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 M. Sussman*	Section: CLINICAL / PROGRAM SERVICES
	Date: March 2016	Supercedes: NEW

1.0 PURPOSE:

1.1 To reduce preventable harm to Patients due to adverse Medication events by developing Medication Reconciliation processes at Transitions of Care.

1.2 To facilitate regional consistency and awareness of Medication Reconciliation best practices in ensuring safe prescribing in any setting (e.g. reduce Medication errors due to omissions, therapeutic duplications, unnecessary need of a Medication, incorrectly prescribed).

1.3 To provide direction on reconciling Medications accurately and completely at Transitions of Care, that all Medication changes are intentional, and any Medication Discrepancies identified are resolved.

1.4 To provide clarity regarding Medication prescribing to the Patient/Patient's caregiver and Health Care Providers.

1.5 To promote involvement of Patient/Patient's caregiver in maintaining an up-to-date Medication list.

1.6 To enhance the collaboration of Health Care Providers, community partners, and Patients/Patient's caregivers in the communication of Medication information at Transitions of Care across the health care continuum.

1.7 To endorse the Winnipeg Regional Health Authority's (WRHA) commitment to Medication Reconciliation and its importance as a Patient safety priority.

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): is a Medication list obtained by a Prescriber or designated Health Care Provider which includes a history of all current Medications a Patient is taking. The Medication history 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 Community Site: refers to a community health centre, or community office where health care services are delivered within the Winnipeg Regional Health Authority.

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

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

2.6 Drug Program Information Network (DPIN): connects all retail pharmacies in Manitoba to a central database 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.

2.7 Facility: refers to a hospital, personal care home, rehabilitative Facility and psychiatric Facility in which health care is provided.

2.8 Health Care Provider: may include physicians, clinical/physician assistants, interns/residents, nurses, nurse practitioners, pharmacists, pharmacy technicians or any other individuals who practices within scope or role.

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

2.10 High Alert Medications: Medications that have an increased risk of causing significant Patient harm when it is used in error. See Safety Controls for High Alert Medications in WRHA Facilities Policy – http://home.wrha.mb.ca/corp/policy/files/110.000.340.pdf

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), 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): is 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 instructions (e.g. orders) regarding their disposition at Transitions of Care. 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 Winnipeg Regional Health Authority 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), and sample drugs. Recreational drugs are documented where appropriate in Patient's Health Record.

2.15 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, resident etc.

2.16 Prescriber: refers to a health care professional who is permitted to prescribe Medications as defined by Provincial and Federal legislation, his/her regulatory college or association, and practice setting.

2.17 Primary Medication History: refers to a quick preliminary Medication history often only consisting of the Medication name, and may not include the use of multiple Information Sources.

2.18 Program: includes any health care services provided by the Winnipeg Regional Health Authority.

2.19 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 Winnipeg Regional Health Authority. It is an interface of care where Medication Orders need to be reviewed, reconciled and modified as necessary for the next Transition of Care.

Internal Transfer: refers to when a Patient is transferred between clinical Programs within the same Acute Care Facility.

2.20 Transitions of Care: refers to the movement of Patients from one health care Facility, Community Site, or Program to another.

3.0 **POLICY:**

3.1 This policy excludes:

- Internal Transfers where the Patient remains under the same Program (e.g. bed relocation).
- Patients undergoing diagnostic procedures (e.g. computed tomography scan (CT scan), bronchoscopy, cholecystography), medical procedures (e.g. central line insertions, peritoneal dialysis catheter insertions, percutaneous endoscopic gastrostomy (PEG) placements) and others as appropriate.
- Community and ambulatory care Patients where Medication management is not the focus in care provided, and where the Program only provides consultation services (i.e. Medications are not prescribed but only recommendations are provided). A Primary Medication History is still required where Medications are prescribed.
- Elective day surgery Patients or Patients admitted for less than 24 hours who had no changes made to their BPMH at the time of Discharge.
- Home Care Patients whose Medications are not monitored or administered by a member of the health care team (i.e. Patient does not require services with Medication management).
- Patients who present to Emergency for less than eight (8) hours and who do not require any of their pre-Admission Medications administered during this time.
- Urgent Internal Transfers or Transfer to another Facility from the transferring Prescriber.
- Patients Discharged against medical advice.
- Death of a Patient.

3.2 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 communicated to the next Health Care Provider.

3.3 Facilities, Community Sites and/or Programs shall have a plan for the implementation and sustainability of the MedRec process in accordance with timelines as required by the Winnipeg Regional Health Authority.

3.4 Community care services, ambulatory care clinics, and the Emergency Program shall define and document rationale as to which Patient/Patient populations require MedRec and the frequency by which a MedRec process shall be completed. Patients identified shall include those at higher risk of adverse Medication events (e.g. Patients prescribed High Alert Medications, Patients with low health literacy).

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

3.5.1 The role and responsibility of each Health Care Provider in the MedRec process shall be defined by the regional Program.

3.5.2 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.

3.6 The BPMH is obtained using a minimum of two reliable Information Sources. A Patient with capacity to provide information on their medication use and/or an interview with Patient's caregiver is preferred as one reliable Information Source. Other reliable Information Sources include but are not limited to: primary care Health Care Provider, community pharmacy, Patient's Health Record, DPIN etc.

3.7 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.

3.8 The BPMH/Primary Medication History shall be documented at the time of Admission on a WRHA Health Information Services approved MedRec form or electronic format established by the Facility/Community Site or Program. If the Patient does not take any Medications than this shall be documented as the BPMH. If unable to obtain a BPMH at the time of Admission, the reason shall be noted on the MedRec form or electronic format. The BPMH/Primary Medication History shall be retained in the Patient's Health Record.

3.9 If the BPMH is obtained before Admission (e.g. elective surgical Patients), the BPMH shall be verified with the Patient/Patient caregiver upon Admission and updated as required. However, if the BPMH is obtained ninety (90) days or more before pre-Admission to a Facility, Community Site and/or Program the BPMH shall be repeated at the time of Admission.

3.10 The BPMH shall be used to generate Admission orders and/or compared against a current Medication list known to the health care team to identify Discrepancies.

3.11 The BPMH shall be referenced at Transitions of Care when reconciling Medications unless the BPMH was taken greater than ninety (90) days from the time of Admission to the time of Transfer/Discharge.

3.12 The final responsibility for reconciliation shall lie with the Prescriber however there is a shared accountability of Health Care Providers in assisting in accurate MedRec.

- In the acute care/long term care setting, the Prescriber is responsible for the reconciliation process and is necessary for providing clear direction regarding each Medication following Transitions of Care.
- In the community care / ambulatory care setting within the WRHA, Health Care Provider(s) shall be assigned to reconcile Patients' Medications and communicate and resolve any Discrepancies with the Prescriber(s).

3.13 MedRec shall occur at Transitions of Care:

- In the acute care/long term care setting: at Admission, Transfer, and Discharge.
- In the community care/ ambulatory care setting within the WRHA: at beginning of service, periodically as appropriate for the Patient population it serves, and at end of service when possible.

3.14 The MedRec process shall be completed in a timely manner at Transitions of Care.

- In the acute care/long term care setting: within 24 hours of Patient being admitted or at Internal Transfer, preferably at the time of ordering Admission or Transfer Medication Orders.
- In the community care setting within the WRHA: within 2 weeks of Patients receiving Medication management services, or within 2 weeks of Discharge from an acute care Facility for existing Patients of the community care Program.
- As close to and prior to Transfer/Discharge from a Facility, or end of service from a community care/ ambulatory care setting when possible.

3.15 In the event that the Prescriber is off-site, Prescriber telephone orders shall be followed at Transfer. Facility specific documentation procedures shall be followed.

3.16 Prescribers issuing an outpatient prescription (e.g. Discharge MedRec prescription) shall follow Provincial legislation, his/her regulatory college or association, and/or practice setting for writing prescriptions and in compliance with WRHA Medication Order Writing Standards Policy - http://home.wrha.mb.ca/corp/policy/files/110.170.040.pdf

3.17 Pharmacist consultation shall occur as established by the Program to assist in MedRec processes at Transitions of Care.

3.18 Medication Discrepancies identified by a Health Care Provider at Transitions of Care shall be communicated to the most responsible Prescriber and/or documented in the Patient's Health Record for resolution by the Prescriber, and/or responsible Health Care Provider using established forms as appropriate (e.g. Addendum form, Community Health Services Communication Form).

3.19 Any communication or Medication orders written at Transfer and/or Discharge shall indicate which Medications are new / changed / continued or stopped. The list of Patient's current Medications shall be communicated to the next Health Care Provider(s) at each Transition of Care.

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

3.21 The Patient/Patient's caregiver shall be provided with written information about the Medications that s/he should be taking following Discharge in a format and language they can easily understand. It shall include Medication name, dose, route and frequency.

3.22 Regionally approved audit tool(s) shall be used for monitoring the compliance, quality of Medication histories, and/or overall MedRec processes. WRHA Programs shall determine the sample size and frequency of re-evaluation appropriate for Patients in their Program for sustainability of the process (e.g. retrospective audit of 10 acute care Patients per unit, auditing of home care clients every 3 months).

3.23 Audit results shall be reported to the respective WRHA Programs for review, feedback and recommendations for quality improvement. In collaboration with Facilities, Community Sites and Programs, results shall be made available to the WRHA Quality and Patient Safety Unit for review and reporting to the organization as appropriate.

3.24 Education on MedRec shall be provided to Health Care Providers on the rationale, steps involved, and tools during orientation in a clinical area or setting and on an ongoing basis with changes in tools or process. Programs and/or clinical areas shall keep evidence of staff education as per established procedures.

3.25 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). Examples of Medication cards include: the It's Safe to Ask Medication wallet card from the Manitoba Institute of Patient Safety, the My MedRec application.

3.26 The MedRec process shall revert back to a paper-based process in the event of a MedRec Application and Electronic Record failure, or scheduled/unscheduled downtime that cannot be resolved in a timely fashion by Manitoba eHealth Service Desk. For printer failure issues, the forms shall be printed and obtained at another location within the Facility (e.g. another Patient care unit, pharmacy).

4.0 PROCEDURE

The procedures for the following areas are outlined on the WRHA Quality Improvement and Patient Safety. See INSITE - http://home.wrha.mb.ca/quality/Medrecpolicy.php

- WRHA Acute Care procedure
- WRHA Long Term Care procedure
- WRHA Emergency Program procedure
- WRHA Ambulatory Care procedure
- WRHA Community Care procedure

5.0 REFERENCES:

5.1 Accreditation Canada (2016). Required Organizational Practices Handbook 2016. Retrieved March 30, 2015 from the World Wide Web: http://www.accreditation.ca/sites/default/files/rop-handbook-2016-en.pdf

5.2 Agency for Healthcare Research & Quality (AHRQ). Medications at transitions and clinical handoffs (MATCH) toolkit for medication reconciliation. Retrieved January 12, 2015 from the World Wide Web: http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/index.html

5.3 Gleason, K.M., McDaniel, M.R., Feinglass, J., et al. (2010) Results of the Medications At Transitions and Clinical Handoffs (MATCH) Study: an analysis of medication reconciliation errors and risk factors at hospital admisison. J Gen Intern Med 25(5):441-447.

5.4 Institute for Healthcare Improvement (IHI). Medication Reconciliation to Prevent Adverse Drug Events. Institute for Healthcare Improvement. Retrieved January 12, 2015 from the World Wide Web: http://www.ihi.org/Topics/ADEsMedicationReconciliation/Pages/default.aspx

5.5 Institute for Safe Medication Practices (ISMP) Canada (2012). Medication Reconciliation (MedRec). Institute for Safe Medication Practices – Canada. Retrieved November 21, 2014 from the World Wide Web: http://www.ismp-canada.org/medrec/

5.6 Kwan, J.L., Lo, L., Sampson, M., Shojania,K.G. (2013) Medication reconciliation during transitions of care as a patient safety strategy: a systematic review. Ann Intern Med 158(5), 397-403

5.7 MARQUIS Investigators (2011). MARQUIS Implementation Manual: A guide for medication reconciliation quality improvement. Society of Hospital Medicine. Philadelphia, PA. Retrieved November 28, 2014 from the World Wide Web: http://tools.hospitalmedicine.org/resource_rooms/imp_guides/MARQUIS/marquis.html

5.8 Mueller, S.K., Sponsler, K.C., Kripalani, S., Schnipper, J.L. (2012). Hospital-based medication reconciliation practices: a systematic review. Arch Intern Med 172(14), 1057-69

5.9 Safer Healthcare Now! (2012). Medication Reconciliation: Getting Started Kits. Safer Healthcare Now. Retrieved November 21, 2014 from www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/default.aspx

5.10 Vogelsmeir, A. (2014) Identifying medication order discrepancies during medication reconciliation: perceptions of nursing home leaders and staff. J Nurs Manage 22(3), 362-372

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