ADMINISTRATION

Procedure

Title	**MEDICATION RECONCILIATION: PRIMARY CARE**	Date Effective	**September 19, 2018**
Document #	**AD-05-05.04**	Date Reviewed	
Scope	**ALL PRIMARY CARE CLINICS**	Date Revised	
Approved By	**SENIOR MANAGEMENT TEAM**	Signature	***Original signed by H. Bryant***
Managed By	**DIRECTOR OF PRIMARY CARE AND CLINICS**		

POLICY

This procedure is part of Northern Health Regions' (NHR) policy AD-05-05 Medication Reconciliation at Care Transitions. Refer to the policy for purpose, definitions, and policy statements.

1.0 ADMISSION Med Rec PROCEDURE / RESPONSIBILITY

1.1 Collect the Best Possible Medical History (BPMH)

BPMH collection will be completed by a health care professional.

1.1.1 Use a minimum of two (2) reliable information sources to collect the BPMH.

1.1.1.1 One (1) information source should be the client or family as appropriate. When the client or family is not a reliable information source, multiple information sources should be considered.

1.1.1.2 When possible, use medication lists or vials as a secondary source to validate the accuracy of information collected through interview. If a medication list is not available, not recent, or not reliable, consider alternative sources such as the:

- Active Medication List in electronic medical record (EMR);
- Client's community pharmacy; or
- DPIN

1.1.2 The collection of the BPMH should occur at each visit where medication is a component of the care.

1.2 Document the BPMH

All health care professionals will be responsible for ensuring the BPMH is documented in the EMR.

1.2.1 The client's community pharmacy will be reviewed and updated if necessary by reception at each visit.

1.2.2 Client's known allergies/intolerances including reaction type will be documented by the health care professional in the allergies band in the EMR.

1.2.3 BPMH will be documented by the prescriber in the active medications band in the EMR. This will include the:

- Name;
- Dose;
- Route of administration;
- Frequency of administration; and
- Duration of the active prescription including if the medication will be prescribed for a short term or continuous duration.

Signatures are automatically generated by the prescriber within the EMR.

1.2.4 Providers to ensure that any duplicate (also known as triplicate) prescriptions are also entered into EMR as part of BPMH.

1.3 Reconcile the BPMH

1.3.1 The BPMH is reconciled at the following times:

- A client's first visit to a primary clinic and no later than the second visit;
- Subsequent visits where medication is a significant component of care or
- Following an admission to an acute care facility.

1.3.2 For initial and subsequent visits to a primary care clinic, the health care provider will:

- Assess and review each medication listed in the BPMH/Active Medication Band. If no discrepancies noted no action is necessary.

1.3.3 Following an admission to an acute care facility the discharge summaries and medication reconciliation forms received to the clinic will be directed to the most responsible provider (MRP) for review. The MRP will:

1.3.3.1 Assess and review each medication listed in the medication reconciliation documentation from the discharging facility against the active medications listed in the EMR, and in conjunction with the client and/or family.

1.3.3.2 Should a patient attend an appointment prior to clinic receiving the discharge summary and med reconciliation documentation, a BPMH will be generated in partnership with the client, family and others as appropriate. The clinic will request the discharge summary and medication reconciliation from the discharging facility to complete the medication reconciliation process as outlined in 1.3.3.1.

1.3.4 Should additions, changes or deletions be required to a medication following reconciliation, medication additions, changes or deletions should be documented in the SOAP as part of the clinical plan.

1.3.4.1 **Additions:** New medications will be added to the Active Medication list in the EMR per 1.2.3.

1.3.4.2 **Changes or Discontinuation:** A change or discontinuation of a medication will be done by selecting and discontinuing the medication from the active medication list including the reason for change. The discontinuation will be confirmed by the Prescriber and faxed to the patient's community pharmacy. Completed discontinuations are archived in the inactive medication list within the EMR. The correct medication order will be added to the active medication list by the Prescriber per 1.2.3.

1.3.4.3 If discrepancies are identified and are outside of the scope of the health care provider to manage, the discrepancies will be tasked to the MRP to manage

1.3.4.5 If the client does not have an MRP, reconciliation will be managed by the prescriber at point of care, or referred to the most recent prescriber involved in the care, if discrepancies are identified by a non-prescriber health care provider

1.4 Communication with Clients

1.4.1 All medications prescribed during a visit to a primary care clinic will be done in accordance to the prescriber's professional standards.

During the BPMH any discrepancies will be assessed for lack of understanding of the treatment regimen. Clarification and necessary education will be provided to the client or family.

Clients will be reminded of the importance of maintaining an active medication list that should be brought to each visit.