FAQs about Medication Reconciliation

Please note that this is a ‘living document’ and will be updated as new questions arise. Please check your portal for the most up-to-date information.

General Questions

1. What is medication reconciliation?
Medication reconciliation (MedRec) is a systematic and comprehensive review of all the medications a client is taking to ensure that medications being added, changed or discontinued are carefully assessed and documented. Health care providers follow a formal process to work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care.

2. How is MedRec assessed in Qmentum?
There are two Required Organization Practices (ROPs) about MedRec:

- One ROP, MedRec as a Strategic Priority, is directed at the leadership of an organization and outlines the steps needed to implement and sustain medication reconciliation in an organization. It is found in the Leadership standards.
- Another ROP, MedRec at Care Transitions, is directed to the front-line where MedRec occurs, and outlines the steps needed to reconcile client medications. It is found in relevant service-based standards. There are five versions (acute care, ambulatory care, home care, long-term care, and substance misuse) to reflect the unique circumstances of different care settings. Four versions (acute care, ambulatory care, home care, and long-term care) were revised, while the substance misuse version remains unchanged since 2012. Appendix A contains a table listing all standards with a MedRec ROP.

3. Is MedRec expected for all organizations?
MedRec is only expected for organizations that manage client medications and use standards that contain the MedRec at Care Transitions ROP.

4. Is MedRec expected for all services?
MedRec is only expected for services where medication management is a component of care and that use Qmentum standards that contain the MedRec at Care Transitions ROP.

5. When does the MedRec as a Strategic Priority ROP apply?
The MedRec as a Strategic Priority ROP applies when an organization manages client medications AND uses Qmentum standards that contain the MedRec at Care Transitions ROP. If the organization does not use any Qmentum standards that contain the MedRec at Care Transitions ROP or the MedRec at Care Transitions ROP does not apply, then the MedRec as a Strategic Priority ROP does not apply.
6. **What is expected of client organizations for implementing MedRec?**

MedRec is expected to be implemented in services that use Qmentum standards that contain the *MedRec at Care Transitions* ROP and where medication management is a component of care. Implementation is not expected for Qmentum standards that do not contain the *MedRec at Care Transitions* ROP. The expectations are staged, as follows:

- **For on-site surveys occurring between 2014 and 2017**, organizations are expected to have implemented the *MedRec at Care Transitions* ROP in at least ONE service. Organizations that use two or more Qmentum standards that contain the MedRec at Care Transitions ROP may choose the service in which they wish to implement MedRec. MedRec is expected to be implemented as per the tests for compliance in the ROP.

- **For on-site surveys occurring 2018 and beyond**, organizations are expected to have implemented the *MedRec at Care Transitions* ROP in ALL services. Implementation is not expected in services that do not use standards that contain the MedRec at Care Transitions ROP. MedRec is expected to be implemented as per the tests for compliance in the ROP.

These expectations apply to all organizations, including those using a sequential survey model.

7. **What if my organization does not implement MedRec as per the expectations of Accreditation Canada?**

Compliance with ROPs has an impact on the decision level that an organization achieves. Like all ROPs, medication reconciliation will become a required follow-up if the tests for compliance are not met during the on-site survey.

8. **What is a service?**

A service is defined by the Qmentum standards used by the organization. It is a broad definition and includes all services (or programs) AND locations that use a given standard. For example:

- A ‘service’ for medicine includes medicine and all its sub-specialties (e.g. nephrology, gerontology) for which the Medicine Services standards apply, across ALL locations.

- A ‘service’ for home care includes all teams that use the Home Care Services or Community Based Mental Health Services and Supports standards (including all home visits and clinics) across all locations. The home and community care version of MedRec allows for targeting, so to implement MedRec in this service an organization should consider all its services, identify clients/visits that require MedRec, and then conduct MedRec for all identified clients/visits across all locations.

- A ‘service’ for ambulatory care includes all clinics and ambulatory care services across all locations that use the Ambulatory Care Services, Ambulatory Systemic Cancer Therapy Services, or Aboriginal Integrated Primary Care Services standards. The ambulatory care version of MedRec allows for targeting, so to implement MedRec in this service an organization should consider all its services, identify clients/visits that require MedRec, and then conduct MedRec for all identified clients/visits across all locations.
9. What resources are available to help?
Accreditation Canada will post a webcast in mid-February about MedRec. It will be available in the client organization and surveyor portals.

Safer Healthcare Now! (www.saferhealthcarenow.ca)
- National Calls are monthly presentations on important patient safety topics, including MedRec. Calls are recorded and archived on the website. Presentations are available in in English and French.

Institute for Safe Medication Practices – Canada (www.ismp-canada.org/medrec)
- A section of the website is dedicated to MedRec, which includes reports, education, and webinars on MedRec. Most materials are available in English and French.
- The Cross Country MedRec Check-Up, which highlights leaders from across the country. Available in English only.

Agency for Health Research and Quality (AHRQ) (www.ahrq.gov)
The Medications at Transitions and Clinical Handoffs (MATCH) Toolkit incorporates the experiences and lessons learned by health care facilities that have implemented the MATCH strategies to improve their medication reconciliation processes. Available in English only.

Acute Care and Long-Term Care Questions

1. When is MedRec needed in acute care?
In acute care, MedRec is always required at admission and discharge, as per the tests for compliance.

Regarding other transitions, not all require MedRec. Complete transfer of client information, including client medications, is already addressed through the Information Transfer ROP.

MedRec is an additional step that is needed for care transitions where clients are at risk of medication errors. Typically these involve a change in medications and a change in the level of care (or responsible prescriber) – such as return from post op, or, from ICU to medicine. Because organizations have different ways of organizing services and defining transitions, Accreditation Canada is unable to apply a universal definition for transitions that require MedRec.

We encourage organizations to take a look at their organization, identify transitions where medication discrepancies or adverse drug events are likely (or have) occurred.
2. When is MedRec needed in long-term care?
Care transitions look different in long-term care than in acute care. Transitions where the MedRec process is needed include admission, re-admission from another service environment, and transfer out/discharge to another service environment. MedRec is almost *never* needed for internal transfers within a long-term care facility (e.g. transfer to an Alzheimer’s unit), since the medication list follows the resident and their prescriber does not usually change.

3. Is a BPMH the same as a primary medications list?
No. A BPMH is a complete list of all medications (prescribed and not prescribed) that a client is taking at home. A BPMH is more comprehensive because it also includes:

- Home medications, including over the counter, vitamins, supplements, traditional medicines, etc.
- The source(s) of medication information (people consulted)
- Actual medication use (not just as prescribed)

4. Does the medication administration record (MAR) qualify as a ‘complete list of medications’?
Probably not, as the MAR is simply a record of current medications. A complete list of medications includes:

- All current medications the client is taking (i.e., the MAR), AND
- Medications that are actively prescribed (e.g. on a cyclical basis such as once monthly vitamin B12 injections or once monthly osteoporosis meds), AND
- All prn/as needed medications that have been ordered with information on the frequency of their use (e.g. from a prn MAR).

5. In long-term care, what happens to the BPMH after admission?
Once generated the BPMH is used to create (or reconcile) admission orders. Once any discrepancies are resolved, the admission orders become the complete and accurate list of resident medications. This complete list of resident medications is then used for MedRec upon re-admission, transfer-out, and discharge.

6. What about clients who have been receiving care for an extended period of time?
In the MedRec at Care Transitions guidelines we indicate that ‘*when a client has been receiving care in a service environment for an extended period of time and is being transferred to another organization or service, the current medications list may be used as a BPMH*’.

- This option is provided because the BPMH (home meds in particular) becomes less relevant (and difficult to obtain) with extended lengths of stay (in that the hospital is their ‘home’).
- By extended period of time we are referring to ALC and other extended length of stay (eLOS) clients. The client has been there long enough that the only medications they are taking at this point are on the organizations list. Organizations need to discuss and decide what is appropriate for them and document its rationale.
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- For organizations transferring or admitting eLOS clients to/from another facility, the current meds list can be the BPMH, once again depending on whether the length of time is sufficient that they have not inadvertently “dropped” something that was being taken at home.

It is important the organizations recognize that using a current meds list as a BPMH for eLOS clients makes an important assumption: that quality MedRec has occurred at admission. If the organization does not completed a quality MedRec process at admission, it is possible the current med list is still reconciled, leaving the patient at ongoing risk of, for example, medication omissions as they transition.

Ambulatory Care and Home Care Questions

1. When is MedRec needed in ambulatory settings?
In ambulatory care, the need for and frequency of MedRec varies depending on the client population. Organizations can use a risk assessment approach to identify clients at risk of medication errors, identify which clients need MedRec and establish the appropriate frequency.

2. When is MedRec needed in home and community-based care settings?
MedRec in home and community-based care looks different than in inpatient and clinic settings. Rather than trying to reconcile medication orders, MedRec in home and community-based settings focuses on determining the client’s medication regimen and making sure that the client has a complete list of all their medications that they share with other health care providers. Organizations can use a risk assessment approach to identify clients at risk of medication errors, and identify clients who need MedRec.

3. How do we identify clients at risk of potential adverse drug events?
Talk to your front-line – they will often have great insight on clients to target, clients who will benefit, and what is likely to succeed.

Look at outcomes – are their clients or clinics where adverse drug events are high and would benefit from MedRec?

Look at risk factors – consider those outlined in the guidelines.

Look for success - if outcomes and risk factors do not indicate an obvious target, consider implementing MedRec where the chances for success are high. This will help build momentum and goodwill.

You can identify a particular type of client or a type of visit, whichever makes sense for your organization. When you identify a target group (e.g. a type of client or type of clinic), all members of the target group should receive MedRec at admission at all locations.

4. Are ambulatory or home care teams responsible for resolving medication discrepancies?
Whenever possible, teams should resolve identified discrepancies in order to protect clients from adverse drug events. Resolving discrepancies is not about determining the appropriateness of medications. Rather, resolving discrepancies is about comparing what the client is prescribed with what they are actually taking.
Teams should first work with the client to resolve medication discrepancies. For example, a client may be taking a medication once daily, not realizing it was prescribed twice daily – the team can resolve this discrepancy. Other discrepancies may require consultation with a prescriber within or outside of the team. If medications can’t be resolved by the team, then the team should communicate discrepancies to the most responsible prescriber and document any actions taken. Teams should also monitor whether discrepancies are resolved (such as at the next visit). It is important to demonstrate that the team is actively working to resolve discrepancies and not simply passing on the responsibility to someone else.

5. We employ support workers, what is their role in MedRec?
Medication management is beyond the scope of practice for support workers, although they may assist with medications. For example, support workers may remind clients to take their medication, or provide clients with a pre-dispensed tray of medications and observe them take them. In these cases, their role in MedRec is very limited – if they observe discrepancies (e.g., a client is not taking medications as prescribed) then they should share this information with a member of their team who has a role in medication management.

Organizations should consider the risk of ‘duty creep’ (where support workers are asked to work outside of their scope) – including risks to clients and workers - when assigning medication management tasks. For example, support workers who administer oral or rectal medications for clients with physical disabilities: the client is primarily responsible for taking their medications, but needs the support worker to open the container and administer the correct amount of medication. What if a support worker gave an incorrect dose of medication at the direction of the client and the client suffered an adverse drug event? What are the consequences for the worker who gave the drug?
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### Appendix A: MedRec ROPs in Qmentum Standards

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