MEDREC ONTARIO NETWORK
FREQUENTLY ASKED QUESTIONS

How do you coordinate medication reconciliation in the community?

MedRec in primary care can be particularly challenging especially when a patient in the community is complex and has multiple care providers. Many players are involved and understanding their unique roles in the medication reconciliation process can help ensure that accurate and up-to-date medication information is communicated at transitions in care.

Cross Sectoral Collaboration

Many patients experience care in multiple settings with multiple providers over extended periods of time. Health care teams are recognizing the need to work together to design collaborative MedRec processes (e.g. involving acute care, primary care, home care, long term care) that enhance inter-team relationships and facilitate the communication of medication information as patients move through the healthcare system. Opportunities exist for community healthcare providers to develop collaborative medication reconciliation processes that enhance communication of accurate medication information from one community provider to another. For more information see SHN! National webinars and resources below:

- Redesigning the Transition Experience: Co-ordinating Patient Focused MedRec Across All Sectors
- Your Discharge is Someone's Admission

Role of Technology

Opportunities to improve efficiency of the MedRec process and reduce transcription errors will occur as advances in technology connect electronic medical records (EMRs) and allow for enhanced communication of medication information at transitions in care. Applications that enable scanning and uploading of information on medication labels make it easier for patients to create, maintain and share an accurate medication list with their healthcare team.

The MyMedRec app is an example of technology that can help patients keep track of their medications and share them with family members and their health care providers..

Roles and Responsibilities for MedRec in the Community

The patient and/or primary caregiver

Engaging with patients and/or their primary caregiver involves creating effective partnerships that support them to be actively involved in their own healthcare.
The patient and/or their primary caregiver are at the centre of every transition in care and play an integral role in the medication reconciliation process. They should be encouraged to:

- ask questions about their medications; for more information see "5 Questions to Ask" available at http://ismp-canada.org/medrec/5questions.htm
- maintain an accurate list of all of the medications they are taking (including prescription and nonprescription medications, vitamins, and natural products); and
- share this medication list with all members of their healthcare team at each visit

Primary care physician and/or Nurse Practitioner

The primary care physician and/or nurse practitioner may have several roles in the MedRec process in the community. If they are the first point of contact for the patient/primary caregiver, they may be responsible for collecting the best possible medication history (BPMH).

They should also encourage patients/primary caregivers to ask questions about their medication and answer any questions they might have. For more information see "5 Questions to Ask" available at http://ismp-canada.org/medrec/5questions.htm.

The primary care physician and/or nurse practitioner can assist in identifying and are responsible for resolving any discrepancies identified by other healthcare professionals involved in the medication reconciliation process (e.g. home care nurse, primary health team/community pharmacist).

They should document any medication changes in the patient's health record and communicate any changes that have been made to the patient/primary caregiver and any relevant healthcare provider involved in their care (e.g. home care nurse, community pharmacist). They should assist the patient/primary caregiver to update their medication list following any changes and encourage them to share it with their healthcare providers at each visit.

Rapid Response/Primary Care/Home Care Nurse (RN, RPN)

If they are the first point of contact for the patient, the nurse may be responsible for initiating the MedRec process. Nurses provide an important communication link between the patient, family and other community healthcare providers.

They can review medication information (e.g. best possible medication discharge plan (BPMDP)/discharge summary from previous facility), interview patients and collect the BPMH, identify discrepancies, and communicate these to the primary care physician and/or nurse practitioner for resolution.

They should provide education to patients/clients and families about their medications, encourage them to maintain an accurate medication list, advocate for their needs and support them to play an active role as co-managers of their care.

Primary Health Team/Community Pharmacist
The role of the primary health team pharmacist, if available, is to coordinate the medication reconciliation process. They may be responsible for initiating the MedRec process by interviewing the patient and collecting the BPMH. The primary health team pharmacist should ensure that medications are selected and ordered appropriately based on the patient's clinical condition and other factors. They can identify discrepancies and communicate these to the primary care physician and/or nurse practitioner for resolution. Wherever possible, they should take primary responsibility for ensuring proper communication of medication information to patients/clients, families and other healthcare providers.

The community pharmacist can assist by performing a comprehensive medication review with the patient/primary caregiver, including an interview and documentation of all medications that the patient is taking. During this process, the community pharmacist can also communicate any identified discrepancies to the primary care provider and/or primary health team pharmacist if applicable.

If a comprehensive medication review is not completed, the community pharmacist can provide a list of medications that have been dispensed for the patient from that particular pharmacy to assist other team members in developing the BPMH. They should provide education to patients/primary caregivers, encourage them to maintain an accurate medication list and emphasize the importance of sharing this record with their healthcare providers at each visit.

References:

A Practical Guide for Safe and Effective Office Based Practices, May 2012. The College of Physicians and Surgeons of Ontario. Toronto, ON. Available at http://www.cpso.on.ca/uploadedFiles/policies/guidelines/office/Safe-Practices.pdf

Ontario Primary Care Medication Reconciliation Guide. Available at http://ismp-canada.org/primarycaremedrecguide/

Safer Healthcare Now! (2015). Medication Reconciliation in Home Care: Getting Started Kit. Safer Healthcare Now! http://ismp-canada.org/download/MedRec/Medrec_HC_English_GSK_v2.pdf