Procedure

Procedure Title:	Medication Reconciliation for **Outpatient Care and Community Based Settings**	
Applies To:	Team Members working in **Ambulatory Care Services, Cancer Care Services, Renal Services, Primary Care, Primary Health Care, Outpatient Mental Health and Addictions**	
Governing Policy:	Medication Reconciliation - NSHA MM-SR-030	
Approved: March 24, 2021	**Effective:** August 9, 2022	**Next Review:** March 24, 2025
Sponsor:	Senior Director, Pharmacy Senior Director Interprofessional Practice and Learning	
Issuing Authority:	Drugs & Therapeutics (D&T) Health Authority Medical Advisory Committee (HAMAC)	
Number NSHA MM-SR-030.04	**Manual:** Medication Management	

PURPOSE

This procedure outlines the roles and responsibilities in medication reconciliation.

COMPETENCY REQUIREMENTS

1. Obtain the following competency requirements, as applicable:
   - 1.1. **All Team Members**
     - ☐ Completion of Drug Information System (DIS) LMS, where DIS is available
   - 1.2. Additional requirements for **Health Care Providers with medication management within their scope of employment**:
     - ☐ Completion of Medication Reconciliation LMS
     - ☐ Review Medication Reconciliation policy - NSHA MM-SR-030

ACCESS REQUIREMENTS

2. **All Team Members:** Obtain access to the following as relevant to practice area:
    - Meditech (Western Zone (WZ), Eastern Zone (EZ), Northern Zone (NZ)
    - BDM (Central Zone Pharmacy)
    - One Content™ (Central Zone (CZ))
    - Drug Information System (DIS)
    - Renal Insight (Renal)
    - Applicable Electronic Medical Records (e.g., MedAccess, Practimax, and Accuro®)

Legend: Provider acronyms used in the procedure. For definitions, refer to Appendix A.	
○ Registered Nurse (RN) ○ Licensed Practical Nurse (LPN) ○ Authorized Prescribers (AP) ○ Most Responsible Health Care Practitioner (MRHCP)	○ Pharmacist (RPh) ○ Pharmacy Practice Assistant (PPA) ○ Health Care Provider (HCP)

PROCEDURE

Task Description	Role (one of the following)
1. Determine if Medication Reconciliation (Med Rec) is required based on clinic criteria in Appendix B. • If a patient is discharged from an inpatient setting within 48 hours of presenting to outpatient setting, the Discharge Medication Reconciliation can serve as the initial Best Possible Medication History (BPMH) if it is available. Proceed to step 5 (omit steps 2, 3, and 4).	Ward aid/Ward Clerk/Clerical PPA/RPh RN/LPN Authorized Prescriber (AP)
2. Obtain client's current medication information. 2.1. Preferred medication reference is DIS. 2.2. Optional sources of information include: □ Community pharmacy □ Previous medication administration record (MAR) □ Client medication bottles/list.	Ward aid/Ward Clerk/Clerical (DIS and contacting community pharmacy only) PPA/RPh RN/LPN Authorized Prescriber

Task Description	Role (one of the following)
□ Electronic Medical Record	
3. Interview client/support person/Delegate/Statutory Decision Maker. This is the primary source of information. Include the following (but not limited to): • All prescribed • Non-prescription (over-the-counter) • Herbals • Vitamins • Supplements • Homeopathic • Investigational drugs • Prescriber samples • High-cost drug program medications, and • Compassionate release drugs	PPA/RPh RN/LPN Authorized Prescriber
4. Document Best Possible Medication History (BPMH) on: • "NSHA and IWK Ambulatory Care Medication Reconciliation Report" found on DIS (preferred if applicable), **or** • Local Med Rec form.	HCP who performed interview Authorized Prescriber
5. During subsequent outpatient care visits, ask the client if there have been any changes in their home medications. This is meant to be a "check in". Documentation source/tools may include (but are not limited to) the following: • Progress/Clinic Notes • Late entry section of Med Rec Form (if available) • Changes to Home Medications form 5.1. The documentation source/tool should be the same in each clinic. 5.2. If significant changes have occurred, comparison with the original BPMH may need to be done and documented as per clinic criteria.	PPA/RPh RN/LPN Authorized Prescriber

Task Description	Role (one of the following)
6. Communicate discrepancies to MRHCP (written/fax, verbal, or telephone depending on urgency).	PPA- written only RPh RN/LPN Authorized Prescriber
7. Resolve discrepancies. • Provide prescription if required. • Ensure that the completed med rec form is part of the client's chart.	Most Responsible Health Care Provider Authorized Prescriber
8. Repeat Med Rec process based on criteria in Appendix B.	PPA/RPh RN/LPN Authorized Prescriber
Discharge or No Further Follow-up	
9. Communicate decision to discharge or that no further follow-up is required to care team.	Authorized Prescriber
10. On the last visit, ensure an up-to-date list of the client's medications are provided to: • Client/family, and • Next care provider □ Examples: primary care provider, community pharmacist, home care services, etc.	Ward aid/Ward Clerk/Clerical PPA RPh RN/LPN MRHCP
11. Provide education and/or medication calendar as appropriate.	RPh RN/LPN Authorized Prescriber

RELATED DOCUMENTS

Medication Reconciliation - NSHA MM-SR-030

Medication Reconciliation LMS

Appendices

Appendix A: Definitions

Appendix B: Clinic Criteria

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Appendix A: Definitions

Authorized Prescriber	A health care professional permitted by legislation, their regulatory college, Nova Scotia Health, and practice setting (where applicable) to prescribe medications and treatments. The authority to order medications is not linked to any particular health profession and may also differ within that health care profession depending upon specific competencies and skills. For the purposes of this policy, examples of an authorized prescriber may include, but are not limited to, a physician, medical resident, nurse practitioner, pharmacist, midwives, or a registered dietician approved to order parenteral nutrition.
Best Possible Medication History (BPMH)	A BPMH is a history created using: ○ A systematic process of interviewing the client/family; and ○ A review of at least one other reliable source of information to obtain and verify all of a client's medication use (prescribed and non-prescribed). This includes, but is not limited to: ● All prescribed ● Non-prescription (over-the-counter) ● Herbals ● Vitamins ● Supplements ● Homeopathic, ● Investigational drugs ● Prescriber samples ● High-cost drug program medications, and ● Compassionate release drugs Complete documentation includes drug name, strength (if applicable), dosage, route frequency and time of last dose (as appropriate).
Current Medication List	The list of medications that the client states that they are taking. It may be the same as the BPMH; however if the BPMH is from the initial visit, these lists may differ.
Delegate/ Statutory Decision Maker	"Delegate" means a person authorized under a personal directive to make, on the maker's behalf, decisions concerning the maker's personal care; "Statutory Decision-Maker" means a nearest relative. "Nearest relative" means, with respect to any person, the relative of that person first listed in the following subclauses:

	(i) spouse, (ii) child, (iii) parent, (iv) person standing in loco parentis, (v) sibling, (vi) grandparent, (vii) grandchild, (viii) aunt or uncle, (ix) niece or nephew, (x) other relative, who, except in the case of a minor spouse, is of the age of majority. (Personal Directives Act)
Discrepancy	A difference between what was prescribed and what the client is actually taking.
Health Care Provider (HCP)	Applies to all staff/students who have a role in medication management within scope of practice/employment – including but not limited to: o Registered Nurse (RN) o Nurse Practitioner (NP) o Licensed Practical Nurse (LPN) o Physician o Pharmacist (RPh) o Pharmacy Practice Assistant (PPA)
Medication Reconciliation (Med Rec)	Is a formal process in which healthcare providers work together with clients, families, and care providers to ensure that accurate, comprehensive medication information is communicated consistently across transitions of care. It requires a systematic and comprehensive review of all the medications a client is taking to ensure that medications being added, changed, or discontinued are carefully evaluated. A component of medication management, medication reconciliation informs and enables prescribers to make the most appropriate prescribing decisions for the client. (CPSI)
Most Responsible Health Care Practitioner (MRHCP)	The physician, clinical associate, or nurse practitioner who has responsibility for directing and coordinating the care and management of an individual client at a specific point in time.
Reconcile	A process that involves: o Review of the BPMH

	○ The identification, communication, and resolution of discrepancies.
Team Member(s)	Includes Health Care Providers and clerical/support staff who have completed the identified competencies and are authorized by their manager.

Appendix B: Clinic Criteria

All Clinics
1. Medication Reconciliation is to be completed when medication management is a major component of care. 2. Each clinic is responsible to identify these client populations along with the frequency at which medication reconciliation should occur. 3. This information is to be documented on the Clinic Criteria Documentation Form (link when available). 4. The unit manager is responsible to update, enforce and maintain the form.
Ambulatory Care Clinics

Medication Reconciliation is to be completed for clients who present for medication administration, prescribing and/or titration.
• Complete on or prior to the initial visit
• Complete on transfer as appropriate.
• Complete on discharge or when no further follow up is required in outpatient clinic.
• Review with each subsequent visit to determine changes
• Repeat Medication Reconciliation process
  o Every six months (next scheduled visit closest to this timeframe)
  o With treatment plan changes
  o For significant status changes

Cancer Care

Medication Reconciliation is to be completed for clients who present for medication administration, prescribing and/or titration.
• Complete on or prior to the initial visit
• Complete on transfer as appropriate.
• Complete on discharge or when no further follow up is required in outpatient clinic.
• Review with each subsequent visit to determine changes
• Repeat Medication Reconciliation process:
  o Every six months (next scheduled visit closest to this timeframe)
  o With treatment plan changes
  o For significant status changes

- At final visit (in preparation for providing information to clients)

Outpatient and Community Based Settings for Mental Health and Addiction Services

Medication Reconciliation is to be completed for clients who present for medication administration, prescribing, and/or titration.

- Start on or prior to the initial visit
- Complete at the time of the initial visit
- Complete on transfer as appropriate.
- Complete on discharge or when no further follow up is required in outpatient clinic.
- During subsequent visits, ask client if there have been any additions or changes in medications since the last visit (i.e., over the counter, prescriptions, etc.)
- Repeat Medication Reconciliation process:
  - Every 12 months
  - With treatment plan changes that may impact medication (i.e., ECT, withdrawal management, etc.)
  - With significant changes to medication (i.e., switching medications, augmentation of existing medication(s), discontinuation of medication, etc.).

Primary Care and Primary Health Care

Medication Reconciliation is to be completed for clients who present for medication administration, prescribing, and/or titration.

- Complete on or prior to the initial visit
- Complete on transfer as appropriate.
- Complete on discharge or when no further follow up is required in outpatient clinic.
- Review with each subsequent visit to determine changes
- Repeat Medication Reconciliation process:
  - Every twelve months (next scheduled visit closest to this timeframe)
  - With treatment plan changes
  - For significant status changes

Renal Services

Pre-Dialysis Clinic/Transplant Clients

- Complete prior to or with initial visit

- Complete on transfer as appropriate.
- Complete on discharge or when no further follow up is required in outpatient clinic.
- Review with each subsequent visit to determine changes (timeframe is client specific).

Peritoneal/Home Hemodialysis/Hemodialysis – In Centre

- Complete prior to or with initial visit
- Complete on transfer as appropriate
- Complete on discharge or when no further follow up is required in outpatient clinic.
    - Review with each subsequent visit to determine changes
- Repeat Medication Reconciliation process
    - Every six months (next scheduled visit closest to this timeframe)
    - With treatment plan changes
    - For significant status changes

VERSION HISTORY

Version:	Effective:	Approved by:	What's changed:
Original	2022-08-09	D&T, HAMAC	N/A
0.1	2022-08-09	Senior Director, IPPL Senior Medical Director, Drugs and Therapeutics Services Network Director, Drugs and Therapeutics Services Network	Changes to Appendix B to clarify Med Rec requirements where Medication Administration is the primary focus of the visit.