Policy

Policy Title:	Medication Reconciliation	
Applies To:	Physicians, Physician Assistants, Registered Nurses, Licensed Practical Nurses, Midwives, Nurse Practitioners, Pharmacists, Pharmacy Technicians, Pharmacy Practice Assistants, and other Health Care Providers (HCPs) who have medication practice as part of their professional role	
Location Applicability:	IWK Health	
Approved: October 3, 2023	**Effective:** October 9, 2023	**Next Review:** October 2027
Sponsor:	Director of Pharmacy	
Approval Authority:	Drugs and Therapeutics	
Number: 10.30	**Manual:** Medication Management	

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This is a working draft document for internal use only.

PURPOSE

Medication Reconciliation is an essential component of safe medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient. It is a formal process in which healthcare providers work together with patients, families and caregivers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. 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 For inpatient services medication reconciliation shall be conducted for:

      2.1.1 All patients who are admitted to the health centre within 24 hours.

      2.1.2 All patients transferred from one inpatient care area to another, excluding off service patients, and those transferred to the Operating Room for the following minor procedures:

      - central line insertion
      - endoscopy
      - biopsy
      - lavage
      - bone marrow examination, lumbar puncture
      - CT scan
      - MRI
      - cardiac catheterization

      Note: All other surgical procedures require a complete rewriting of orders postoperatively and medication reconciliation upon patient transfer.

      2.1.3 All patients upon discharge, with the exception of newborns from 5A/5B.

   2.2 For ambulatory services medication reconciliation shall be conducted for:

      2.2.1 All patients in the Emergency Department, including Emergency Mental Health and Addictions Service (EMHAS), upon decision to admit.

      - The responsibility for medication reconciliation rests with the admitting care team.
      - The medication reconciliation process may begin in the ED but must be completed in the receiving unit.

      2.2.2 Ambulatory patients when medication management is a major component of care or if the patient is considered at a higher risk of a medication adverse drug event (see definitions-Appendix A)

         2.2.2.1 Select patients as defined and identified by the clinical teams *(see Appendix B, C, D)*

   2.3 Medication Reconciliation is NOT required of any Primary Health Care Team.

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/clinic visit. The BPMH must be generated from at least two sources.

4. The Health Care Provider (HCP) must involve the patient/family/caregiver 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. The steps involved with transfer medication reconciliation (i.e., comparing and reconciling with the admission med rec) should be initiated during the process of preparing to transfer the patient. In the case of an urgent transfer, the accepting prescriber may complete the medication reconciliation process once the patient is transferred.

6. The steps involved with discharge medication reconciliation (i.e., comparing and reconciling with the admission med rec) must occur prior to the time of discharge.

7. Any discrepancies identified by the HCP must be immediately resolved by the Most Responsible Prescriber upon notification. For ambulatory care, team is responsible for resolving any discrepancies specific to their care of the patient and ensuring medication history in chart is complete.

8. Quantitative analysis of medication reconciliation activities at admission, transfer and discharge shall be coded by Health Records according to criteria established by Canadian Institute for Health Information (CIHI). IWK Centre-Wide Medication Reconciliation audit data for inpatients is collated monthly and a Decision Support Services (DSS) report prepared by IWK Performance Analytics. Ambulatory care team data is not captured in the DSS report, so mechanisms must be in place to ensure medication reconciliation audits are preformed biannually (at a minimum).
    - Clinical managers shall ensure that quality audits are performed to measure effectiveness, improve completion and accuracy rates of the medication reconciliation process.
    - The IWK Medication Reconciliation Working Group will review the metrics produced by the audit process and report quarterly to the Medication Management Safety Steering Committee.

GUIDING PRINCIPLES AND VALUES

Delivering safe, high-quality care is a strategic priority of the IWK. The IWK strives to reduce serious safety events through a strengthened culture of quality and safety. By providing clear direction and promoting a standardized approach to the medication reconciliation process, the number of patients with unintended medication discrepancies will be reduced, thereby significantly decreasing the potential of medication errors and ensuring a safer medication management system.

REFERENCES

Medication Reconciliation in Acute Care: Getting Started Kit. Safer Healthcare Now!
Institute for Safe Medication Practices Canada. (2019). *Medication Reconciliation (MedRec).*
https://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Medication%20Reconciliation/Acute%20Care/MedRec%20(Acute%20Care)%20Getting%20Started%20Kit.pdf

Patient Safety Essentials Toolkit: Boston: Institute for Healthcare Improvement, 2019 (available at ihi.org) Patient Safety Essentials Toolkit | Institute for Healthcare Improvement (ihi.org)

Medication Reconciliation Policy, Health Care BC, Policy BCD-11-11-41007 Last revision Dec 14 2021
http://shop.healthcarebc.ca/CST_Documents/CSTMedicationReconciliationPolicy.pdf

Accreditation Canada Required Organizational Practices 2020 Handbook Qmentum for on-site surveys starting January 2021

Institute of Safe Medication Practices Canada, 5 Questions to Ask About Your Medication
https://www.ismp-canada.org/medrec/5questions.htm

NS Health Medication Reconciliation
https://policy.nshealth.ca/Site_Published/NSHA/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=95400

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

Policies

3.07 Medication Order Requirements
https://policy.nshealth.ca/Site_Published/IWK/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=102463

3.90 Medication Brought into Hospital by Patients
https://policy.nshealth.ca/Site_Published/IWK/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=93318

10.05 Verbal/Telephone Orders for Medications
https://policy.nshealth.ca/Site_Published/IWK/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=72206

Appendices

Appendix A – Definitions

Appendix B - Children's Health Program - Patient Criteria for Ambulatory Medication Reconciliation

Appendix C - Women's and Newborn Health Program Patient Criteria for Ambulatory Medication Reconciliation

Appendix D - Mental Health and Addictions Program Patient Criteria for Ambulatory Medication Reconciliation

Appendix A

Definitions

BPMH
A medication history created using a systematic process of interviewing the patient/family/caregiver and reviewing at least one other reliable source of information to obtain and verify all of the patient's medications (including prescription, non-prescription, traditional, holistic, herbal, homeopathic medications, vitamins, supplements, investigational drugs, prescriber samples, high-cost drug program medications, compassionate release medications, special access medications, and recreational drugs or other substances including alcohol and cannabis. The BPMH includes the drug names, dosages, routes, and frequencies and time of last dose (as appropriate). It captures the patient's actual medication use, which may differ from their list of prescribed medications.

Discrepancy
Inaccurate medication, dose, route or frequency information listed **OR** home medication has been changed or discontinued but lacks documentation to support the rationale.

Health Care Provider
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
- Physician Assistant
- Midwife
- Pharmacist
- Registered pharmacy technician
- Pharmacy Practice Assistant (PPA)

High Risk for Adverse Medication Event
The risk of developing a significant adverse event is determined by the type and effect of medication commonly prescribed and the frequency of the medication changes in a specific patient population. High risk may also refer to patients deemed to be noncompliant with their medication regimen, or those patients who have many comorbidities, requiring frequent medication changes, or on multiple medications.

Interprofessional
A partnership between a team of health providers and a client in a participatory, collaborative and coordinated approach to shared decision-making around health and social issue. (CIHC)

Medication Reconciliation
Is a formal process in which healthcare providers work together with patients, families, and caregivers, 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
The physician, midwife, or nurse practitioner who has responsibility for directing and coordinating the care and management of an individual patient at a specific time.

Reconcile
A process that involves review of the BPMH and identification, communication, and resolution of discrepancies. Reconciliation includes reviewing for omissions, duplications and dosing errors or confusion surrounding the medication.

Transfer
For the purpose of Medication Reconciliation, when a patient is transferred or referred to another setting, service, practitioner or level of care within the IWK (internal transfer) or to another facility (example – home hospital). This excludes off service patients (those relocated for off-service bed use).

Appendix B

Children's Health Program - Patient Criteria for Ambulatory Medication Reconciliation

Note: If any patient is being seen in an ambulatory care setting in children's health and is at high risk for an adverse medication event then medication reconciliation should be completed.

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CH Service	BPMH Required (√) (√ indicates all patients)	FREQUENCY
Allergy Service	Asthma patients	Upon initial visit and annually at minimum
Cardiac Care	Transplant Patients; Patients with inherited heart disease	Each visit
Complex Respiratory Clinic	√	Each visit
CF Clinic	√	Each visit
Complex Care Clinic	√	Each visit
Developmental Clinic	√	Each visit
Dentistry/Oral Maxillofacial Surgery	Patients undergoing sedation	Each visit
Emergency Department Patients	Upon decision to admit	Upon Admission
Endocrine	Diabetes Insipidus; Hypocalcemia; Infusion Patients	Each visit
Diabetes Clinic	All new diabetic patients – Type I & Type II	Initial visit and annually at a minimum
GI Clinic	Liver transplant patients; intestinal failure patients	Each visit
Hematology/Oncology	√	Day 1 of treatment cycle
Immunology	New patients, IVIG & Transplant patients	Each visit
Infectious Disease	HIV patients	Each visit
Medical Day Assessment & Treatment Unit	√	Each visit
Nephrology	All CKD4 and CKD5 Patients	Each visit
Neurology	Complex Neurology Patients	Each visit
Pain Care	All new patients	Annually
Pediatric Advanced Care	√	Each visit
Pediatric Consultation Clinic	√	Each visit
Pediatric Gynecology	All patients (managed by WH program)	Each visit
Rehab Clinic	√	initial visit, then monthly unless changes
Renal Dialysis Unit (RDU)	√	initial visit, then monthly unless changes

Resident Continuity Clinic	√	Each visit
Rheumatology Services	All connective tissue disease patients (systemic lupus erythematosus, juvenile dermatomyositis, vasculitis [GPA, EGPA]); All patients receiving methotrexate and/or a biologic.	Each visit

Appendix C

Women's & Newborn Health Program
Patient Criteria for Ambulatory Medication Reconciliation

WH Service	BPMH Required (√) (√ indicates all patients)	FREQUENCY
All patients	√	• Upon initial visit • When a NEW SYSTEMIC medication is started, stopped, or the dose changed excluding formulation change of birth control pill, topical medications, such as topical nasal steroids, vaginal creams, skin creams, or topical ear drops. • As deemed appropriate by the medical staff
All ongoing patients where medication management is a major component of care	√	• Annually
All patients booked for elective and non-elective surgery	√	• Before procedure
All patients undergoing invasive procedures	√	• Before procedure
Midwifery patients	√	• Upon initial visit • Upon admission for delivery
All patients	√	• At transition of care back to care provider (this may be in the form of a dictated letter found in patient care inquiry in Meditech® or written summary back to care provider in the community)

Appendix D

Mental Health & Addictions Program
Patient Criteria for Ambulatory Medication Reconciliation

MHA Service	BPMH Required (√ indicates all patients)	FREQUENCY
Adolescent Intensive Services (Day Treatment Service x 3)	√	• Upon admission to program • Upon discharge
Children Intensive Services (Day Treatment Service x 1)	√	• Upon admission to program • Upon discharge
Emergency Mental Health and Addictions Service (EMHAS)	√	• Upon admission to Garron
Nova Scotia Youth Centre Youth Forensic Services (Waterville)	√	• Upon admission to program • Upon discharge
Specific Care Clinics (SCC) (Complex Pts.) Psychiatry led clinics • Autism SCC • Obsessive Compulsive Disorder SCC • Mood Disorders SCC • Eating Disorders SCC • Concurrent Disorders SCC • Forensic SCC • Psychosis SCC • Tourette's SCC	√	• Upon first visit • As needed, determined by Physician due to complexity • Upon Discharge
Reproductive Mental Health	√	• Upon first visit • As needed, determined by Physician due to complexity • Upon Discharge
Urgent Care Clinic (UCC)	• If during UCC visit it is noted medication is a component of care	• Upon first appointment • As needed and if changes in medication • Upon discharge
Community Mental Health and Addictions • Dartmouth • Halifax • Sackville	√ All patients deemed as "high risk"	• Upon first visit • As needed, determined by Physician due to complexity • Upon Discharge

Version History

(To Be Completed by the Policy Office)

Major Revisions (e.g. Standard 4-year review)	Minor Revisions (e.g. spelling correction, wording changes, etc.)
October 3, 2023	April 16, 2019 - BHMH information sources clarified