Many gaps and breakdown points are evident with medication transitions.

**MEDICATION RECONCILIATION**

is a key component to clearly communicating medications at discharge. But it is just a starting point.

Leverage medication reconciliation as an opportunity to enhance medication safety:
• Review for appropriateness
• Streamline or simplify the regimen
• Assess patient and caregiver understanding
• Delivering appropriate counseling

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**SOLUTIONS are required**

Rationale for creating a toolkit and medication safety checklist at transitions:
• Reduces conflicting information on discharge documents
• Engages patient in the plan
• Identifies reasons for non-adherence prior to going home
• Connects the patient with primary care prescriber for appropriate medication follow-up

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**Step 1:**

Define and identify patients at risk for a medication-related readmission

**Patients at risk of a medication-related readmission:**
• Taking 5 or more medications
• Multiple medication changes while in hospital
• Taking high-risk medications
• Previously hospitalized for an adverse drug reaction
• Over 75 years of age
• Limited care supports at home
• If non-adherence would cause therapeutic failure

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**Step 2:**

Involve the entire care team

• Enlist team members
• Assign roles to each player
• Involve pharmacists for complex patients
• Handover to community partners

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**Step 3:**

Follow the Checklist

This checklist identifies the key process to facilitate the transition of patients and their medications safely home.

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**Step 4:**

Refer for Follow-Up

Remember to refer patients for follow-up with their community pharmacist (MedsCheck Follow-up or a MedsCheck at Home) or their primary care provider to ensure they are able to put their new medication regimen into action.

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To access the toolkit and checklist go to www.ismp-canada.org/transitions/

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