

Medication Reconciliation: Between Hospital and Home

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Faculty/Presenter Disclosure

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Learning Objectives

Participants will be able to:

- Learn about the issues of medication management in seniors at transitions of care
- Consider medication reconciliation as a strategy in a family physician's clinic
- Become familiar and use the resources for medication reconciliation

Cynthia



Cynthia, an 80-year-old lady, visits you, her family physician, for follow-up after discharge from hospital, accompanied by her daughter. She has recently been discharged after a four week stay in hospital for complications from coronary artery disease and congestive heart failure. She also suffers from diabetes, hypertension, and osteoporosis. Her discharge diagnosis includes mild cognitive impairment. Towards the end of the 15-minute visit, you review her medications and count 12 of them!

Issues of Medication Management

The family physician has limited time to address all the patient's concerns, including optimizing medications



Issues of Medication Management

The older adult with multiple co-morbidities will typically have a long list of medications. Seniors with 3 or more chronic conditions are taking an average of six prescription medications (CIHI, 2011).



Photo from: [https://upload.wikimedia.org/wikipedia/commons/1/10/Mediciner_\(Small\).jpg](https://upload.wikimedia.org/wikipedia/commons/1/10/Mediciner_(Small).jpg)

Issues of Medication Management

Polypharmacy, particularly >5 medications, is associated with increased incidence of drug-related adverse events. In 2010-2011, 1 in 200 Canadian seniors (more than 27,000 seniors) had hospitalizations related to adverse drug reactions (CIHI, 2013).



Issues of Medication Management

Adverse events including medication errors are common in the post-discharge period.

The health system currently has significant deficiencies in safety at discharge (Snow, 2009).

Medication errors tend to occur in transitions of care (Desai, 2013).

Strategies for Medication Management

Medication management in family physician's offices are being done through a variety of interventions (Kucukarslan, 2011) that may include:

- a. Collaboration among healthcare providers – physicians or prescribers, pharmacists, nurses or care coordinators, and case workers
- b. Telephone or face-to-face follow-ups
- c. Creation of algorithms and treatment plans

MedRec as a Strategy

Definition: “Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate & comprehensive medication information is communicated consistently across transitions of care.”

(Institute of Safe Medication Practices in Canada: ISMP)

MedRec as a Strategy

- It has been identified by the W.H.O., as part of their High 5s project, highlighting the top 5 safety priorities internationally.
- MedRec is an Accreditation Canada Required Organizational Practice (Accreditation Canada, 2012)
- It is a major safety initiative to improve communication about medications as patients' transition through healthcare settings.

MedRec as a Strategy

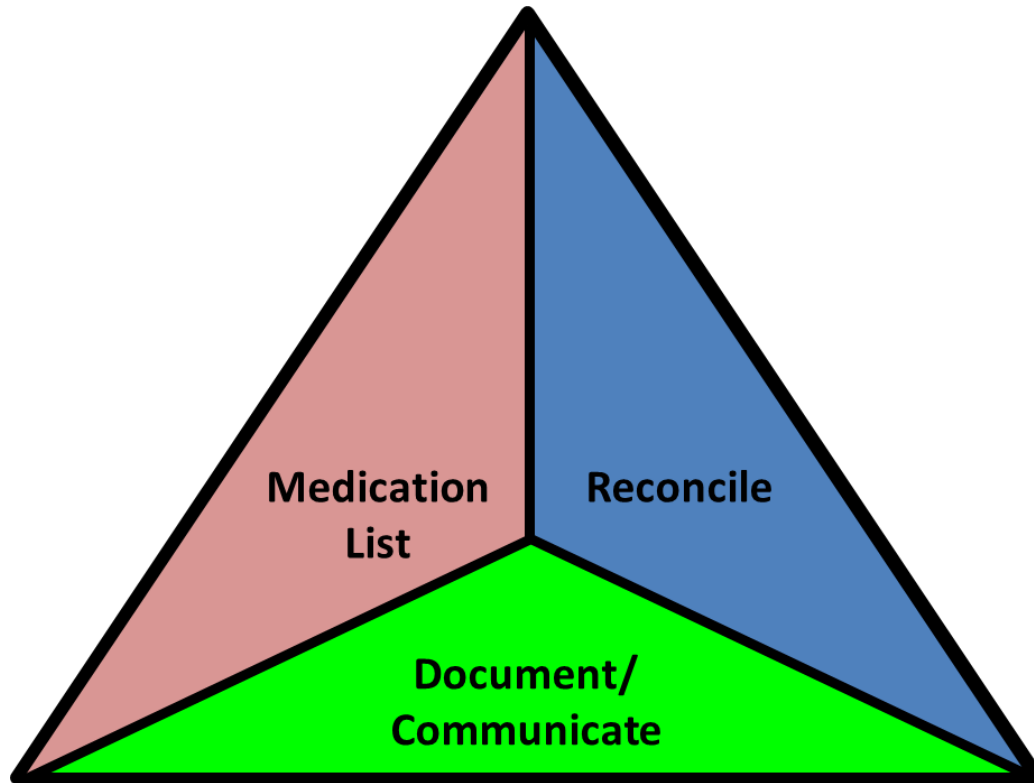
- It is a fundamental to medication management and builds on the medication 'history- taking' physicians have been using for years.
- It helps the physicians make the appropriate (de)prescribing decisions for their patients and is an opportunity to encourage patients to be involved in the medication safety (Frank,2014).

MedRec as a Strategy

It requires:

- a. Best Possible Medication History(BPMH):
Generation of a complete and up to date medication list including drug name, dosage, route and frequency
- b. Reconciliation of the medication list and identification of discrepancies
- c. Documentation and communication

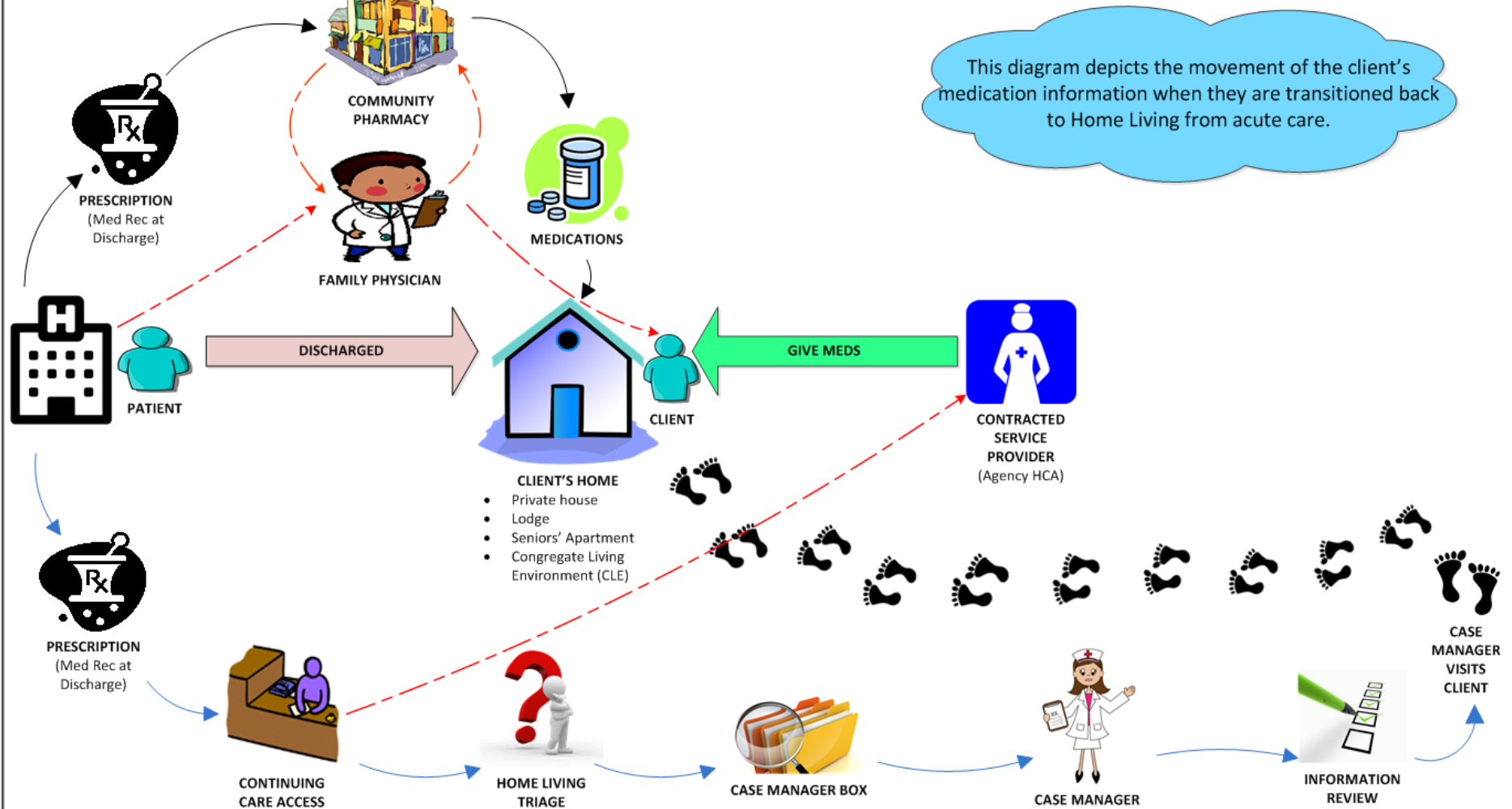
MedRec as a Strategy



MedRec as a Strategy

- It is done during admission and discharge from hospital.
<http://insite.albertahealthservices.ca/assets/acrd/tms-acrd-medrec-strategic-priority.pdf>
- It is being done across Alberta Health Services and Covenant Health as patients' transition between care settings.

Medication Information Movement in the Client Journey



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MedRec as a Strategy

- Case managers are responsible for MedRec at admission for clients on homecare in the community. They are expected to provide the same when their clients are being discharged home from hospital.

Prescriber:	a.	ph#	Information Source	Discrepancy Codes
	b.	ph#	<input type="checkbox"/> A – Client	1. No discrepancy
	c.	ph#	<input type="checkbox"/> B – Caregiver	2. Med not currently prescribed
	d.	ph#	<input type="checkbox"/> C – Medication vials	3. Client not taking med
	e.	ph#	<input type="checkbox"/> D – Client's own med list	4. Different frequency
Pharmacy:	1.	ph#	<input type="checkbox"/> E – Bubblepack/Dosette	5. Different route
	2.	ph#	<input type="checkbox"/> F – NetCare PIN Profile	6. Different dose
	3.	ph#	<input type="checkbox"/> G – Discharge info from Facility	7. OTC not taken as directed
	4.	ph#	<input type="checkbox"/> H – Other _____	8. Other _____

Medication Record sent to Prescriber		
<input type="checkbox"/> Yes	Prescriber: <input type="checkbox"/> a. <input type="checkbox"/> b. <input type="checkbox"/> c.	<input type="checkbox"/> No <input type="checkbox"/> Client managing medication <input type="checkbox"/> Client refused <input type="checkbox"/> Client following up with prescriber <input type="checkbox"/> Other _____

Assessor Name	Assessor Signature	Date
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MedRec for Home Care



1. Identify the Client

- Ensure MedRec is completed.

2. Create the Best Possible Medication History and Identify the Differences

- Minimum of 2 sources
- Establish what medication the client is actually taking
- Identify and document differences

MedRec for Home Care



3. Resolve and Communicate Differences

- Identify differences that require resolution by a prescriber
- Work with client to initiate resolution of differences
- Document actions taken

4. Close the Medication Reconciliation Loop

- Confirm that resolution of differences has occurred
- Educate the client and/or caregivers
- Document actions taken

MedRec in Primary Care:

Environmental scan

Primary Care Networks (PCNs) in Alberta have started to use the materials offered through the online portal for resources and tools:

1. Bow Valley PCN – is using public materials to encourage and support patients in creating and maintaining their own medication list.
2. Kalyna County PCN – currently doing medication reviews with their geriatric population.
3. Peaks to Prairies PCN – have identified MedRec as a possibility and plan to examine the materials that are available and support mechanisms.
4. Red Deer PCN – will do MedRec/medication review if it is requested by a physician for a particular patient

MedRec in Primary Care:

Environmental scan

5. Oliver PCN – has a MedRec process where high risk patients discharged from hospital are identified for medication review with the pharmacist. Other patients get flagged based on set criteria regarding risk.

6. Calgary Rural PCN – has had success in partnering with the hospital in Strathmore project on seamless discharge, as well have a team of pharmacists that support medication reviews within the PCN.

7. Heartland PCN is examining medrec possibility within smaller communities (e.g. Redwater) and hope to build off the success there.

MedRec in Primary Care:

Environmental scan

8. Edmonton Southside PCN – conducting research regarding the information coming from hospitals, partnering with AHS & CH, including med management.
9. Edmonton West PCN – have a similar program to Oliver PCN for targeted patients. As well, have tried to establish links with pharmacists within the hospital.
10. Calgary Foothills PCN – Have a MedRec form that is used within the PCN for new patients; it's done as needed.
11. Westview PCN – Pharmacists supporting physician offices will reconcile medications for patients once a discharge summary arrives from the hospital (if needed), additionally pharmacists support complex care plans and medical assessments with medication reviews if needed.

The Journey to Appropriate Medication Management



Patient in the Hospital



Patient at Home



Patient in clinic



MedRec
at Admission

MedRec
at Discharge

MedRec
Support at Home

MedRec
in Community

MedRec Online Resources

Institute of Safe Medication Practices in Canada

<http://www.ismp-canada.org/medrec/>



The screenshot shows the website for the Institute of Safe Medication Practices (ISMP) Canada. The browser address bar displays www.ismp-canada.org/medrec/. The ISMP Canada logo is in the top left, with the text "Institute for Safe Medication Practices Canada" and "A Key Partner in the Canadian Medication Incident Reporting and Prevention System (CMIRPS)" below it. A navigation bar includes links for "Français", "ISMP (US)", "Contact Us", and "Feedback", along with a search field. A left sidebar lists various site sections like "Home", "Safety Bulletins", "Report a Medication Incident", "News", "Education", "Products & Services", "Publications", "Current Projects", "CMIRPS", "Related Links", "Definitions", "About Us", and "Contact Us". The main content area features a large heading "Medication Reconciliation (MedRec)" and a sub-navigation bar with tabs for "About MedRec", "Provincial", "National", "International", "Education & Training", "Contact Us", and "FAQ". A "SHARE" button with social media icons is also present. The main text defines medication reconciliation as a formal process for ensuring accurate medication information across care transitions.

Home

Safety Bulletins >

Report a Medication Incident

News >

Education >

Products & Services >

Publications >

Current Projects >

CMIRPS

Related Links

Definitions

About Us >

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[Français](#) [ISMP \(US\)](#) [Contact Us](#) [Feedback](#) Search:

Medication Reconciliation (MedRec)

[SHARE](#) [f](#) [t](#) [e](#) ...

[About MedRec](#) [Provincial](#) [National](#) [International](#) [Education & Training](#) [Contact Us](#) [FAQ](#)

Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking (known as a BPMH) to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient.

MedRec Online Resources

W.H.O. Collaborating Centre for Patient Safety in Support

<http://www.who.int/patientsafety/implementation/solutions/high5s/h5s-fact-sheet.pdf>

High 5s Fact Sheet

The High 5s Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation Standard Operating Protocol

The High 5s Assuring Medication Accuracy at Transitions in Care: Medication Reconciliation (MedRec SOP) outlines the standard steps of medication reconciliation, guidance for implementation, references and suggestions for quality measurement. The purpose of this SOP is to reduce the potential for adverse drug events (ADEs) as a cause of harm to patients. Preventable ADEs are largely the result of miscommunication and unavailable or incorrect information.

MedRec Online Resources

Alberta Health Services – Medication List Campaign

<http://www.albertahealthservices.ca/info/page12614.aspx>

The screenshot shows a web browser window with the URL www.albertahealthservices.ca/info/page12614.aspx. The page header includes the Alberta Health Services logo, the 811 Health Link logo (Health Advice 24/7), and a search bar labeled "Search AHS". Navigation links for Home, Contact, Staff, and Help are also present. A blue navigation bar contains dropdown menus for ABOUT AHS, FIND HEALTH CARE, INFORMATION FOR, CAREERS, NEWS, and AHS IN MY ZONE. The breadcrumb trail reads "Home > Information For > Medication Lists". The main content area features a large teal banner with the text "Medication Reconciliation". Below this, the "Know Your Medications" section explains the importance of keeping an up-to-date list of medications and provides a link to "MedList here". The "AHS Links" section includes a link to "Physician Education". The "External Links" section is partially visible at the bottom.

Home | Contact | Staff | Help

Search AHS

ABOUT AHS ▾ FIND HEALTH CARE ▾ INFORMATION FOR ▾ CAREERS ▾ NEWS ▾ AHS IN MY ZONE ▾

Home > Information For > Medication Lists

Medication Reconciliation

Know Your Medications

Keep an up-to-date list of all the medication you take. This list is important to help make sure you're getting the right medication at the right time. Find tools to create a [MedList here](#).

At Alberta Health Services, we are working to ensure that healthcare providers across the province capture WITH prescribers to make sure that a patient's medication list is complete, accurate, and up to date.

AHS Links

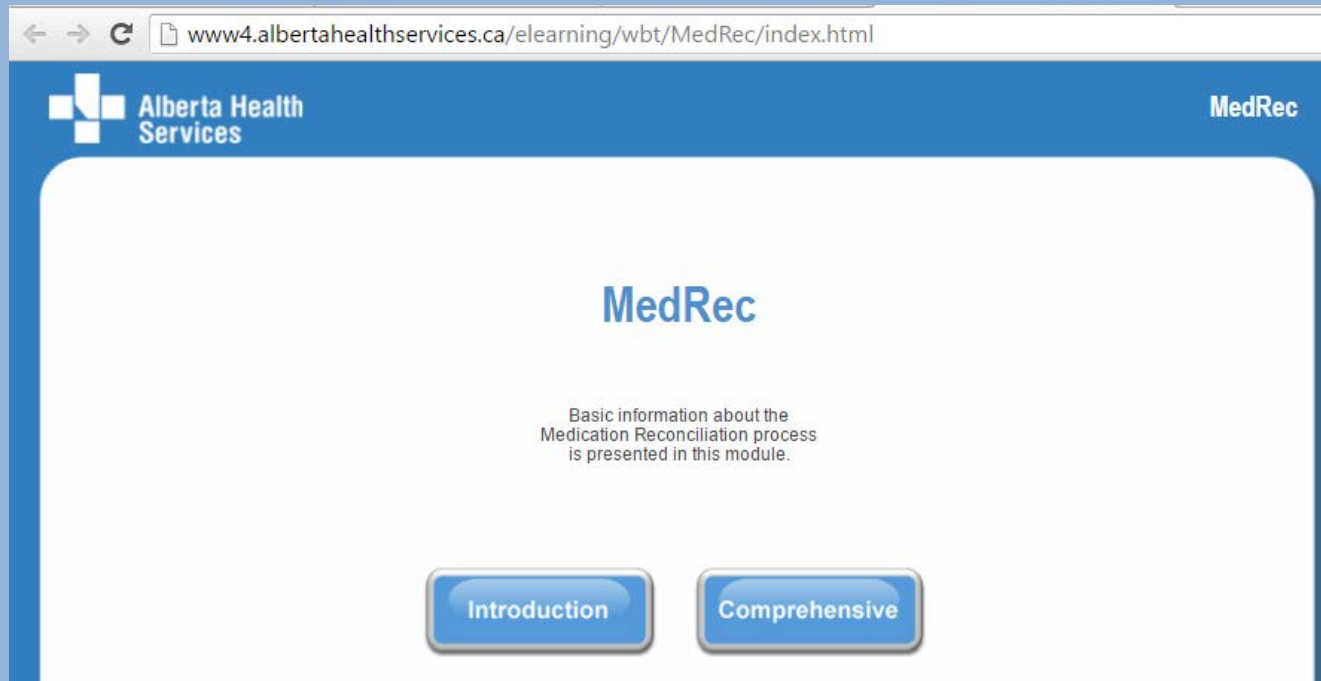
- [Physician Education](#)

External Links

MedRec Online Resources

Alberta Health Services – Medication Reconciliation eLearning Module

<http://www4.albertahealthservices.ca/elearning/wbt/MedRec/index.html>



The screenshot shows a web browser window displaying the MedRec eLearning module landing page. The browser's address bar shows the URL: www4.albertahealthservices.ca/elearning/wbt/MedRec/index.html. The page features a blue header with the Alberta Health Services logo on the left and the text "MedRec" on the right. The main content area is white and contains the following text:

MedRec

Basic information about the Medication Reconciliation process is presented in this module.

At the bottom of the page, there are two blue buttons with rounded corners: "Introduction" and "Comprehensive".

MedRec Online Resources

MyHealth.Alberta.ca – Medication Lists and Tools

<https://myhealth.alberta.ca/alberta/Pages/medicine-tracking-tools.aspx>

The screenshot displays the MyHealth.Alberta.ca website interface. At the top, a dark blue navigation bar contains links for Home, About MyHealth.Alberta.ca, Feedback, Important Phone Numbers, and Frequently Asked Questions. Below this is a search bar with the text "All MyHealth.Alberta.ca" and a search icon. The MyHealth.Alberta.ca logo is prominently displayed on the left. A secondary navigation bar highlights "Health Information & Tools" in blue, with other options like Home, MyHealth Videos, and Health Care Locator. Underneath, a blue bar lists categories: Health A-Z, Healthy Living, Tests & Treatments, Medications, Find Health Care, Health Alerts, and Patient Care Handouts. The main content area shows the breadcrumb "Health Information & Tools > Health A-Z > Medication Lists and Tools" and social sharing options (Facebook, Twitter, Email, Share, Print). On the left, there are links for "Know Your Medications", "Medication Lists and Tools", "Resources", and "Other Places to Get Help". The central heading is "Medications", and the main title is "Medication Lists and Tools". On the right, a "Related Links" section lists: "Keeping Track of Medicines", "Quick Tips: Taking Medicines Wisely", "Wise Health Consumer", and "Video: Do You Have a Medlist?".

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Questions:



References

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