Policy & Procedure

Policy Title:	Medication Reconciliation
Applies To:	Team Members with medication management within their scope of employment.
Related Procedure(s):	Medication Reconciliation for Acute Care Services - NSHA MM-SR-030.01 Medication Reconciliation for Long Term Care - NSHA MM-SR-030.02 Medication Reconciliation for Continuing Care - NSHA MM-SR-030.03 Medication Reconciliation for Outpatient Care and Community Based Settings - NSHA MM-SR-030.04 Medication Reconciliation for 24-hour Cardiology Transfer Patient - NSHA MM-SR-030.05

Approved:	**Effective:**	**Next Review:**
March 24, 2021	Aug 9, 2022	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	**Manual:** Medication Management

PURPOSE

Medication Reconciliation is an essential component of safe medication management. The purpose of this policy is to provide direction and promote consistency in the Medication Reconciliation process.

POLICY STATEMENTS

1. The process of Medication Reconciliation must be an interprofessional, team approach.

2. Medication Reconciliation must occur at the following care transition points:

   2.1. **Admission (or intake where appropriate)** into Nova Scotia Health (see procedures for specific criteria).

   - Medication Reconciliation for Acute Care Services - NSHA MM-SR-030.01
   - Medication Reconciliation for Long Term Care - NSHA MM-SR-030.02
   - Medication Reconciliation for Continuing Care - NSHA MM-SR-030.03
   - Medication Reconciliation for Outpatient Care and Community Based Settings - NSHA MM-SR-030.04
   - Medication Reconciliation for 24-hour Cardiology Transfer Patient - NSHA MM-SR-030.05

   2.2. **Transfer between** a Nova Scotia Health facility/clinic to the following:

   2.2.1. **Another Nova Scotia Health care facility/clinic**

   - The sending site is responsible to complete the transfer med rec form.
   - A new BPMH must not be completed when transferring into another Nova Scotia Health facility/unit. A copy of the original BPMH must be sent with the transfer information.

   2.2.2. **Another service within the same Nova Scotia Health facility/clinic where care is provided by a different care team/service.**

   - The sending unit is responsible to complete the transfer medication reconciliation form.
   - A discharge prescription (i.e., Discharge Medication Reconciliation form) **may** need to be provided for Nova Scotia Health Long Term care residents where medications are not supplied by Nova Scotia Health in addition to the transfer medication reconciliation form.
   - Transfer for bed utilization reasons within the same facility where the Authorized Prescriber does not change do not require Med Rec.

   > **Exception**: Closed units where orders have to be written upon admission to the unit. The receiving unit is responsible to complete the transfer medication reconciliation form in these cases (Example: ICU).

   2.3. **Discharge** from Nova Scotia Health.

   2.3.1. **It may include discharge to an external care/service provider or discharge home.**

   - When a patient is discharged from an inpatient setting to an outpatient setting/Continuing Care or non-Nova Scotia Health Long Term Care setting, a copy of the discharge medication reconciliation form must be sent to ensure continuity of care.

- ◻ When a patient from Northern Zone, Western Zone or Eastern Zone is transferred to the Cardiac Short Stay Unit at the Halifax Infirmary (HI) and is intended for discharge post cardiac catheterization as per Medication Reconciliation for 24-hour Cardiology Transfer Patient - NSHA MM-SR-030.05.

3. Medication Reconciliation must be initiated with the generation of the Best Possible Medication History (BPMH) of all medications the patient is taking at the time of admission.
4. The Health Care Provider (HCP) must involve the patient and/or family/ Delegate/Statutory Decision Maker as a key participant whenever possible in the medication reconciliation process at all transitions of care. This is especially important when collecting a BPMH.
5. At admission (or intake where appropriate), each medication listed on the BPMH must be addressed by an Authorized Prescriber and reconciled by an HCP.

   5.1. This must be completed within the following time frames:

   - ◻ Acute Care – 24 hours
   - ◻ Long Term Care – 48 hours
   - ◻ Continuing Care – first visit; or as identified by the home care service
   - ◻ Outpatient Care and Community Based Settings – first visit; or as identified by the outpatient care service.

6. The steps involved with transfer medication reconciliation (i.e., comparing and reconciling) must be completed during the process of preparing to transfer the patient.
7. The steps involved with discharge medication reconciliation (i.e., comparing and reconciling) must occur prior to the time of discharge.
8. Any discrepancies identified by the HCP must be immediately resolved by the Authorized Prescriber upon notification.
9. Each interdisciplinary team must perform Medication Reconciliation audits annually (at a minimum).
   - The Nova Scotia Health Drugs and Therapeutics committee (or delegate committee) will review the metrics produced by the audit process.

PROCEDURE

1. Refer to the appropriate procedure:
   - Medication Reconciliation for Acute Care Services - NSHA MM-SR-030.01
   - Medication Reconciliation for Long Term Care - NSHA MM-SR-030.02
   - Medication Reconciliation for Continuing Care - NSHA MM-SR-030.03

- Medication Reconciliation for Outpatient Care and Community Based Settings - NSHA MM-SR-030.04
- Medication Reconciliation for 24-hour Cardiology Transfer Patient - NSHA MM-SR-030.05

REFERENCES

Accreditation Canada. (2020). *Required Organizational Practices Handbook 2020*.

Alberta Health Services. (2019). *Medication Reconciliation* (Policy No. PS-05). Retrieved from https://extranet.ahsnet.ca/teams/policydocuments/1/clp-medication-reconciliation-ps-05-policy.pdf

Canadian Patient Safety Institute. (2020). *Medication Reconciliation (Med Rec): Getting Started Kit.* Retrieved from http://www.patientsafetyinstitute.ca/en/toolsResources/pages/med-rec-resources-getting-started-kit.aspx

RELATED DOCUMENTS

Medication Reconciliation for Acute Care Services - NSHA MM-SR-030.01

Medication Reconciliation for Long Term Care - NSHA MM-SR-030.02

Medication Reconciliation for Continuing Care - NSHA MM-SR-030.03

Medication Reconciliation for Outpatient Care and Community Based Settings - NSHA MM-SR-030.04

Medication Reconciliation for 24-hour Cardiology Transfer Patient - NSHA MM-SR-030.05

Medication Reconciliation LMS

Appendices

Appendix A: Definitions

* * *

Appendix A: Definitions

Authorized Prescriber	A health care professional permitted by legislation, their regulatory college, NSH, 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 patient/family; and ○ 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). This includes, but is not limited to: • All prescribed • Non-prescription (over-the-counter) • Herbals • Vitamins • Supplements • Homeopathic • Health remedies • 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).
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 patient 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: ○ Registered Nurse (RN) ○ Nurse Practitioner (NP) ○ Licensed Practical Nurse (LPN) ○ Physician ○ Pharmacist ○ Pharmacy Practice Assistant (PPA)
Long Term Care	Includes the following: ○ Veterans units ○ Stand Alone Nova Scotia Health Long Term Care Facilities ○ Designated Long Term Care units (does NOT include Transitional Care Units (TCU) or Alternative Level of Units (ALC)
Medication Reconciliation (Med Rec)	Is a formal process in which healthcare providers work together with patients, 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 patient 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 patient. (CPSI)
Most Responsible Prescriber (MRHCP)	The physician, clinical associate, or nurse practitioner who has responsibility for directing and coordinating the care and management of an individual patient at a specific point in time.
Patient	All persons who receive or have requested health care or services from Nova Scotia Health and its Health Care Providers and also means, where applicable: ○ A co-decision-maker with the person; or ○ An alternate decision-maker on behalf of the person
Reconcile	A process that involves: ○ 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.

This is a CONTROLLED document for internal use only. Any documents appearing in paper form are not controlled and should be checked against the electronic file version prior to use.

DISTRICT HEALTH AUTHORITY POLICIES BEING REPLACED

AVDHA 260.006 Best Possible Medication History (BPMH) and Medication Reconciliation (Med Rec) for Admission, Transfer, and Discharge

CBDHA 3-027 Medication Reconciliation

CBDHA 3-290 Procedure for Discharge Calendar/Counseling

CDHA MM 50-003 Medication Reconciliation

CEHHA 304-016 Patient Discharges to Nursing Homes

CEHHA 304-017 Medication Reconciliation

CHA 012-DW.035 Best Possible Medication History and Medication Reconciliation

CHA 217-008 Best Possible Medication History and Medication Reconciliation

GASHA 3-80 Medication Reconciliation

PCHA 32-m-20 Medication Reconciliation

SSH-NU-100-640 Medication Reconciliation

SWDHA 518.0 Medication Reconciliation

SWNDHA 800.128 Post-Admission Medication Reconciliation

SWNDHA 800.129 Best Possible Medication History

SWNDHA 800.2389 Medication Reconciliation Processes-Perinatal Services

VERSION HISTORY

Version:	Effective:	Approved by:	What’s changed:
Original	2022-08-09	D&T, HAMAC	N/A
2025-02-19	2024-03-04		Added 24 hr Cardiology Transfer Patient procedure to Policy 2.1, 2.3.1, and Procedure section