MEDICATION RECONCILIATION

PURPOSE

- To demonstrate Alberta Health Services’ (AHS) commitment to medication reconciliation and its importance as a patient safety initiative.

- To ensure consistency and awareness of medication reconciliation and best practices with the goal of reducing adverse drug events through ensuring accurate and complete transfer of medication information at transitions of care.

POLICY STATEMENT

- Medication reconciliation is an essential component of safe medication management.

- The process of medication reconciliation is interprofessional, interdependent and is reliant on a team approach.

- Patient/family and/or the participation of an alternate decision maker is an integral component of the medication reconciliation process.

- Initiation of the medication reconciliation process occurs for each patient as determined by a health care professional at each of the following care transitions:
  - Admission into the health care system.
  - Transfer to another health care setting, service, or level of care within Alberta Health Services where orders need to be reviewed &/or rewritten according to local guideline/policy (e.g., a patient going from acute care to long term care, from one AHS facility to another, acute care to home care, operating room to inpatient unit, ICU to step down unit).
Discharge process of exiting the system or services of Alberta Health Services. It may include continuation of service or care by another agency or provider not a part of AHS or when no further services are required (e.g. a patient going from acute care to home, acute care to non-AHS care providers).

APPLICABILITY

Compliance with this policy is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

POLICY ELEMENTS

1. Responsibility

   1.1 It is the responsibility of each unit/clinic/care setting/program to determine specific roles and responsibilities for completing the medication reconciliation process in their area.

   1.2 The health care professional is responsible to involve the patient and/or family/alternate decision maker as a key participant in the medication reconciliation process.

   1.3 It is the professional responsibility of all health care professionals that have medication management within their scope of practice and job duties to participate in the collection of an accurate patient medication history and to identify any discrepancies in medication therapy.

   1.4 An authorized prescriber is responsible to address and resolve the discrepancies.

2. Process

   2.1 The process for medication reconciliation is initiated with the generation of the best possible medication history (BPMH) of all medications the patient is taking at the time of admission.

   2.2 At admission, medications are reconciled by a health care professional (intentionally continued, discontinued, or modified) within the following time frames, where possible, and in accordance with section 1.3 of this policy:

   a) acute care – 24 hours;

   b) long term care – 48 hours;

   c) home care – two (2) home visits;

   d) ambulatory care – first (1st) visit; or

   e) supportive living – one (1) week.
2.3 The health care professional shall:

a) at admission, generate a BPMH using at least two (2) sources of information, such as but not limited to –
   - interview with the patient/family or alternate decision maker (when available the patient’s current medication list may be used as a source of information),
   - electronic provincial health record (Netcare/PIN),
   - community pharmacy record,
   - medication packages (vials, bubble pack, bottles), and/or
   - previous admission records/discharge summary;

b) use the current medication list as the BPMH for those patients coming directly from another facility where patient has had a long stay, e.g., long term care (6 months);

c) document all medication information collected on the BPMH;

d) use the BPMH to –
   - create admission orders, and/or
   - compare the medication list against admission, transfer, referral or discharge medication prescriptions by identifying and/or resolving any discrepancies;

e) at all care transitions, document and communicate to the patient, and/or the next health care professional –
   - any changes to medications that have been made or new medications that have been added, and
   - the reason for the changes in medications.

2.4 There are mechanisms established to support, measure, and continuously improve the effectiveness of the medication reconciliation process.

DEFINITIONS

Authorized prescriber means a health care professional who is permitted by Federal and Provincial legislation, her/his regulatory college, Alberta Health Services and practice setting (where applicable) to prescribe medications.
Best possible medication history means a complete and up-to-date list (electronic or paper) of the patient’s current medications using at least two sources including:

- name of the medication (all prescribed, over-the-counter, herbal, vitamin, homeopathic, health remedies and substances of abuse);
- dosage;
- route of administration;
- frequency of administration; and
- time of last dose (as appropriate).

Patient means all persons who receive or have requested health care or services from Alberta Health Services and its health care professionals and also means, where applicable:

a) a co-decision-maker with the person; or

b) an alternate decision-maker on behalf of the person.

REFERENCES

- Alberta Health Services Governance Documents:
  - Consent to Treatment/Procedure(s) (PRR-01)
- Non-Alberta Health Services Documents:
  - Accreditation Canada Required Organizational Practice, **Medication Reconciliation**

VERSION HISTORY

<table>
<thead>
<tr>
<th>Date</th>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 30, 2011</td>
<td>Initial Approval</td>
</tr>
<tr>
<td>May 1, 2012</td>
<td>Initial Effective</td>
</tr>
<tr>
<td>February 18, 2015</td>
<td>Revised</td>
</tr>
<tr>
<td>October 2, 2015</td>
<td>Housekeeping Change</td>
</tr>
<tr>
<td>March 17, 2016</td>
<td>Revised</td>
</tr>
<tr>
<td>December 16, 2017</td>
<td>Next Review</td>
</tr>
</tbody>
</table>