMH)

Vs Chemo Regime

BPMH Completed at first visit

# Medication Reconciliation Process Surgical Pre-Admission Clinic

**Yes**



Patients attending pre-admission clinic and any patients with COPD and booked procedure of laproscopic choleycystectomy

**No**

***Day of Surgical Procedure***

* Admitting nurse completes the BPMH

***Pre-Admission Clinic Visit*** BPMH completed by Pre- admit clinic nurse during Pre-admit visits







DISCHARGE

***Authorized Prescriber***

**Compares:**

Both Home and Hospital medications present on the discharge medication reconciliation power form

**Provides:**

* Discharge medication plan for the patient (includes prescription)

***Day of Surgical Procedure***

* Admitting nurse verifies the BPMH obtained at pre-admission clinic with patient and documents any changes along with

compliance

* Return Patient’s medication brought in.



***Documents***

* Discharge order
* Completes discharge medication reconciliation power form
* EMR medication profile (office document if needed)

***MRN***

* Reviews orders
* Contacts the prescriber for clarification where discrepancies exists
* Provides education to the patient and/or SDM on medication
* Request permission to discard discontinued medication.
* Provides copy to patient
* Faxes copy to Family Physician

Reconciliation Complete

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Medication Reconciliation Process

Non‐Admitted Emergency Target Population

Patient attending Emergency Department NOT admitted with final discharge diagnosis of Congestive Heart Failure (CHF)

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|  | MRN in emergency department completes the BPMH using as many  sources as possible. | |  |
| \*If time permits can use assistance of Pharmacy Technician\* | | | |

Authorized Provider at Discharge will:

* Compare both home and hospital medications being prescribed and complete medication reconciliation power form
* Provide prescriptions to patients upon discharge

Most Responsible Nurse (MRN) will:

* Contact provider for clarifications as needed
* Provide education to patient and/or family member/SDM
* Return medications to patients
* Provide discharge medication reconciliation copy to patient
* Fax copy to family physician office.

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