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
Imagine

You come into the hospital wearing size 32 grey pants, a red shirt, blue shoes, and a black belt....
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” *
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
“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
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 complication. 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 and 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 Eiford & 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
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?

**PROACTIVE MEDICATION RECONCILIATION MODEL**

**STEP 1**
- Primary Medication History

**STEP 2**
- Admission Orders

**STEP 3**
- Verify every medication in BPMH has been assessed by prescriber.

**MEASURE**
- Independent observer measures at a time point after team's usual medication reconciliation process.

**RETROACTIVE MEDICATION RECONCILIATION MODEL**

**STEP 1**
- BPMH

**STEP 2**
- Admission Orders

**STEP 3**
- BPMH

**STEP 4**
- Compare BPMH with AMOs and resolve any discrepancies

**MEASURE**
- Independent observer measures at a time point after team's usual medication reconciliation process.
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 reinstated
**TRANSFER**

**Medication Reconciliation and Order Form**

Transfer from: [ ]

<table>
<thead>
<tr>
<th>ALLERGIES/TOLERANCES &amp; REACTIONS</th>
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**Medications at Time of Transfer**

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<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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**PHYSICIAN's Review & Order**

Review each medication and check off appropriate box.

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<thead>
<tr>
<th>Change (see next page)</th>
<th>Do Not Order</th>
<th>Reason for Not Ordering or Changing</th>
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**Physician Signature:** ____________________________  **Physician Printed Name:** ____________________________  **Date:** ____________  **Time:** ____________

**Medications at Time of Transfer Recoped By:** ____________________________  **Date:** ____________  **Time:** ____________

**Orders Transcribed By:** ____________________________  **Date:** ____________  **Time:** ____________

**Orders Verified By:** ____________________________  **Date:** ____________  **Time:** ____________

**Orders Faxed/Sent to Pharmacy:** [ ]  **Date:** ____________  **Time:** ____________

**DO NOT REMOVE OR THIN FROM THE CHART**

*Please place Reconciliation Forms in the Orders Section*

June 2, 2008  7102-0676-7

**PART 1 of 2**
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
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 sustained improvement, 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 of 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.
Between July to December 2009, there has been an trend towards sustained improvement.
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.

www.saferhealthcarenow.ca
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 reconciliation processes in this sector
OVERALL: Percentage of discrepancies that require clarification

Discrepancy Rate

Percentage of Discrepancies

Pilot Teams

Atlantic
Ontario
Western
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

- Provides acute care with discharge med rec process
Kaizen Event at Ontario LTC (Castleview)

Improved CWT Process for Medication Reconciliation

Patient accepted to CWT or re-admission → DC planner sends (email/fax) info to CWT and MD → Resident arrives → Compilation of standardized form with standardized procedure (BPMH) → MD in home? yes → MD does assessment → MD completes standardized form and writes medical order → Nurse calls MD with BPMH → Fax BPMH to MD → Decision is made, orders are clarified and documented on chart

Fax to pharmacy
1) DC summary info
2) admission orders (completed BPMH)

Pharmacy reconciles "orders" with DC summary → Discrepancies? yes → Requires immediate resolution? yes → Pharmacy calls RN to initiate 3-way call with MD → Paper documentation by pharmacy → Medications sent to floor → safer healthcare now!

Information:
1) medications (BPMH)
2) diagnosis
3) prescriptions (ODB compatible)
4) changes in medication regimen with rationale
5) set time for admission to LTC

1) unintentional discrepancies
2) undocumented intentional discrepancies
3) automatic substitution where possible
4) keep track of discrepancies here
Supports for Medication Reconciliation
British Columbia

BC Health Guide

www.bchealthguide.org
# Medication Card

**It’s Safe to Ask About Your Medications**

*Vous pouvez poser des questions au sujet de vos médicaments*

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!*

<table>
<thead>
<tr>
<th>Name/Nom:</th>
<th>Family Doctor’s Name/ Nom du médecin de famille:</th>
</tr>
</thead>
<tbody>
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</table>

**Manitoba Health Registration #/N° d’immatriuculation Santé Manitoba:**

<table>
<thead>
<tr>
<th>Personal Health ID #/N° d’identification personnelle (9 numbers/chiffres):</th>
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</table>

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

---

**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!

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Strength</th>
<th>How much</th>
<th>How often</th>
<th>Date/Date</th>
<th>Reason for taking</th>
<th>Who prescribed</th>
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</thead>
<tbody>
<tr>
<td>Name du médicament</td>
<td>Puissance</td>
<td>Quantité</td>
<td>Fréquence</td>
<td>Started/Début</td>
<td>Motif de l’administration</td>
<td>Qui a prescrit</td>
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<tr>
<td>Example: My drug</td>
<td>20 mg</td>
<td>1 tablet</td>
<td>2 times a day</td>
<td>May 1, 2008</td>
<td>blood pressure</td>
<td>Dr. Doe</td>
</tr>
<tr>
<td>Exemple : mon médicament</td>
<td>20 mg</td>
<td>1 comprimé</td>
<td>2 fois par jour</td>
<td>1er mai 2008</td>
<td>haute pression</td>
<td>Dr. Tremblay</td>
</tr>
</tbody>
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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.*
It’s Safe to Ask

Ask your doctor, nurse or pharmacist...

1. What is my health problem?
2. What do I need to do?
3. Why do I need to do this?

www.safetoask.ca
## Provincial Electronic Medication Databases

<table>
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<tr>
<th>Provinces</th>
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<th>Capability to Print a BPMH Form</th>
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<td>Pharmanet</td>
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<td>AB</td>
<td>Alberta NetCare HER Pharmaceutical Information Network (PIN)</td>
<td>Yes</td>
<td>No</td>
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<td>SK</td>
<td>Pharmaceutical Information Program (PIP)</td>
<td>Yes</td>
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<tr>
<td>MB</td>
<td>Drug Programs Information Network (DPIN)</td>
<td>Yes</td>
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<td>ON</td>
<td>Drug Profile Viewer (DPV)</td>
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<td>QB</td>
<td>QSIM</td>
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<td>Drug Information Systems (DIS)</td>
<td>Yes</td>
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<td>NFLD</td>
<td>The Pharmacy Network</td>
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<td>No</td>
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<td>NB</td>
<td>Prescription Drug Program</td>
<td>No</td>
<td>No</td>
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<td>NS</td>
<td>Nova Scotia Hospital Information System (NShIS)</td>
<td>No</td>
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</table>
About TELUS health space

Canada’s First Consumer eHealth Service

TELUS health space™, powered by Microsoft® HealthVault™, is Canada’s first consumer eHealth service that puts Canadians in control of their health information. It is the kind of service that can serve as the foundation for building new models of care in Canada where citizens have access to their personal health information and a variety of online tools for health and wellbeing, chronic disease management, paediatric care and much more, helping Canadians take an active role in their healthier lifestyles.
Medication Record Book from Rx&D (Order Free copies)

Knowledge is the best medicine
Ask the questions, get the answers
- What is the name of the medicine?
- Why am I taking it and what does it do?
- How do I take it?

Brought to you by:

To order more copies, contact:
Canada’s Research-Based Pharmaceutical Companies (Rx&D)
Email: knowledge@canadapharma.org
Website: www.canadapharma.org
(downloadable copy also available)
1-800-363-0203
fax: 613-236-6861
### Medication Reconciliation

**Source of info**
- Family/caregiver
- Pt interview
- Vials

**Community pharmacy**
- PILLS R US
  - 905-284-9374

### Medication #1
- **Medication**: NIFEDIPINE XL 60MG PO DAILY
- **Intervention**: Called MD
- **Intentional or not**: Unintentional
- **Action taken**: Order changed
- **Explanation**: MD ORDERED 30MG PO DAILY.

### Medication #2
- **Medication**: PARIET 20MG PO DAILY
- **Intervention**: Not necessary
- **Intentional or not**: Documented intentional
- **Action taken**: Order unchanged
- **Explanation**: MD DISCONTINUED IT.

### Medication #3
- **Medication**: ATORVASTATIN 80MG PO QHS
- **Intervention**: Not necessary
- **Intentional or not**: Documented intentional
- **Action taken**: Order unchanged
- **Explanation**: MD DISCONTINUED IT.

### Medication #4
- **Medication**: METFORMIN 250MG PO TID
- **Intervention**: Not necessary
- **Intentional or not**: Documented intentional
- **Action taken**: Order unchanged
- **Explanation**: MD DISCONTINUED IT.
Medication History
### Meditech and Medication Reconciliation

**Current Date/Time PHA**  
**Process Interventions**

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<tr>
<th>View</th>
<th>Document</th>
<th>Document</th>
<th>Add</th>
<th>Patient</th>
<th>Edit</th>
<th>View</th>
<th>&gt;More</th>
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<tbody>
<tr>
<td>History</td>
<td>Now</td>
<td>Interv's</td>
<td>Interv</td>
<td>Notes</td>
<td>Text</td>
<td>Protocol</td>
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**Patient**  
AC000188/05 PHATEST, ALICE  
Status: ADM IN  
Room: 3257  
Attend Dr: SOLH  
SOLOW, HENRY L.  
Admit: 30/01/06  
Bed: A

### Additional Interventions

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<th>User</th>
<th>Name</th>
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<th>Edit?</th>
<th>Status</th>
<th>Srce</th>
<th>Prot</th>
<th>View?</th>
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<td>3 PHA Medication Reconciliation</td>
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<td>4 PHA Anticoagulation Record</td>
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<td>5 PHA Discharge Counseling/Reconciliation</td>
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- 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
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.
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.
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
<table>
<thead>
<tr>
<th>Name of Medication</th>
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<th>Reason for Taking</th>
<th>Dose &amp; Time Taken</th>
<th>Date Stopped</th>
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**Prescription Medications:**

- Often have own names (generic & brand).
- This information can be found on the medication package or the information sheet that comes with it.
- Record both names, wherever possible.
- Also record any over-the-counter medications, vitamins, herbs or nutritional supplements.

**Write down the date that you started taking this medicine.**

**Reasons for Taking:**

- Always keep a record of why you are taking each medication as 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 reasons 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