

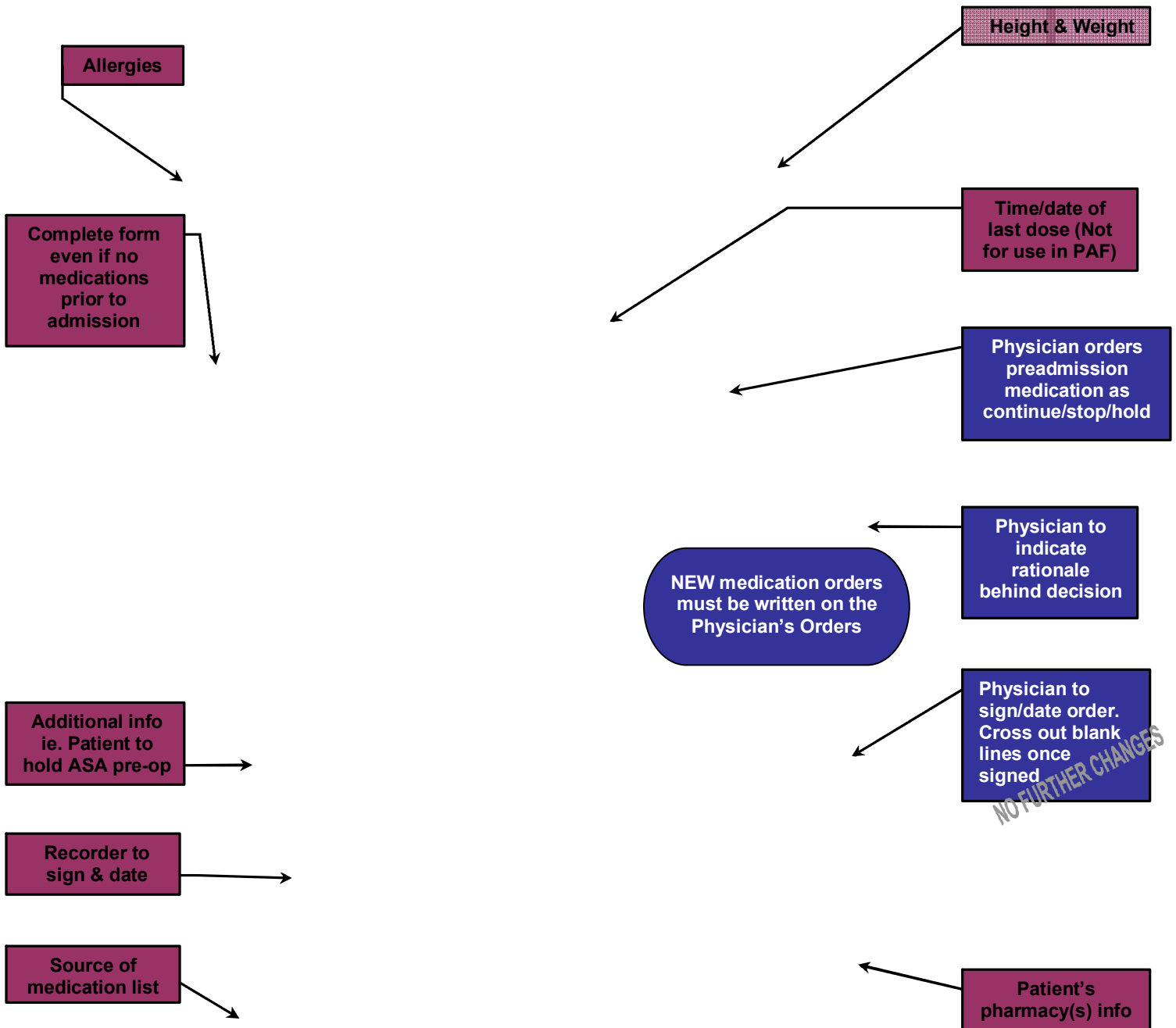
St. Michael's Hospital Medication Reconciliation Learning Package



What is Medication Reconciliation?

- A formal process which begins with obtaining a complete and accurate list of each patient's home medications at the time of admission to hospital, called the **Best Possible Medication History (BPMH)**,
- Physician's orders on *admission, transfer and discharge* are compared to the BPMH
- Discrepancies are identified, discussed and resolved with changes made to the orders when necessary.

Process for units that have NOT implemented CPOE



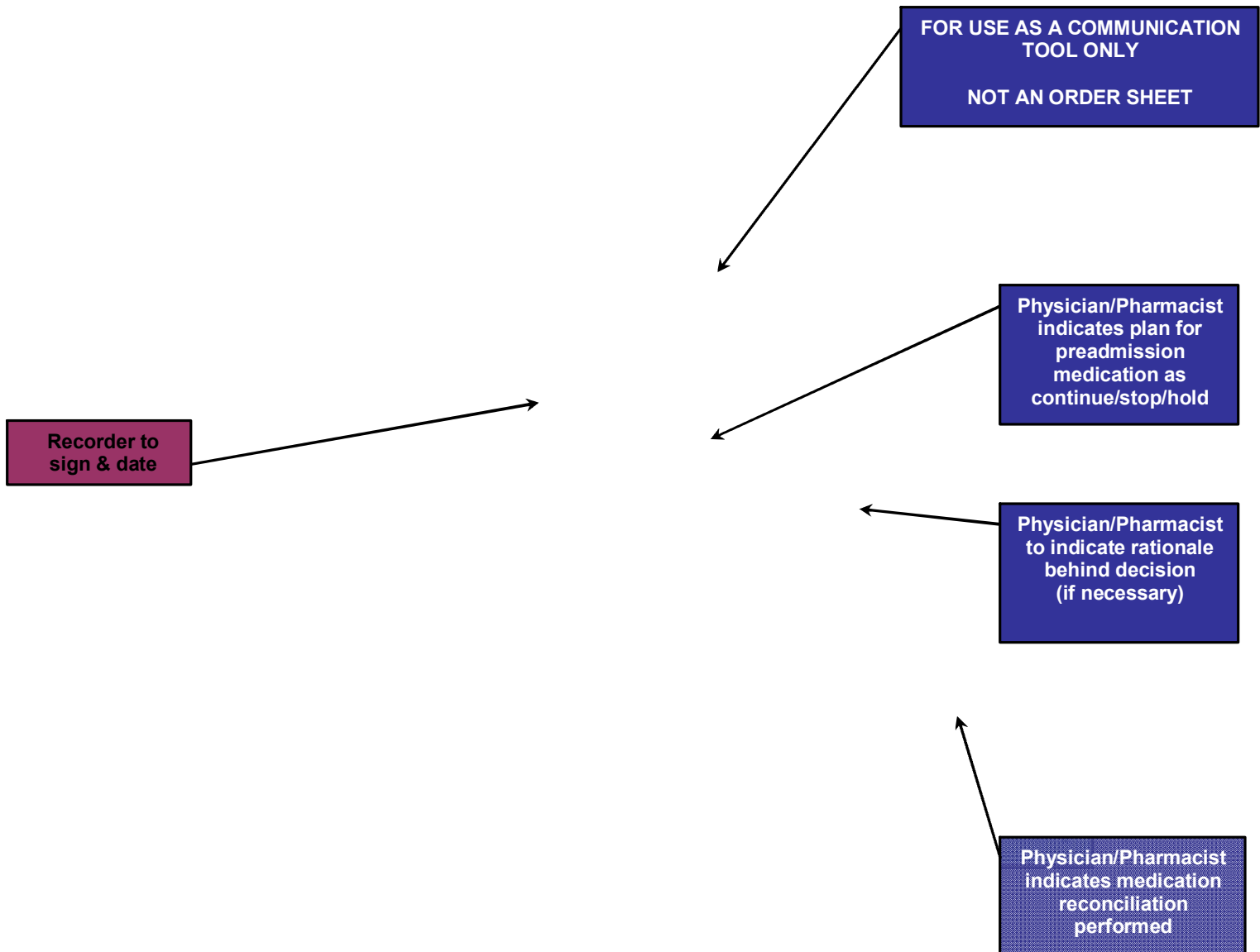
If collecting BPMH after admission or new information is obtained after admission orders are written use Form II.

Purple boxes are multidisciplinary / Blue boxes are Physician only

Process for units that have NOT implemented CPOE

AFTER ADMISSION USE FORM II

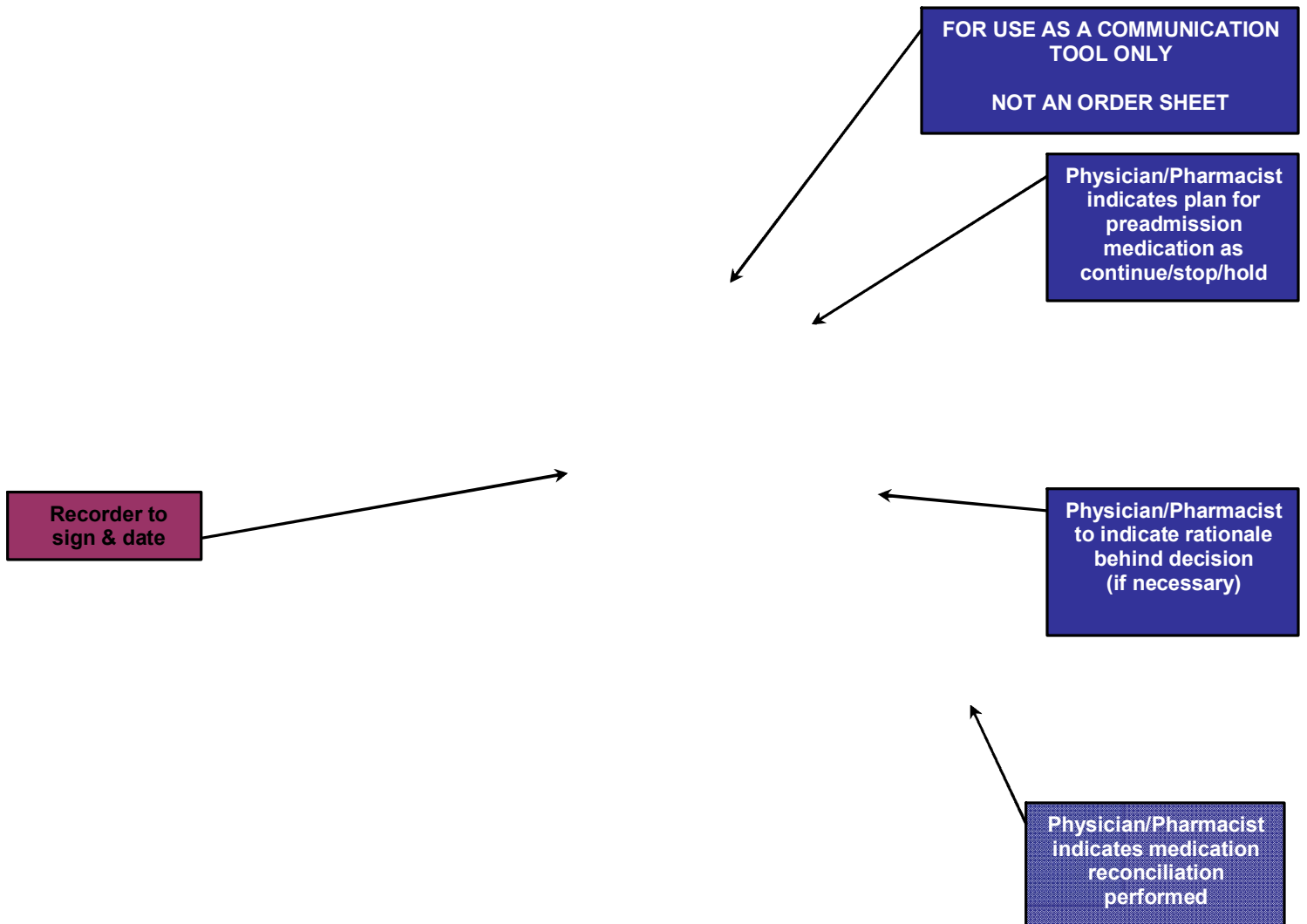
Form II is to be used if no BPMH was collected preadmission or as an addendum for new information.



Medications that are to be ordered must be written on the physician orders form.

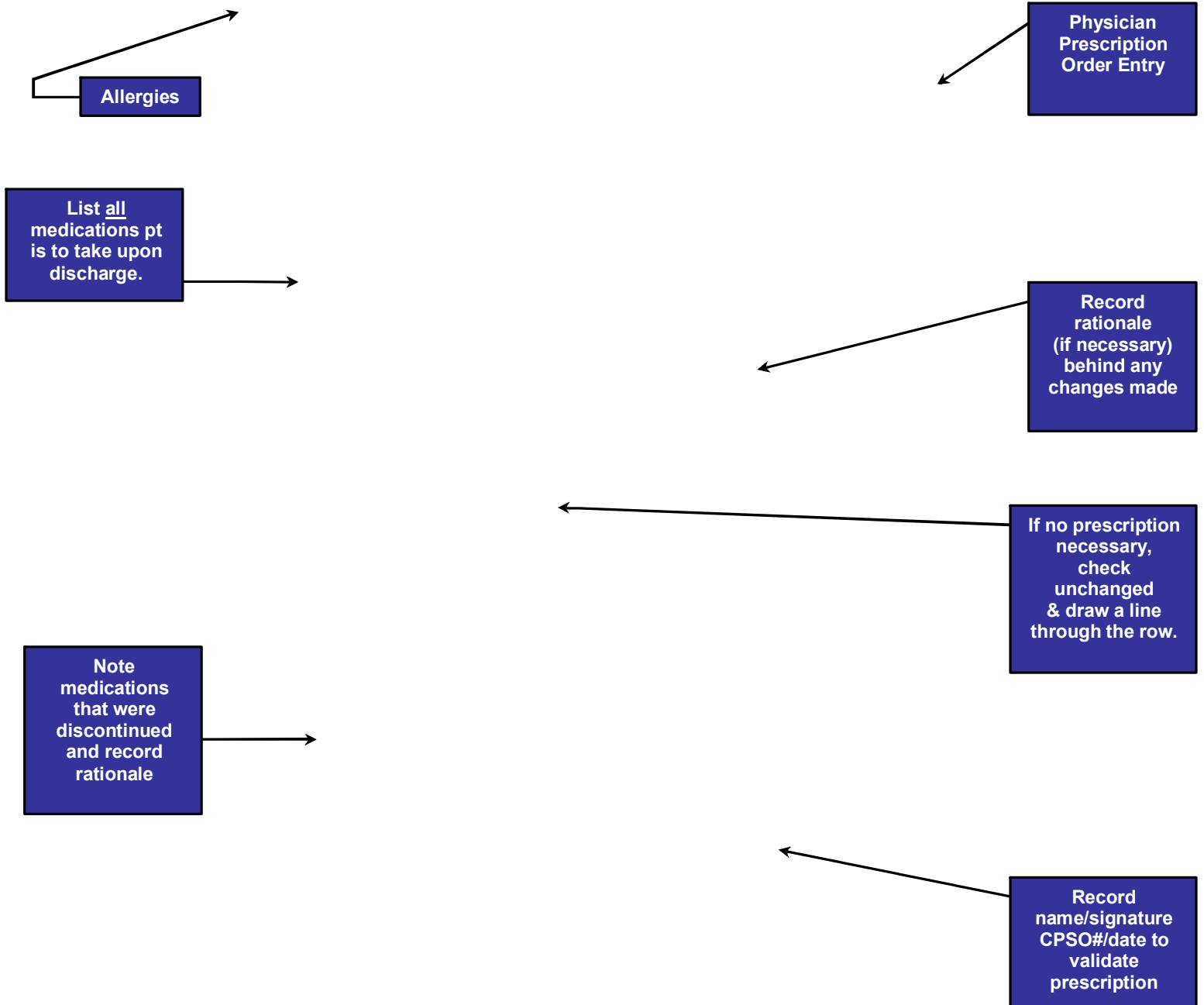
Process for units that HAVE implemented CPOE

FORM II FOR ADMISSION BPMH



Medications that are to be ordered must be entered into CPOE.

Process for units that have NOT implemented eDischarge



Top white copy - prescription

Middle yellow copy - with pt to family MD

Bottom pink copy - stays with chart

Process for units that HAVE implemented eDischarge

Edit Summary

BOOTS-T, PUSSN DOB: 1962-03-18 MRN: 3053912 Encounter #: 00302071675 Status: Amended Preliminary

View Finalize

1. Patient's Info 2. Diagnoses 3. Course In Hospital 4. Investigations 5. Discharge 6. Medication 7. CC List

Allergy/Intolerance to Medication & Food:

Allergy information can now be recorded

Select 'Rx' if prescription required

Limited Use Codes can be added

Indicate status of Med - new, changed or unchanged since hospital admission

Discharge Medications:

No.	Medication Name	Dose	Route	Freq	Rx	Qty.	Repeats	LU#	Status	Rationale if new/changed
	ARICEPT	10 mg	PO	DAILY	<input checked="" type="checkbox"/>	30	12		Changed	
	TENORMIN	50 mg	PO	DAILY	<input type="checkbox"/>				New	
	ASAPHEN		PO	DAILY	<input type="checkbox"/>				Unchanged	

All medications the patient will be taking upon discharge should be included.

Add More Medication

Discontinued Medications:

List all discontinued preadmission medications and provide rationale, if necessary

No.	Discontinued Medication Name	Rationale for Discontinuation
	HYDROMORPHONE	
2		
3		

Add More Medication

Special Instructions:

ertertoertqertyeryyh

Previous

Next

Save

Cancel

There will be a printout of a prescription and letter for the pt, a copy is transferred to the electronic record.

Medication Reconciliation at ADMISSION

Process for units that have NOT implemented CPOE

The **Preadmission Medication List and Physician Order Form I** combines the BPMH and admission orders together on one form.

- The BPMH will be collected prior to the admission orders being written when possible by the **first point of contact**.

Preadmission Medication List Form II is used *if the BPMH is not collected prior to admission or new medication information arises after admission orders are written,*

- Form II is not an order sheet.
- List all Patient medications taken prior to admission not previously recorded on Form I and/or document any updates or revisions.
- **Preadmission Medication List Form II** is to be reconciled with the preadmission medications and admission orders.
- Medications from **Preadmission Medication List Form II** that are to be ordered must be written on the regular Physician order form by Physician.

Process for Units that HAVE implemented CPOE

Preadmission Medication List and Physician Order Form II is used by the first point of contact to record the BPMH.

- The PHYSICIAN would then reconcile and document the plan for each preadmission medication upon admission.
- Any updates or revisions will continue on the same form.

NOTE: This IS NOT AN ORDER FORM; it is a communication tool. Any medications that are to be continued or held must be entered into CPOE.

Medication Reconciliation at TRANSFER

It is a dual responsibility. The unit writing orders will reconcile the BPMH with the MAR. The receiving unit will reconcile the transfer orders of the sending facility/service with the BPMH and the sending units MAR. This will be done by *Physician/Pharmacist*.

Medication Reconciliation at DISCHARGE

Upon discharge the Physician will review the BPMH; the last 24 hr MAR and reconcile this with the discharge medications.

- All medications the patient will be taking post discharge will be recorded, noting status.
- Any preadmission medications that were discontinued during the hospital stay will be recorded under 'Discontinued Medications'

Who is responsible for the form?

- Collecting the BPMH is a *multidisciplinary* responsibility and begins with the first person who sees the patient, this may include Physician, NP, Pharmacist or RN,
- Reconciliation is done by Physician or Pharmacist

Where do Form I and II belong in the chart?

- Form I and II are to be placed at the beginning of the Physician orders.

Why are our current medication practices being improved upon?

The collection of accurate, complete home medication information from patients upon admission is a significant patient safety issue. Medication errors are the *leading cause of injury to hospitalized patients*, and over *half of the errors occur at transfers of care*. In 2005, the rate of medication errors during hospitalization was estimated at *52 per every 100 admissions*. A 2006 SMH study revealed that *33% of patients had 1 or more of their chronic medications omitted at hospital discharge*.

- Medication reconciliation will help to improve the communication of patient's medication information between health care practitioners at transition points of care.
- The process allows for a reduction in medication errors and adverse drug events to patients.
- Medication reconciliation is a SMH corporate objective, a CCHSA accreditation standard and a *Safer Healthcare NOW!* Initiative.

Where We Are to Date (Apr, 2010)

- Pilot unit, 7CV, for medication reconciliation completed January 2009
- Med Rec has been implemented within all in-patient services
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How Are We Measuring Success?

- Percent reconciled updates will be distributed to directors on a quarterly basis
- Baseline audits (10-20 patients/unit) are collected prior to implementation
- Informal chart checks for initial 3 weeks of implementation
- Follow-up audits (10 patients/unit/month) x 3 months after implementation

*Cardiovascular has improved from a mean of 2.9 **undocumented intentional discrepancies** per patient to 1.6 errors per patient and **unintentional discrepancies** have decreased from a mean of 0.4 to 0.2 errors per patient following implementation of the medication reconciliation process.*

For further information contact med rec team at medrec@smh.ca

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- Corporate Sponsor: Doug Sinclair