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# Medication Reconciliation in Home Care Pilot Project

VON CANADA

ismp CANADA

# Key Objective

Develop and validate a framework to aid homecare providers in the implementation of medication reconciliation into their care delivery processes.

This framework was to take into consideration the unique challenges of the home care delivery setting in Canada

This was done by exploring, developing and testing medication reconciliation strategies for implementation in the home care setting

# Target Population

## (Eligibility Criteria)

**Those clients transferred from an acute care setting to the home care organization for service**

# Sample Population

**611 clients with a completed Best Possible Medication History**

# Measures
# Pilot Average

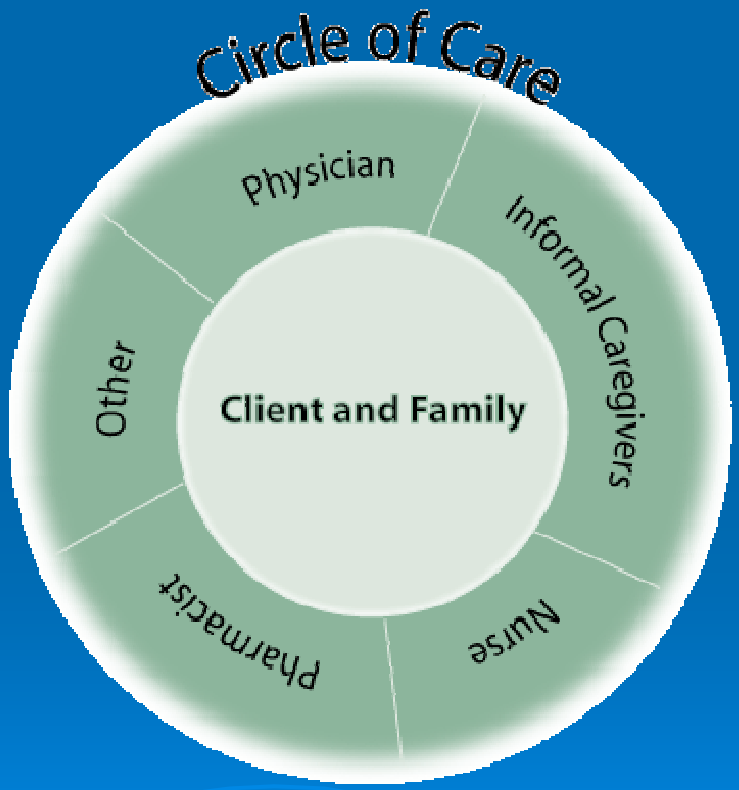
1. Percentage of eligible clients with a BPMH: **86%**
2. Time to complete the BPMH: **40 min**
3. Percentage of eligible clients with at least one discrepancy that requires clarification: **45.2%**
4. Type & frequency of discrepancies:

   **2.3 per client**

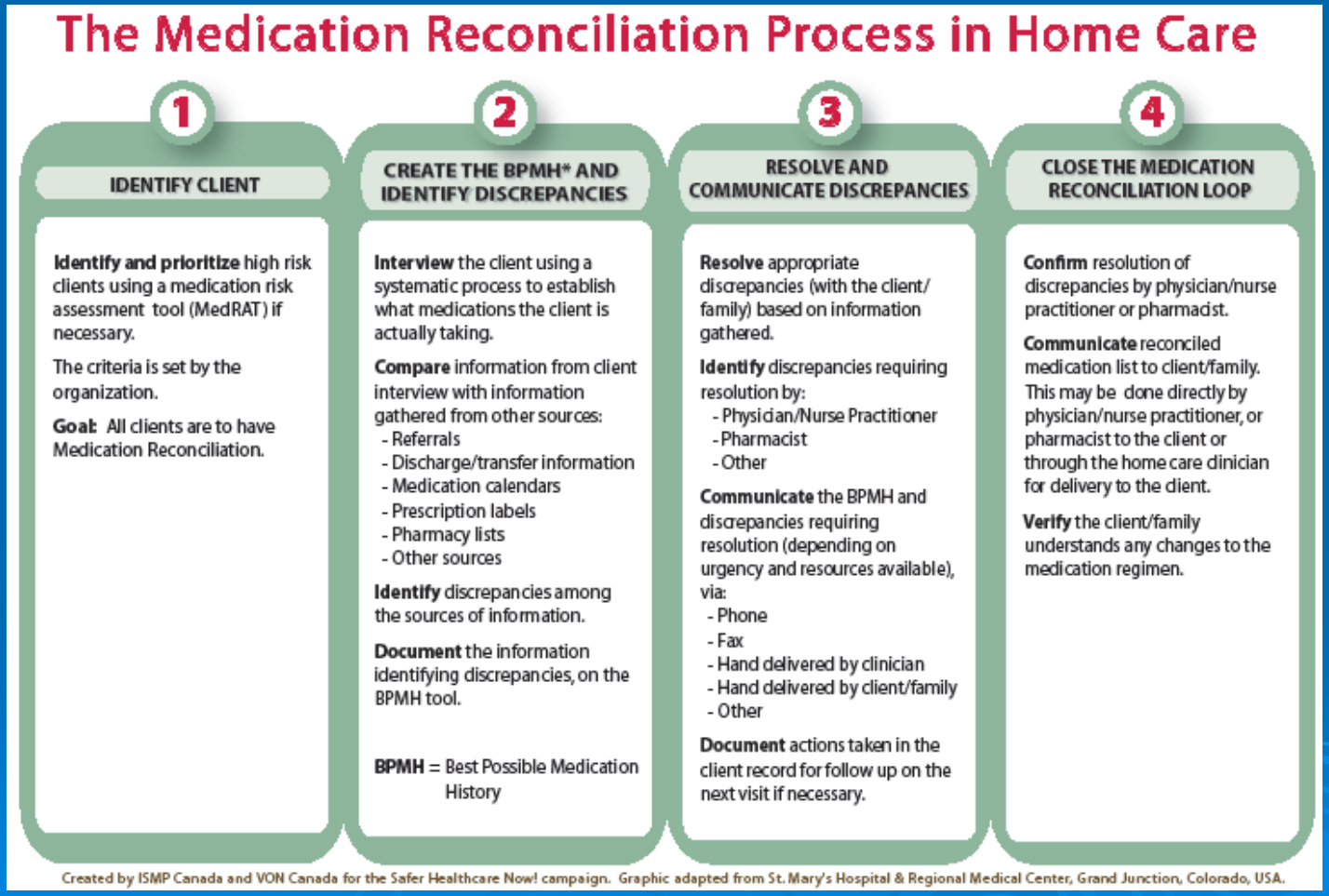
# What did we Identify?

Challenges
Factors
Successes
Lessons Learned

# Who


Circle of Care
physician
Informal Caregivers
Nurse
Pharmacist
Other
Client and Family

# How


The Medication Reconciliation Process in Home Care
1
IDENTIFY CLIENT
Identify and prioritize high risk clients using a medication risk assessment tool (MedRAT) if necessary.
The criteria is set by the organization.
Goal: All clients are to have Medication Reconciliation.
2
CREATE THE BPMH* AND IDENTIFY DISCREPANCIES
Interview the client using a systematic process to establish what medications the client is actually taking.
Compare information from client interview with information gathered from other sources:
- Referrals
- Discharge/transfer information
- Medication calendars
- Prescription labels
- Pharmacy lists
- Other sources
Identify discrepancies among the sources of information.
Document the information identifying discrepancies, on the BPMH tool.
BPMH = Best Possible Medication History
3
RESOLVE AND COMMUNICATE DISCREPANCIES
Resolve appropriate discrepancies (with the client/family) based on information gathered.
Identify discrepancies requiring resolution by:
- Physician/Nurse Practitioner
- Pharmacist
- Other
Communicate the BPMH and discrepancies requiring resolution (depending on urgency and resources available), via:
- Phone
- Fax
- Hand delivered by clinician
- Hand delivered by client/family
- Other
Document actions taken in the client record for follow up on the next visit if necessary.
4
CLOSE THE MEDICATION RECONCILIATION LOOP
Confirm resolution of discrepancies by physician/nurse practitioner or pharmacist.
Communicate reconciled medication list to client/family. This may be done directly by physician/nurse practitioner, or pharmacist to the client or through the home care dinician for delivery to the client.
Verify the client/family understands any changes to the medication regimen.
Created by ISMP Canada and VON Canada for the Safer Healthcare Now! campaign. Graphic adapted from St. Mary's Hospital & Regional Medical Center, Grand Junction, Colorado, USA.

# When

## Medication Reconciliation in Home Care
## Sources of Information

### Admission

**Goal:** To establish a complete, accurate medication list including prescribed and non-prescribed medication.

*Compare*

What the client is actually taking (obtained through interview with client/family)

*Versus*

Possible sources of information to create the BPMH:

- Referrals (admission orders)
- Best Possible Medication Discharge Plan (from a health care facility)
- Medication calendars
- Prescription labels
- Pharmacy lists
- MAR (Medication Administration Record)
- Electronic client data base
- Other sources

*Start with the most recent sources of information

Establish the client's current medication list (BPMH) to identify and resolve discrepancies.

Once all discrepancies have been identified and resolved the end result is the reconciled medication list.

BPMH = Best Possible Medication History

### Risk Points

**Goal:** To support communication with the client's circle of care related to their medication regiment. Risk points may exist along the continuum of care such as:

- Health practitioner/clinic appointments
- Change in client health status
- Standards set by organization
- Care transferred to alternate level of care within the organization
- Other

The Clinician reviews and updates the reconciled medication list identifying any changes to the client's medication regimen.

*Compare*

What the client is actually taking (obtained through interview with client/family)

*Versus*

Possible sources of information to update the reconciled medication list:

- Current reconciled mediation list
- New prescriptions
- Prescription labels
- Pharmacy lists
- Updated physician orders
- Clinic/physician summaries
- Electronic client data base
- Other sources

Once all discrepancies have been identified and resolved, update the clients current reconciled medication list.

### Discharge

**Goal:** To communicate an up-to-date, complete and accurate list of the client's current medications, thereby supplying the next provider of care with adequate information to provide medication reconciliation.

*Compare*

What is the client actually taking (obtained through interview with client/family)

*Versus*

Possible sources of information to update the reconciled medication list:

- Current reconciled medication list
- New prescriptions
- Discharge physician orders
- Prescription labels
- Pharmacy lists
- Discharge orders
- Electronic client data base
- Other sources

Once all discrepancies have been identified and resolved, update and communicate the client's current reconciled medication list to the next provider of care. If the client is being discharged into self care, the clinician verifies that the client/family understands any changes to their medication regimen.

Created by [illegible]

# Next Steps

- Report and recommendations to SHN! Steering Committee
- Development of an Get Started Kit
- Planning for ongoing support to Homecare organizations & teams that want to engage in medication reconciliation
- Work with Accreditation Canada to ensure Required Organizational Practices (ROPs) take homecare challenges into account
- Advocacy by pilot co – lead organizations to communicate  importance of supporting medication reconciliation in home care