Strengthening Medication Safety in Long-term Care

Model Policy 1 for Testing

To support LTC Homes in their review and updating of medication management policies

Medication Reconciliation (MedRec)

Purpose:

The purpose of this policy is to describe the steps of the Medication Reconciliation (MedRec) process in the Home and how it will be evaluated. MedRec at transitions of care is a key step to ensure medication safety.[i,ii] MedRec has been identified as an integral part of the solution to improve medication management upon care transition from hospital to LTC.[iii]

(See Appendix A: Key Terms)

Scope:

This policy applies to all long-term care practitioners involved in the:

- admission/re-admission MedRec process
  - admission/re-admission from acute care or admission from another LTC Home
  - admission from community
- transfer MedRec process to acute care or another organization.

Overview of Process:

MedRec must be performed at all transitions of care. This involves both admission (e.g., from acute care, community, another Long-Term Care Home) or readmission to the Home (e.g., a resident has been absent from the Home for a defined number of days during which their bed was held), and at transfer.

MedRec is a 3-step process:[iii]

- Step 1 - Create a complete and accurate Best Possible Medication History (BPMH) of the resident's medications including name, dosage, route, and frequency. This includes: a systematic process of interviewing the resident/ substitute decision maker (SDM)* where possible, and a review of at least one other reliable source of information.
- Step 2 - Reconcile medications: Use the BPMH to create admission orders; identify and resolve all differences or discrepancies within 48 hours.
- Step 3 - Document and communicate any resulting changes in medication orders to the relevant providers of care and resident and/or SDM wherever possible.

The process of MedRec is interprofessional, interdependent and reliant on a team approach. Resident and/or SDM engagement is important and the BPMH process must be designed to ensure this occurs. A standardized MedRec process that is reliably implemented supports safe medication management and applicable Accreditation requirements.[iv] See page 5 and 6 for process maps.

MedRec Process at Admission/Re-Admission

Obtaining Sources of Information

Director of Care or Designate

1. Admission/re-admission from acute care or admission from another LTC Home:
    a. Identifies new/existing resident for admission/re-admission.
    b. Requests admission package including applicable sources of information: (Appendix B: Sources of Information Table)
    c. Contacts the staff at the transferring site to ensure discharge medication information is faxed to the receiving long-term care Home and/or the Pharmacy Service Provider (PSP) in advance of the resident's arrival.

2. Admission from community:
    a. Requests admission package including applicable sources of information: (see Appendix B: Sources of Information Table)
    b. Schedules an interview with resident and SDM to review current medication list.

Nurse/Pharmacist/Registered Pharmacy Technician:

Step 1 – Generate BPMH

1. Gathers relevant sources of information (Appendix B: Sources of Information Table) applicable to the type of admission/re-admission.
2. Reviews and compares the sources of information.
3. Documents a preliminary medication list along with indications for each medication and last dose given. Sending facility and community care providers may need to be contacted to understand the rationale for each medication or changes to medications if not clearly documented.
4. Interviews the resident/SDM, to confirm ACTUAL medication use using the Appendix B: BPMH Interview Guide/Checklist.
5. Makes revisions and documents on a BPMH form based on actual medication use.

Step 2 – Identify and Resolve Discrepancies

1. Identifies red flags and discrepancies between sources of information that require clarification.
2. Completes a final review of the best possible medication history.
3. Organizes a call with the prescriber/nurse/pharmacist to review orders.
4. Faxes the BPMH to the most responsible prescriber (MRP), LTC Home or pharmacy provider as applicable.
5. For new residents, reviews each medication verbally with the prescriber and nurse/pharmacist to confirm therapeutic appropriateness and obtains authorization to fill and administer the medication.
6. For re-admitted residents, intentional medication changes and all discrepancies are communicated to the prescriber for assessment, resolution, and documentation to fill and administer the medication. At readmission, all medications that were on the LTC medication list (MAR or medication profile) prior to the acute care admission must have an order to continue, discontinue or hold. Blanket Orders to "continue medications from hospital" are not accepted.
7. Nurse or pharmacist addresses any questions, concerns and/or red flags and resolves any discrepancies with prescriber within 48 hours of admission.

Step 3 - Document and communicate the medication information

1. Documents and sends the completed medication list which become the admission orders to the pharmacy service provider or to the LTC Home.
2. Double checks the delivered medications and the medication administration record to the admission orders. Any identified discrepancies are resolved before administration to the resident.
3. Communicates any medication changes to the resident/SDM as applicable.

Transfer MedRec Process to Acute Care or Another Organization

When transfer to acute care or another organization is required:

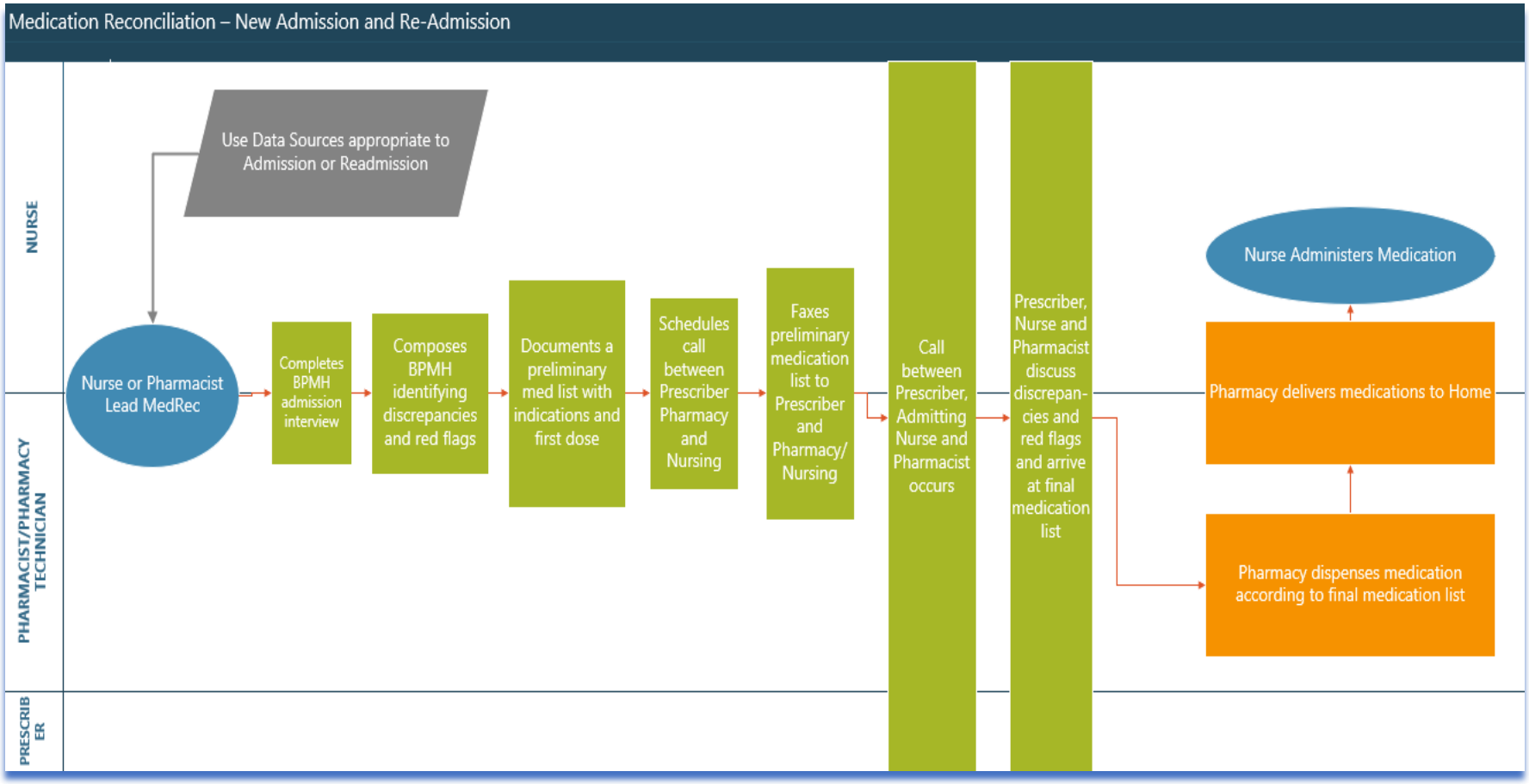
Nurse

1. Assembles transfer package to be sent with resident which includes:
    - most recent medication administration record and last doses given,
    - any recent changes to medications, if possible,
    - resident transfer form, allergies, diagnoses, falls risk, recent height, weight
    - direct contact number of Home, ward or unit for communication on status or questions.
2. Informs the SDM and pharmacy service provider that the resident has transferred to acute care and to suspend dispensing and delivery of medications until further notice.

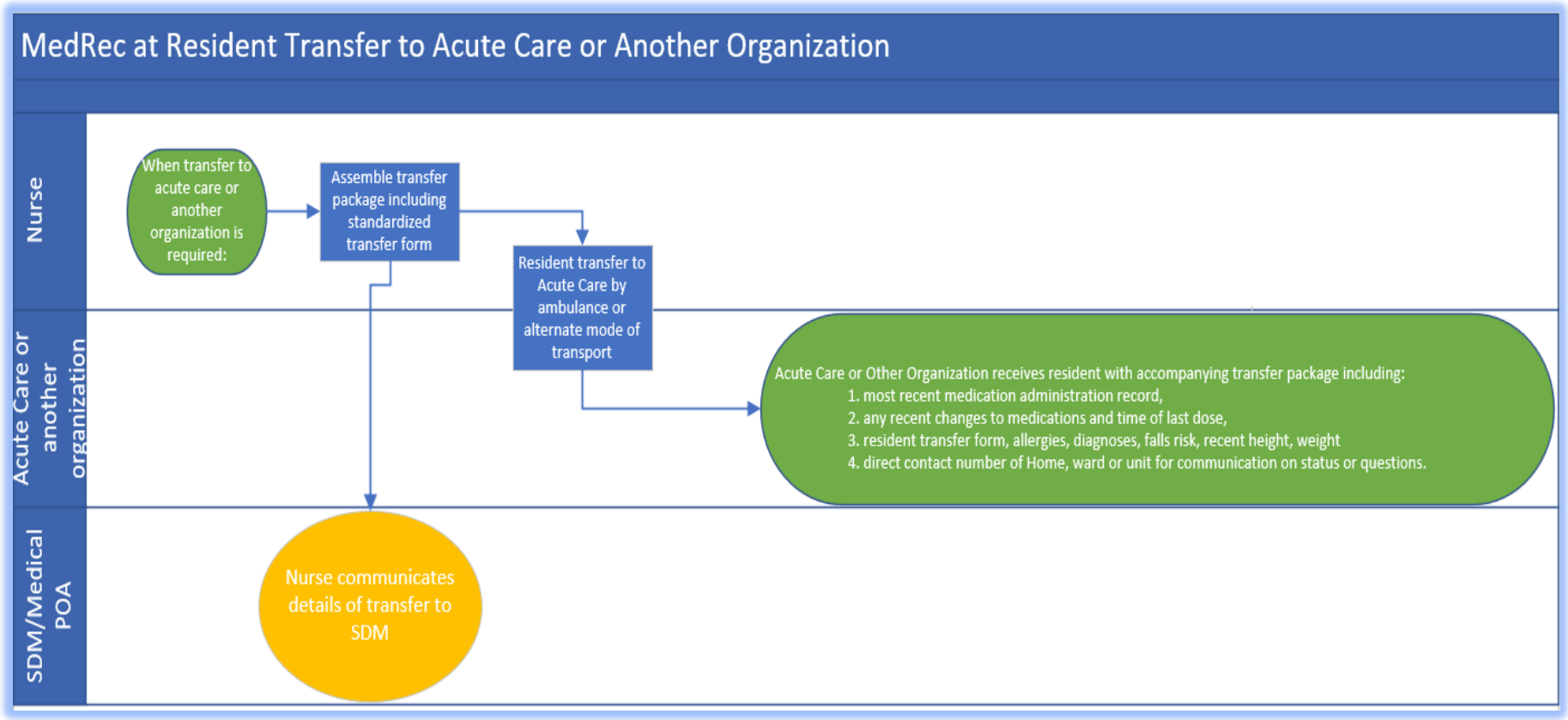
Monitor to ensure the process is completed. (See Appendix D: Measuring and Sustaining Improvements)

Process Map:

New Admission and Re-Admission MedRec Process



Transfer MedRec Process



Appendix A: Key Terms

Term	Definition
Medication Reconciliation[iii] (MedRec)	**Medication reconciliation** is a formal process in which healthcare providers work together with residents, 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 resident 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 resident.
Transitions of care[iii]	Transitions of care refers to the movement of a resident between health care providers, and settings as their condition and care needs change.
Best Possible Medication History (BPMH) [iii]	A Best Possible Medication History (BPMH) is a history created using: 1) a systematic process of interviewing the resident/SDM; and 2) a review of at least one other reliable source of information to obtain and verify the resident's medication use (prescribed and non-prescribed). Complete documentation includes drug name, dosage, route and frequency. The BPMH is a snapshot of the resident's actual medication use story, which may be different from what is contained in their records. This is why the resident involvement is vital.
Substitute Decision Maker (SDM)	SDM members and other significant people (as identified by the care recipient) who provide care and assistance to individuals living with a physical, mental or cognitive condition.[v,vi] *also referred to as Medical Power of Attorney (POA)

Appendix B: Sources of Information Table[iii]

For more information: https://www.ismp-canada.org/download/MedRec/MedRec-LTC-GSK-EN.pdf

Type of Admission	*Sources of Information*
Admission from Hospital or another LTC Home	• Most current medication list (Medication Administration Record (MAR) or medication profile) • Discharge summary/prescriptions • Interview resident/SDM (using BPMH Interview Guide) • Pre-acute medications if MedRec is not documented from acute care
Re-admission from Hospital	Resident's long-term care MAR prior to hospital transfer COMPARE WITH: • Interview resident/SDM to confirm changes, where possible • Most current medication list (MAR or medication profile) • Discharge summary/prescriptions
Admission from Community	• Review "medication list" from resident • Check medication vials/blister pack • Review community pharmacy profile, provincial electronic health records • See SDM physician records • Community pharmacist medication review program (e.g., MedsCheck) COMPARE WITH: • Interview resident/SDM (using BPMH Interview Guide or a checklist) to verify **actual** use

Appendix C: BPMH Interview Checklist

For more information visit: https://www.ismp-canada.org/LTC/medication-safety.htm

BPMH Interview Self-Evaluation Checklist

Reference: BPMH Interview Guide: SHN_medcard_09_EN.pdf (ismp-canada.org)

Tasks	Completed √
Introduce yourself and profession to resident/Substitute Decision Maker (SDM)	
Establish **reason for interview**	
Ask about any **allergies and type of reaction**	
Ask about **prescription medications**: verify medication names, dose, route, frequency.	
Ask about **recent changes** to resident's medications	
Ask resident how they have been taking the medications (check adherence by comparing to what is prescribed)	
Ask if resident is using any **OTC/non-prescription medications**: verify name, dose, route, freq. (e.g., ask specifically about aspirin)	
Ask about **vitamins**	
Ask about any **minerals**	
Ask about any **supplements**	
Ask about any **eye drops**	
Ask about any **ear drops**	
Ask about any **nose drops or sprays**	
Ask about any **inhalers/sprays**	
Ask about any **medicated patches**	
Ask about any **medicated creams or ointments**	
Ask about any **injectable medications** (e.g., q6monthly injectables (denosumab) or q3-4 monthly injectables leuprorelin, epoetin provided by the dialysis clinic, quarterly iron infusions, methotrexate)	
Ask about using any medication **samples/study meds, recreational medications (e.g., cannabis)**	
Ask about **antibiotics/vaccines (e.g., Covid-19)** in past 3 months. Record the date and type received.	
Ask about the names and contact information of the **community pharmacy/pharmacies and SDM physician**	
Thank resident/substitute decision maker for the interview	

Appendix D: Measuring and Sustaining Improvements

Measurement helps us know whether we are meeting our targets for quality and safety. The recommended indicator to measure MedRec is the:

> **Percentage of Residents admitted or transferred from acute care receiving Medication Reconciliation within 48 hours.**

Please refer to the Measurement of Medication Safety in Long-Term Care for more information.

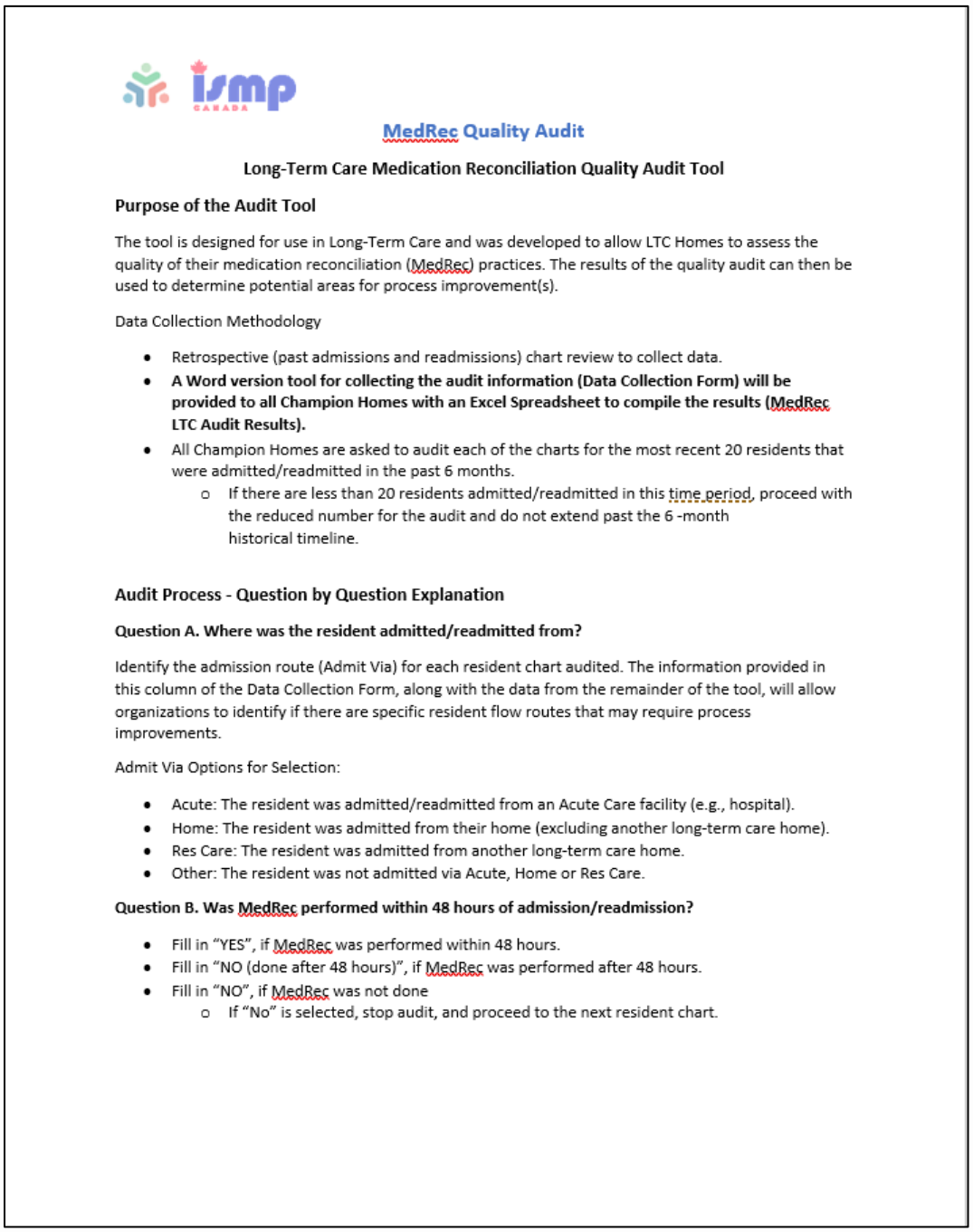
In addition, the MedRec Quality Audit Tool can be used by long term care organizations to measure the quality of the basic elements of their MedRec process on admission. This data will be helpful in identifying specific elements in need of process improvement and potentially reducing the occurrence of preventable drug events.[vii]

Auditors are encouraged to resolve and report unintentional discrepancies identified during the quality audit as medication incidents or good catches through their local incident reporting systems and to ISMP Canada (https://www.ismp-canada.org/err_ipr.htm) so that learning and improvements can be shared.

Homes are responsible for monitoring compliance with the MedRec process and to improve compliance when required.

Appendix E – LTC MedRec Quality Audit Instructions[vii]

For more information visit: https://www.ismp-canada.org/LTC/medication-safety.htm



MedRec Quality Audit

Long-Term Care Medication Reconciliation Quality Audit Tool

Purpose of the Audit Tool

The tool is designed for use in Long-Term Care and was developed to allow LTC Homes to assess the quality of their medication reconciliation (MedRec) practices. The results of the quality audit can then be used to determine potential areas for process improvement(s).

Data Collection Methodology

- Retrospective (past admissions and readmissions) chart review to collect data.
- **A Word version tool for collecting the audit information (Data Collection Form) will be provided to all Champion Homes with an Excel Spreadsheet to compile the results (MedRec LTC Audit Results).**
- All Champion Homes are asked to audit each of the charts for the most recent 20 residents that were admitted/readmitted in the past 6 months.
    - If there are less than 20 residents admitted/readmitted in this time period, proceed with the reduced number for the audit and do not extend past the 6 -month historical timeline.

Audit Process - Question by Question Explanation

Question A. Where was the resident admitted/readmitted from?

Identify the admission route (Admit Via) for each resident chart audited. The information provided in this column of the Data Collection Form, along with the data from the remainder of the tool, will allow organizations to identify if there are specific resident flow routes that may require process improvements.

Admit Via Options for Selection:

- Acute: The resident was admitted/readmitted from an Acute Care facility (e.g., hospital).
- Home: The resident was admitted from their home (excluding another long-term care home).
- Res Care: The resident was admitted from another long-term care home.
- Other: The resident was not admitted via Acute, Home or Res Care.

Question B. Was MedRec performed within 48 hours of admission/readmission?

- Fill in "YES", if MedRec was performed within 48 hours.
- Fill in "NO (done after 48 hours)", if MedRec was performed after 48 hours.
- Fill in "NO", if MedRec was not done
    - If "No" is selected, stop audit, and proceed to the next resident chart.

Long-Term Care Medication Reconciliation Quality Audit Tool (continued)

Question C. Was BPMH obtained with more than 1 source of information?

- The Best Possible Medication History (BPMH) is most accurate when developed based on information obtained from more than one source. See 'Sources of Information Resource to Use' infographic for the possible sources of information.
- Fill in "YES" if the BPMH has been developed based on information obtained from more than one source.
- Fill in "NO" if more than one source is not documented in the resident chart (i.e. only one source recorded).
- Fill in "UNCLEAR" if the chart documentation does not allow the auditor to respond confidently "yes/no" (i.e. no sources recorded).

Question D. Was actual medication use verified?

- Fill in "YES" if there has been verification of medication use through resident or caregiver interview OR if sources include a medication administration record (MAR).
- Fill in "NO" if there has not been verification through an interview or MAR.
- Fill in "UNCLEAR" if the chart documentation does not allow you to respond confidently "yes/no".
- Fill in "UNABLE TO PERFORM" if the interview was not possible due to resident specific factors (e.g., non-verbal resident, unable to contact a substitute decision maker).

Question E. Do the BPMH and Admission Orders specify drug name, dose, strength, route, and frequency for each medication?

- Fill in "YES" if all applicable medication order components are provided in the BPMH and Admission Orders.
- Fill in "NO" if there are missing components in the BPMH or Admission Orders.
    - Note: In situations where the auditor identifies a medication listed without a specified route or strength AND the medication is only available by a particular route (e.g., by mouth/PO), at the discretion of the auditor/organization they may wish to indicate a "yes" response.

Question F. Is every medication in the BPMH accounted for in the Admission Orders?

- Fill in "YES" if there are NO unaccounted for differences between the BPMH (as collected) and the admission orders.
- Fill in "NO" if there are outstanding unaccounted for differences between the BPMH (as collected) and the admission orders.

Long-Term Care Medication Reconciliation Quality Audit Tool (continued)

Question G. Has the prescriber documented a rationale for 'Holds' and 'Discontinued' meds?

- Fill in "YES"/ "N/A" if all BPMH medications that have been discontinued or held in the admission orders include documentation of a rationale for this action OR if there are no BPMH medications that were discontinued or held on admission.
- Fill in "NO" if there are any BPMH medications that are discontinued or held in the admission orders that lack an accompanying rationale for this action.
- Fill in "UNCLEAR" if the chart documentation does not allow you to respond confidently "yes/no".

Question H. Have all discrepancies been communicated, resolved, and documented?

- Fill in "YES / N/A" if there were no discrepancies identified between the BPMH and the admission orders.
- Fill in "YES / N/A" if adequate evidence (documentation such as progress note or prescriber order) is identified to support the resolution of any identified differences between the BPMH and the Admission Orders.
- Fill in "NO" if there are outstanding identified differences that do not appear to have been resolved.
- Fill in "Unclear" if the chart documentation does not allow you to respond confidently "yes/no".

Adapted with permission from SHN! Medication Reconciliation Quality Audit Tool - Acute Care, Long-Term Care and Rehab Instructions and Legend for Completing the MedRec Quality Audit Form. Accessed: https://www.patientsafetyinstitute.ca/en/toolsResources/psm/Documents/Packages/MedRec/MedRec-LTC_Quality-Audit_Instructions.pdf

Appendix F – Medication Reconciliation Quality Audit Data Collection Form – LTC[vii]

For more information visit: https://www.ismp-canada.org/LTC/medication-safety.htm

Medication Reconciliation Quality Audit Data Collection Form – Long-Term Care

Data Collection Form

Date: (dd/MM/yy): _______________ Auditor Name: ____________________

Resident #	A: Admit via	B: MedRec Performed within 48 hours	C: BPMH using more than 1 source	D: Actual Med Use verified with Resident/ Caregiver	E: Each med has drug name, dose, strength, route, frequency on BPMH & Admission orders	F: Every med in BPMH is accounted for in admission orders	G: Prescriber has documented rationale for 'Holds' and 'Discontinued meds	H: Discrepancy(ies) communicated, resolved, and documented
	□ Acute □ Home □ Res Care □ Other	□ Yes □ No (done after 48 hours) □ No (Go to next chart)	□ Yes □ No □ Unclear	□ Yes □ No □ Unclear □ Unable to perform	□ Yes □ No	□ Yes □ No	□ Yes, N/A □ No □ Unclear	□ Yes, N/A □ No □ Unclear
	□ Acute □ Home □ Res Care □ Other	□ Yes □ No (done after 48 hours) □ No (Go to next chart)	□ Yes □ No □ Unclear	□ Yes □ No □ Unclear □ Unable to perform	□ Yes □ No	□ Yes □ No	□ Yes, N/A □ No □ Unclear	□ Yes, N/A □ No □ Unclear
	□ Acute □ Home □ Res Care □ Other	□ Yes □ No (done after 48 hours) □ No (Go to next chart)	□ Yes □ No □ Unclear	□ Yes □ No □ Unclear □ Unable to perform	□ Yes □ No	□ Yes □ No	□ Yes, N/A □ No □ Unclear	□ Yes, N/A □ No □ Unclear
	□ Acute □ Home □ Res Care □ Other	□ Yes □ No (done after 48 hours) □ No (Go to next chart)	□ Yes □ No □ Unclear	□ Yes □ No □ Unclear □ Unable to perform	□ Yes □ No	□ Yes □ No	□ Yes, N/A □ No □ Unclear	□ Yes, N/A □ No □ Unclear
	□ Acute □ Home □ Res Care □ Other	□ Yes □ No (done after 48 hours) □ No (Go to next chart)	□ Yes □ No □ Unclear	□ Yes □ No □ Unclear □ Unable to perform	□ Yes □ No	□ Yes □ No	□ Yes, N/A □ No □ Unclear	□ Yes, N/A □ No □ Unclear

Instructions

1. Using the paper Word document, perform a retrospective audit of the last 20 residents admitted/re-admitted within the last 6 months[1]. Home to keep a record of resident's name for each chart audited in a separate file. (See LTC Audit Notes)
2. Follow-up with any outstanding discrepancies identified through the audit; i.e., resolve with the team.
3. Share learning and good catches with team and ISMP Canada.
4. Transfer data to the MedRec LTC Quality Baseline Audit Excel worksheet and send the file to ISMP Canada through the file sharing folder.
5. Any questions? Email: alice.watt@ismpcanada.ca

[1] Some Homes may have less than 20 admissions/readmissions in 6 months; if more than 20, use the most recent ones.

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Strengthening Med Safety in Long-Term Care

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Medication Reconciliation – Long-Term Care Audit Notes – For Internal Home use only.
Home to keep a record of resident's name for each chart audited.

Resident #	Resident Name	Outstanding discrepancies to be resolved by team. Follow-up with staff and team for: • Sharing & Learning • Good catches or incidents to report
1		
2		
3		
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7		
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Audit Notes: For internal use only. Not to be sent to ISMP Canada

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Appendix G – LTC MedRec Quality Baseline Audit Tool[vii]

For more information visit: https://www.ismp-canada.org/LTC/medication-safety.htm

	Admit via	B. MedRec Performed within 48 hours	C. BPMH using more than 1 source	D. Actual med use verified by resident/SDM source	E. Each med has drug name,dose, strength,route ,frequency on BPMH and admission orders	F. Every med in BPMH is accounted for in Admission Orders	G. Prescriber has documented rationale for 'Holds' and 'Discontinued' meds	H. Discrepancy communicated, resolved and documented	MedRec Quality Score
Resident	Acute, Home, Res Care, Other	Select Yes, No (done after 48 hours), No; If No, go to the next chart	Select Yes, No or Unclear	Select Yes, No or Unclear, Unable to Perform	Select Yes,No	Select Yes or No	Select Yes, No,Unclear, or N/A	Select Yes, N/A No, Unclear	Total Quality Score
1									0
2									0
3									0
4									0
5									0
6									0
7									0
8									0
9									0
10									0
11									0
12									0
13									0
14									0
15									0
16									0
17									0
18									0
19									0
20									0
Total		0	0	0	0	0	0	0	0
RESULT		0%	0%	0%	0%	0%	0%	0%	0%
Measure		MedRec-LTC 1	MedRec-LTC 2	MedRec-LTC 3	MedRec-LTC 4	MedRec-LTC 5	MedRec-LTC 6	MedRec 7	MedRec-LTC 8

References:

[i] Medication Safety in Transitions of Care. Geneva: World Health Organization; 2019 (WHO/UHC/SDS/2019.9). Licence: CC BY-NC-SA 3.0 IGO.

[ii] Fredrickson, B. et al. Interventions to improve the continuity of medication management upon discharge of patients from hospital to residential aged care facilities. *Journal of Pharmacy Practice and Research.* 2019 49, 162-170. doi: 10.1002/jppr.1462.

[iii] Medication reconciliation in Long-Term Care: Getting started Kit. Canadian Patient Safety Institute/ISMP Canada; 2017. Available from: https://www.ismp-canada.org/download/MedRec/MedRec-LTC-GSK-EN.pdf

[iv] Accreditation Canada, Qmentum, Long-Term Care Services, version 14

[v] SDM (Informal) (definition). SDM Alliance website: https://www.org/definitions-0

[vi] SDM (definition). Canadian Coalition 2014; quoted in Mobilizing Action Integrated Action Plan: A Canada that recognizes, respects and supports the integral role of SDM s in society. Updated August 2015: Available from: https://www.carerscanada.ca/wp-content/uploads/2015/09/Moblizing-Action-Plan-Report_21.pdf

[vii] Measures: Medication Reconciliation webpage. Canadian Patient Safety Institute. Accessed July 21st, 2021 Available from: https://www.patientsafetyinstitute.ca/en/toolsResources/psm/pages/medrec-measurement.aspx