Reducing Harm | Improving Healthcare | Protecting Canadians

Medication Reconciliation (MedRec)

safer healthcare now!

Frequently Asked Questions

Where can I find resources about MedRec at discharge?

There are several resources which contain information about MedRec at discharge.

Safer Healthcare Now! resources

The Medication Reconciliation in Acute Care Getting Started Kit version 3 was published in 2011. The kit was developed in partnership by the Institute for Safe Medication Practices Canada (ISMP Canada) and the Canadian Patient Safety Institute (CPSI). The kit was written to help engage interprofessional/ interdisciplinary teams in a dynamic approach for improving quality and safety while providing a basis for getting started. The kit represents the most current evidence, knowledge and practice, as of the date of publication and includes what has been learned since the first kits were released in 2005. Within the kit there are dedicated sections related to MedRec at discharge. The kit is accessible here.

National Calls/Webinars

Since 2006, several webinars have featured content relevant to Discharge MedRec they include:

- January, 2014, "Got Med Wreck? Targeted Repairs from the Multi-Center Medication Reconciliation Quality Improvement Study (MARQUIS)" – Speaker: Dr. Jeffrey Schnipper. To access the recording and slides click here.
- April, 2014, "Results of the Pharmacy Discharge Facilitator Initiative for High-Risk Medical Inpatients" – Speaker: Colleen Cameron. To access the recording and slides click here.
- May, 2011, "Getting Started and Moving Forward with Med Rec at Discharge" - Speaker: Kim Tiwana. To access the recording and slides click here.
- September, 2009, "Passing the Baton: Medication Reconciliation at Internal Transfer and Discharge" – Speaker: Olavo Fernandes. To access the recording and slides click here.

Medication Reconciliation at Discharge Virtual Action Series

In 2011 and 2012 Safer Healthcare Now! hosted an interactive series for discharge MedRec. The series highlighted tools, resources and ideas to get MedRec at discharge up and running in one unit with a plan for spread across organizations. To access the recordings to the webinars and slides click here.

MedRec Community of Practice

On this website, designed for sharing of information, there are forms, policies, educational resources and more on MedRec in all settings. To access these documents, click here.

ISMP Canada Resources

ISMP Canada developed a suite of tools, with support from the Ontario Ministry of Health and Long-Term Care, to facilitate MedRec at discharge, including:

- Steps for Creating the Best Possible Medication History Discharge Plan
- Best Possible Medication History Discharge Plan
- Best Possible Medication History Discharge Plan Patient Interview Guide
- Best Possible Medication History Discharge Plan Checklist
- Discharge Plan Medication Schedule
- Hospital to home – Facilitating Safe Medications at Transitions Checklist and Toolkit

To access all ISMP Canada MedRec related resources visit www.ismp-canada.org/medrec.

Accreditation-related resources

The following are excerpts from Accreditation Canada's 2015 Required Organizational Practices (ROP) Handbook and Accreditation Canada's 2016 ROP Handbook.

Additional guidance on this ROP can be found in the handbook related to medication reconciliation as a strategic priority and medication reconciliation at care transitions (e.g., acute care services, ambulatory care, emergency department, home and community care, long-term care, substance misuse. Organizations are also encouraged to view Accreditation Canada's "MedRec FAQ" documents accessible via an organization's Accreditation Canada web portal.

Accreditation Canada Required Organizational Practice Medication Reconciliation at Care Transitions – Acute Care Services

With the involvement of the client, family, or caregiver (as appropriate), the team generates a Best Possible Medication History (BPMH) and uses it to reconcile client medications at transitions of care.

TESTS FOR COMPLIANCE

Major	Upon or prior to admission, the team generates and documents a Best Possible Medication History (BPMH), with the involvement of the client, family, or caregiver (and others, as appropriate).
Major	The team uses the BPMH to generate admission medication orders OR compares the Best Possible Medication History (BPMH) with current medication orders and identifies, resolves, and documents any medication discrepancies.
Major	A current medication list is retained in the client record.
Major	The prescriber uses the Best Possible Medication History (BPMH) and the current medication orders to generate transfer or discharge medication orders.
Major	The team provides the client, community-based health care provider, and community pharmacy (as appropriate) with a complete list of medications the client should be taking following discharge.

Please go to https://www.accreditation.ca/ for the most recent updates to the ROPs.