ROP Fact Sheet: Medication Reconciliation at Care Transitions

Accreditation Canada defines a Required Organizational Practice (ROP) as an essential practice that organizations must have in place to enhance patient/client/resident safety and reduce risk.

**ROP: With the involvement of the patient, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile patient medications at transitions of care.**

Tests for Compliance:

1. Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the patient, family, or caregiver (and others, as appropriate).
2. The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.
3. A current medication list is retained in the patient record.
4. The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.
5. The team provides the patient, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the patient should be taking following discharge.

Medication Reconciliation is an essential patient safety practice. Because patients are especially vulnerable at handoffs of care, particular attention should be given any time that medications are ordered or changed, and when patients move to a different level of care or point in the continuum.

**Meeting this ROP: what compliance looks like:**

1. **We have implemented MedRec at admission for all inpatients.**
   - Medication Reconciliation is completed when patients are admitted through the Pre-Admission clinic, Emergency Department or directly to a nursing unit
   - On admission or as close to admission as possible, a nurse, pharmacist or physician verifies and documents the best possible medication history (BPMH) with the patient, family or caregiver:
     - By asking patient/family to show all the medications and explain how they take each
     - By including all medications, i.e. non-prescription, supplements, complementary/alternative...
     - By identifying any discrepancies to be resolved by prescribers
   - Prescribers resolve and document any discrepancies in the BPMH

2. **The verified BPMH is used to inform all subsequent medication orders.**
   - Prescribers use the BPMH information to write admission orders, or
   - Prescribers compare the admission orders to the verified BPMH as soon as possible
   - The verified, reconciled BPMH follows the patient through their healthcare journey as part of their medical record
3. The verified BPMH and medication orders are reviewed and communicated to the next provider at key handoffs of care:
- All transfers in or out of ICU
- Post-operatively, and any time orders are discontinued and rewritten
- Transfers between acute care and rehabilitation care
- Discharges to other facilities, or home to the care of GP or specialist
- This includes what medications to continue, discontinue, or take differently, and timeframes (i.e. VTE prophylaxis for next 3 months)

4. Our patients leave with a clear understanding of their medications and how to take them:
- We give patients a Best Possible Medication Discharge Plan in patient-friendly language that goes over the information that is also shared with their next provider
- We use evidence-based sources to educate patients about their medications and encourage them to ask questions

5. We monitor compliance with Medication Reconciliation on an ongoing basis to sustain improvement.

What You May Be Working On:
- Continuing to improve the workflow and communication around verifying and documenting the BPMH as part of the interdisciplinary work that clinical teams do every day.
- Auditing compliance with Medication Reconciliation and using the results for improvement
- Engaging our patients to be actively involved and understand their medications, i.e. developing pamphlets to encourage questions and build confidence in managing one’s own medications
- Partnering with community pharmacies to support patients in the community
- Continuing to focus on the patient’s journey by developing consistent, reliable systems and processes for communicating medication information at transition points.

Surveyors could ask:
- How does the team collect the patient’s BPMH and verify it with the patient/family?
- What happens if a discrepancy is found, i.e. medications that interact with each other, or that the patient takes differently than as prescribed?
- Do you have access to up-to-date patient information to make decisions on what can be safely prescribed?
- Where can I find the verified BPMH in the medical record?
- What process do you follow for reordering medications after transition (i.e. post-op, post-transfer)?
- How is medication information transferred to the next provider of care?
- What written information do patients receive on their medications at discharge?
- How do you ensure that your patient understands the medication information provided and can self-manage?

We want to hear from you!
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