Disclaimer: The most up-to-date Learning Module can be found on the CDHA Safer Healthcare Now website http://chdinfra.cdha.nshealth.ca/departmentservices/saferhealthcarenow/index.html and the CDHA Policies and Procedures website (Intranet and Internet) at http://policy.nshealth.ca/Site_Published/dha9/dha9_home.aspx (Search for MM 50-003 Medication Reconciliation).
Table of Contents

1. Learning Objectives
   Steps to Completing Self – Study Learning Module    Page 3

2. Background
   • What is medication reconciliation?
   • Why are we doing this?   Page 4-5

3. Sample Medication Reconciliation and Admission Form    Page 6-7

4. Sample Medication Reconciliation and Admission Order from HSM    Page 8

5. Sample Medication Reconciliation and Admission Form (NCR)
   Sample accompanying Physician order form    Page 9-11

6. Sample Medication Reconciliation and Internal Transfer Order    Page 12-13

7. Sample Medication Reconciliation and Discharge Prescription    Page 14

8. Case Studies
   a. Same Day Surgery Unit    Page 15-20
   b. Inpatient units    Page 21-23
   c. Acknowledgement of Completion    Page 24

9. References    Page 25-32
Medication Reconciliation

Learning Objectives

Upon Completion of this module, the RN / LPN will be able to:

Identify the purpose of Medication Reconciliation
  a. Identify and explain key components of a Best Possible Medication History (BPMH)
  b. Identify responsibilities of team members in obtaining a BPMH
  c. Demonstrate the ability to complete the BPMH
  d. Outline the process for reconciling a BPMH (Inpatient Units only)

Steps to Completing Learning Module:

1. Review Learning Module (pp 4-14)

2. Complete the Case Study that applies to your work area:
   a. Case Study for Same Day Surgery Units (pp 15 – 20)
   b. Case Study for Inpatient Units (pp 21-23)

3. Complete Reference readings:
   a. Medication Reconciliation MM 50-003
   b. Medication Orders for Inpatients MM 15-003
   c. Pocket Guide (Tips for the BPMH Interview/ Frequently asked Questions)
   d. Stop Med Errors sticker
   e. Sample Physician Poster
   f. Medication Reconciliation and Admission Form CD1908MR_07_09
   g. Medication Reconciliation and Internal Transfer Order CD1907MR_07_09
   h. Medication Reconciliation and Discharge Prescription- CD1910MR_07_09

4. Sign Acknowledgement of Completion of Self Study Package
MEDICATION RECONCILIATION

ATTENTION: THIS IS A PATIENT SAFETY INITIATIVE

The medication reconciliation process at Capital Health has been developed to ensure that patients have the most complete and accurate medication list possible. This self study learning module has been developed to provide you with information on how the process works and what your role is in keeping patients safe. We are hopeful that you will gain insight and cooperation in moving this initiative forward allowing us to provide greater levels of safety for our patients.

What is medication reconciliation?

It is a formal process of:

- Obtaining a complete and accurate list of each patient’s current home medications (name, dosage, frequency and route). This list is known as the BEST POSSIBLE MEDICATION HISTORY or BPMH.
- Prescribers then use the BPMH as a reference to write medication orders during their stay and upon discharge from the hospital.
- Any discrepancies identified in the recorded BPMH are brought to the attention of the prescriber to ensure changes are made to the orders, when appropriate.

Why are we doing this?

To provide safer care!

The Canadian Adverse Events Study found:
- 7.5 % of patients admitted to acute care hospitals experienced one or more adverse events.
- Over 30% of these events were drug or fluid related.
- 37% of these events were judged to be highly preventable.

A 2005 Canadian study found:
- 53% of patients had at least one unintentional discrepancy on admission
- 38.6 % were judged to have the potential to cause moderate to severe discomfort or clinical deterioration.
- 46.4% of the discrepancies consisted of an omission of a regularly used medication.
- Up to 50% of medication errors occur at transition points (i.e. admission, transfer and discharge) in care.
- A 2006 Capital Health audit revealed that there are on average, in the population studied, almost 2 medication discrepancies on admission per patient. When you consider the number of admissions to Capital Health, this represents a potential of 56,000 medication errors directly related to poor history taking and documentation practices.

- The hospital accrediting body (CCHSA) has made it a requirement to complete medication reconciliation upon admission to the hospital.
- Capital Health has signed on to the Safer Health Care NOW! Initiative, and medication reconciliation is one of ten quality/safety improvement initiatives.
Where will we be implementing the medication reconciliation process?

Medication Reconciliation is being implemented throughout Capital Heath. A policy to support medication reconciliation has been developed. **It is important to read this policy and understand the expectations of the various health care providers related to Medication Reconciliation.**

How has Capital Health implemented this process?

Capital Health has decided to incorporate medication reconciliation processes for **admission, transfer and discharge.** The transfer piece will follow in time.

In order to embed Medication Reconciliation into current processes, Capital Health developed 4 forms:

1. The Medication Reconciliation and Admission Form functions as the BPMH documentation, which can then be used to generate admission orders (from the BPMH).

2. The Medication Reconciliation and Admission Order (generated from Horizon Surgical Manager HSM) functions as the BPMH documentation, which can then be used to generate admission orders for patients admitted through Pre-Admission Clinic. This version of the form electronically generates certain fields in the form from data entered in HSM.

3. The Medication Reconciliation and Internal Transfer Form is used to document a complete list of all transfer medications to be actioned by the receiving physician.

4. The Medication Reconciliation and Discharge Prescription functions as a discharge prescription, **and** lists all medications the patient is taking at the time of discharge.
### Completing the Medication Reconciliation and Admission Form (NCR)

**Document Patient’s name**

Attach Patient Label

Should always be the **first page** under the “physician’s orders” tab in the chart.

**Whoever has taken the BPMH documents their name and the sources used to generate the BPMH**

---

**Do not thin from chart**

**Document height & weight**

Allows pharmacy to verify creatinine clearance and weight based dosing.

**The primary responsibility for taking the BPMH**

- **Emergency / Ambulatory Care**
  - Resident / Physician
- **Pre-admission clinic**
  - PAC nurse
- **Direct Admissions**
  - Inpatient Admitting RN / LPN

---

**Physicians must fill out these sections.**

For each drug listed in the BPMH, the physicians need to:
- Assess if the drug should be continued / discontinued
- Check the appropriate column.
- If they wish to change a dose, route or frequency of a med, check the “change” column and write the new order
- For ANY change or discontinuation to meds document rationale.

---

**REMEMBER!**

The BPMH should only include meds as they were taken at home.

**NO CHANGES** to meds on admission should be documented in this column.

---

**Best Possible Medication History (BPMH)**

<table>
<thead>
<tr>
<th>(prescription, OTC, vitamin, herbal and natural products)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Medications</strong></td>
</tr>
<tr>
<td>- No Known Drug Allergies</td>
</tr>
<tr>
<td>- Allergies as follows (please describe reaction)</td>
</tr>
<tr>
<td><strong>History taken by:</strong></td>
</tr>
<tr>
<td>Source: □ Patient □ Family □ HPF □ Rx vials Community Pharmacy □ Family Physician □ Other_</td>
</tr>
<tr>
<td>Reconciled/Verified by: □ Date: __________ □ Time: __________</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th><strong>Prescriber to complete upon admission</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orders for Changes to Home Meds</strong></td>
</tr>
<tr>
<td>(Orders for new medications to be written on a separate physician order form)</td>
</tr>
<tr>
<td><strong>Emergency Gas Duty Complete</strong></td>
</tr>
</tbody>
</table>

---

**Late additions to BPMH - Requires separate MD Order**

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

**Details or Discrepancies identified upon reconciliation**

---

**Authorized Prescriber:** ____________________________  **Date:** (yyyy/mm/dd): __________

**Prescriber name:** ____________________________  **Registration no.:** __________

---

Top copy - chart  Bottom copy - pharmacy
Completing the Medication Reconciliation and Admission form - Focus on Reconciliation

Reconciliation = verifying that the BPMH is the best possible + verifying that documentation to support discontinuation or changes is complete.

<table>
<thead>
<tr>
<th>No Known Drug Allergies</th>
<th>Allergies as follows (please describe reaction)</th>
<th>History taken by:</th>
<th>Source: ☐ Patient ☐ Family ☐ HPF ☐ Rx vials Community Pharmacy ☐ Family Physician ☐ Other: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Reconciled/Verified by:</td>
<td>Date: _______________________ Time: __________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height _____ cm</th>
<th>Weight _____ kg</th>
<th>SCr _____ micromoles</th>
<th>CrCl _____ mL/min</th>
</tr>
</thead>
</table>

### Best Possible Medication History (BPMH)
- (prescription, OTC, vitamins, herbal and natural products)

#### Home Medications
- Name / Dose / Route / Frequency / Last dose
- ☐ No Home Medications
- ☐ Additional Medication Information Required

#### Prescriber to complete upon admission
- Reconcile / Verify

#### Details of Discrepancies Identified upon Reconciliation

Late additions to BPMH are documented here.
Prescriber reviews the late additions and writes orders for the medications on a separate physician's order form.

Reconciliation must occur no more than 24 hours after admission – this can be completed by Physicians, Nursing, and Pharmacists.

**Step 1:**
Use two independent sources of information to complete the BPMH and check off which sources were used.

**Step 2**
If inaccuracies are found in the BPMH (dose, route, frequency or inaccurate medications) **or** a rationale for changed or discontinued meds is missing, check off discrepancy and detail identified discrepancy in the box on bottom of form.

**Step 3**
Check off ‘complete’ if home medication is accurate and rationale for changes to home medications is written.

Authorized Prescriber: __________________________ Date (yyyy/mm/dd): __________________________
Prescriber name: __________________________ Registration no.: __________________________
Medication Reconciliation and Admission Orders
(From HSM - Horizon Surgical Manager)

Same Day Admission patients, arrive to the inpatient unit with a Medication Reconciliation and Admission Order form *generated from Horizon Surgical Manager (HSM)*. There are some slight differences between this form and its NCR counterpart (shown above).

The bubbles below highlight the unique aspects of the HSM generated Med Rec Admission Order. Please note sections in yellow electronically auto-populate into this report.
Can you spot the errors in the documentation of these meds? (see page 11 for answers)
**Diagnosis:**

**PHYSICIAN'S SIGNED ORDERS**

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>Admission orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/19/2022</td>
<td>1900</td>
<td>H. Failure</td>
</tr>
</tbody>
</table>

- Heart Healthy Diet
- Diabetic Diet
- Fluid Restriction 1.5 L/day
- Ins & Outs
- Scr, CBC, Electrolytes
- HbA1C

- Start Furosemide 80mg IV bid
- Lansoprazole 30mg po daily
- Levofloxacin 500mg IV today, then 500mg IV daily starting tomorrow

**Resident**
Documentation “errors” answer key

- Lasix, Fosamax and Pariet are all brand name products and by policy orders should be written generically (e.g. furosemide, alendronate and rabeprazole)

- “od” is an unsafe abbreviation. “Daily” is, by policy, how to indicate a once daily dosing.

- Metformin’s tablets strength was not indicated. Metformin comes as a 500 mg and an 850 mg tablet. Always include the total dose in mg to avoid this error.

- Fosamax 70 mg po weekly- should include the day of the week the patient takes their dose. (i.e. alendronate 70 mg po on Thursdays)

- Last Dose Taken - information not documented
**Medication Reconciliation and Internal Transfer Order**

**Capital Health**
Departments of Pharmacy, Nursing and Medicine

**Medication Reconciliation and Internal Transfer Order**

Patient: ___________________________________________________________________________ Transfer from: __________ to __________

- [ ] No Known Drug Allergies
- [ ] Allergies as follows (please describe reaction)

<table>
<thead>
<tr>
<th>Transferring Prescriber to Complete</th>
<th>Accepting Prescriber to Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Transfer Medications</td>
<td>Check appropriate column to transform list into transfer medication orders.</td>
</tr>
<tr>
<td>Using RPMH and current MAR from transferring unit, generate a list of all transfer medications</td>
<td>Complete rationale when required.</td>
</tr>
<tr>
<td>Medication Name / Dose / Route / Frequency</td>
<td></td>
</tr>
<tr>
<td>Prescriber writing transfer medication list:</td>
<td></td>
</tr>
<tr>
<td>Signature __________ Date __________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Continue</th>
<th>Discontinue</th>
<th>Change</th>
<th>Rationale for D/C or change</th>
<th>Physician Orders for changes to Transfer Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- It is the responsibility of the **Transferring Prescriber** to document a complete list of all transfer medications.

- Active medication orders are not created until the accepting prescriber transforms the transfer medication list into orders by choosing to continue, discontinue or change each medication and signs / dates the form.
This list of meds is transcribed to the new MAR

<table>
<thead>
<tr>
<th>Prescribing Prescriber to Complete</th>
<th>Accepting Prescriber to Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Transfer Medications</td>
<td>Check appropriate column to transform list into transfer medication orders.</td>
</tr>
<tr>
<td>Using BPMH and current MAR from transferring unit, generate a list of all transfer medications</td>
<td>Complete rationale when required.</td>
</tr>
<tr>
<td>Medication Name / Dose / Route / Frequency</td>
<td></td>
</tr>
<tr>
<td>Prescriber writing transfer medication list:</td>
<td></td>
</tr>
<tr>
<td>Signature: Smith</td>
<td>Date: 2020.04.27</td>
</tr>
<tr>
<td>ECASA 81mg po OD</td>
<td>Continue: Yes</td>
</tr>
<tr>
<td>Ramipril 10mg po OD</td>
<td>Discontinue: Yes</td>
</tr>
<tr>
<td>Carvedilol 25mg po bid</td>
<td>Change: Yes</td>
</tr>
<tr>
<td>Furosedime 20mg po OD</td>
<td>Rationale for D/C or change:</td>
</tr>
<tr>
<td>Allopurinol 150mg po OD</td>
<td>elevated creatinine: 50mg po OD</td>
</tr>
<tr>
<td>Lipitor 10mg po OD</td>
<td>Physician Orders for changes to</td>
</tr>
<tr>
<td>Doxazosin 4mg po OD</td>
<td>Transfer Medications</td>
</tr>
<tr>
<td>Ranitidin 150mg po bid</td>
<td></td>
</tr>
<tr>
<td>Co Sept Flop ear/eye bid</td>
<td></td>
</tr>
<tr>
<td>Xalatan 0.005 night both eyes 4hs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Meds discontinued at time of transfer</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furosedime</td>
<td>- monitor fluid retention - nausea allergy</td>
</tr>
<tr>
<td>Xalatan eye 4hs</td>
<td></td>
</tr>
</tbody>
</table>

Note meds that require reassessment after transfer
Sample Med Rec and Discharge Prescription form

Capital Health

Departments of Pharmacy, Nursing and Medicine

Medication Reconciliation and Discharge Prescription

Patient: H. Failure Site: H.I Unit 6.2

☐ No Known Drug Allergies

Dr. Allergies as follows (please describe reaction)
Penicillin (anaphylaxis)

Confidential Facsimile transmission to:
Intended Pharmacy:
Pharmacy fax #:
Date: ________ Time: ________

**If faxing, please see box on reverse for instructions**

---

<table>
<thead>
<tr>
<th>List of Discharge Medication</th>
<th>Reconciliation</th>
<th>Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>All medications to be taken on discharge</td>
<td>Compare List of Discharge Meds to BPMH and check appropriate column</td>
<td>Narcotics &amp; controlled drugs can be listed on this form. Prescriber must also write the Narcotic Rx on a TriPLICATE pad.</td>
</tr>
</tbody>
</table>

**List of Discharge Medication**

- Enalapril 5mg po bid
- Carvedilol 12.5mg po bid
- Furosemide 80mg po bid
- Alendronate 70mg weekly
- Calcium 500mg po bid
- Reboxetine 20mg po daily
- Neovolin nPH 20 units 1 unit support

**Reconciliation**

- New: Increased to target dose
  - XLms
  - Fml fluid retention

- New: To replace Metformin
  - IV 12

**Prescriptions**

- Quantity
- Repeats
- Special: Add code

---

**Discontinued Medications**

- Metformin 1 tab tid

**Rationale for Discontinuation**

- Contraindication (renal impairment)

---

☐ Other non-prescription drugs and NHP D/C on admission. Pt may resume in consultation with community care provider(s) on D/C.

Prescriber Certification for Faxed Prescriptions: This prescription represents the original of the prescription drug order. The pharmacy address as noted above is the only intended recipient and there are no others. The original prescription has been invalidated by marking it in such a way that it cannot be resubmitted.

Authorized Prescriber: Resident Date (yyyy/mm/dd): 2009/12/30
Prescriber name: Resident CPSNS #: 12000 Pager #: 13000

Medication Reconciliation Orders

First copy - Patient/Home Pharmacy Second copy - Chart Third copy - Family Physician

CD1910MR_07_09 Page 1 of 1
Case Study: For Same Day Surgery Units

Pre Admission Clinic Nurse:
During the clinic appointment, the patient provides you with a handwritten list of their home medications which include the following:

- Metoprolol Tartrate 75 MG twice daily
- Levothyroxine 0.088 mg daily
- Lasix 40mg daily
- Crestor 10mg daily
- Proctofoam HCL PRN
- Salbutalmol 1 Puff every 4 hours
- Nitrodur on at 8:00 am, off at 8:00 pm
- Vitamin D 800mg

1. Upon review of the list you note that certain information is missing. Identify the missing information. How would you verify the list for accuracy?

2. What questions would you ask the patient about their medications as listed?

3. After entering the medications in HSM, what do you document in the HSM Current Medication Comments box?

Pre Op Nurse:
4. On the day of surgery, what is your responsibility with the BPMH obtained in Pre Admission Clinic?

5. How do you print the Med Rec Report from HSM?

HSM Downtime:
6. Which form do you use to document the BPMH during HSM downtime?
Pre Admission Clinic Nurse
1. Missing information: no dose for Salbutamol and Nitrodur, no route or frequency for Vitamin D. To verify the accuracy of the list, obtain a faxed list of meds from patient’s home pharmacy. Place a barcode label on the Pharmacy list and file in the patient record.

2. Review each medication on the list and ask the patient “how do you take this medication?”
   a. **It is important that you document the medication exactly how the patient is taking it - this may be different than what the bottle states.**
   b. Refer to *Tips for the Best Possible Medication History Interview* to guide your questions.

3. Current Medication Comment (in HSM)
   
<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/10/21</td>
<td>BPMH obtained by S. Jones RN. Sources used: patient, handwritten list and faxed pharmacy list – Shoppers Quinpool Rd 429-1707. Patient instructed to bring medications to hospital on the day of surgery.</td>
</tr>
</tbody>
</table>

Pre Op Nurse

4. Ask the Patient:
   a. Have any of your medications changed since your visit to Pre Admission Clinic?
   b. Have you been started on any new medications?
   c. Which medications did you take today?

Document:
   a. All Changes to medications – eg. dose changes / new medications
   b. Date and Time that each medication was last taken
   c. You must also document a note in the Current Medication Comment box explaining all changes that you make to the original BPMH (see below)

<table>
<thead>
<tr>
<th>Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/10/21</td>
<td>BPMH obtained by S. Jones RN. Sources used: patient, handwritten list and faxed pharmacy list – Shoppers Quinpool Rd 429-1707. Patient instructed to bring medications to hospital on the day of surgery.</td>
</tr>
<tr>
<td>2010/10/26</td>
<td>BPMH updated by R. Smith LPN. Metoprolol dose increased to 100 mg po bid by family doctor.</td>
</tr>
</tbody>
</table>
Answer Key: Same Day Surgery Units (cont)

5. Follow the steps outlined in “How to Print the Medication Reconciliation Report” (see pages 16-18).

6. HSM Downtime Documentation
   a) Use the Medication Reconciliation and Admission form CD 1908MR_07_09 to record the BPMH.
   b) On the HSM Downtime Documentation - Current Medications section note: “See Medication Reconciliation and Admission Form”

For additional scenarios specific to SDSU, please review “Frequently Asked Questions / Answers SDSU - Medication Reconciliation” (available from your Nurse Educator or Manager)
How to Print the Medication Reconciliation Report From Charts in HSM

Exit the HSM chart by clicking ‘Exit’

You are now back at the HSM HOME Page

1. Select reports

2. Select Production Custom

3. Select Med Rec

4. OK

5. Click on link
6. Complete fields in Case Search page and Search

7. Select patient

8. Verify Correct Pt. – Click OK
9. The Med Rec report opens in a PDF file format. Verify it is the correct patient’s report.

10. Click on the PRINTER icon. The Print window will appear.

11. Verify the correct printer is identified. Use the drop down to change the printer if needed.

12. Click the OK button to print the report.

To return to the Preop chart,
- Click ‘X’ to close the viewed PDF report.
- Click the Cancel icon to close the window.
- Click the Exit icon to close HSM Reports.
- You will be returned to the HSM base screen.
- Under the Clinical Data menu, bring up the search screen in the usual manner to activate a patient’s chart.

IMPORTANT: Place the printed Medication Reconciliation and Admission Form in the patient chart at the front of the Physician Order section.
Case Studies – for Inpatient Units

Case Study #1: Direct Admission to Inpatient Unit

Your patient is a booked admission from home and provides you with a handwritten list of medications which include the following:

- Metoprolol Tartrate 75 MG twice daily
- Levothyroxine 0.088 mg daily
- Lasix 40mg daily
- Crestor 10mg daily
- Proctofoam HCL PRN
- Salbutalmol 1 Puff every 4 hours
- Nitrodur on at 8:00 am, off at 8:00 pm
- Vitamin D 800mg

1. Upon review of the list you note that certain information is missing. Identify the missing information.

2. How would you verify the list for accuracy?

3. What questions would you ask the patient about their medications as listed?

Case Study #2: Post-Op Admission to Inpatient Unit

A patient is admitted Post Op from PACU with the HSM Medication Reconciliation and Admission order form on their chart. The form has been completed by the attending surgical resident.

1. Before you transcribe the medication orders to the MAR, what should you check for on the form?

2. How do you go about reconciling / verifying the medications?

3. What is the process to follow in each of the three examples of a discrepancy?
   a) Missing documentation to support changes/discontinuations
   b) Discrepancy in the BPMH as listed (i.e. the patient takes metoprolol 25 mg po bid instead of the listed metoprolol 50 mg po bid)
   c) Late additions to the BPMH (eg. three days after the patient is admitted they ask: “why haven’t I been getting my eye drops?”)
Answer Key – Inpatient Units

Case Study #1

1. Missing information: no dose for Salbutalmol and Nitrodur, no route or frequency for Vitamin D.

2. To verify the accuracy of the list, obtain a faxed list of meds from patient’s home pharmacy. Place a barcode label on the Pharmacy list and file in the patient record.

3. Review each medication on the list and ask the patient “how do you take this medication?”
   a) It is important to document the medication exactly how the patient is taking it - this may be different than what the bottle states.
   b) Refer to Tips for the Best Possible Medication History Interview to guide your questions.

Case Study #2

1. Before sending the Medication Reconciliation and Admission form to Pharmacy, ensure the following are complete:
   a) Allergies, Ht & Wt documented
   b) Physician has checked all boxes (continue, discontinue, change)
   c) Discontinued or changed orders – Physician has documented a rationale
   d) Authorized Prescriber has signed orders

2. Verification / Reconciliation is a double check against the most reliable source of medication information, one of which should be the patient. Verification / Reconciliation is completed prior to or at the time of the 24 hour chart check.
   a) During reconciliation, it is best to include the patient in the review of their medications.
   b) This process also involves comparing the patient’s hand written list with the Pharmacy faxed list in order to check for any discrepancies.

If no discrepancies are identified, Reconciliation / Verification are now complete and the healthcare team member can now:

   c) Check off Complete box column
   d) Complete the Verified by section (include your signature, date, time)
Case Study #2  (cont)

3. Discrepancies

a) Missing Documentation (no rationale) for discontinue or change orders
   1. Check off discrepancy box
   2. Detail identified discrepancy in box provided on bottom of form.
   3. Notify the prescriber that they need to describe the rationale for the change (either on the form or in the progress notes).

b) Discrepancy in the BPMH as listed
   1. Check off the discrepancy box,
   2. Detail identified discrepancy in box provided on bottom of form.
   3. If necessary, write a progress note detailing the corrected medication. Title Progress Note: MED REC
   4. You then must notify the prescriber of the discrepancy, as they may wish to alter their in-hospital medications as a result of this discovery.

c) Late Additions to the BPMH
   If at any point after the med rec form has been signed off by the prescriber, it is noted that a medication has been omitted altogether from the med rec form:

   1. Document the omitted med under “Late additions to BPMH”
   2. Notify the prescriber of this “late addition”. Again, the prescriber may wish to alter their in-hospital medication orders as a result of this discovery.
   3. “Late additions” are to be written in a physician’s order by the prescriber (i.e. “Continue timolol 0.5 % eye drops to both eyes bid”).
Medication Reconciliation

Acknowledgement of Inservice Attendance and Completion of Self Study Package

I _____________________________ have received education regarding Medication Reconciliation.

☐ I have read the Medication Reconciliation Self Study Learning module, and I understand its contents.

☐ I have attended an education session on Medication Reconciliation.

☐ I have read the Medication Reconciliation Self Study Learning module and attended an education session; however I need further clarification to enhance my understanding of the content. I will seek out additional resources to meet my additional learning needs. (E.g. Clinical Nurse Educator, Health Services Manager, Charge Nurse, Pharmacist).

__________________________________
Signature

__________________________________
Date

Please sign and date and return to your Manager.
Medication Reconciliation Learning Module

References:

CDHA Policies:

- Medication Orders for Inpatients MM 15-003
- Medication Reconciliation MM 50-003

Additional References:

- Tips for taking BPMH / FAQ pocket card Interview PrinA899
- Stop Med Errors – stickers available in printing PrinA893
- Stop Med Errors Poster for Physicians PrinA897
- Medication Reconciliation and Admission Form CD1908MR_07_09
- Medication Reconciliation and Internal Transfer Order CD1907MR_07_09
- Medication Reconciliation and Discharge Prescription CD1910MR_07_09
Medication Reconciliation
Tips for the Best Possible Medication History Interview

A BPMH aims to record what a patient is taking, not how the medication is prescribed.

Ask patient:

- if they have up-to-date list of home medications.
- the name(s) of any community pharmacy where they have filled medications.
  Anticipate and inquire about multiple pharmacies.
- if they brought their prescription vials with them.
- if they have recently been admitted to the hospital.
- if they are using:
  - eye drops, inhalers, sprays, patches, etc.
  - over the counter drugs, vitamins, supplements, herbal products and traditional remedies.
  - any physician-provided medication samples.
  - any drugs being issued as part of a clinical trial.

Considerations:

- Whenever possible, try to validate each drug listed in the BPMH with at least 2 sources of information (e.g. patient interview, medication vials, medication lists, community pharmacy, and primary care physician). Exception: There is a sense the patient is an excellent historian.
- Use client’s medical conditions as a trigger to ask about commonly used medication classes for those medical conditions.
- When examining vials or prescription records, review the date filled to confirm recency. Whenever possible, consider patient adherence / compliance with prescribed regimens (has the medication been recently filled?).
- Don’t assume patients are taking medications according to prescription vial labels.
  - Use open-ended questioning styles: “Tell me how you take this medication”. Non-judgmental, comfortable question will allow patient to describe how they actually take a medication.
  - When inspecting medication vials, inquire about recent changes from vial directions (i.e. dose changes, stopped medications from initiated by either the patient or the physician).
  - Inquire about why they may be taking medication differently from directions (concerns about side effects, allergic reactions or lack of efficacy).
  - Be cautious that some vials may contain medications other than those on the label (patients at times re-arrange medications from those originally dispensed).

Adapted from University Health Network, Toronto, ON
Prepared by Kristie Small, Pharm D candidate
Frequently Asked Questions

What does it mean to reconcile the meds on admission?

- It means that you are confirming that:
  - the BPMH contains all medications the patient was taking at home.
  - for each medication listed the dose, route, and frequency are as the patient was taking at home.
  - the documentation describing rationale for changes to BPMH meds, upon admission, has been completed.

What is the process for reconciling on admission?

- Once the BPMH is documented, the interviewer should assess how confident they are that the list is complete and accurate. For example, if the interviewer feels the patient is an excellent historian AND the rationale for changes to medications on admission have been documented, the medications can be signed off as “reconciled” (i.e. check “complete” column in “reconciliation section” and sign/ date/ time the “reconciled by” section).

- If, however there is uncertainty with respect to the BPMH (i.e. have not verified each drug with at least 2 sources), physicians, nurses or pharmacists, should identify which sources of information were already utilized and verify the list using additional sources of information. They would also confirm that the rationale for changes to medications on admission has been documented.

Whose responsibility is it to acquire the BPMH?

- The primary responsibility for initial completion of the BPMH is as follows:
  
  *Emergency/ Ambulatory Clinic-* the admitting resident/ physician
  *Same Day Surgery patients-* the pre-admission clinic nurse
  *Direct admissions-* the admitting nurse

- While the primary responsibility for completing the BPMH is designated above, it remains a team effort to ensure the best possible medication history is collected and documented.

Whose responsibility is it to complete the reconciliation?

- It is a shared responsibility between physicians, nursing and pharmacy.

What are the key steps required to complete the medication reconciliation process?

- Use the form and fully complete all sections.
- Take the time to take a best possible medication history. Average time to acquire the BPMH (data from other centres): 20-25 minutes.
- Ensure rationale for any medication change(s) is clearly documented.
- Communicate within the healthcare team to ensure process is complete.
Stickers available in Print Shop

Order #  PrinA893
Sample Physician Poster

Order # PrinA897

Capital Health

STOP MED ERRORS

Rec the Meds!
Reduce the risk for your patients

“I was convinced of the importance of med rec during my MTU rotations. More than once, patients were admitted in the middle of the night with a written list of medications that we took as accurate. When the list was double-checked in the morning we found there were whole classifications of meds not listed. That was a real eye-opener to me because of the patient safety implications”

Dr. Lori Connors, third-year internal medicine resident, August 2007.

Reconciling your patients’ medications will make a difference:

• A 2006 audit at Capital Health showed that medication histories are often incorrect or incomplete.
• On average, there was nearly one unintentional discrepancy per patient in the medication histories.
• On average, documentation supporting intentional medication changes was lacking for one medication per patient.
• This means 56,000 potential medication errors a year for Capital Health patients.
• In other jurisdictions, using a medication reconciliation process helped decrease the rate of medication errors by 70% and adverse drug events by 15% over a seven-month period.


Medication reconciliation is an official Capital Health policy now.

• Sometimes a prescriber unintentionally changes a medication through poor history taking and subsequent documentation.
• Sometimes a prescriber makes an intentional change in a medication but the change is not clear to others because of poor documentation.
• Capital Health’s goal: Reduce both kinds of discrepancies by 75%.
• Two standardized forms were developed to assist with medication reconciliation. The first form is both the patient’s medication history (the best possible medication history, or BPMH) and an admission order. The second form provides a reconciled list of discharge meds and discharge prescriptions.

It’s a four-step process for you, the prescriber:

• Create the BPMH of all home medications for each patient on the form, confirming with the patient and other available sources.
• Document rationale for changes to medications as they are made.
• Use the BPMH as a reference when writing orders both on admission and while the patient is in hospital.
• Use the Medication Administration Record (MAR) and the BPMH as a reference when writing discharge prescriptions.

Where you can go for more detail:

• Your unit manager.
• The charge nurse.
• The pharmacist.

Or contact Pauline MacDonald, Planning Consultant, Quality and Risk Management, 473-7991
Capital Health

Departments of Pharmacy, Nursing and Medicine

Medication Reconciliation and Admission Form

Patient: ____________________________

☐ No Known Drug Allergies
☐ Allergies as follows (please describe reaction)

History taken by: ________________________

Source: ☐ Patient ☐ Family ☐ HPF ☐ Rx vials
Community Pharmacy ________________________

☐ Family Physician ☐ Other ________________________

Reconciled/Verified by: ________________________

Date: _______ Time: _______

Height _______ cm Weight _______ kg SCr _______ micromoles CrCl _______ mL/min

<table>
<thead>
<tr>
<th>Best Possible Medication History (BPMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(prescription, OTC, vitamins, herbal and natural products)</td>
</tr>
<tr>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Home Medications Name / Dose / Route / Frequency / Last dose</td>
</tr>
<tr>
<td>☐ No Home Medications</td>
</tr>
<tr>
<td>☐ Additional Medication Information Required</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Late additions to BPMH - REQUIRES separate MD Order</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Authorized Prescriber: ____________________________ Date (yyyy/mm/dd): ____________________________

Prescriber name: ____________________________ Registration no: ____________________________

Top copy - chart Bottom copy - pharmacy

Page 1 of 1
## Medication Reconciliation and Internal Transfer Order

Patient: ___________________________  Transfer from: ___________________________ to ___________________________

- **No Known Drug Allergies**
- **Allergies as follows (please describe reaction)**

### Transferring Prescriber to Complete List of Transfer Medications
Using BPMH and current MAR from transferring unit, generate a list of all transfer medications.

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prescriber writing transfer medication list:

- **Signature**: ___________________________  **Date**: ___________________________

### Accepting Prescriber to Complete
Check appropriate column to transform list into transfer medication orders. Complete rationale when required.

<table>
<thead>
<tr>
<th>Continue</th>
<th>Discontinue</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale for D/R or change</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Physician Orders for changes to Transfer Medications

### Meds discontinued at time of transfer

<table>
<thead>
<tr>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Meds for re-assessment in 24h

<table>
<thead>
<tr>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

---

Accepting/Authorized Prescriber: ___________________________  Date (yyyy/mm/dd): ___________________________

Prescriber name: ___________________________  Registration no: ___________________________

Top copy - chart  Bottom copy - pharmacy  Page 1 of 1
## Medication Reconciliation and Discharge Prescription

### List of Discharge Medication

<table>
<thead>
<tr>
<th>Medication Name / Dose / Route / Frequency</th>
<th>Prescribed</th>
<th>New</th>
<th>Rationale for drug addition / change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reconciliation

- **Compare List of Discharge Meds to BPMH and check appropriate column**

### Prescriptions

- **Quantity**
- **Reports**
- **MS Special Auth Code**

### Discontinued Medications

<table>
<thead>
<tr>
<th>Discontinued Medications</th>
<th>Rationale for Discontinuation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Information

- **Confidential Facsimile transmission to**
- **Intended Pharmacy:**
- **Pharmacy fax #:**
- **Date:**
- **Time:**

**Note:** If faxing, please see box on reverse for instructions.

---

**Authorized Prescriber:**

**Date:**

**Prescriber name:**

**CFSNS #:**

**Pager #:**

---

**First copy - Patient/Home Pharmacy**

**Second copy - Chart**

**Third copy - Family Physician**

**Printed:**

**CD1910MR_07_09**

---