

### POLICY

**POLICY SCOPE:** This policy applies to all healthcare professionals at BC Children's Hospital and Sunny Hill Health Center.

Medication Reconciliation is the responsibility of the most responsible prescriber for the patient. Obtaining and communicating the Best Possible Medication History and documenting and resolving any medication discrepancies are the responsibility of all healthcare professionals.

Medication Reconciliation is conducted in partnership with patients and families to ensure that the medication reconciliation documentation reflects the current use of medications and is utilized to communicate accurate and complete information about patients' medications across care transitions (on admission, transfer, and discharge).

- Medication Reconciliation is conducted for all patients who are admitted to hospital, including patients who are admitted from the Emergency Department or the Operating Room.
- Medication Reconciliation is conducted for all patients transferred from the Pediatric Intensive Care Unit to other inpatient units.
- Medication Reconciliation is conducted on discharge for all patients admitted under Oncology.
- For ambulatory patients, Medication Reconciliation is conducted for some patient populations receiving care as defined by the clinical area:
  - Ambulatory Care Program,
  - Surgical Services Program,
  - Oncology, Hematology & BMT Outpatient Program,
  - Emergency Department:
    - patients who are transferred to the Clinical Decision Unit
  - Mental Health
  - Sunny Hill Health Center

### DEFINITIONS

**Medication Reconciliation** – a formal process in which the healthcare providers work together with patients, families and care providers to generate a Best Possible Medication History, identify and resolve medication discrepancies, and communicate a complete and accurate list of medications.

**Best Possible Medication History (BPMH)** – a medication history created using a systematic process of interviewing the patient/family/care provider 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, vitamins and supplements). The BPMH includes the drug names, dosages, routes, and frequencies. It captures the patient's actual medication use, which may differ from their list of prescribed medications.

**Prescriber** – healthcare professional who is able to prescribe medications as part of their scope of practice (e.g. physician, nurse practitioner).

**Healthcare professional** – Refers to physician, pharmacist, nurse, or nurse practitioner.

**Patient** – Refers to patient, family or care provider.

**End of Service** – Discharge of patient from service or episode of care.

### PROCEDURE

#### Medication Reconciliation on Admission:

1. Unit coordinator/clerk generates Medication Reconciliation form using PharmaNet or another acceptable source is utilized (e.g. PROMIS, current clinical record (Powerchart) or discharge summary).
2. Healthcare professional obtains BPMH at time of admission and documents it on the Medication Reconciliation form. In some areas (e.g. Mental Health and Oncology/Hematology/BMT), the information is documented on form entitled "Medication History and Order Form on Admission (MHOFA)"
3. Prescriber reviews the BPMH and makes decisions about the patient's current medications. Prescriber documents/prescribes medications to be continued, changed, or discontinued on the Medication Reconciliation form or MHOFA.
4. If medications cannot be reconciled by the most responsible prescriber, they must consult the appropriate prescriber to reconcile the patient's medications.
5. Medication Reconciliation on admission must be completed within 24 hours of admission.
6. Medication Reconciliation or MHOFA form must be signed by the prescriber, even if the patient is currently not taking any medications.

#### Medication Reconciliation on Transfer:

7. The transferring prescriber reviews the patient's admission BPMH and current medications (e.g. Medication Administration Record and current prescriber's orders).
8. The transferring prescriber documents/prescribes medications to be continued, changed, or discontinued on the form entitled "BCCH Physicians' Orders on Patient Transfer within Inpatient Care Areas."
9. The accepting prescriber reviews the "BCCH Physicians' Orders on Patient Transfer within Inpatient Care Areas" form and documents/prescribes medications on the prescriber's orders.

#### Medication Reconciliation on Discharge:

10. The prescriber reviews the patient's admission BPMH and current medications (e.g. Medication Administration Record and current prescriber's orders). The prescriber creates a discharge medication list, which includes the following information:
  - a. Medications taken prior to admission and are to be continued (at the same or different dosage)
  - b. Medications taken prior to admission which are to be stopped
  - c. Medications started in hospital which are to be continued (at the same or different dosage)
  - d. Medications started in hospital which are to be stopped
  - e. Medications that are to be started at discharge
11. The prescriber or designated healthcare provider communicates the plan and provides the discharge medication list to the patient, and the patient's community healthcare team.
12. The prescriber provides a discharge prescription, as needed, to the patient.

#### Medication Reconciliation for Ambulatory Care Clinics and Anaesthetic Care Unit:

13. Medication Reconciliation is required for specified clinics that prescribe and/or administer medication(s) and is completed at the end of service.
14. Healthcare professional obtains BPMH in collaboration with the patient and documents with whom the BPMH was verified. This may occur via telephone consultation or in person.
15. Prescriber reviews the BPMH and makes decisions about the patient's current medications. Prescriber documents/prescribes medications to be continued, changed, or discontinued on the Medication Reconciliation form.

16. Should any changes be made to the patient's current medications during their stay in the ambulatory care clinic or anaesthetic care unit the prescriber includes an updated medication list in the dictated medical summary which is provided to community care providers and is retained in the patient's health record.
17. The prescriber provides a discharge prescription as needed to the patient.

### **Medication Reconciliation for the Oncology, Hematology & BMT Program: Ambulatory Care Clinic**

18. Medication Reconciliation must be completed at the start of each new cycle of chemotherapy for oncology patients on active treatment. For oncology, haematology or bone marrow transplant patients not on active chemotherapy treatment, or for patients receiving a prolonged cycle of chemotherapy lasting longer than 3 months, medication reconciliation must be completed every 3 months at minimum or at the next clinic visit if it has been greater than 3 months since their last visit.
19. Healthcare professional obtains BPMH in collaboration with the patient and compares it to the current medication list populated from PharmaNet and/or patient's health record.
20. Healthcare professional reconciles with the patient and documents medication discrepancies in the patient's chart.
21. Changes to the patient's current medications during their clinic visit are communicated to the patient and a prescription is provided as needed.
22. The updated medication list is included in the dictated medical summary and is provided to community care providers and is retained in the patient's health record.
23. At the end of service, the prescriber or designated healthcare provider provides the medication list to the patient, as well as the patient's community healthcare team.

### **Medication Reconciliation for the Emergency Department: Clinical Decision Unit (CDU)**

24. Unit clerk generates Medication Reconciliation form using PharmaNet or another acceptable source is utilized (e.g. PROMIS, current clinical record (Powerchart) or discharge summary).
25. Healthcare professional obtains BPMH at time of admission and documents it on the Medication Reconciliation form.
26. Prescriber documents/prescribes medications to be continued, changed, or discontinued on the Medication Reconciliation form.
27. If medications cannot be reconciled by the most responsible prescriber, they must consult the appropriate prescriber to reconcile the patient's medications.
28. Medication Reconciliation form must be signed by the prescriber, even if the patient is currently not taking any medications.
29. Should any changes be made to the patient's current home medications during their stay in the CDU, the prescriber creates a discharge summary with new medications prescriptions required to be filled on discharge. This is communicated to the patient and they are given a copy of the discharge summary/ prescriptions.

### REFERENCES

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## Appendix 1 Ambulatory Medication Reconciliation

This policy applies to the Ambulatory Program at BC Children's Hospital.

### DEFINITIONS

**End of Service** – Discharge of patient from service

**Episode of care** – Treatment occurs over several days on an outpatient basis.

**High Risk for Adverse 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.

### Ambulatory Clinics required to complete Medication Reconciliation

Medication reconciliation is conducted for ambulatory patient populations considered at a higher risk of a medication adverse drug event.

Allergy/asthma  
Biochemical Diseases  
Cardiology  
Child & Family (from a social context)  
Complex Care  
Cystic Fibrosis  
Dentistry  
Diabetes  
Endocrine  
GI  
Infectious Diseases (ID)  
Integrated Pain Service  
Multi Organ Transplant (MOT)  
Nephrology  
Neurology/Spinal cord/Spasticity  
Neuromuscular  
Nurse Practitioner Clinic  
Youth Clinic (if a physician is seeing patient)  
Orthopaedics – only on CP patients and any patients receiving sedation  
Ophthalmology – ERG patients receiving sedation  
Renal Clinic  
Renal Dialysis Unit (RDU)  
Medical Day Unit (If medications are being administered)  
Rheumatology

### Frequency of Medication Reconciliation

Medication reconciliation for “high risk” clinics will be completed during **each** clinic visit or episode of care for the Renal Dialysis Unit and Medical Dialysis Unit. The rationale for determining frequency is related to the timing patients are seen in the clinics and the frequency medications require modification. Most patients attend clinics bi-annually or annually. Medications are often changed related to growth and development or symptom management.

### Criteria High Risk Clinic Classification

Ambulatory patients are at risk of potential adverse drug events when their care is highly dependent on medication management or the medication used are known to be associated with potential adverse drug events. Other factors that may contribute to the patient population be classified as high risk are:

- Multiple medications used to manage disease process
- Multiple comorbidities
- Known or perceived compliance issues
- Patient population requires frequent medication changes to manage symptoms

Home medications could potentially impact medications administered