The Lay of the Land
Medication Reconciliation in Canada
SHN - Across the Continuum

Margaret Colquhoun B.Sc.Phm., R.Ph., FCSHP
Project Leader ISMP Canada
SHN Intervention Lead Medication Reconciliation

A Medication Reconciliation Allegory

(or metaphor!)

By Mark Kearney, Pharmacist,
Queensway Carleton Hospital

ismp CANADA

safer healthcare now!

Imagine

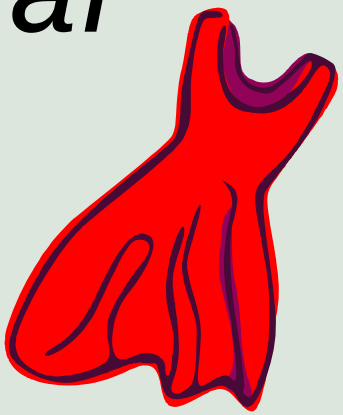
You come into the hospital wearing size 32 grey pants, a red shirt, blue shoes, and a black belt….

ISMP CANADA

safer healthcare now!

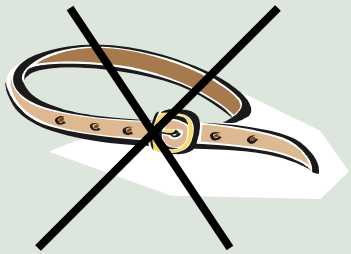
You leave the hospital

...wearing a red dress

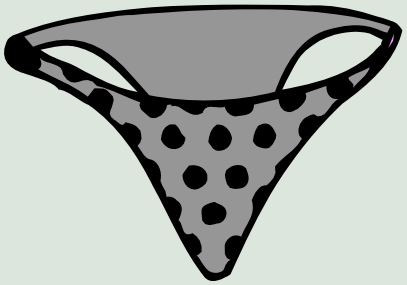


A blue shirt ...

No belt

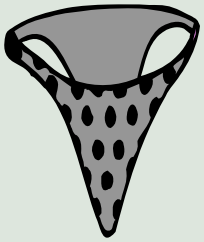


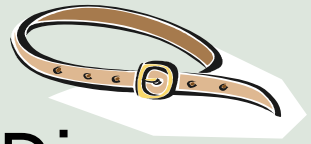
... and a size 32 grey thong!



What happened?

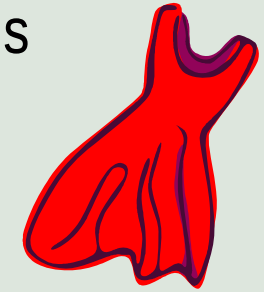
- Unintentional Discrepancy
  - Ordered a grey thong instead of grey pants
  - Forgot to reorder your belt





- Undocumented Intentional Discrepancy
  - Blue a better colour for you so substituted in place of red shirt but nobody was told

- Intentional Discrepancy
  - Everyone told you that you had the legs for a dress so we replaced your pants



I'm Going to Talk About

- What we've learned in SHN! (Re medication reconciliation)
- Measurement learning and clarification
- Medication reconciliation at transfer and discharge
- Where we're going…….

Evidence Supporting Medication Reconciliation is Strong

- **The beginning - January 2006 – Sentinel Event Alert by Joint Commission: 63% of 350 sentinel (harm/ death) events related to medications attributed to communication issues; 50% might be resolved through medication reconciliation**
- **Canadian Studies –Forster, Cornish etc**
- **"Strong Medication Reconciliation Efforts Lowers ADE Readmissions" ***
  - ***Pharmacy Practice News Issue 8/2009;volume 36:08**

What We've Learned

- There can still be a surprising amount of resistance
- BPMH training is required
- We need national support at higher levels
- We need to build the case in a more compelling way
- Still need to work with Accreditation Canada – e.g. triage, clinics, response rates

SHN Medication Reconciliation Learning

- It is a lot of work
- Patient must be at the centre – Lynn Hall "nurses interested in solving problems"
- The answers are local
- Discharge medication reconciliation may have even more impact than admission
  - Significant potential for business case for staff at discharge

SHN Medication Reconciliation Learning

- Teams that have succeeded and changed their processes would NOT go back to the old way (Donna Denison story)
- It takes commitment: up front and ongoing – commitment to "one source of truth" for meds prior to admission
- Requires prompts e.g. post-discharge medication reconciliation phone call

Interior Health Region
Kelowna BC

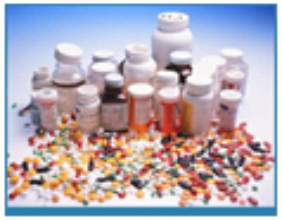
" I saw a very bright, cognitively well client and applied the medication reconciliation process during my visit. She told me that until this day she had no idea what medications she was taking and wondered why no one had discussed this with her in the past. During the course of the interview I discovered that the hospital had made changes to her medication regime that had not been discussed with the client. She was upset at the fact that the hospital had not advised her of the change but was grateful that I identified and resolved the discrepancy."

Erna Somfai RN
Pilot Team Member

- Medication reconciliation needs to be marketed

If time is money, following these steps to prevent medication errors on admission is a sound investment!

STEP 1: Extra time it takes to document admission medication history specifically on the medication reconciliation form: **0 minutes**



STEP 2: Time needed for pharmacist to take a "Best Possible Medication History" (BPMH): **30 minutes**

STEP 3: Time it takes to compare the BPMH to the admission medication orders: **5 minutes**

STEP 4: Time it takes to identify and reconcile discrepancies between the BPMH & the admission medication orders: **10 minutes**

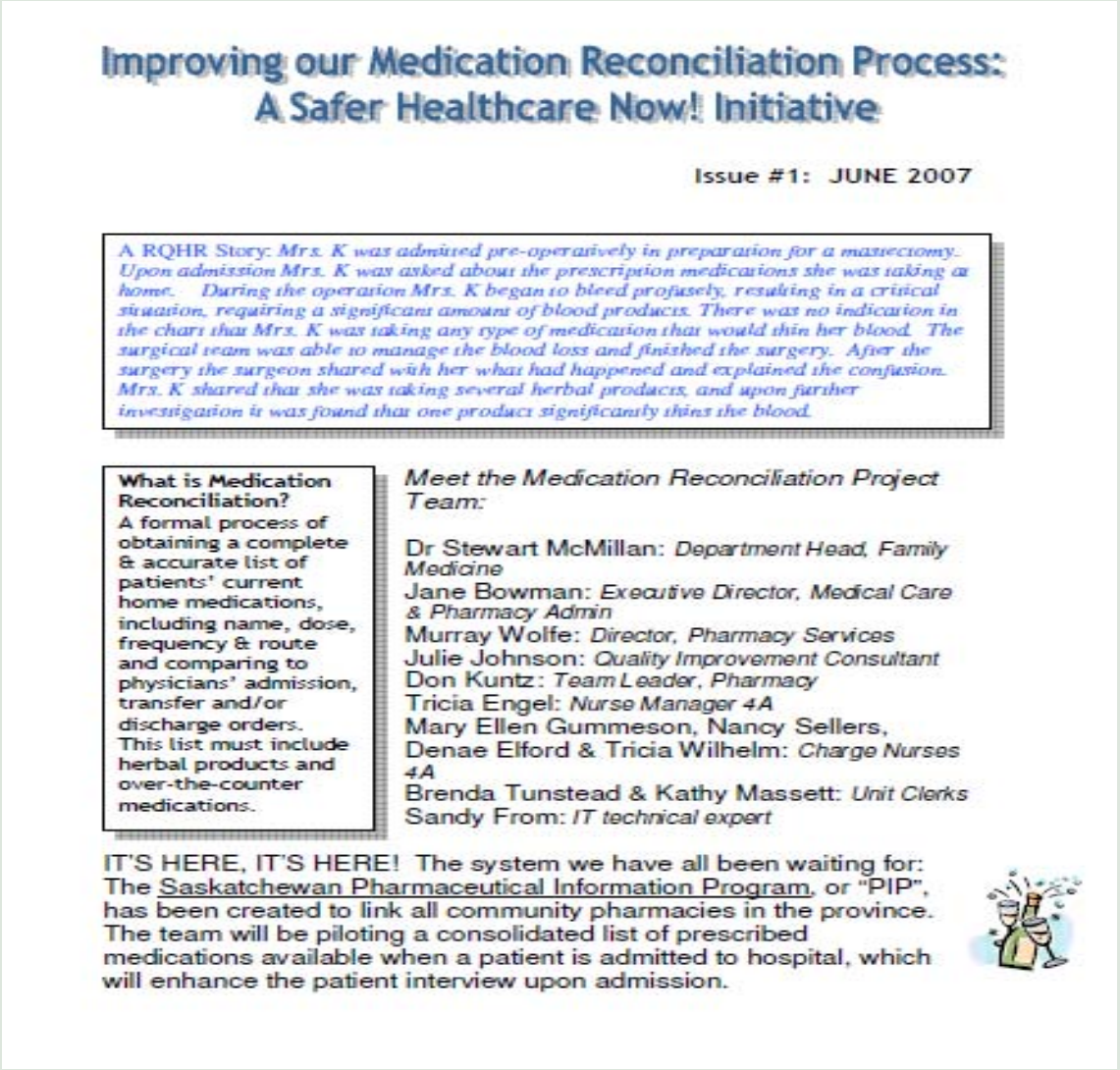
Time & effort you didn't spend managing the outcome of a medication error…….. PRICELESS!

SickKids

Adapted from the VA National Center for Patient Safety, June 2005

Monthly MedRec Newsletter

- Local stories create buy-in



Improving our Medication Reconciliation Process: A Safer Healthcare Now! Initiative

Issue #1: JUNE 2007

A RQHR Story: *Mrs. K was admitted pre-operatively in preparation for a mastectomy. Upon admission Mrs. K was asked about the prescription medications she was taking at home. During the operation Mrs. K began to bleed profusely, resulting in a critical situation, requiring a significant amount of blood products. There was no indication in the chart that Mrs. K was taking any type of medication that would thin her blood. The surgical team was able to manage the blood loss and finished the surgery. After the surgery the surgeon shared with her what had happened and explained the confusion. Mrs. K shared that she was taking several herbal products, and upon further investigation it was found that one product significantly thins the blood.*

What is Medication Reconciliation?
A formal process of obtaining a complete & accurate list of patients' current home medications, including name, dose, frequency & route and comparing to physicians' admission, transfer and/or discharge orders. This list must include herbal products and over-the-counter medications.

Meet the Medication Reconciliation Project Team:

Dr Stewart McMillan: *Department Head, Family Medicine*
Jane Bowman: *Executive Director, Medical Care & Pharmacy Admin*
Murray Wolfe: *Director, Pharmacy Services*
Julie Johnson: *Quality Improvement Consultant*
Don Kuntz: *Team Leader, Pharmacy*
Tricia Engel: *Nurse Manager 4A*
Mary Ellen Gummeson, Nancy Sellers, Denae Elford & Tricia Wilhelm: *Charge Nurses 4A*
Brenda Tunstead & Kathy Massett: *Unit Clerks*
Sandy From: *IT technical expert*

IT'S HERE, IT'S HERE! The system we have all been waiting for: The Saskatchewan Pharmaceutical Information Program, or "PIP", has been created to link all community pharmacies in the province. The team will be piloting a consolidated list of prescribed medications available when a patient is admitted to hospital, which will enhance the patient interview upon admission.

Used with Permission From Regina Qu'Appelle Health Region

St Michael's Hospital

Grand Rounds Faculty Disclosure

- "All presenters are involved in the St. Michael's Hospital Medication Reconciliation project and are unashamedly biased in their views on the subject."

Dr. Ken Balderson

SHN! – Med Rec Teams Reporting to Central Measurement Team

National Statistics:

- Over 450 teams
- Average of 100 teams reporting every month to Central Measurement Team
- Have amazing experience in acute care, LTC and home care

Measurement of Your Progress

- If you are new, begin with baseline:
  - After your usual process of writing admission orders, create a BPMH and compare to the orders to identify unintentional or undocumented intentional discrepancies
- Create a medication reconciliation process and test it
- Measure and report discrepancies until improvement is sustained for several months
- Move to % reconciled

ISMP CANADA

safer healthcare now!

Measurement Learning from Teams

Several similar interdisciplinary practice models or processes possible (acute and LTC)

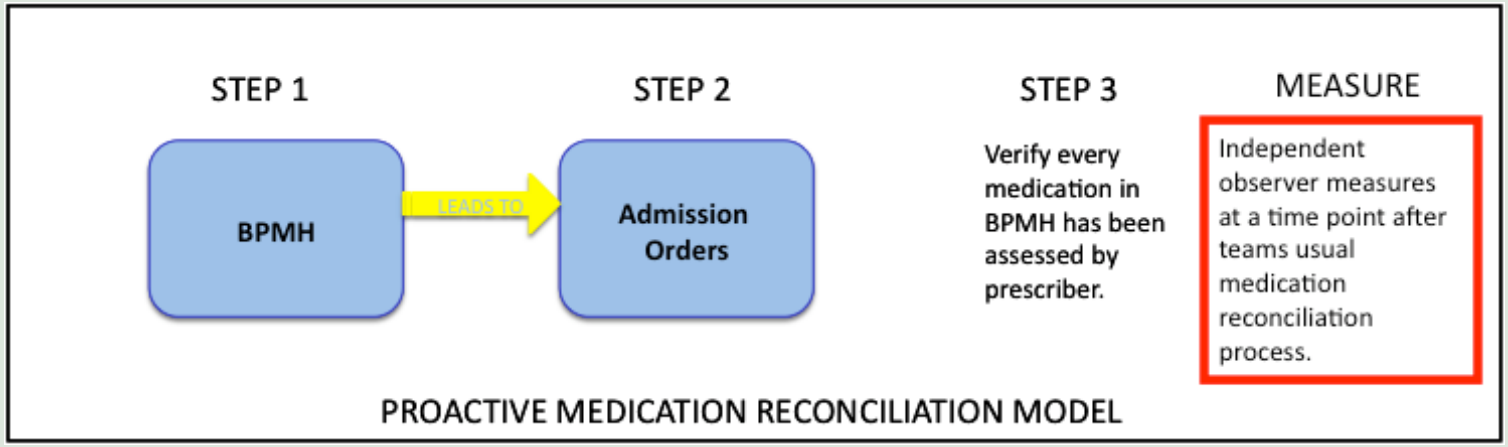
Important to distinguish for measurement and implementation purposes

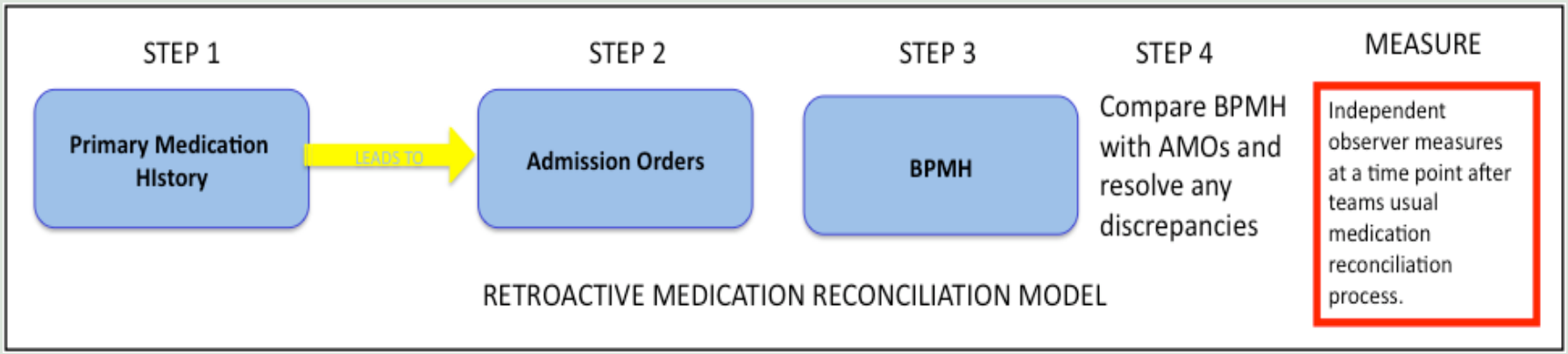
1. Proactive Reconciliation
2. Retroactive Reconciliation
3. Hybrid model of 1 and 2

Measurement Learning

- Everyday reconciliation process and measurement process are actually distinct and different activities
- After baseline, team needs to measure **after** reconciliation in order to measure the quality of the reconciliation, or improvement

When should you measure ?





SHN Measure for Admission Medication Reconciliation

Measure % of patients with formal reconciliation at admission (AC measure)

- Ensure quality is maintained by reinstituting discrepancy measurement yearly
- Denominator is total admissions (can be by unit or institution)
- Aligns with Accreditation Canada performance indicators
- Reduces SHN measurement burden

Transfer and Discharge

- Feedback from teams: many have moved toward sustaining admission med rec and are now earnestly focused on transfer and discharge
- Principles, processes and tips on these interfaces in national calls
- Planning national webinar series to focus on discharge
- Small number of teams submitting data re transfer and discharge

Transfer

- Identify which transfers
  - ICU to general unit
  - General unit to continuing care
  - When orders need to be rewritten
- Create process to bring forward BPMH to compare with transfer orders so that home meds which may have been stopped are reinstituted

St-Boniface General Hospital

Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg

TRANSFER
Medication Reconciliation and Order Form

Transfer from: _____ to _____

ALLERGIES/INTOLERANCES & REACTIONS

☐ None Known ☐ Unable to Obtain

Medications at Time of Transfer List all Regularly Scheduled and PRN Medications (Including prescription, OTC, drops, patches, creams, injections, inhalers) Medication, Dose, Route and Frequency	PHYSICIAN's Review & Order Review each medication and check off appropriate box			
	Continue as written	Change (see next page)	Do Not Order	Reason for Not Ordering or Changing
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

Physician Signature: **Physician Printed Name:** **Date:** **Time:**

Medications at Time of Transfer Recopied By: _____ **Date:** _____ **Time:** _____

Orders Transcribed By: _____ **Date:** _____ **Time:** _____

Orders Verified By: _____ **Date:** _____ **Time:** _____

☐ **Orders Faxed/Sent to Pharmacy** **Date:** _____ **Time:** _____

PART 1 of 2

DO NOT REMOVE OR THIN FROM THE CHART
Please place Reconciliation Forms in the Orders Section

DISCHARGE

AT DISCHARGE:

The goal of discharge medication reconciliation is to reconcile the medications the patient is taking prior to admission and those initiated in hospital, with the medications they should be taking post-discharge to ensure all changes are intentional and that discrepancies are resolved prior to discharge.

Compare:

Best Possible Medication History (BPMH)

and the

Last 24 hour Medication Administration Record (MAR)

plus

New medications started upon discharge

to identify and resolve discrepancies and prepare the Best Possible Medication Discharge Plan (BPMDP)

Discharge Reconciliation

Using the BPMH and last 24 hour MAR & discharge prescription as references evaluate and account for:

1. **New medications started in hospital (from MAR)**
2. **Discontinued medications (from BPMH)**
3. **Adjusted medications (from BPMH)**
4. **Unchanged medications that are to be continued (from BPMH)**
5. **Medications held in hospital**
6. **Non-formulary/formulary adjustments made in hospital**
7. **New medications started upon discharge (from discharge prescription)**
8. **Additional comments as appropriate – e.g. status of herbals or medications to be taken at the patient's discretion**

ismp CANADA

safer healthcare now!

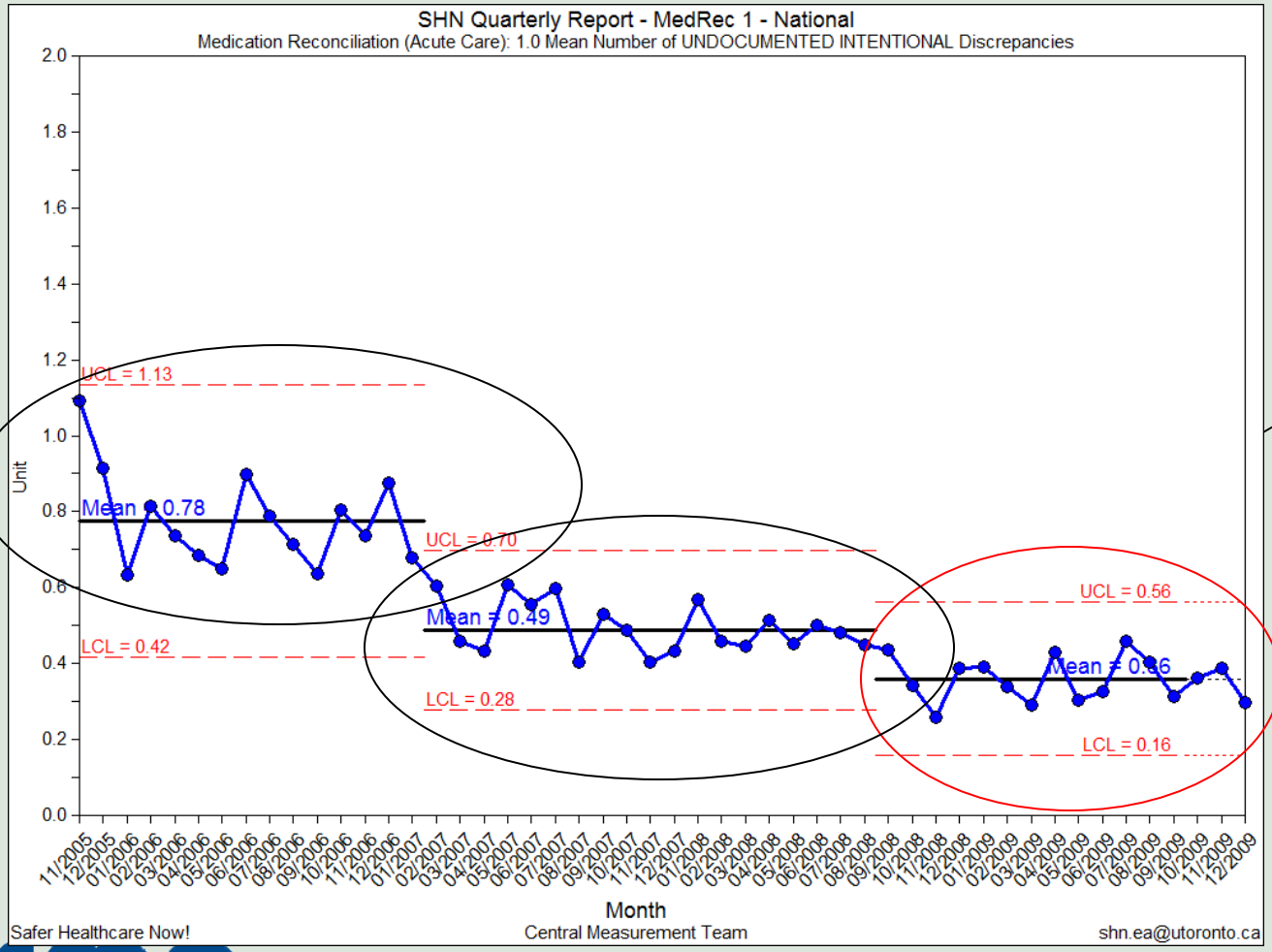
Discharge medication reconciliation

- Webinar series -January –March 2011
- Re-engineered Discharge – potential to reduce hospital readmissions (Boston Medical and AHRQ)
- "Homeward Bound" – 9 projects
- Readmissions as an opportunity for medication reconciliation resources

Acute and Long-Term Care National Data 2005-2009

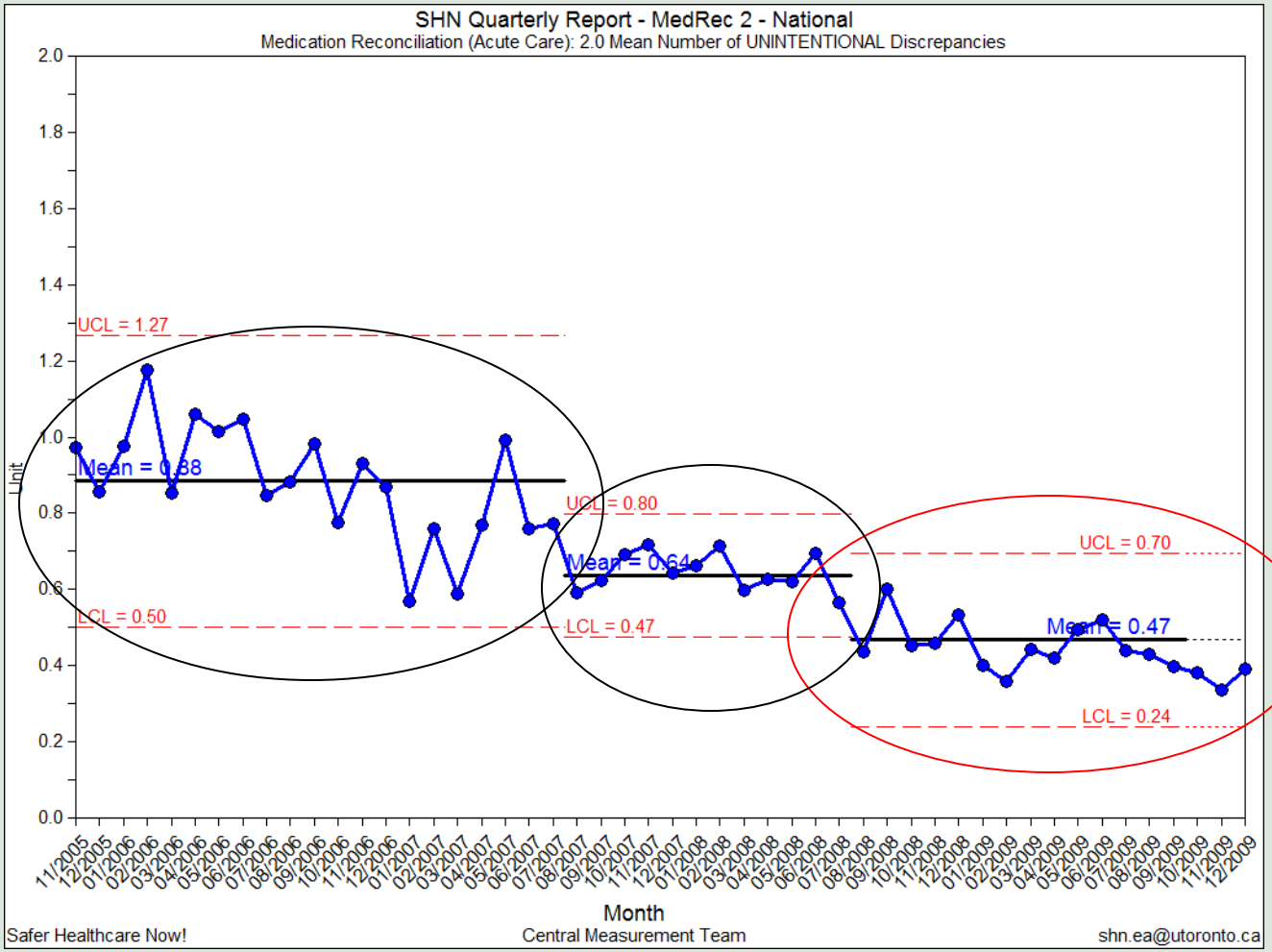
Mean Number of Undocumented Intentional Discrepancies

Acute Care - National Data



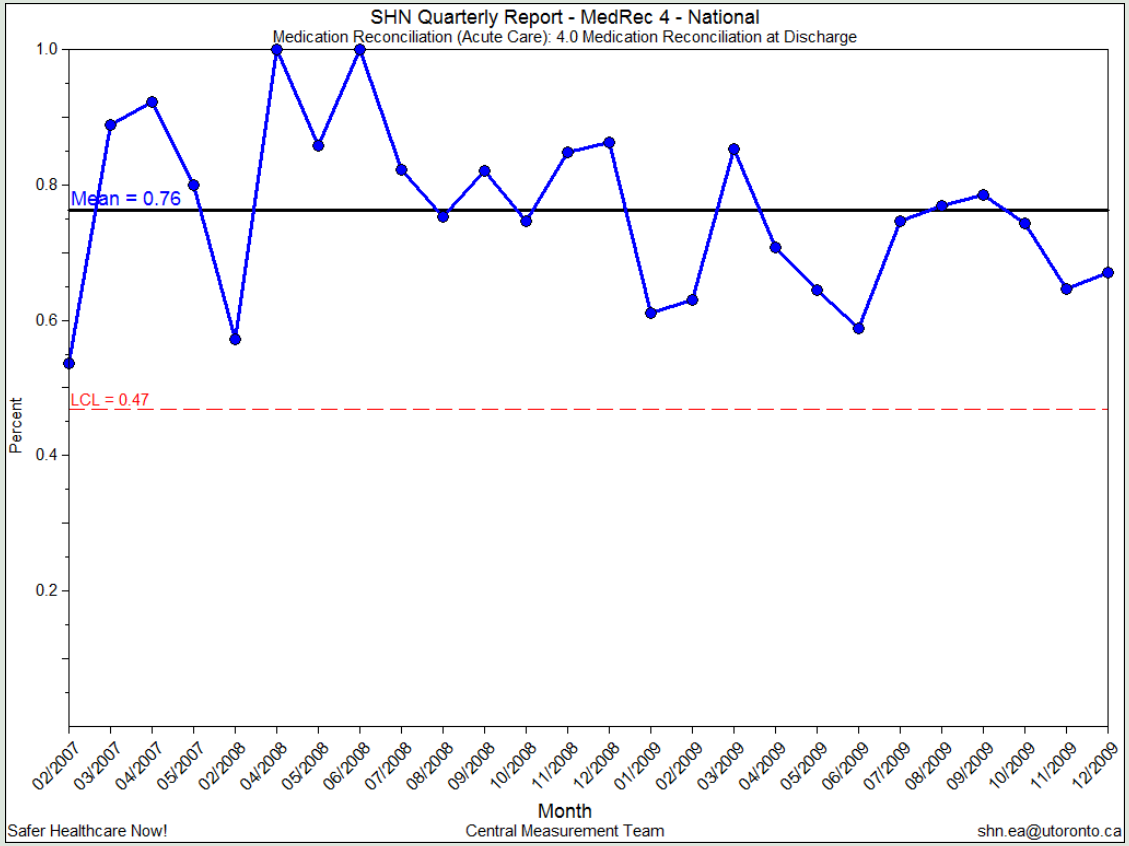
This chart is subdivided into 3 zones. The third zone begins in late 2008 and through all of 2009 – showing <u>sustained improvement</u>, averaging 0.36 UI discrepancies per patient from 0.78 in 2006

Mean Number of Unintentional Discrepancies
Acute Care – National Data



This chart is subdivided into 3 zones.
The third zone begins in late 2008 and through all of 2009 – showing sustained improvement and holding gains, averaging 0.47 unintentional discrepancies per patient from 0.88 in 2007-2008.

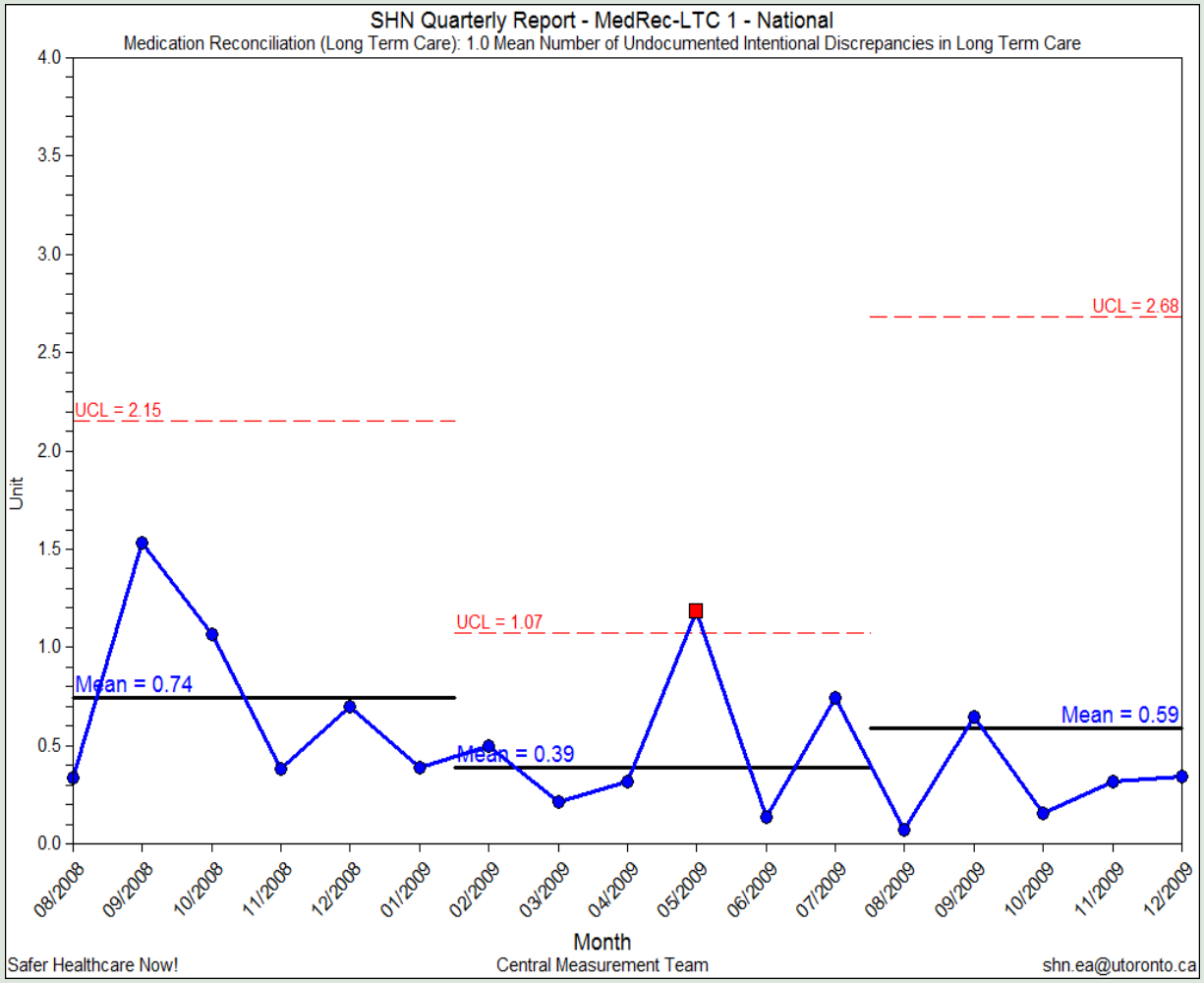
Percentage of Patients Reconciled at Discharge
Acute Care – National Data



Data is scattered due to small sample size, average percentage of patients reconciled at discharge is ~ 76%.

Relatively new measure for SHN! teams.

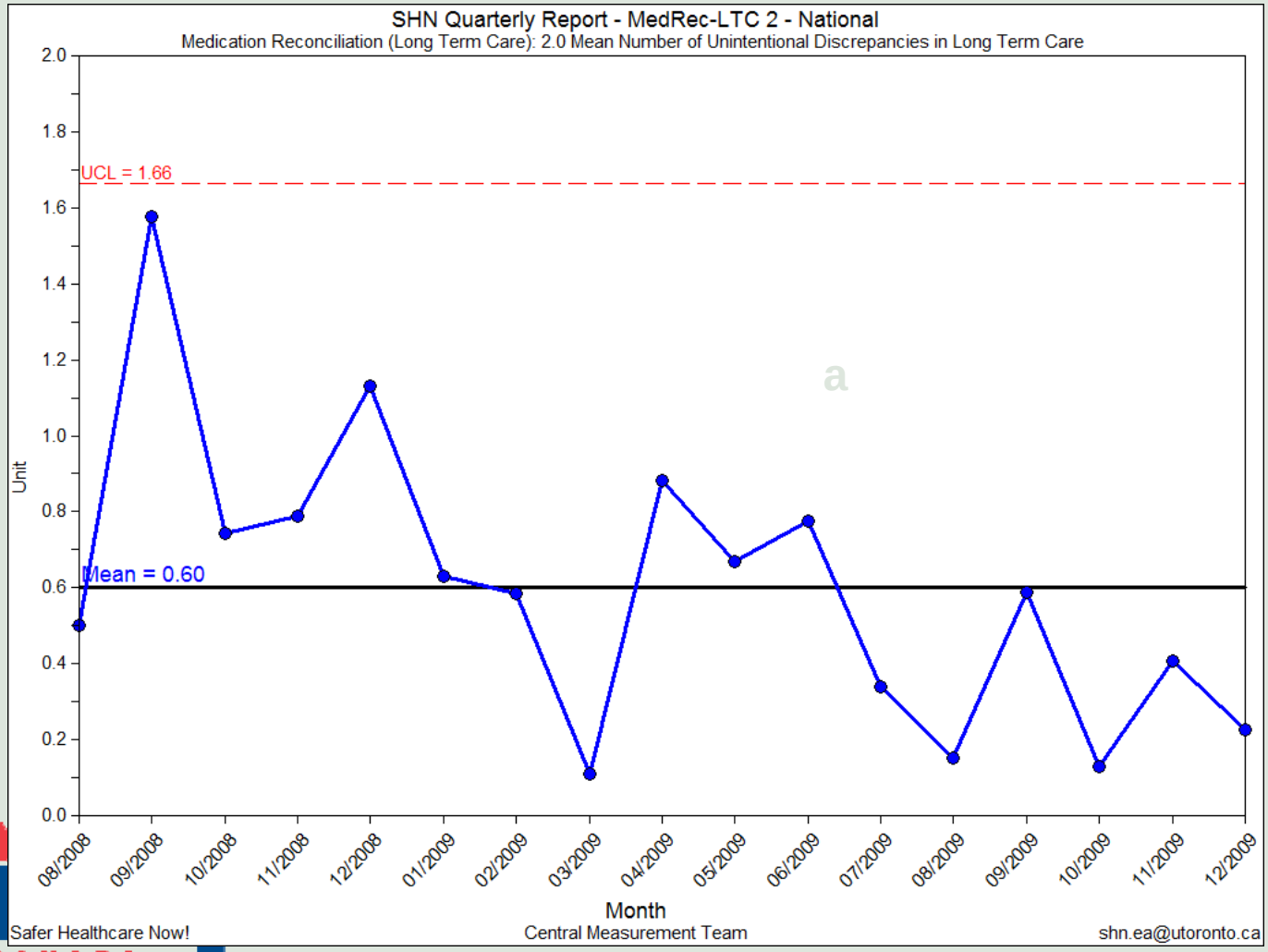
Mean Number of Undocumented Intentional (UI) Discrepancies
Long-Term Care – National Data



With an ever increasing number teams joining the campaign since August 2008 in Long-term care – (a total of 63 teams reporting data) , the UI discrepancies have been fluctuating due to teams being at various stages of implementation. The mean increased from 0.59 from 0.39 over the last year.

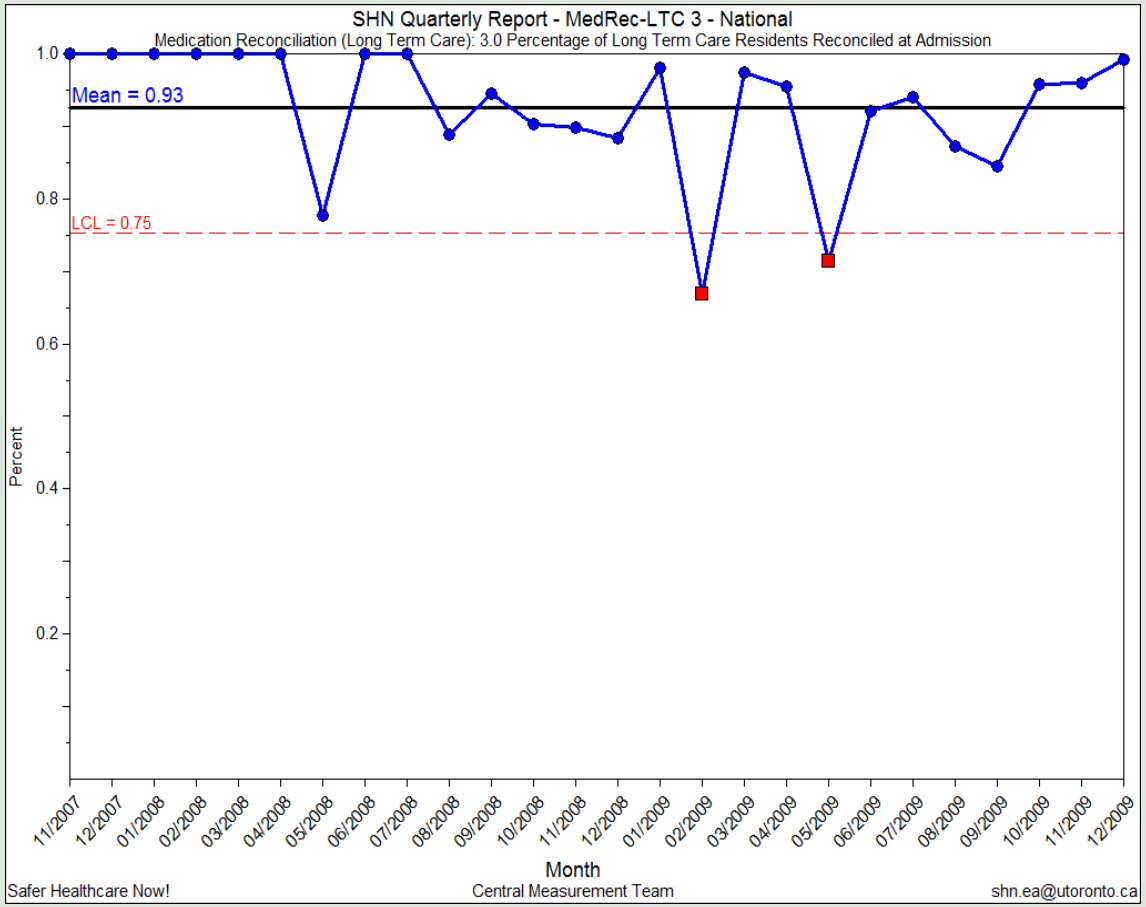
We anticipate an improvement in 2010 as teams learn how to measure and improve their processes.

Mean Number of Unintentional Discrepancies Long-Term Care – National Data



Between July to December 2009, there has been an trend towards sustained improvement.

Percentage of LTC Residents Reconciled at Admission
Long-Term Care – National Data



The percentage of LTC residents reconciled at admission has shown a trend towards improvement in the last 3 months in 2009.

Medication Reconciliation Homecare

- SHN! Homecare GSK available NOW
- Evidence shows significant issues with medication errors in home care.
- Have identified a process and tools
- Webinar series open to all – fall 2010

Homecare Pilot Project

- To develop/validate framework to aid homecare providers in the implementation of medication reconciliation into care delivery processes.
  - *Took into consideration the unique challenges of the homecare delivery setting in Canada.*
  - *Done by developing and testing medication reconciliation strategies for implementation in the homecare setting*.

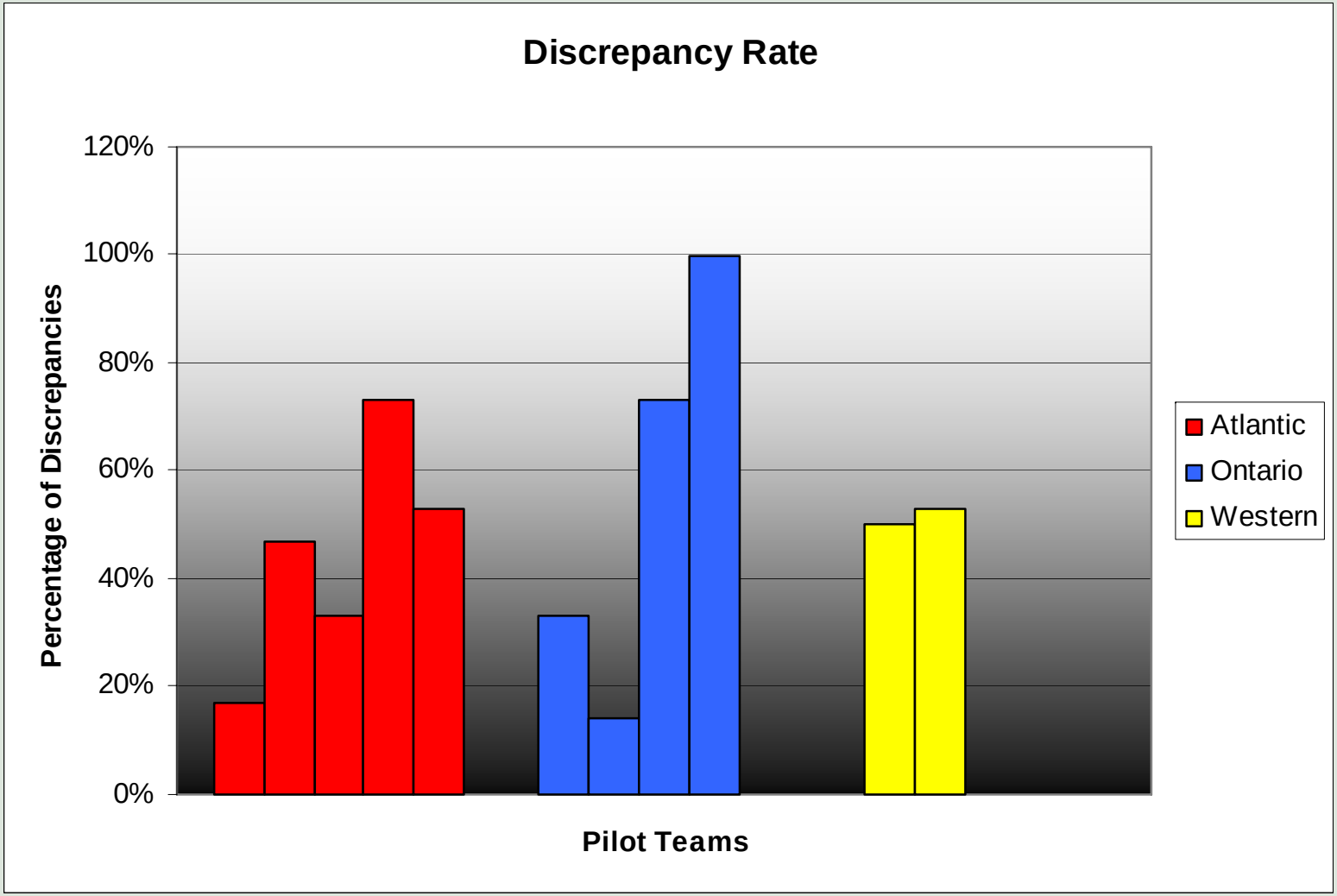
ismp CANADA

safer healthcare now!

What Home Care Teams Did?

- Applied a structured medication reconciliation process to targeted client populations
- Tested tools, guides and measures to determine what works and doesn't in home care setting.
- Collected data on 611 clients
- Identified challenges unique to medication reconcilation processes in this sector

OVERALL: Percentage of discrepancies that require clarification



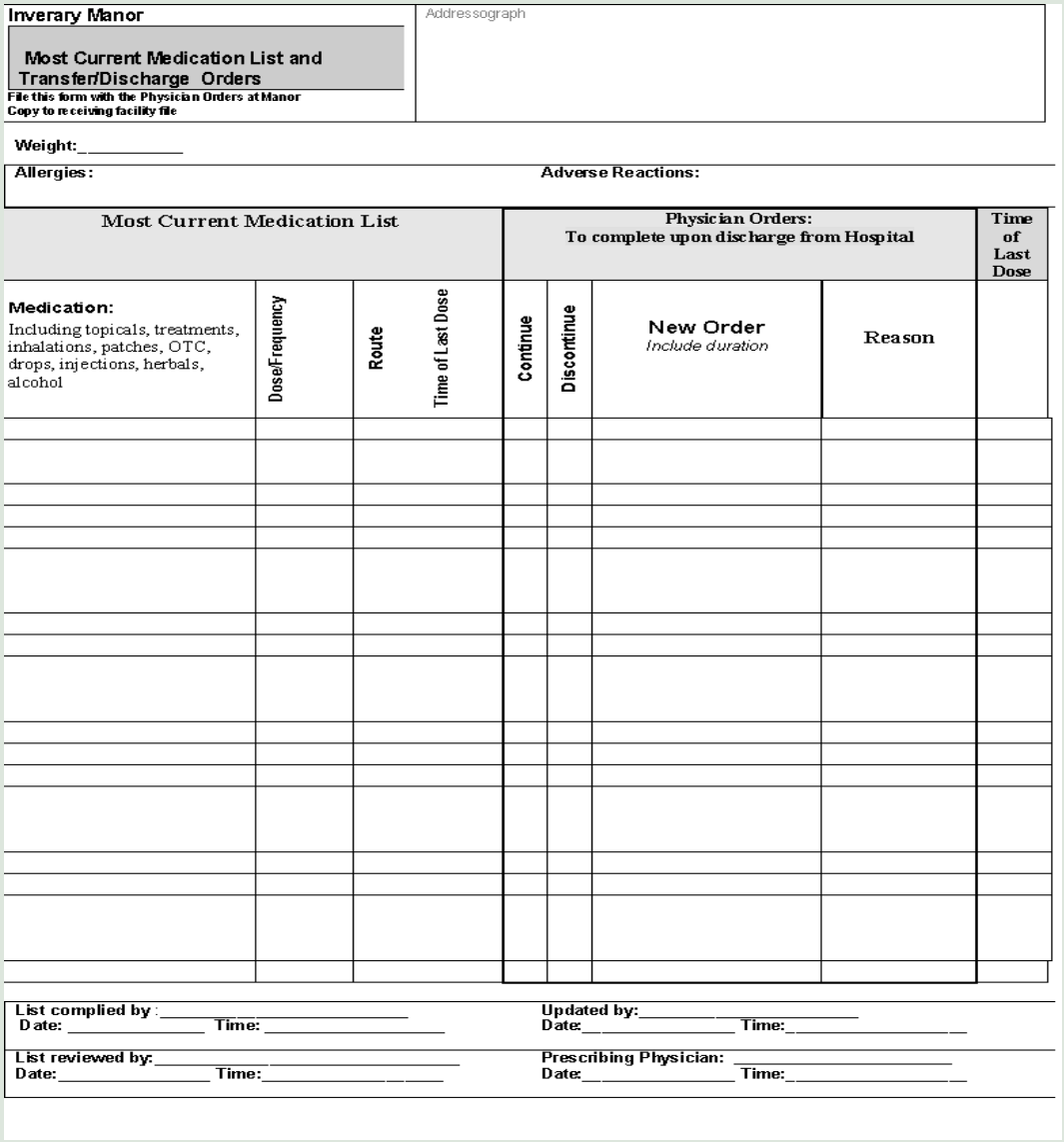
Acute Care

- Excellence and frustration
- IT vendors have more medication reconciliation modules available
- Most acute care is still paper-based
- More linking with community practice on horizon (e.g. PIP and MedsCheck)

Long Term Care

- In spite of several collaboratives – low enrolment in SHN- many LTC sites could benefit from SHN

Inverary Manor LTC: Transfer Form



Inverary Manor

Most Current Medication List and Transfer/Discharge Orders

File this form with the Physician Orders at Manor
Copy to receiving facility file

Addressograph

Weight:_____

Allergies:

Adverse Reactions:

Most Current Medication List					Physician Orders: To complete upon discharge from Hospital			Time of Last Dose
Medication: Including topicals, treatments, inhalations, patches, OTC, drops, injections, herbals, alcohol	Dose/Frequency	Route	Time of Last Dose	Continue	Discontinue	New Order *Include duration*	Reason	

List complied by:_____
Date:_____ **Time:**_____

Updated by:_____
Date:_____ **Time:**_____

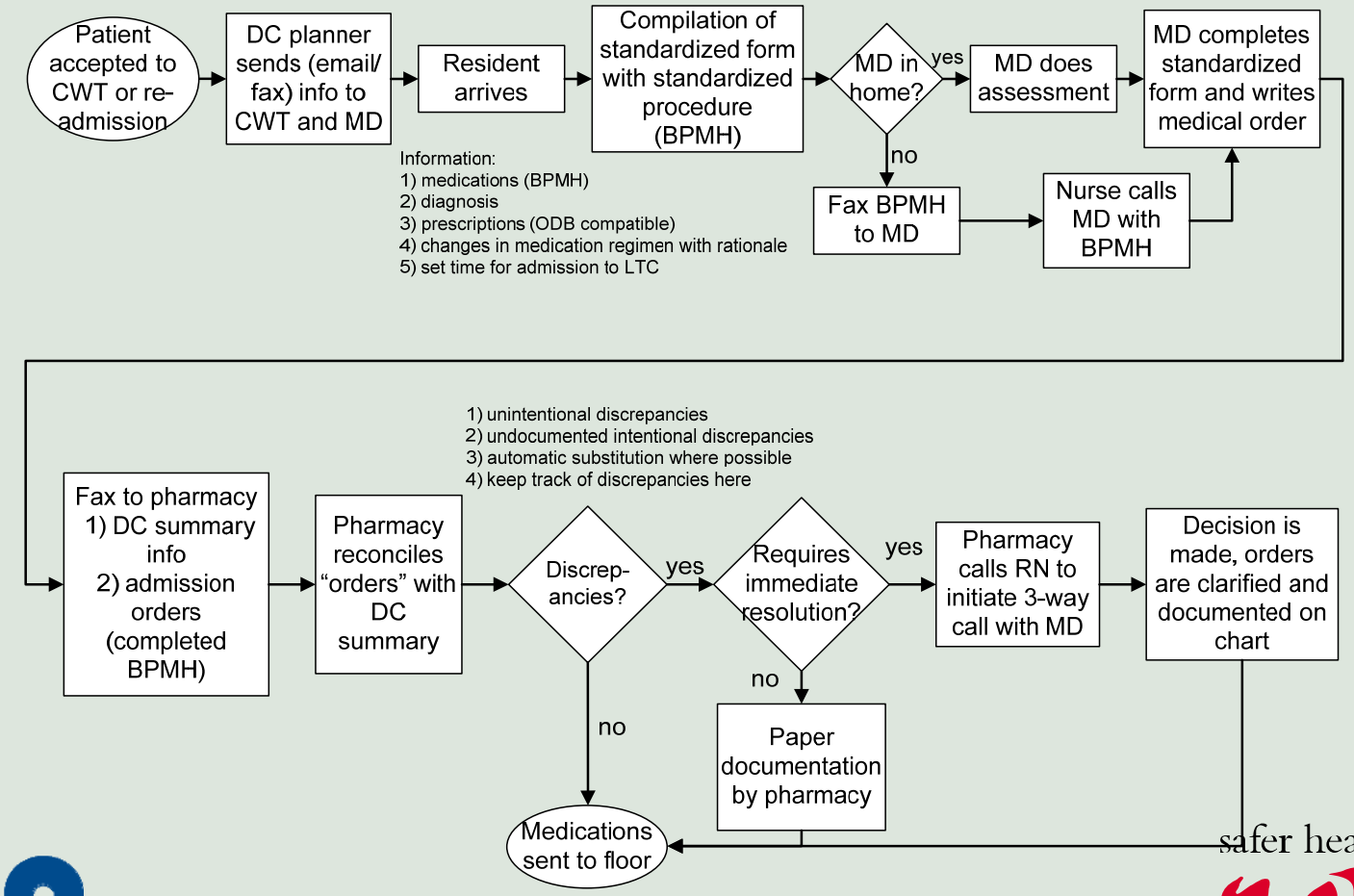
List reviewed by:_____
Date:_____ **Time:**_____

Prescribing Physician:_____
Date:_____ **Time:**_____

- Provides acute care with discharge med rec process

Kaizen Event at Ontario LTC (Castleview)

Improved CWT Process for Medication Reconciliation



Supports for Medication Reconciliation

British Columbia

BC Health Guide

www.bchealthguide.org

Medication Card

EMERGENCY RESPONSE INFORMATION/*INFORMATION POUR LES SITUATIONS D'URGENCE*

Manitoba Institute for Patient Safety

It's Safe to Ask About Your Medications
Vous pouvez poser des questions au sujet de vos médicaments

Institut Pour la Sécurité des Patients du Manitoba

Share your medication list with your doctor, nurse and pharmacist. Carry this card with you at all times!
Communiquez votre liste de médicaments à votre médecin, votre infirmière et votre pharmacien. Ayez cette carte avec vous en tout temps!

Name/*Nom* :

_____

Manitoba Health Registration #/*N° d'immatriculation Santé Manitoba* :

_____

Personal Health ID #/*N° d'identification personnelle* (9 numbers/*chiffres*) :

_____

Medical Plan #/*Autre nom et N° d'assurance santé* (e.g. Blue Cross) :

_____

Family Doctor's Name/*Nom du médecin de famille* :

_____

Phone/*N° de téléphone* :_____

Emergency Contact/*Nom contact en cas d'urgence* :

_____

Phone/*N° de téléphone* :_____

Pharmacy Name/*Nom de pharmacie:*

_____

Completed Health Care Directive/*une directive en matière de soins de santé?* ☐ Yes/*Oui* ☐ No/*Non*

Medical History/*Antécédents médicaux* :

- ☐ diabetes/*diabète*
- ☐ high blood pressure/*haute pression*
- ☐ heart disease/*maladie de cœur*
- ☐ breathing problems/*problèmes respiratoires*
- ☐ other medical problems (list below)/ *autres problèmes médicaux (veuillez préciser)*

_____ _____

My allergies or bad reactions to medications:
Allergies ou réactions indésirables aux médicaments :

_____ _____

_____ _____

LIST ALL MEDICATIONS THAT YOU TAKE. INCLUDE HERBAL MEDICINE AND VITAMINS.
INDIQUEZ TOUS LES MÉDICAMENTS QUE VOUS PRENEZ, Y COMPRIS LES PLANTES MÉDICINALES ET LES VITAMINES.
Update your list by crossing out old medications and adding new ones!/*Mettez votre liste à jour en rayant les vieux médicaments et en ajoutant les nouveaux!*

Medication name *Nom du médicament*	Strength *Puissance*	How much *Quantité*	How often *Fréquence*	Date/*Date*		Reason for taking *Motif de l'administration*	Who prescribed *Qui a prescrit*
				Started/*Début*	Stopped/*Fin*		
Example: My drug Exemple : mon médicament	20 mg 20 mg	1 tablet 1 comprimé	2 times a day 2 fois par jour	May 1, 2008 1er mai 2008		blood pressure haute pression	Dr. Doe Dr Tremblay

If you have questions call your pharmacist, or, The Manitoba Information Line for Everyone (474-6493).
Si vous avez des questions, téléphonez votre pharmacien ou la ligne d'information publique en composant le 474-6493.

MANITOBA INSTITUTE FOR PATIENT SAFETY

It's Safe to Ask

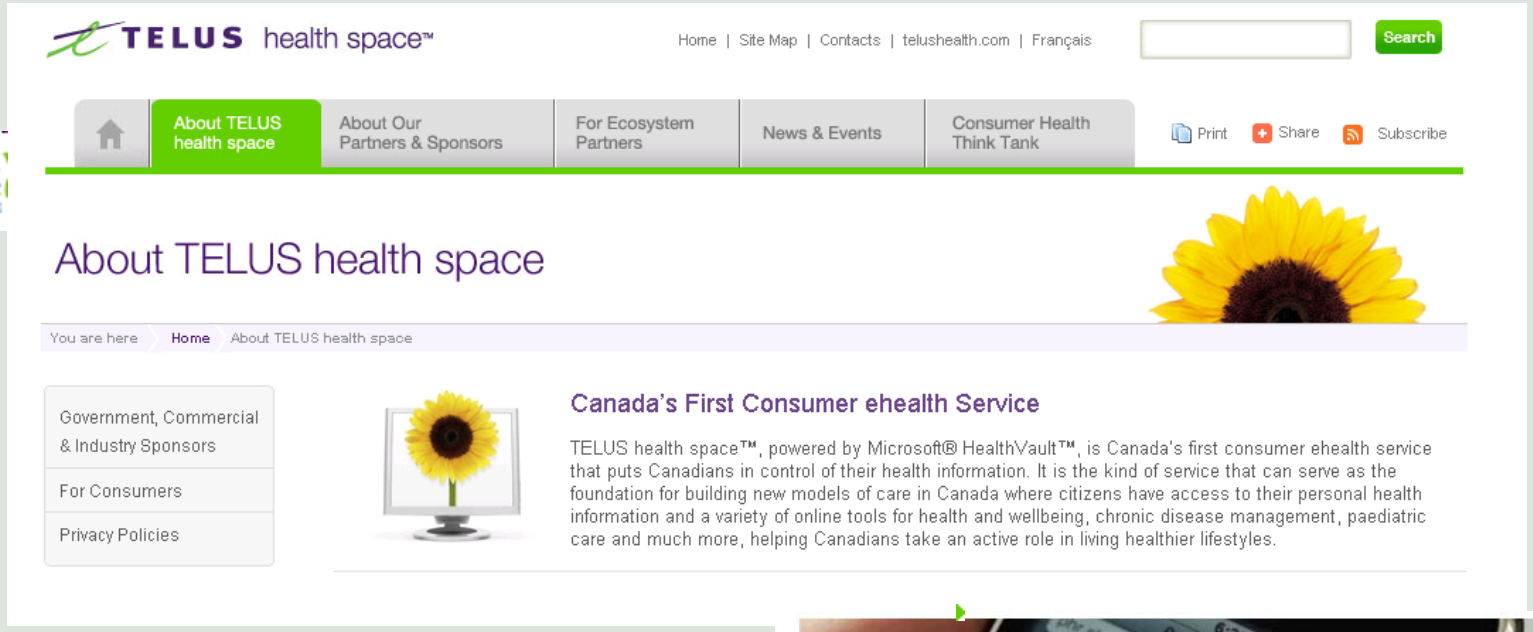
www.safetoask.ca

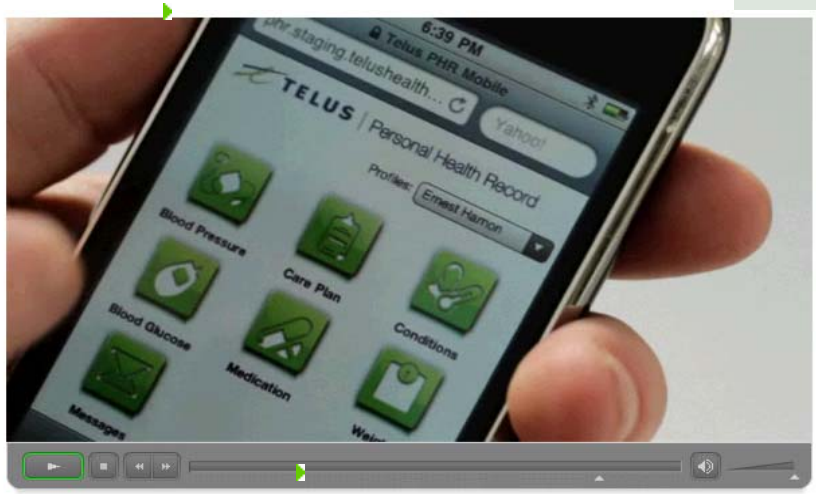
Provincial Electronic Medication Databases

Provinces	Provincial Electronic Medications Database	ER access	Capability to Print a BPMH Form
BC	Pharmanet	Yes	Yes
AB	Alberta NetCare HER Pharmaceutical Information Network (PIN)	Yes	No
SK	Pharmaceutical Information Program (PIP)	Yes	Yes
MB	Drug Programs Information Network (DPIN)	Yes	No
ON	Drug Profile Viewer (DPV)	Yes	No
QB	QSIM	No	No
PEI	Drug Information Systems (DIS)	Yes	No
NFLD	The Pharmacy Network	Yes	No
NB	Prescription Drug Program	No	No
NS	Nova Scotia Hospital Information System (NShIS)	No	No

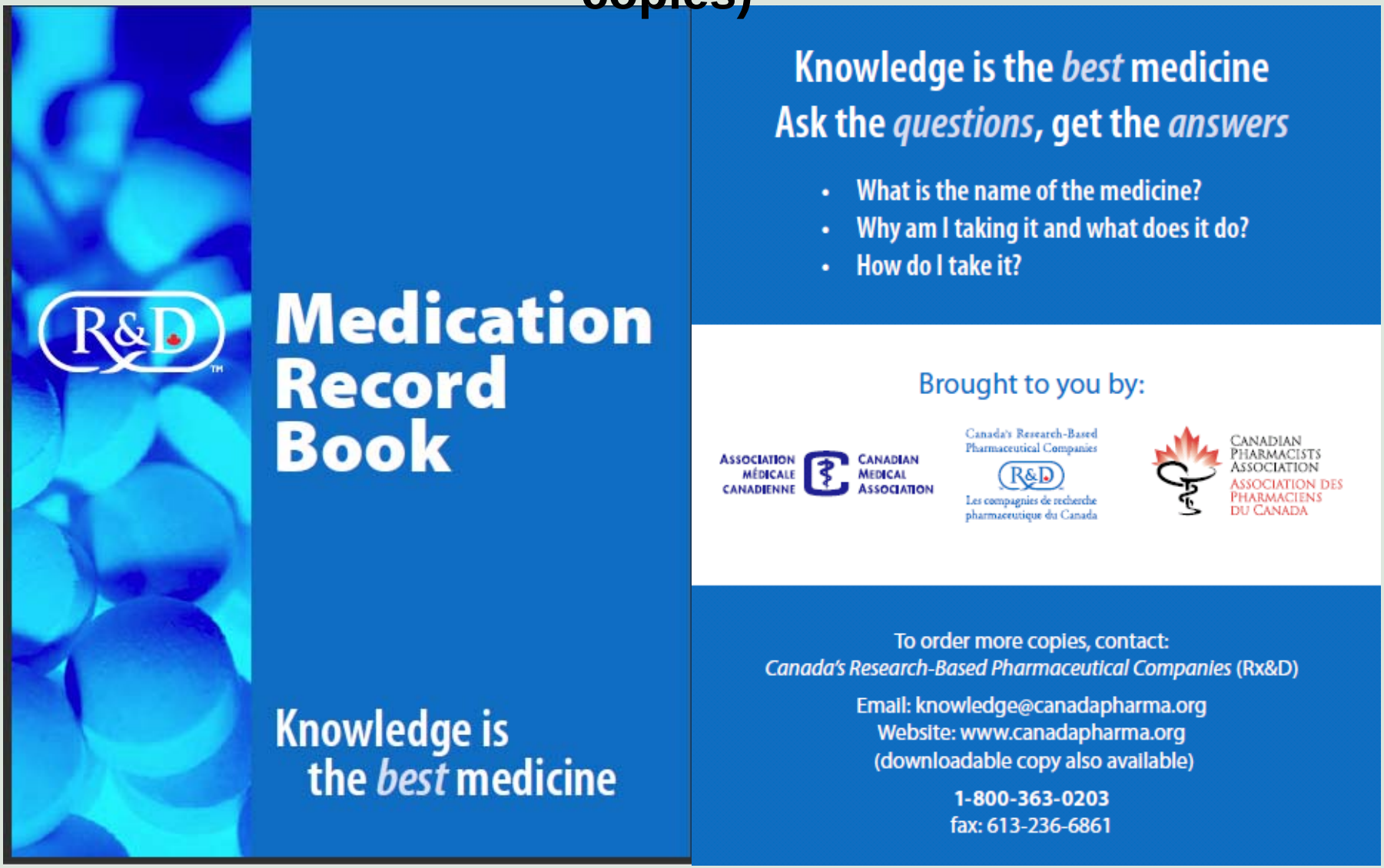
TELUS health space™

http://telushealthspace.com/





Medication Record Book from Rx&D (Order Free copies)



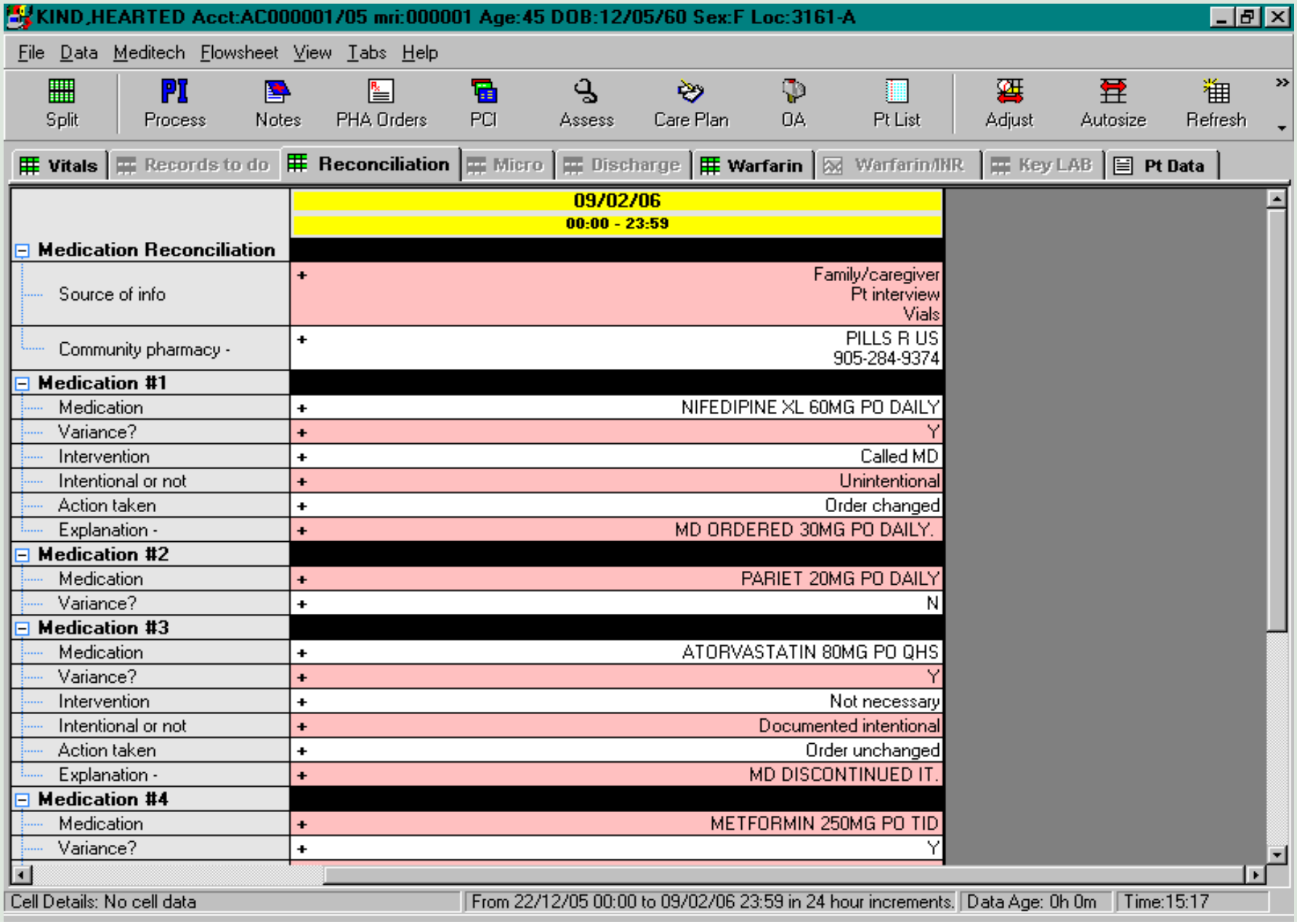

911 Medical ID PLUS™ Family
1GB USB
This Card Contains
My Emergency Medical Information
To access my information push tab out (contact up). Plug into USB Port on any Windows™ computer.
www.911medicalid.com U.S. Patent 7,136,288 B2 - Powered by Freecom


911 Medical ID PLUS™ Family
1GB USB
My Emergency Medical Information

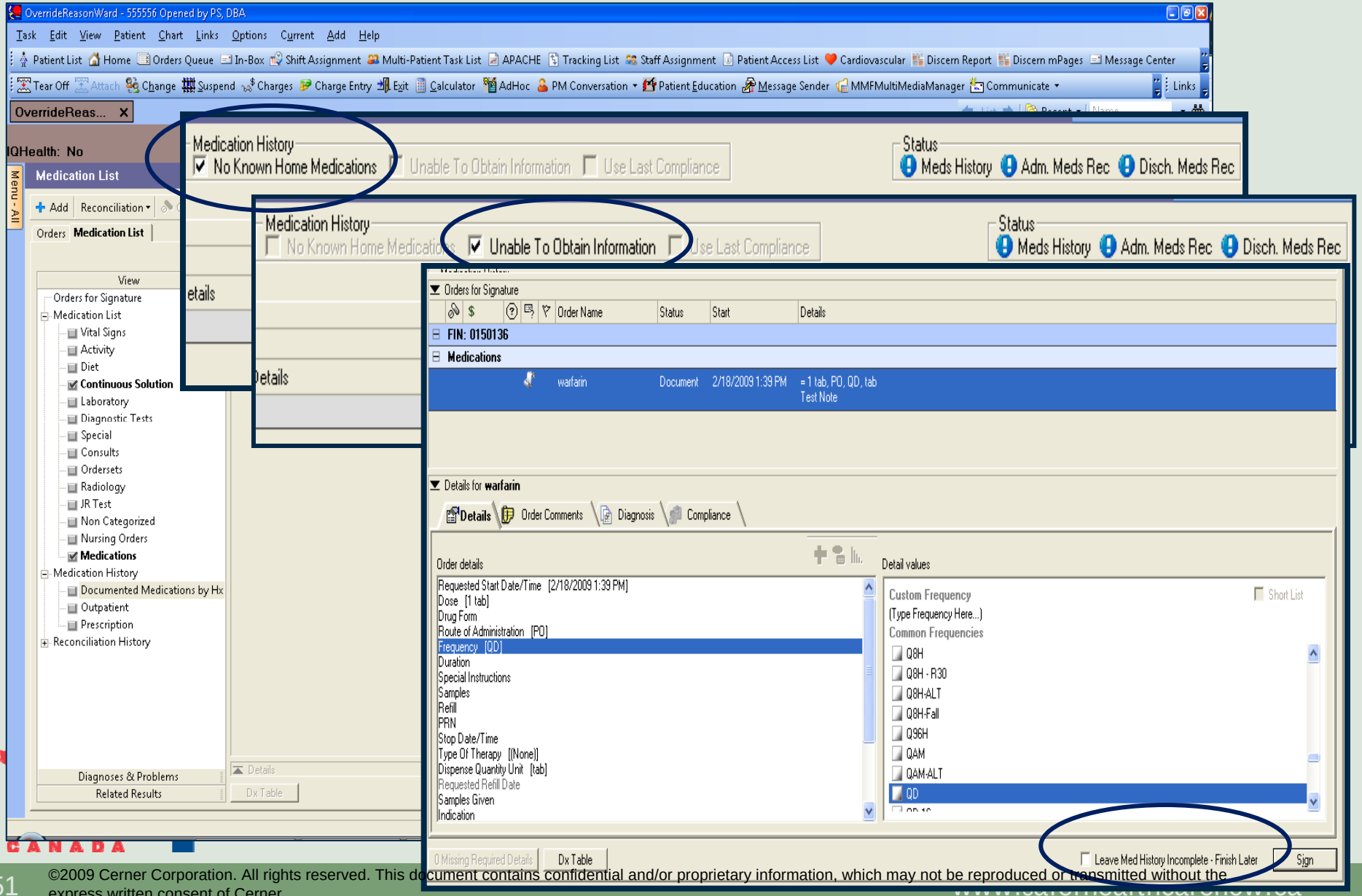

911 Medical ID
Version 2.1.3672.21403
My Emergency Summary
My Family Profiles
My Files
Print
Help
Exit
Connect to or Update Your Online Records
To all medical personnel and medical institutions: Please treat all information on this card as if it were provided by me directly.
I hold you harmless for all actions based on the accuracy of information on this card.
Personal
Conditions
Medications
Allergies
Doctors/ Dentists
Surgeries/ Treatments
Insurance
Family History/ Social History
NAME
Country - United States of America
Title
First
Douglas
Middle
Last
Aamoth
Date of Birth
Not that important
Address Line 1
I Can't. This is going on the internet and not everyone likes me there.
Address Line 2
City
Boston
State
MA
Zip Code
Still can't
Home Phone
Again, can't
Work Phone
Better to e-mail me
Organ Donor
Religious Preference
I prefer you keep it to yourself
Cell Phone
iPhone 3GS
Driver's License No.
Yes, not no.
Change Your Picture
Living Will
Resuscitation Instructions
Power Of Attorney
My Medical Tests And Lab Results
Home Phone
Work Phone
Cell Phone
008-2010 MEMI Tech, LLC. All rights reserved.

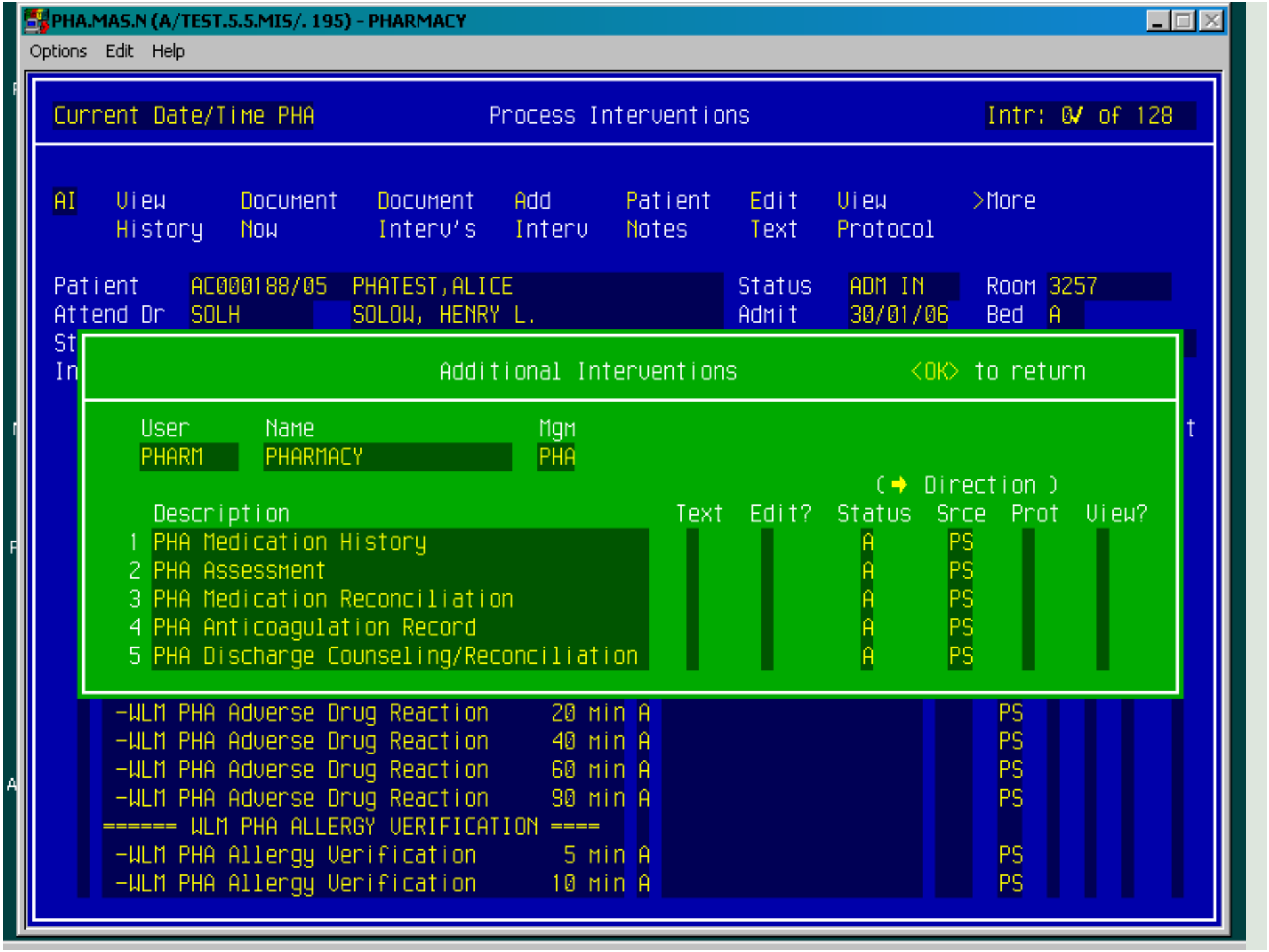

This Card Could Save Your Life!
Physician Recommended
911 Medical ID PLUS™ Family

Visual FlowSheet - Reconciliation



Medication History

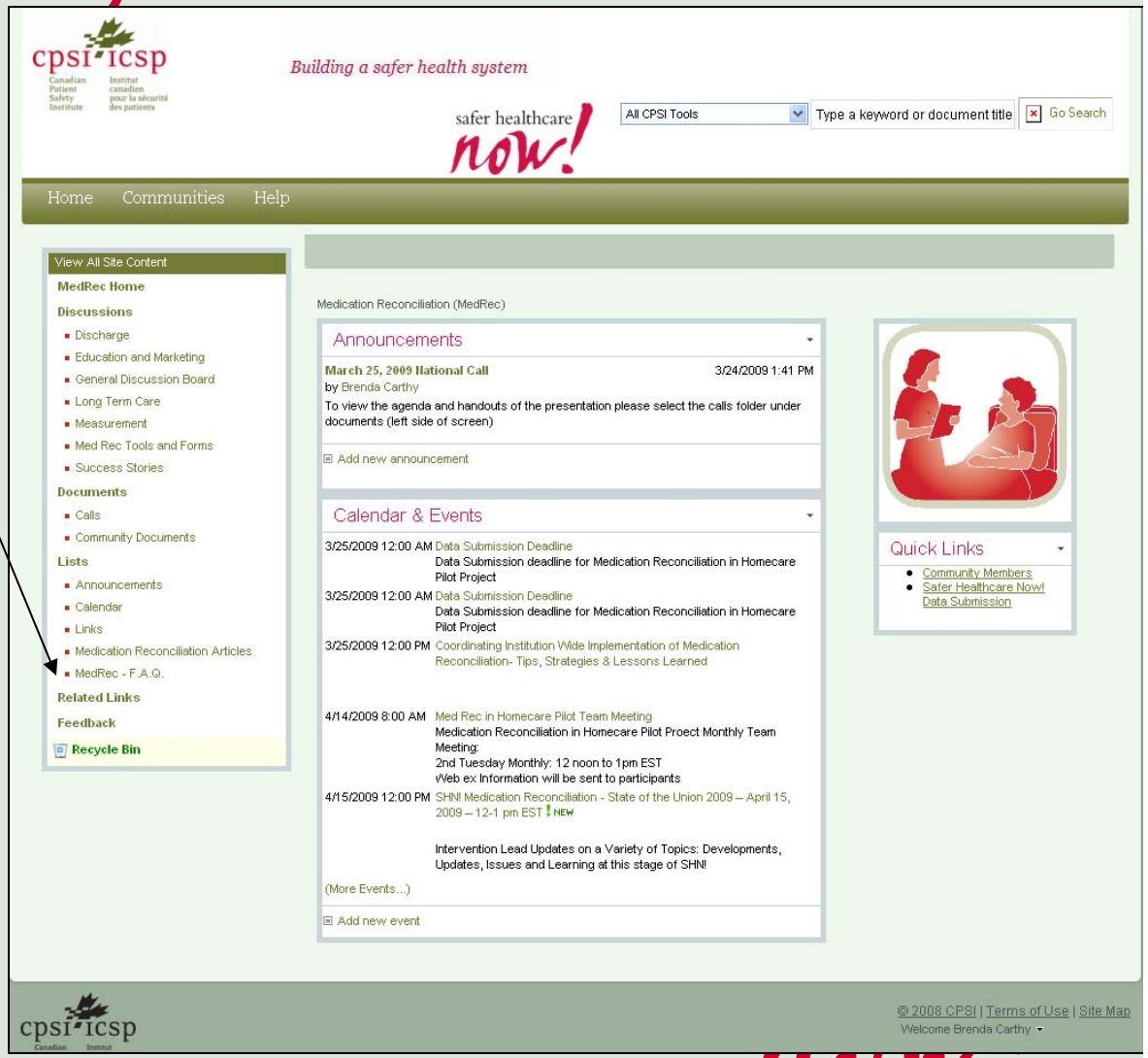



PHA.MAS.N (A/TEST.5.5.MIS/. 195) - PHARMACY
Options Edit Help
Current Date/Time PHA
Process Interventions
Intr: 0 of 128
AI View History
Document Now
Document Interv's
Add Interv
Patient Notes
Edit Text
View Protocol
>More
Patient AC000188/05 PHATEST,ALICE
Status ADM IN
Room 3257
Attend Dr SOLH SOLOW, HENRY L.
Admit 30/01/06
Bed A
Additional Interventions
<OK> to return
User PHARM
Name PHARMACY
Mgm PHA
(Direction)
Description
Text
Edit?
Status
Srce
Prot
View?
1 PHA Medication History
2 PHA Assessment
3 PHA Medication Reconciliation
4 PHA Anticoagulation Record
5 PHA Discharge Counseling/Reconciliation
-WLM PHA Adverse Drug Reaction 20 min A
-WLM PHA Adverse Drug Reaction 40 min A
-WLM PHA Adverse Drug Reaction 60 min A
-WLM PHA Adverse Drug Reaction 90 min A
====== WLM PHA ALLERGY VERIFICATION ====
-WLM PHA Allergy Verification 5 min A
-WLM PHA Allergy Verification 10 min A

Med Rec Communities of Practice (CoP)

New Community of Practice

- FAQ's based on years of experience
- **Recorded calls**
- **Tutorials**



safer healthcare now!

ismp CANADA

Top 10 Practical Tips

How to Obtain an Efficient, Comprehensive and Accurate Best Possible Medication History (BPMH)

1. **Be proactive.** Gather as much information as possible prior to seeing the patient. Include primary medication histories, provincial database information, and medications vials/ lists.
2. **Prompt questions about non-prescription categories:** over the counter drugs, vitamins, recreational drugs, herbal/traditional remedies.
3. **Prompt questions about unique dosage forms:** eye drops, inhalers, patches, and sprays.
4. **Don't assume patients are taking medications according to prescription vials** (ask about recent changes initiated by either the patient or the prescriber).
5. **Use open-ended questions:** ("Tell me how you take this medication?").
6. **Use medical conditions as a trigger** to prompt consideration of appropriate common medications.
7. **Consider patient adherence with prescribed regimens** ("Has the medication been recently filled?").
8. **Verify accuracy:** validate with at least two sources of information.
9. **Obtain community pharmacy contact information:** anticipate and inquire about multiple pharmacies.
10. **Use a BPMH trigger sheet** (or a systematic process / interview guide). Include efficient order/optimal phrasing of questions, and prompts for commonly missed medications.

Adapted with permission from O. Fernandes PharmD, University Health Network, 2008

Medications: More Than Just Pills

Prescription Medicines

These include anything you can only obtain with a doctor's order such as heart pills, inhalers, sleeping pills.

Over-The-Counter Medicines

These include non-prescription items that can be purchased at a pharmacy without an order from the doctor such as aspirin, acetaminophen, laxatives, other bowel care products, **herbs** like garlic and Echinacea or **vitamins** and **minerals** like calcium, B12 or iron.

DON'T FORGET THESE TYPES OF MEDICATIONS

Eye/Ear Drops

Inhalers

Nasal Spray

Patches

Liquids

Injections

Ointments/Cream

Prompt the patient to include medicines they take **every day** and also ones taken **sometimes** such as for a cold, stomachache or headache.

safer healthcare now!

ismp CANADA

Adapted from Vancouver Island Health Authority

Best Possible Medication History Interview Guide

safer healthcare now!

ismp CANADA

Prevent Adverse Drug Events through Medication Reconciliation

www.SaferHealthcareNow.ca

Introduction

- Introduce self and profession.
- I would like to take some time to review the medications you take at home.
- I have a list of medications from your chart/file and want to make sure it is accurate and up to date.
- Would it be possible to discuss your medications with you (or a family member) at this time?
  - Is this a convenient time for you? Do you have a family member who knows your medications that you think should join us? How can we contact them?

Medication Allergies

- Are you allergic to any medications? If yes, what happens when you take (allergy medication name)?

Information Gathering

- Do you have your medication list or pill bottles (vials) with you?
- *Use show and tell technique when they have brought the medication vials with them*
  - How do you take (medication name)?
  - How often or When do you take (medication name)?
- *Collect information about dose, route and frequency for each drug. If the patient is taking a medication differently than prescribed, record what the patient is actually taking and note the discrepancy.*
- Are there any prescription medications you (or your physician) have recently stopped or changed?
- What was the reason for this change?

Community Pharmacy

- What is the name and location of the pharmacy you normally go to? *(Anticipate more than one).*
  - May we call your pharmacy to clarify your medications if needed?

Over the Counter (OTC) Medications

- Do you take any medications that you buy without a doctor's prescription? *(Give examples, i.e., Aspirin).* If yes, how do you take (OTC medication name)?

Vitamins/Minerals/Supplements

- Do you take any vitamins (e.g. multivitamin)? If yes, how do you take (vitamins name(s))?
- Do you take any minerals (e.g. calcium, iron)? If yes, how do you take (minerals name(s))?
- Do you use any supplements (e.g. glucosamine, St. John's Wort)? If yes, how do you take (supplements name(s))?

Eye/Ear/Nose Drops

- Do you use any eye drops? If yes, what are the names? How many drops do you use? How often? In which eye?
- Do you use ear drops? If yes, what are the names? How many drops do you use? How often? In which ear?
- Do you use nose drops/nose sprays? If yes, what are the names? How do you use them? How often?

Inhalers/Patches/Creams/Ointments/Injectables/Samples

- Do you use inhalers?, medicated patches?, medicated creams or ointments?, injectable medications (e.g. insulin)? For each, if yes, how do you take (medication name)? *Include name, strength, how often.*
- Did your doctor give you any medication samples to try in the last few months? If yes, what are the names?

Antibiotics

- Have you used any antibiotics in the past 3 months? If so, what are they?

Closing

This concludes our interview. Thank you for your time. Do you have any questions?

If you remember anything after our discussion please contact me to update the information.

Note: Medical and Social History, if not specifically described in the chart/file, may need to be clarified with patient.

Adapted from University Health Network

My Medication Record			
Name:	**Birthdate:** / /	**Height:**	**Weight:**
Care Providers *(name & number):*			
Last Reviewed *(date done & with whom):* / /			
Allergies & Responses:			

Name of Medications:	Date Started:	Reason for Taking:	Dose & Times Taken:	Date Stopped:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

Medication record:

My Medication Record			
Name:	**Birthdate:**	**Height:**	**Weight:**
Care Providers *(name & number):*			
Last Reviewed *(date done & with whom):*			
Allergies & Responses:			

Name of Medications:	Date Started:	Reason for Taking:	Dose & Times Taken:	Date Stopped:
Prescription medicines often have two names (generic & brand). This information can be found on the medicine package or the information sheet that comes with it. Record both names, whenever possible. Also record any over-the-counter medications, vitamins, herbs or nutritional supplements.	Write down the date that you started taking this medicine.	Always keep a record of why you are taking each medication so that you and all your health care providers know.	Record the amount of medication you take and each time of day the medicine is to be taken. It is best to mark in the dosage in milligrams (mg) or other dosage units instead of the number of pills taken each time.	Write down the date and reason why you stopped taking the medication.

What's Next

- National Roundtable
- Webinar Series – homecare fall 2010 acute care winter 2011
- Work with Accreditation Canada
- Work to let Ministries of Health know that medication reconciliation meets their needs to assist with reducing hospital readmissions


© Erik Johansson