Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg — Caring for Health / À l'écoute de notre santé	Level: **REGIONAL** Applicable to all WRHA governed sites and facilities (including hospitals and personal care homes), and all funded hospitals and personal care homes. All other funded entities are excluded unless set out within a particular Service Purchase Agreement.		1
POLICY	Policy Name: **Medication Reconciliation**	Policy Number: 110.000.380	Page: 1 of 8
	Approval Signature: *Original Signed by Kerstin L Jordan*	Section: CLINICAL / PROGRAM SERVICES	
	Date: September 2023	Supercedes: March 2016	

1.0 PURPOSE:

1.1 To define a standardized Medication Reconciliation process for improving the accuracy and completeness of Medication information documented and communicated at Transitions of Care.

1.2 To support Patient safety and mitigate risk of adverse drug events by consistently applying the Medication Reconciliation process across all settings for ongoing Medication Management.

1.3 To emphasize an interdisciplinary approach where Patient/Patient Caregivers and community partners are an integral component of the Medication Reconciliation process.

1.4 To identify, document and communicate Medication Discrepancies to the most responsible Health Care Provider for resolution.

2.0 DEFINITIONS:

2.1 Admission: refers to the formal acceptance of a Patient to a Facility, Community Site or Program.

2.2 Best Possible Medication History (BPMH): a Medication list which identifies the Patient's current use of Medications obtained by a Prescriber or designated Health Care Provider using at least two sources of information, one of which should include an interview with the Patient and/or Caregiver (as appropriate). The Medication list includes detailed information such as the Medication name (generic name preferred for single active ingredient products), dose, route of administration, and frequency of administration.

2.3 Caregiver: a person who is providing care because of a prior relationship with a Patient. A Caregiver may or may not be a biological family member. Caregivers may be from the Patient's formal or informal support network.

2.4 Community Site: refers to a community health centre, or community office location within the Winnipeg Regional Health Authority where health care services are delivered (e.g. Access Fort Garry, Access Winnipeg West).

2.5 Discharge: refers to a Patient who returns home from a Facility and/or who no longer requires health care services from any Community Site or Program.

2.6 Discrepancy: indicates a difference between what the Patient is taking and the information obtained from other sources. These differences may include Medications that Patient is no longer taking, omission of a Medication, or differing Medication directions.

2.7 Drug Program Information Network (DPIN*)*: a central database which connects all retail pharmacies in Manitoba and allows for direct on-line submission of prescription drug claims to Pharmacare. As an Information Source, it provides the Health Care Provider with a dispensing history.

2.8 Facility: refers to a geographic location such as a hospital, personal care home, rehabilitative or psychiatric centre where Patients can be admitted for at least one night.

2.9 Health Care Provider: may include physicians, clinical/physician assistants, interns/residents, nurses, nurse practitioners, pharmacists, pharmacy technicians or any other WRHA health care professional who practices within their scope or role.

2.10 Health Record: refers to a paper Health Record, Electronic Patient Record (EPR) or Electronic Medical Record (EMR).

2.11 Information Source(s): are used in collecting the Best Possible Medication History. All of the following may be considered to be reliable sources of information including but not limited to: Patient, Patient's Caregiver, Patient Medication list, Drug Program Information Network (DPIN, eChart), Medication containers, community pharmacy, Medication Administration Record (MAR), Medication Reconciliation forms, Electronic Patient Record (EPR), and primary care Health Care Provider.

2.12 Medication Reconciliation (MedRec): a formal structured process in partnership with the Patient/Patient's Caregiver in identifying the most accurate list of all the Medications a Patient is taking and using this list to include reconciliation details regarding their disposition at Transitions of Care (i.e. which Medications are new / changed / continued or stopped). It is a process to verify and communicate accurate Patient Medication information at transition points to reduce/prevent adverse Medication events.

2.13 Medication Reconciliation Application: a web-based application developed for the WRHA which extracts Patient Medication information from pharmacy source systems and combines the information with manually entered data to produce reconciliation forms.

2.14 Medication(s): includes prescription drugs, over-the-counter drugs (including vitamins, supplements and herbal Medications), medical cannabis, and sample drugs. Traditional medicines, recreational drugs and clinical study drugs are documented where appropriate in Patient's Health Record.

2.15 Medication Management: involves provision of a culturally safe Patient-centered standard of care that optimizes safe, effective, and appropriate drug therapy. Care is provided through collaboration with Patient/Caregivers and their health care team.

2.16 Patient: any individual receiving health care provided by a WRHA Facility, Community Site, or Program, regardless of whether they are referred to as a Patient, client, individual or resident.

2.17 Patient-centered: an approach to health care where Patients are viewed as active participants, with consideration of their values, preferences and needs to support shared decision making. Caregivers may also be involved where applicable.

2.18 Prescriber: a health care professional who is permitted to prescribe Medications as defined by provincial and federal legislation, their regulatory college or association, and practice setting.

2.19 Primary Medication History: a preliminary Medication history often only consisting of the Medication name and may not include the use of multiple Information Sources.

2.20 Program: includes any health care services provided by the WRHA. Program models may provide any one or combination of inpatient, community or ambulatory care services, e.g. Primary Care, Medicine, or Surgery.

2.21 Transfer: refers to a change in responsible medical service within a Facility or the relocation of a Patient to another Facility/ Community Site within or outside the WRHA. It is an interface of care where Medication Orders need to be reviewed, reconciled and modified as necessary for the next Transition of Care.

Interfacility Transfer refers to when a Patient is transferred from one Facility to another Facility.

Intrafacility Transfer refers to when a Patient is transferred between clinical Programs within the same Facility.

2.22 Transition of Care: the movement of Patients from or within one health care Facility, Community Site, or Program to another, including Admission, Transfer and Discharge. These are critical communication points in the Patient's care trajectory during which the transfer of information is vulnerable.

3.0 POLICY:

3.1 Health Care Providers shall include the Patient/Caregiver as participating members of the healthcare team (i.e. Patient-centered care) involving them in the Medication Reconciliation process when possible.

3.2 The overall Medication Reconciliation process shall include the following three steps:

i. Create a BPMH of actual Medication use.
ii. Compare the BPMH with current Medications prescribed (i.e. reconcile) and resolve Discrepancies as appropriate.
iii. Document and communicate resulting Medication changes, as appropriate.

3.3 Facilities, Community Sites and/or Programs shall ensure that a process is in place for reconciling Medications at Transitions of Care so that a complete and accurate list of current Medications is documented in the Patient Health Record and communicated to the next Health Care Provider.

3.3.1 MedRec shall be completed in the Emergency / Urgent Care department for Patients:

- with decision to admit, including to another Facility, or
- whose length of stay in the department exceeds eight (8) hours, or
- who require any of their Medications to be administered, and/or
- at the Health Care Provider's discretion.

3.3.2 Ambulatory care clinics (see Appendix 1) shall ensure a MedRec process is in place for Patients attending their clinic in the initial phase of implementation of the MedRec process throughout the WRHA.

3.3.2.1 Clinics not included in Appendix 1 shall clearly define rationale using the Medication Reconciliation Ambulatory Care Clinics/Services Exclusion template (see Appendix 2) or within their supporting documents (e.g. standardized operating procedures, guidelines).

3.3.3 Primary care clinics and Programs in the community care setting (e.g. home care) shall define and document their target population that require MedRec and the frequency by which MedRec processes shall be completed.

3.4 The MedRec process is a shared responsibility involving the Patient/Patient's Caregiver and Health Care Providers.

3.4.1 The role and responsibility of each Health Care Provider in the MedRec process shall be defined by Facilities, Community Sites and/or Programs.

3.4.2 Each Program shall ensure that a designated Health Care Provider with appropriate expertise or training is responsible for performing a Best Possible Medication History (BPMH) at Admission.

3.5 Clinical judgement shall be used to determine the most appropriate and reliable Information Sources from which to obtain the BPMH/Primary Medication History.

3.5.1 If only one reliable Information Source is available at the time of Admission, then a BPMH cannot be obtained. In this situation, a Primary Medication History using one reliable Information Source shall be documented. Subsequent attempts to obtain the BPMH by getting a second reliable Information Source shall be made.

3.6 The BPMH/Primary Medication History shall be documented at the time of Admission at a minimum on a WRHA Health Information Services approved MedRec form or electronic format established by the Facility/Community Site or Program.

3.6.1 If the Patient does not take any Medications, this shall be documented on the approved MedRec form or electronic format.

3.6.2 BPMH interviews may be conducted by telephone or video communication depending on Patient/Caregiver's own resources, preferences or limitations. Patient shall be informed of any security or privacy limitations associated with the communication method selected prior to the interview.

3.7 The BPMH obtained prior to Admission to a Facility, Community Site, and/or Program shall be verified with the Patient/Patient Caregiver on Admission and changes documented.

3.7.1 The BPMH shall be repeated at time of Admission if previously obtained 90 days or more prior to Admission.

3.8 The BPMH obtained greater than 90 days prior to Transfer/Discharge shall not be utilized to identify discrepancies when performing MedRec.

3.8.1 The current Medication orders at Transfer/Discharge shall be considered the accurate list of current Medications or BPMH.

3.9 MedRec shall be completed and documented for Patients in:

- Acute care: at Admission, Intrafacility/ Interfacility Transfer, and Discharge. Exceptions:
  - At Discharge, elective surgery Patients, or Patients registered for day surgery/minor procedure with a length of stay not exceeding 48 hours who had no changes made to their BPMH.
  - Patients undergoing procedures such as those medical and diagnostic in nature.
  - Patients transferred from one unit to another for bed relocation.
- Long term care: at Admission, Interfacility Transfer, and Discharge
- Community care/ ambulatory care setting: at beginning of service, as part of the Periodic Health Review, and at end of service when possible.

3.10 The MedRec process shall be completed in a timely manner on Admission in:

- Acute care/long term care setting: within 24 hours of Admission, preferably at the time of ordering Admission or Transfer Medication Orders.
- Ambulatory care setting: on first visit or earliest possible opportunity.
- Community care setting: within 2 weeks of Patients receiving Medication Management services, or on first visit or earliest possible opportunity following Discharge from an acute care Facility for existing Patients of the community care Program.

3.11 The MedRec process on Transfer/Discharge shall be completed in:

- Acute care/long term care setting: as close to and prior to Transfer/Discharge from a Facility.
- Community care/ambulatory care setting: at end of service when possible.

3.12 Programs and/or Facilities shall be encouraged to liaise with site pharmacy resources regarding availability to assist in MedRec processes at Transitions of Care.

3.13 Medication Discrepancies identified by a Health Care Provider shall be communicated to the most responsible Prescriber for resolution.

3.13.1 Unresolved discrepancies and action taken shall be documented in the Patient's Health Record.

3.14 Health Care Providers shall provide documentation and clear communication of Medication changes to Patient/Caregiver and to the next Health Care Provider(s) at Transitions of Care and as needed. This shall include, at a minimum, the disposition of each Medication at Transitions of Care.

3.15 Blanket statements such as “resume Medications”, “continue home Medications”, “continue pre-op orders” shall not be acceptable. See WRHA Policy # 110.170.040 Medication Order Writing Standards

3.16 Health Care Providers shall promote Patient engagement in their own care by discussing and communicating Medication related changes (when possible) and provide appropriate written information about the Medications in a format and language that can easily be understood.

3.17 Programs shall monitor compliance and measure effectiveness which shall (at a minimum):

- Evaluate the MedRec process used at Transitions of Care;
- Include the voice of Patients/Patient’s Caregiver, and Health Care Providers in the evaluation process to determine if they received the information required;
- Provide results/feedback to Health Care Providers as soon as possible;
- Use the evaluation results to make improvements when needed; and
- Inform Site/Program leadership of the results for review.

3.18 Education on MedRec shall be provided to Health Care Providers at orientation, during staff training on site, and/or reviewed as needed. Programs, Facilities and/or Community Sites shall keep evidence of staff education as per established procedures.

3.19 Health Care Providers shall educate Patients/Patient’s Caregivers of the importance of keeping an up-to-date Medication list and sharing this list with all providers of care (e.g. primary care provider, specialists, nursing stations, community pharmacists).

4.0 PROCEDURE

Refer to the procedures outlined on the WRHA Quality Improvement and Patient Safety webpage: https://home.wrha.mb.ca/old/quality/Medrecpolicy.php

4.1 WRHA Acute Care procedure
4.2 WRHA Long Term Care procedure
4.3 WRHA Emergency program procedure
4.4 WRHA Ambulatory Care procedure
4.5 WRHA Community Care procedure

5.0 REFERENCES

5.1 Accreditation Canada (2019): Required Organizational Practice Handbook 2019.

5.2 Alberta Health Services; Medication Reconciliation policy; PS-05 (September 2019)

5.3 Hession M (2018). Best Practice Medication Reconciliation in the Outpatient Setting. University of Massachusetts Amherst, Doctor of Nursing Practice Projects; https://scholarworks.umass.edu/cgi/viewcontent.cgi?article=1167&context=nursing_dnp_capstone ; accessed June 16, 2019

5.4 Interior Health Authority Medication Reconciliation policy; AK0800 (August 2019) https://www.interiorhealth.ca/AboutUs/Policies/Documents/Medication%20Reconciliation.pdf ; accessed May 8, 2020

5.5 IWK Health Centre ; Medication Management Policy/Procedure 4.64 (February 2019) http://policy.nshealth.ca/site_published/iwk/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=54628 accessed October 2019

5.6 London Health Sciences Centre; Discussion and overview of the Evidence-Based Practice Knowledge Broker for ambulatory care; November 2019

5.7 Medication Safety in Transitions of Care. Geneva: World Health Organization; 2019 https://apps.who.int/iris/bitstream/handle/10665/325453/WHO-UHC-SDS-2019.9-eng.pdf?ua=1 accessed June 2019

5.8 Northern Health Region; Medication Reconciliation at Care Transitions policy; AD-05-05 (May 2018).

5.9 Ontario Primary Care Medication Reconciliation Guide. https://www.ismp-canada.org/download/PrimaryCareMedRecGuide_EN.pdf accessed January 2020

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