Policy Name:	Policy Number:
MEDICATION RECONCILIATION	**0179**
	Effective Date: **March 3, 2010**
Approved By: Executive Team	Date Revised: September 27, 2021
Reason for Revision: Click on item below and select item from list. **CONTENT- Enter BELOW Reason for change Ex: Combined Policy ## and ##.** Combined Policy 0179 and SOP-0179 (N)	Next Date for Review: September 27, 2024
Section: Section 01 - Delivery of Care to Residents and Families	Page No: **Page 1 of 5**

Policy

Medication reconciliation is an important patient safety initiative that is an essential component of safe medication management. The goal is to reduce adverse drug events by ensuring accurate and complete transfer of medication information at times of transition of care. This policy will provide guidelines and outline roles and responsibilities to help ensure consistency and awareness of medication reconciliation.

APPLICABILITY

Physicians, Registered Nurses (RN), Pharmacy, Unit Clerks

POLICY ELEMENTS

1. Medication reconciliation is reliant on an interdisciplinary team approach, which includes the resident and/or family as a key participant.
2. Medication reconciliation will be completed at every transition of care.
3. A Best Possible Medication History (BPMH), using at least two sources, must be completed. The Resident should be one of the sources utilized when at all possible. When a resident is unable to participate, the reason should be documented in the clinical record.
4. Pharmacy will review a WellNet Profile, going back for the last month for all new admissions. The Pharmacist will identify any discrepancies.
5. The physician is responsible to address any discrepancies that may arise from the Medication Reconciliation process, and decide which medications will be continued, discontinued, or any new orders. The indication for use and reason for discontinuing all medication should also be provided.
6. Education on medication reconciliation will be provided at orientation and as needed.
7. Compliance with medication reconciliation will be monitored and is part of ongoing chart audits.

DEFINITIONS

Medication Reconciliation:	A structured process in which an interdisciplinary team partners with the Resident to ensure an accurate and complete transfer of medication information at transitions of care.
Best Possible Medication History:	A complete and up-to-date list all the Resident's current medications using at least two sources. Medications include prescription medication, and non-prescription medication, tradition, holistic, herbal, vitamins and supplements. Information gathered include: Name of medication, Dosage, Frequency, Route, and when last taken.
Transition of Care:	A Resident move from one health care setting to another. This includes admission to Agapé Hospice, re-admission, transfer to another facility and discharge to the community.

REQUIRED FORMS AND EQUIPMENT REFERENCES

Electronic forms location – FORMS
Hardcopy forms location – Nursing Station file Cabinet and Marshall's Pharmacy

1. Admission Medication Orders
2. Medication Reconciliation
3. Best Possible Medication History
4. Discharge/Transfer
5. Resident specific WellNet Profile – located at Marshall's Pharmacy

REFERENCES

Accreditation Canada. (2016). "Required Organization Practices Handbook 2017".
Accreditation Canada Qmentum. (2016). "Standards: Hospice, Palliative, End-of-Life Services for Surveys Starting After January 01, 2017" Ver.11.
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Accreditation Canada Qmentum. (2016). "Standards: Medication Management Standards for Community-Based Organizations for Surveys Starting After January 01, 2017". Ver.11
Alberta Health and Wellness. (2016). "Continuing Care Health Service Standards", Prepared by Continuing Care Branch.

Alberta Health Services. (2012).PS-05. Medication Reconciliation Policy; Revision Effective Date, March 17, 2016.

Procedure

Medication reconciliation is an important patient safety initiative that is an essential component of safe medication management. The goal is to reduce adverse drug events by ensuring accurate and complete transfer of medication information at times of transition of care.

Procedure

1. Once a Resident has accepted a bed, the Unit Clerk will notify Pharmacy, so they will be prepared to compare 1 month of Wellnet Profile to the Medication Reconciliation forms.
2. The RN obtains the best possible medication history from all available sources and at **least two sources** and enters it in the Admission Medication Orders, Medication Reconciliation Form.
3. When more than one sheet is required for the best possible medication history, number the pages in the top right hand corner.
4. The resident is a key source of information, and is asked to participate in building the best possible medication history (BPMH). If a resident is unable to participate, his/her legal substitute decision maker will be asked.
5. When interviewing the Resident and/or substitute decision maker, it is important to ask not only which medications are being taken, but also when and how. It is commonly found that many people do not take their medication how and when it is prescribed. If the resident is taking the medication differently than stated, ensure the appropriate discrepancy code is assigned.
6. Once the medication list has been reviewed and approved by the physician, the RN will fax the medication orders to pharmacy.
7. Pharmacy will compare the orders received with the WellNet profile from the last month.
8. If there are discrepancies, Pharmacy will review it with the RN and Physician to clarify.
9. The RN processes the orders as per Procedure Transcribing and Checking Doctors Orders.
    a. If medication orders received via a telephone order, they are processed as per – Procedure - Transcribing and Checking Doctor’s Orders.
    b. Upon the next personal visit to Agapé Hospice, the physician will sign the telephone order on the Admission Medication Orders, Medication Reconciliation sheet.

10. Any further medication orders will be written on the regular Doctor's Order Sheet. The order must contain an indication for use.
11. The same forms are used for both admissions and re-admission.
12. When a Resident is transferred to another facility, the RN will:
    a. Prepare a current medication list using the Agapé Hospice Best Possible Medication History at transition using the Discharge/Transfer form.
    b. Make a copy of the Admission Medication Orders, Medication Reconciliation / Best Possible Medication History form from admission.
    c. Ensure that all documents listed above accompany the resident to the receiving facility.
13. When a Resident is discharged to home, the RN will:
    a. Prepare a current medication list using the Agapé Hospice Best Possible Medication History Discharge/Transfer form.
    b. Send the above documentation with the resident.

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Medication Reconciliation Process Map