



TITLE

MEDICATION RECONCILIATION

SCOPE

Provincial

APPROVAL AUTHORITY

Alberta Health Services Executive

SPONSOR

Quality and Healthcare Improvement

PARENT DOCUMENT TITLE, TYPE AND NUMBER

Not applicable

DOCUMENT #

PS-05

INITIAL EFFECTIVE DATE

May 1, 2012

REVISION EFFECTIVE DATE

September 9, 2019

SCHEDULED REVIEW DATE

September 9, 2022

NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

If you have any questions or comments regarding the information in this document, please contact the Policy & Forms Department at policy@ahs.ca. The Policy & Forms website is the official source of current approved policies, procedures, directives, standards, protocols and guidelines.

OBJECTIVES

- 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.
- To reduce medication discrepancies that have the potential to result in adverse drug events by ensuring the accurate and complete transfer of medication information at care transitions (i.e., **admission, transfer, and discharge**).

PRINCIPLES

Medication reconciliation is an essential component of safe medication management that consists of three (3) steps (refer to Section 2 below):

- Step 1 – Generate a **Best Possible Medication History (BPMH)**;
- Step 2 – Reconcile the BPMH at care transitions; and
- Step 3 – Document and communicate the medication information.

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

The patient and/or **family** are integral components of the medication reconciliation process.

APPLICABILITY

Compliance with this document 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).

ELEMENTS

1. Responsibility

- 1.1 **Health care professionals** shall involve the patient and/or family as key participants in the medication reconciliation process when possible.
- 1.2 Health care professionals who have medication management within their scope of practice and job duties are responsible for generating a BPMH (Step 1), in accordance with Section 2.1 below.
- 1.3 An **authorized prescriber** is responsible for reconciliation of the BPMH at care transitions (Step 2), which includes addressing and resolving any discrepancies (differences) in medication therapy.
- 1.4 Health care professionals are responsible for documenting the medication information (in digital and non-digital formats) and communicating the complete list of medications that the patient should be taking at care transitions (Step 3).
 - a) Documentation in the health record in digital and non-digital formats must be referenced to the health care professional completing this activity.
 - b) The unit/clinic/care setting/program leadership shall determine which team members are responsible for distributing the medication list.
- 1.5 Given the variety of health care professionals that comprise a team, each unit/clinic/care setting/program shall determine the specific roles and responsibilities of team members for completing each step of the medication reconciliation process.
 - a) Implementation of the 3-step medication reconciliation process varies across clinical areas because of differences in care requirements. Refer to accreditation requirements and AHS *Medication Reconciliation Process Overview* documents on Insite for specific clinical areas.

2. Process

- 2.1 Step 1: Generate a BPMH. The process for medication reconciliation is initiated with the generation of the BPMH of all medications the patient is taking at the time of admission. The health care professional shall either:

- a) at admission, generate a BPMH using at least two (2) sources of information, one (1) of which should include an interview with the patient and/or family (as appropriate). Another source of information may be:
- (i) the patient's own list;
 - (ii) an electronic patient database (e.g., Netcare Pharmaceutical Information Network [PIN], clinical database);
 - (iii) the patient's medication containers (e.g., vials, bottles, bubble packs);
 - (iv) medication calendars;
 - (v) the Medication Administration Record (MAR);
 - (vi) new or existing prescriptions for the patient;
 - (vii) community pharmacy lists;
 - (viii) referrals or physician orders;
 - (ix) discharge/transfer information; or
 - (x) the Emergency Medical Services (EMS) record;
- or
- b) use the current medication list as the BPMH for those patients transferred from another facility where the patient has had a long stay, e.g., long-term care (at least three [3] months).

2.2 Step 2: Reconcile the BPMH at care transitions (admission, transfer, and discharge).

- a) An authorized prescriber shall address and resolve medication discrepancies within the following time frames, where possible:
- (i) Acute Care – 24 hours;
 - (ii) Ambulatory Care – first visit;
 - (iii) Home Care – two (2) home visits;
 - (iv) Long-Term Care – 48 hours; and
 - (v) Supportive Living – one (1) week.
- b) When necessary, the authorized prescriber shall generate medication orders upon admission, transfer, and/or discharge.

- 2.3 Step 3: Document and communicate the medication information.
- a) At all care transitions, the health care professional shall document and communicate the following information to the patient and/or family, and to applicable health care professional(s) including community pharmacists involved in the patient's care:
- (i) any changes to the patient's medications that have been made or new medications that have been added;
 - (ii) the reason(s) for the changes in the patient's medications; and
 - (iii) a complete list of medications the patient should be taking following transfer or discharge.

3. Evaluation

- 3.1 Zones/programs/site operations shall be responsible for monitoring compliance with the medication reconciliation process and to improve compliance when required.

DEFINITIONS

Admission means the process by which a patient enters the healthcare system.

Authorized prescriber means a health care professional who is permitted by Federal and Provincial legislation, their regulatory college, Alberta Health Services, and practice setting (where applicable) to prescribe medications.

Best Possible Medication History (BPMH) means a complete and up-to-date list of the patient's current medications at the time of admission verified using at least two sources of information. The BPMH includes:

- a) name of the medication (all prescribed, over-the-counter, herbal, vitamin, homeopathic, health remedies and substances for recreational use);
- b) dosage;
- c) route of administration;
- d) frequency of administration; and
- e) time of last dose (as appropriate).

Discharge means the patient has exited the system or services of Alberta Health Services. The patient's care may be continued by another agency or provider not a part of AHS.

Family (-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practises within scope and role.

Medication reconciliation means a structured process in which health care professionals partner with the patient, family, and caregiver for an accurate and complete transfer of medication information at transitions of care. The information is used to verify/validate the patient's admission, transfer, referral or discharge medication orders to reduce medication errors and adverse medication events at all points of care.

Patient means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

- a) a co-decision-maker with the person; or
- b) an alternate decision-maker on behalf of the person.

Transfer means the responsibility of the patient's care has changed to another service or level of care within Alberta Health Services and orders need to be reviewed or rewritten in accordance with local processes. For example, a patient is transferred from the operating room to inpatient unit or from the ICU to a step down unit.

REFERENCES

- Alberta Health Services Resources:
 - *Medication Reconciliation Process Overviews*
- Non-Alberta Health Services Documents:
 - *Accreditation Canada Required Organizational Practices Handbook*
 - *Accreditation Canada Standards*

VERSION HISTORY

Date	Action Taken
February 18, 2015	Revised
October 2, 2015	Housekeeping Change
March 17, 2016	Revised
September 9, 2019	Revised