Transitions Between Hospital and Home

Close to Time of Discharge: Medication Reconciliation at Discharge

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Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, specialists etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up.

Figure 1 is an outline of **innovative practices and evidence-informed best practices** that are designed to improve transitions between hospital and home.

The use of these practices varies significantly across the province. Teams are encouraged to prioritize the implementation of evidence-informed best practices before adoption of the innovative practices.

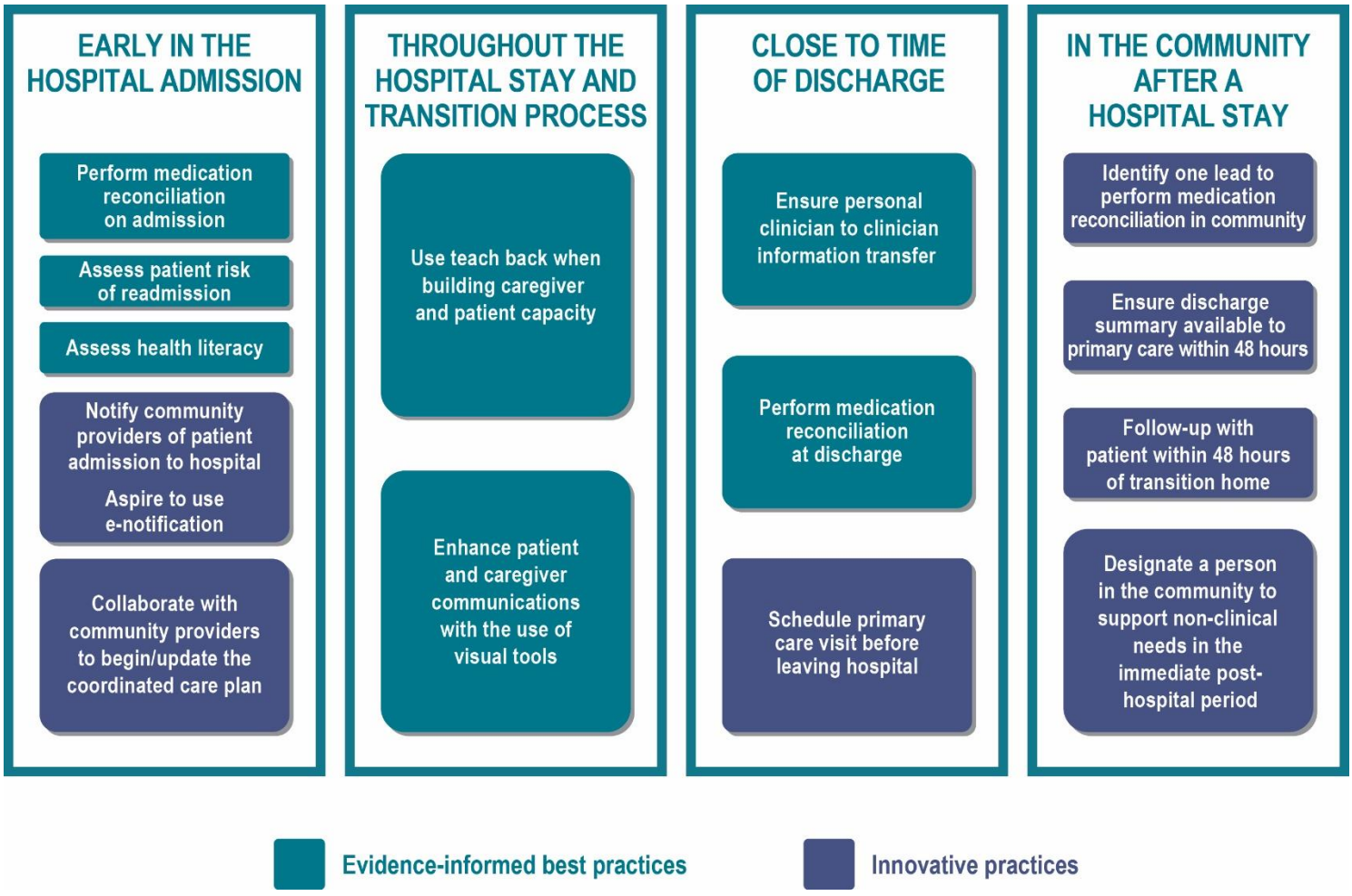

Figure 1: Practices to Improve Transitions Between Hospital and Home

The material for Transitions Between Hospital and Home was developed in collaboration with Health Links and the Clinical Reference Group.

Description of this Evidence-Informed Best Practice

Medication reconciliation (Med Rec) is a formal, systematic process in which health care professionals partner with patients to ensure accurate and complete medication information during transitions of care.[1] The result of discharge medication reconciliation should be clear and comprehensive information for the patient and other care providers. According to ***Safer Healthcare Now***, "*discharge medication reconciliation clarifies the medications the patient should be taking post discharge by reviewing:*

- *Medications the patient was taking prior to admission (Known as a Best Possible Medication History - BPMH)*
- *Most current MAR (medication administration record) or medication profile;*
- *New medications planned to start upon discharge*."[1]

Tools and Resources

In an environmental scan and literature review, the following tools were found to be highly effective and commonly used for medication reconciliation at discharge. The decision to implement or administer one of these tools must be considered alongside other locally contextually relevant information.

Perform Medication Reconciliation at Discharge		
Name of Tool	**Overview**	**Considerations/Links**
BPMH (Best Possible Medication History)	According to the ***Institute for Safe Medication Practices (ISMP) Canada***, **BPMH** is a "history created using: 1) a systematic process of interviewing the patient/family; and 2) a review of at least one other reliable source of information to obtain and verify all of a patient's medication use (prescribed and non-prescribed). Complete documentation includes drug name, dosage, route and frequency. The BPMH is more comprehensive than a routine primary medication history which is often a quick preliminary medication history which may not include multiple sources of information."[2]	• The **BPMH** is a "snapshot" of the patient's actual medication use, which may be different from what is contained in their records. This is why the patient involvement is vital. • More information and tools for creating BPMH can be found at ISMP Canada: https://www.ismp-canada.org/medrec/
Medication Reconciliation in Acute Care: Getting Started Kit	**The Getting Started Kit** from ***ISMP Canada*** and ***Safer Healthcare Now*** provides "support to start the process on small numbers of patients, make changes, and gradually develop, implement and evaluate medication reconciliation broadly using quality improvement processes."[1]	• The **Getting Started Kit** from ***Safer Healthcare Now*** *i*ncludes an update on measurement, proactive and retroactive models for medication reconciliation at admission, expanded BPMH guidelines, and updated resources. • The **Getting Started Kit** is available at: http://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Medication%20Reconciliation/Acute%20Care/MedRec%20%28Acute%20

[1] Bernier P, Boiteau P, Cass M, Couves L, Esmail R, Harries B. Safer Healthcare Now! Campaign April 2009 How-to Guide: Rapid Response Teams. Available from: http://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Rapid%20Response%20Teams/RRT%20Getting%20Started%20Kit.pdf

[2] Institute for Safe Medication Practices Canada. Definition of Best Possible Medication History (BPMH). Available from: https://www.ismp-canada.org/medrec/

		Care%29%20Getting%20Started%20Kit.pdf
MyMedRec phone app for patients	**MyMedRec** phone app for patients is a portable up to date health record that can be easily shared with your family, doctor, nurse, pharmacist or anyone else involved in your healthcare.	• The **MyMedRec** app for patients can be found at: http://www.knowledgeisthebestmedicine.org/index.php/en/app
5 Questions to Ask	Multiple organizations have collaborated to create a set of five (5) questions to help patients and caregivers start a conversation about medications to improve communications with their health care provider. Examples include: • Doctor's appointment (e.g. family physician or specialist) • Interaction with a community pharmacist • Discharge from hospital to home • Visit by home care services	• **5 Questions to Ask** poster can be downloaded at: https://www.ismp-canada.org/medrec/5questions.htm

Additional Resources

For additional information on Quality Improvement, please visit: http://qualitycompass.hqontario.ca/portal/getting-started.

For additional information on Medication Reconciliation, please visit:

- *Accreditation Canada*
  https://accreditation.ca/
- *Medication Management on Home and Community Care*
  http://qualitycompass.hqontario.ca/portal/Home-and-Community-Care/Medications-Management
- *Medication Reconciliation in Acute Care*
  http://qualitycompass.hqontario.ca/portal/plans-hospital/Medication-Reconciliation-at-Admission
- *Canadian Patient Safety Institute*
  http://www.patientsafetyinstitute.ca/en/Topic/Pages/Medication-Reconciliation-(Med-Rec).aspx

References

Systematic Reviews

1. Kwan JL, Lo L, Sampson M, Shojania KG. Medication Reconciliation During Transitions of Care as a Patient Safety Strategy: A Systematic Review. Annals of Internal Medicine. 2013;158(5 Pt 2):397-403. Available from: http://annals.org/article.aspx?articleid=1656444

2. Mueller SK, Sponsler KC, Kripalani S, Schnipper JL. Hospital-Based Medication Reconciliation Practices: A Systematic Review. Arch Intern Med. 2012 Jul 23;172(14):1057-69.

Supporting Resources

3. Bell CM, Brener SS, Gunraj N, Huo C, Bierman AS, Scales DC, Bajcar J, Zwarenstein M, Urbach DR. Association of ICU or Hospital Admission with Unintentional Discontinuation of Medications for Chronic Diseases. JAMA. 2011;306(8):840-847. Available from: http://jama.jamanetwork.com/article.aspx?articleid=1104261.

4. Boockvar KS, Blum S, Kugler A, Livote E, Mergenhagen KA, Nebeker JR, Signor D, Sung S, Yeh J. Effect of Admission Medication Reconciliation on Adverse Drug Events from Admission Medication Changes. Arch Intern Med. 2011; 171(9):860- 861. Available from: http://archinte.jamanetwork.com/article.aspx?articleid=487036.

5. Boockvar KS, Santos S, KushnirukA, Johnson C, Nebeker JR. Medication Reconciliation: Barriers and Facilitators from the Perspectives of Resident Physicians and Pharmacists. J Hosp Med. 2011 Jul-Aug;6(6):329-372011;6(6):329-337.

6. Gleason KM, McDaniel MR, Feinglass J, Baker DW, Lindquist L, Liss D, Noskin GA. Results of the Medications at Transition and Clinical Handoffs (MATCH) Study: An Analysis of Medication Reconciliation Errors and Risk Factors at Hospital Admission. J Gen Intern Med. 2010; 25(5):441-447. Available from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2855002