ACCREDITATION CANADA
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Required Organizational Practices

Handbook 2017

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MEDICATION RECONCILIATION AS A STRATEGIC PRIORITY

For the following sets of standards: *Leadership, Leadership for Aboriginal Health Services, Leadership for Small Community-based Organizations*

A documented and coordinated medication reconciliation process is used to communicate complete and accurate information about medications across care transitions.

NOTE: Accreditation Canada will move toward the full implementation of medication reconciliation in two phases.

For on-site surveys between 2014 and 2017, medication reconciliation should be implemented in ONE service (or program) that uses a Qmentum standard containing the Medication Reconciliation at Care Transitions Required Organizational Practice (ROP). Medication reconciliation should be implemented as per the tests for compliance for each ROP.

For on-site surveys in 2018 and beyond, medication reconciliation should be implemented in ALL services (or programs) that use Qmentum standards containing the Medication Reconciliation at Care Transitions ROP. Medication reconciliation should be implemented as per the tests for compliance for each ROP.

GUIDELINES

Medication reconciliation is recognized as an important safety initiative by the Canadian Patient Safety Institute and the World Health Organization. Medication reconciliation can be a cost-effective way to reduce medication errors (e.g., omissions, duplications, incorrect orders) and the re-work often associated with medication management. *Safer Healthcare Now!* offers a "Getting Started Kit" for various sectors (including acute care, long-term care, and home care).

Medication reconciliation is a three-step process, whereby the team (e.g., physicians, nurses, pharmacists) works in partnership with clients and families to generate a Best Possible Medication History (BPMH), identifies and resolves medication discrepancies, and communicates a complete and accurate list of medication to the client and their next care provider.

An organizational policy signals leadership's commitment to medication reconciliation and provides overarching guidance (e.g., an overview of the process, roles and responsibilities, care transitions where medication reconciliation is required, exemptions). Allocating resources to staffing, education, tools, information technology, etc., also demonstrates a commitment to medication reconciliation. Team education should include the rationale for and steps involved in medication reconciliation. The Agency for Healthcare Research and Quality's MATCH toolkit provides more information about medication reconciliation training. Evidence of education can include things like orientation checklists, a list of education sessions offered, attendance lists, competency evaluation forms, sign-off sheets for having read policies/procedures.

Implementing and sustaining medication reconciliation throughout an organization will be more successful if it is led by an interdisciplinary coordination team. Depending on the organization, the coordination team could include senior leaders (including clinical leaders representing medicine, nursing, and pharmacy); team members who are directly involved in the process; information technology staff; representatives from quality, risk, and safety committees; and clients and families.

It is important to monitor, in consultation with the coordination team and clinical team members, whether the medication reconciliation policy is being followed (e.g., Do clients receive medication reconciliation? Is the BPMH documented?) and the quality of the process (e.g., Is the BPMH complete? Are medication discrepancies identified and resolved?). Patient Safety Metrics provides a free audit tool to monitor compliance with medication reconciliation and the quality of the process.

TESTS FOR COMPLIANCE

Major	There is a medication reconciliation policy and process to collect and use accurate and complete information about client medication at care transitions.
Major	Roles and responsibilities for completing medication reconciliation are defined.
Major	There is a plan to implement and sustain medication reconciliation that specifies services/programs, locations, and timelines.
Minor	The organizational plan is led and sustained by an interdisciplinary coordination team.
Major	There is documented evidence that team members (including physicians) who are responsible for medication reconciliation are provided with relevant education.
Minor	Compliance with the medication reconciliation process is monitored and improvements are made when required.

REFERENCE MATERIAL

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- Safer Healthcare Now! (2013). *Patient Safety Metrics: Med Rec Quality Audit Tool*. www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/measurement.aspx

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Acute Care Services (inpatient)

For the following sets of standards: *Acquired Brain Injury Services, Cancer Care, Correctional Service of Canada Health Services, Critical Care Services, Hospice Palliative and End-of-Life Services, Medicine Services, Mental Health Services, Obstetrics Services, Perioperative Services and Invasive Procedures, Provincial Correctional Health Services, Rehabilitation Services, Spinal Cord Injury Acute Services, and Spinal Cord Injury Rehabilitation Services.*

Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications across care transitions.

GUIDELINES

Research suggests that more than 50 percent of clients have at least one discrepancy between the medications they take at home and those ordered upon admission to hospital. Many of these discrepancies have the potential to result in adverse drug events. *Safer Healthcare Now!* offers a "Getting Started Toolkit" for medication reconciliation in the acute care setting, which includes a number of tools and forms.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is taking, and how they are being taken (dose, frequency, and route of administration). Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, a community pharmacist, or a provincial database. Partnering with clients and families is essential when documenting how medications are taken, as the reality may be different from what is prescribed. The gathered lists of medications are compared, and when differences (i.e., medication discrepancies) are identified, they are resolved by the most responsible prescriber, who indicates which medications should be continued, discontinued, or modified and the reason(s) why. An up-to-date BPMH is then documented and shared with the client, family, and their next service provider. Clients need information about the medications they should be taking in a format and language they understand.

When a client has received care in a service environment for an extended period of time and is transferred to another health care organization or service, the current medication list may be used as the BPMH. The definition of 'an extended period of time' must be specified in organizational policy.

Once generated, the BPMH follows the client throughout their health care journey and is an important reference tool for reconciling medications across care transitions. Medication reconciliation is repeated and the BPMH is updated at any transition of care when medication discrepancies can be introduced. For example, it should happen at discharge or when medications are changed or reordered as part of a transfer involving a change in the service environment (e.g., from critical care to a medicine unit, or from one facility to another within an organization). Medication reconciliation is not required for bed relocation.

TESTS FOR COMPLIANCE

Major	Upon or prior to admission, a Best Possible Medication History (BPMH) is generated and documented in partnership with clients, families, caregivers, and others, as appropriate.
Major	The BPMH is used to generate admission medication orders OR the BPMH is compared with current medication orders and any medication discrepancies are identified, resolved, and documented.
Major	A current medication list is retained in the client record.
Major	The prescriber uses the BPMH and the current medication orders to generate transfer or discharge medication orders.
Major	The client, community-based health care provider, and community pharmacy (as appropriate) are provided with a complete list of medications the client should be taking following discharge.

REFERENCE MATERIAL

- American Medical Association. (2007). *The physician's role in medication reconciliation*. American Medical Association . http://bcpsqc.ca/documents/2012/09/AMA-The-physician%E2%80%99s-role-in-Medication-Reconciliation.pdf
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MEDICATION RECONCILIATION AT CARE TRANSITIONS

Acute Care Services (outpatient)

For the Perioperative Services and Invasive Procedures Standards.

In partnership with clients, families, or caregivers, medication reconciliation is initiated for a target group of outpatients who may be at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for outpatients).

GUIDELINES

Medication reconciliation is a structured process to communicate accurate and complete information about client medications at care transitions. Organizations use a risk assessment approach, working with team members to identify the client groups or procedures where there is the greatest risk of patient safety incidents and where initiating medication reconciliation will be of most benefit.

Targets may begin with a small group of clients, expanding as success with medication reconciliation is achieved. The rationale for the target group(s) is documented by the team and takes into account risk (e.g., clinical condition, complexity of their medication regimen, risks associated with the procedures) and factors that may affect the process (e.g., client flow).

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is taking, and how they are being taken (dose, frequency, and route of administration). Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, a community pharmacist, or a provincial database. Partnering with clients and families is essential when documenting how medications are taken, as the reality may be different from what is prescribed. The goal of medication reconciliation is to identify and communicate which medications should be continued, discontinued, or modified, and the reasons why. *Safer Healthcare Now!* Communities of Practice provide BPMH tools and forms.

TESTS FOR COMPLIANCE

Major	The criteria for a target group of outpatients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.
Major	For outpatients in the target group, a BPMH is generated in partnership with clients, families, or caregivers, and documented.
Major	For outpatients in the target group, the current medication list is updated to reflect changes made to medications, and the changes are communicated to the client, family, and next care provider.

REFERENCE MATERIAL

- American Medical Association (2007). The physician's role in medication reconciliation. American Medical Association . http://bcpsqc.ca/documents/2012/09/AMA-The-physician%E2%80%99s-role-in-Medication-Reconciliation.pdf
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- Mueller, S.K., Sponsler, K.C., Kripalani, S., Schnipper, J.L. (2012). Hospital-based medication reconciliation practices: a systematic review. *Arch.Intern.Med.* 172(14), 1057-69.

MEDICATION RECONCILIATION AT CARE TRANSITIONS

Ambulatory Care

For the following sets of standards: *Aboriginal Integrated Primary Care Services, Ambulatory Care Services, Cancer Care, and Remote/Isolated Health Services.*

Medication reconciliation is conducted in partnership with clients and families to communicate accurate and complete information about medications at ambulatory care visits where the client is at risk of potential adverse drug events. Organizational policy determines which type of ambulatory care visits require medication reconciliation, and how often medication reconciliation is repeated.

GUIDELINES

Ambulatory care includes a wide range of services and client populations, thus targeting medication reconciliation to clients or populations that are at risk of adverse drug events is encouraged. Ambulatory care clients are at risk when their care is highly dependent on medication management OR the medications typically used are known to be associated with adverse drug events. Medication reconciliation may be targeted to all clients receiving selected ambulatory care services, or to selected clients in any ambulatory care service. Organizations should apply a risk assessment approach, working with team members to identify client groups that are at most risk and likely to benefit from medication reconciliation. Targets may begin with a small group and then expand as success with medication reconciliation is achieved. The rationale for the target(s) and the frequency of medication reconciliation is documented, and any factors that influence the decision (e.g., risk of adverse drug events, work flow) are considered.

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is taking, and how they are being taken (dose, frequency, and route of administration). Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, a community pharmacist, or a provincial database. Partnering with clients and families is essential when documenting how medications are taken, as the reality may be different from what is prescribed. The gathered lists of medications are compared, and when differences (i.e., medication discrepancies) are identified, they are resolved by the most responsible prescriber, who indicates which medications should be continued, discontinued, or modified and the reason(s) why. This is done either at the clinic or by referral. An up-to-date BPMH is then documented and shared with the client, family, and their next service provider. Clients need information about the medications they should be taking in a format and language they understand.

Safer Healthcare Now! Communities of Practice provide a number of BPMH tools and forms.

TESTS FOR COMPLIANCE

Major	The type of ambulatory care visits that require medication reconciliation are identified and documented.
Major	For ambulatory care visits that require medication reconciliation, the frequency at which medication reconciliation should occur is identified and documented.
Major	During or prior to the initial ambulatory care visit, a Best Possible Medication History (BPMH) is generated and documented in partnership with the client, family, caregivers, and others, as appropriate.
Major	During or prior to subsequent ambulatory care visits, the BPMH is compared with the current medication list and any medication discrepancies are identified and documented. This is done as per the frequency required by the organization.
Major	Medication discrepancies are resolved in partnership with clients and families OR medication discrepancies are communicated to the client's most responsible prescriber and actions taken to resolve medication discrepancies are documented.
Major	When medication discrepancies are resolved, the current medication list is updated and retained in the client record.
Major	The client and the next care provider (e.g., primary care provider, community pharmacist, home care services) are provided with a complete list of medications the client should be taking following the end of service.

REFERENCE MATERIAL

- American Medical Association. (2007). *The physician's role in medication reconciliation*. American Medical Association. http://bcpsqc.ca/documents/2012/09/AMA-The-physician%E2%80%99s-role-in-Medication-Reconciliation.pdf
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MEDICATION RECONCILIATION AT CARE TRANSITIONS

Emergency Department

For the *Emergency Department Standards.*

Medication reconciliation is initiated in partnership with clients, families, or caregivers for clients with a decision to admit and for a target group of clients without a decision to admit who are at risk for potential adverse drug events (organizational policy specifies when medication reconciliation is initiated for clients without a decision to admit).

GUIDELINES

Medication reconciliation is a structured process to communicate accurate and complete information about client medications at care transitions. The medication reconciliation process is initiated for clients with a decision to admit and for a target group of non-admitted clients who are identified as being at risk for adverse drug events. Organizations use a risk assessment approach, working with team members to identify the client groups that are the most at risk for adverse drug events and that are most likely to benefit from medication reconciliation.

Targets may begin with a small group of clients, expanding as success with medication reconciliation is achieved. The rationale for the target group(s) is documented and takes into account factors that may affect the process (e.g., client flow).

Medication reconciliation begins with generating a Best Possible Medication History (BPMH) that lists all the medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) the client is taking, and how they are being taken (dose, frequency, and route of administration). Creating the BPMH involves interviewing the client, family, or caregivers, and consulting at least one other source of information such as the client's previous health record, a community pharmacist, or a provincial database. Partnering with clients and families is essential when documenting how medications are taken, as the reality may be different from what is prescribed. The goal of medication reconciliation is to identify and communicate which medications should be continued, discontinued, or modified, and the reasons why. *Safer Healthcare Now!* Communities of Practice provide BPMH tools and forms.

TESTS FOR COMPLIANCE

Major	Medication reconciliation is initiated for all clients with a decision to admit. A Best Possible Medication History (BPMH) is generated in partnership with clients, families, or caregivers, and documented. The medication reconciliation process may begin in the emergency department and be completed in the receiving inpatient unit.
Major	The criteria for a target group of non-admitted clients who are eligible for medication reconciliation are identified and the rationale for choosing those criteria is documented.
Major	When medications are adjusted for non-admitted clients in the target group, a BPMH is generated in partnership with clients, families, or caregivers, and documented.
Major	For non-admitted clients in the target group, medication changes are communicated to the primary health care provider.