Team Name: Pharmacy and Therapeutics Team Lead: Director - Pharmacy Approved by: Regional Lead - Medical Services & Chief Medical Office	Reference Number: CLI.6010.PL.009 Program Area: Pharmacy and Therapeutics Policy Section: General
Issue Date: December 11 2014 Review Date: January 24 2019 Revision Date: August 31 2023	Subject: Medication Reconciliation

Use of pre-printed documents: Users are to refer to the electronic version of this document located on the Southern Health-Santé Sud Health Provider Site to ensure the most current document is consulted.

POLICY SUBJECT:
Medication Reconciliation

PURPOSE:
The purpose of this policy is to provide guidance for the medication reconciliation process at care transitions.

BOARD POLICY REFERENCE:
Executive Limitation (EL-2) Treatment of Clients

POLICY:
Medication reconciliation is a process designed to prevent medication errors at client/ transition points. In Southern Health-Santé Sud medication reconciliation will be conducted on key transitions in care. The transitions are grouped as follows:

Admission Reconciliation (Best Possible Medication History – BPMH):

- Transition from home to an acute care facility
- Transition from home to Personal Care Home (PCH)
- Transition from PCH to another PCH site
- Transition from an acute care facility to another acute care facility
- Transition from PCH to an acute care facility

End of Service Reconciliation (Discharge Medication Plan):

- Transition from an acute care facility to home
- Transition from an acute care facility to PCH
- Transition from PCH to home

Transfer Reconciliation:

- Transition from one unit of an acute care facility into another unit of the same facility (Regional Centres only)

Home Care:

- Medication reconciliation will be conducted on admission and resumption of care for clients in homecare where medication management is a component of the client's care or based on clinical assessment.

Obstetrical Care:

- Medication reconciliation will be conducted on admission and discharge where medication management is a component of the client's care or based on clinical assessment.

DVT/VTE Prophylaxis:

- Follow the Venous Thromboembolism Prophylaxis Guideline CLI.4510.SG.001
- Check the appropriate treatment box
- Review with patient "Clot Prevention" Teaching sheet
- Re-evaluate the need for prophylaxis following transfer/discharge

The procedure for medication reconciliation at these transition points are described in the following "Procedure" section and summarized in the Medication Reconciliation: Quick Reference Guide CLI.6010.PL.009.SD.01

At this time, procedures for medication reconciliation are not implemented in ambulatory care areas of the region or for patients in our Emergency Departments who are not being admitted. The prescriber at his or her discretion can either conduct or direct another qualified health care practitioner to conduct a Best Possible Medication History (BPMH) on ambulatory care clients or patients in our Emergency Departments who are not being admitted.

DEFINITIONS:

Medication reconciliation: An interdisciplinary process intended to enhance client safety by decreasing the risk of adverse drug events. Medication reconciliation is a structured, shared process whereby healthcare professionals:

- Work with the client, family, and caregivers (as appropriate), and at least one other source of information, to generate a BPMH. A BPMH is a list of all current medications (including prescription, non-prescription, traditional, holistic, herbal, vitamins, and supplements) that the client is taking prior to seeking care.
- Identify and resolve differences (discrepancies) between the BPMH and medications ordered at transition points.
- Document and communicate up-to-date information about client medications to the client and their next service provider, as appropriate.

Best Possible Medication History (BPMH): A list of all medications (all prescriptions, over the counter (OTC), as needed, herbs/vitamins/alternative therapies, inhalers, eye/ear drops, nasal mists, injections, patches, cream/ointments) the client is currently taking, even though it may be different from what was actually prescribed. The BPMH captures the name, dose, frequency, and

route of administration for each medication. Creating the BPMH involves interviewing the client, family, or caregivers (as appropriate), and consulting at least one other source of information such as the client's previous health record, the community pharmacist, or a provincial database.

End of Service (Discharge Medication Plan): A critical transition of care that puts clients at risk of potential adverse drug events. End of service includes discharge home, and external transfer to another service environment or community-based service provider. Examples include a move from acute care to long-term care or hospice, from rehabilitation to home care, or from acute care to home/self-care. The goal of medication reconciliation at end of service is to reconcile the medications the client was taking prior to admission with those initiated in hospital and with those that should be taken at end of service.

Home: For the purposes of this policy, home refers to any environment where the person resides in a community setting, either independently or dependently.

Med Reconciliation Transfer Profile: BDM transfer report which replaces the Transfer Reconciliation & Order Form attached example (CLI.6010.PL.009.SD.02).

Medication Reconciliation and Discharge Order Form: BDM discharge report which replaces Discharge Medication Plan and Prescription attached example (CLI.6010.PL.009.SD.03).

Med Rec Addendum – Therapeutic Substitution Form: This is an order form completed by pharmacists when: clarifying medications with the prescriber in reference to the list of medications written on the "Best Possible Medication History and Admission Reconciliation and Order Form" substituting a medication that is non-formulary as per the Autosubstitution policy.

Transfer: Any transition of care when medications are changed or re-ordered, including internal transfers involving a change in the level of care (e.g. from critical care to a medicine unit). Transfer is not required for bed relocation. Similar to admission, the goal of medication reconciliation at transfer is to compare the medications the client was receiving on the transferring/sending unit with those that were being taken at home to determine if any medications need to be continued, restarted, discontinued, or modified.

PROCEDURE:

Admission Reconciliation: (BPMH)

Transition from home to an acute care facility

- The most appropriate qualified healthcare professional (HCP), a nurse, pharmacist or prescriber, within the facility will obtain the BPMH on all clients admitted to care. The most appropriate HCP will be determined within the site and may vary between sites and within a site depending on availability.
- The HCP will document the medications identified onto the BPMH and Admission Reconciliation & Order Form.
- The HCP will utilize, at minimum the DPIN/e-Chart medication list along with consultation with the client or caregiver in the generation of the BPMH. It is

important to capture and confirm what, when, and how the client takes their medications. Other available resources should be explored as required (e.g. bottles/blister packs, caregiver, transfer chart, clinic records, etc).

- Complete the section "Compliance and Assessment of Education Needs" which helps to elicit this information to provide an educational opportunity.
- If the client is not on medications at home, check the box indicating, "Takes No Medications".
- After the BPMH and Admission Reconciliation & Order Form is completed, the HCP will sign and date the form including time of completion.
- Prescriber reviews the BPMH and Admission Reconciliation & Order Form and makes a conscious decision to "Continue", "Change", or "Do Not Order" each medication listed and document this by checking the appropriate box on the form.
- The prescriber must document what the change is and the rationale for all changes to the BPMH list. This is completed in the "Change to Medication Taken Prior to Admission and Reason" column.
- After completion the prescriber will sign and date the form including time of completion. The BPMH and Admission Reconciliation & Order Form then becomes the admission orders for the client. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the *"Physician/Prescriber Orders"* form.
- Fax/Scan the BPMH and Admission Reconciliation & Order Form to pharmacy following standard facility processes.
- Process and transcribe medications ordered onto the *Medication Administration Record* (MAR).

<u>Med Rec Addendum – Therapeutic Substitution Form</u>

Pharmacists:

- List all new medication information obtained about prescription and over-the-counter (OTC) medications taken prior toadmission including dose, route, and frequency in the left-hand column labeled "Clarification of Medications prior toAdmission"2.Use a second form if there is insufficient space and indicate the page number in the bottom right hand corner.3.Check all applicable boxes in the section labeled "Information Source"4.Review each new medication with the physician and check off the appropriate box
- Check off "Continue" if the medication is to be continued according to new information obtained. The previous order forthat medication is therefore discontinued.b.Check off "Change" if the new medication instructions (dose/route/frequency) is to be changed. Write the new order in the"Prescriber's changed orders" section.5.Check off "Do not order/Discontinue" if the medication clarified with the prescriber is NOT to be ordered or if the previouslyordered medication is to be discontinued.6.Document the reason for clarification of the medication taken prior to admission by checking off the appropriate box("omission" of the medication, different "dose/frequency", patient is "no longer taking" the medication or "other" withreason). Provide any other comments as appropriate (For

example: Indicate reason for not changing the previousmedication order based on new medication information)7.Indicate the prescriber's name with whom the orders were clarified with "Orders clarified with".8.Sign/print your name and record the date and time.9.Make a copy of the completed form for pharmacy records.10.Send the completed form to the unit for processing and inclusion in the patient's chart.

Nurses/Unit Clerks:

- Transcribe ONLY orders that are checked in the box marked "continue" and discontinue any corresponding orders for thespecified medication.12.Discontinue the medication from the Medication Administration record if the medication (same dose/route/frequency) ischecked off as "Do not order/Discontinue".13.Transcribe all medication orders written in the "Prescriber's changed orders" section.14.In the " Automatic Therapeutic substitution" section, discontinue the medication indicated and transcribe the new "Changeto" medication order.15.As per established procedures complete the transcription/verification section of the form.16.File the completed form in the Orders section of the chart in reverse chronological order.

Prescriber:

- Review and co-sign the order form within 24 hours from the time that the medication order was taken by a pharmacist.

<u>Transition from home to PCH</u>

- The most appropriate qualified HCP, a nurse, pharmacist or prescriber, servicing the facility will obtain the BPMH on all clients admitted to care. The most appropriate HCP will be determined within the site and may vary between sites and within a site depending on availability.
- The HCP will document the medications identified onto the BPMH and Admission Reconciliation & Order Form.
- The HCP will utilize appropriate resources in generation of the BPMH. It is important to capture and confirm what, when, and how the client takes their medications. Appropriate resources could include the DPIN/e-Chart medication list, consultation with the client or caregiver, bottles/blister packs, clinic record, etc.
- After the BPMH and Admission Reconciliation & Order Form is completed, the HCP will sign and date the form including time of completion.
- Prescriber reviews the BPMH and Admission Reconciliation & Order Form and makes a conscious decision to "Continue", "Change", or "Do Not Order" each medication listed and documents by checking the appropriate box on the form.
- The prescriber must document what the change is and the rationale for all changes to the BPMH list. This is completed in the "Change to Medication Taken Prior to Admission and Reason" column.
- After completion the prescriber will sign and date the form including time of completion. The BPMH and Admission Reconciliation & Order Form then becomes the admission orders for the client. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the "Physician/Prescriber Orders" form.

- Fax the BPMH and Admission Reconciliation & Order Form to the pharmacy responsible for servicing the PCH facility at least 2 business days in advance of the client being transitioned.

Transition from PCH to another PCH site

- The sending PCH will provide a copy of the most recent MAR to the receiving PCH. This should be sent at least 2 business days in advance of the client being transitioned. Order changes occurring in the interval after the MAR is sent will have to be communicated to the receiving PCH.
- The receiving PCH will utilize the most recent MAR to complete the BPMH and Admission Reconciliation & Order Form.
- After the BPMH and Admission Reconciliation & Order Form is completed, the HCP will sign and date the form including time of completion.
- Prescriber reviews the BPMH and Admission Reconciliation & Order Form and makes a conscious decision to "Continue", "Change", or "Do Not Order" each medication listed and documents by checking the appropriate box on the form.
- The prescriber must document what the change is and the rationale for all changes to the BPMH list. This is completed in the "Change to Medication Taken Prior to Admission and Reason" column.
- After completion the prescriber will sign and date the form including time of completion. The BPMH and Admission Reconciliation & Order Form then becomes the admission orders for the client. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the "Physician/Prescriber Orders" form.
- Fax the BPMH and Admission Reconciliation & Order Form to the pharmacy responsible for servicing the PCH facility at least 2 business days in advance of the client being transitioned.

Transition from an acute care facility to another acute care facility

- The sending acute care facility will provide the following:
    - Inter-facility Transport Checklist (if applicable)
    - A copy of the original BPMH and Admission Reconciliation & Order Form
    - A copy of the most current MAR
- The receiving acute care facility will utilize the information provided by the sending facility and complete the BPMH and Admission Reconciliation & Order Form.
- After the BPMH and Admission Reconciliation & Order Form is completed, the HCP will sign and date the form including time of completion.
- Prescriber reviews the BPMH and Admission Reconciliation & Order Form and makes a conscious decision to "Continue", "Change", or "Do Not Order" each medication listed and document this by checking the appropriate box on the form.
- The prescriber must document what the change is and the rationale for all changes to the BPMH list. This is completed in the "Change to Medication Taken Prior to Admission and Reason" column.

- After completion the prescriber will sign and date the form including time of completion. The BPMH and Admission Reconciliation & Order Form then becomes the admission orders for the client. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the *"Physician/Prescriber Orders"* form.
- Fax/Scan the BPMH and Admission Reconciliation & Order Form to pharmacy following standard facility processes.
- Process and transcribe medications ordered onto the *Medication Administration Record* (MAR).

Transition from PCH to an acute care facility*

- The sending PCH facility will provide the following:
    - A copy of the most current MAR
- The receiving acute care facility will utilize the information provided by the sending facility and complete the BPMH and Admission Reconciliation & Order Form.
- After the BPMH and Admission Reconciliation & Order Form is completed, the HCP will sign and date the form including time of completion.
- Prescriber reviews the BPMH and Admission Reconciliation & Order Form and makes a conscious decision to "Continue", "Change", or "Do Not Order" each medication listed and document this by checking the appropriate box on the form.
- The prescriber must document what the change is and the rationale for all changes to the BPMH list. This is completed in the "Change to Medication Taken Prior to Admission and Reason" column.
- After completion the prescriber will sign and date the form including time of completion. The BPMH and Admission Reconciliation & Order Form then becomes the admission orders for the client. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the *"Physician/Prescriber Orders"* form.
- Fax/Scan the BPMH and Admission Reconciliation & Order Form to pharmacy following standard facility processes.
- Process and transcribe medications ordered onto the *Medication Administration Record* (MAR).

*Note: Transition from a PCH to an acute care facility that involves a routine procedure, assessment in the emergency room, or a short stay that does not result in admission to the acute care facility will not require the generation of a BPMH and Admission Reconciliation & Order Form at the acute care facility or a "Discharge Medication Plan and Prescription" when they return to the PCH.

End of Service Reconciliation: (Discharge Medication Reconciliation)

Transition from an acute care facility to home

- The most appropriate qualified HCP, a nurse, pharmacist or prescriber, within the facility will prepare the discharge medication list using the following resources:
    - BPMH and Admission Reconciliation & Order Form
    - The current MAR

- New medications to be started upon discharge

- All scheduled and routinely used PRN medications should be recorded onto the "Discharge Medication Plan and Prescription" under the appropriate headings provided.
- The "Discharge Medication Plan and Prescription" is to be reviewed by the prescriber (if he/she did not initially create the list). All changes require a rationale in the comment section of the form including new medications to be started upon discharge and those that have been discontinued. The unchanged medications that were listed from the original BPMH do not require a rationale.
- Once reviewed the prescriber is to sign the "Discharge Medication Plan and Prescription".
- Any drugs listed on the "Discharge Medication Plan and Prescription" that require a triplicate prescription as per the Manitoba Prescribing Practices Program (M3P) will require a separate prescription. For a list of drugs that require a triplicate prescription, refer to the College of Pharmacists of Manitoba website or click: List of Drugs Covered by the Manitoba Prescribing Practices Program (M3P)
- The nurse will complete and sign the facility specific Discharge Instructions/Plan form and confirm reconciliation on the "Discharge Medication Plan and Prescription."
- Once signed the yellow copy remains on the chart.
- White copy (original) can either be:
  - Given to the client as a final prescription **OR**
  - Faxed to a pharmacy of their choice. If the copy is faxed, the original should be stamped as faxed, dated and retained in the chart.
  - The pink copy is to be stamped "Physician Copy" and is forwarded to the primary care provider by Health Information Services. Where there is no primary care provider recorded within the chart, the pink copy will remain in the chart.
  - A photocopy of the "Discharge Medication Plan and Prescription" shall be forwarded to Homecare, Palliative Care &/or other applicable services if the patient is under an applicable program.
  - Education provided to the client upon discharge will include but not be limited to the following:
    - Review the "Discharge Instructions/Plan form."
    - Educate client on the importance of carrying a current list of medications with them at all times.

Transition from an acute care facility to home when using BDM's Medication Reconciliation and Discharge Order Form:

- The most appropriate HCP, a nurse, or prescriber; or the most appropriate administrative personnel, a unit assistant or ward clerk; will notify the pharmacy of a request for a Medication Reconciliation and Discharge Order
- Pharmacist or delegated pharmacy staff member will access Patient Profile Reports in BDM and create the report titled SH-SS Discharge Med Rec Report for the requested patient visit and print or fax the generated report to the appropriate unit

- The most appropriate qualified HCP, a nurse, pharmacist or prescriber, within the facility will verify the "Medication Reconciliation and Discharge Order Form" provided by pharmacy using the current MAR (ensure no additional or omitted medication orders) by communicating back to pharmacy the missing orders, updating the profile and reprinting the report OR changes written on the form
- The "Medication Reconciliation and Discharge Order Form" is to be reviewed by the prescriber while referring to the "BPMH and Admission Reconciliation & Order Form" All medications changed since admission require a rationale in the comment section of the form. The unchanged medications that were listed from the original BPMH do not require a rationale. New medications or changes made at the time of discharge as well as documentation whether to restart or discontinue pre-admission medications not ordered in hospital should be included on the last page of the "Medication Reconciliation and Discharge Order Form"
- Once reviewed the prescriber is to sign each page of the "Medication Reconciliation and Discharge Order Form".
- Any drugs listed on the "Medication Reconciliation and Discharge Order Form" that require a triplicate prescription as per the Manitoba Prescribing Practices Program (M3P) will require a separate prescription. For a list of drugs that require a triplicate prescription, refer to the College of Pharmacists of Manitoba website or click: List of Drugs Covered by the Manitoba Prescribing Practices Program (M3P)
- The nurse will complete and sign the facility specific Discharge Instructions/Plan form and confirm reconciliation on the "Medication Reconciliation and Discharge Order Form"
- Once signed a copy of the form should be made and marked as a "Physician Copy" to be forwarded to the primary care provider by Health Information Services, if no primary care provider is recorded within the chart this step is not required
- If the prescription is given to the client as the final prescription a copy must first be made to be retained in the chart.
- If the prescription is faxed to a pharmacy of the patient's choice, then the original should be stamped as faxed, dated and retained in the chart.
- A photocopy of the "Discharge Medication Plan and Prescription" shall be forwarded to Homecare, Palliative Care &/or other applicable services if the patient is under an applicable program.
- Education provided to the client upon discharge will include but not be limited to the following:
    - Review the "Discharge Instructions/Plan form."
    - Educate client on the importance of carrying a current list of medications with them at all times.

Transition from an acute care facility to PCH

- The following process shall be initiated before client leaves the acute care facility. The prescription is to be provided to the pharmacy at least 2 business days in advance of the client being transitioned. Order changes occurring in the interval after the prescription is sent will also have to be communicated to the pharmacy.

- The most appropriate qualified healthcare professional (HCP), a nurse, pharmacist or prescriber, within the sending acute care facility will prepare the medication list using the following resources
  - BPMH and Admission Reconciliation & Order Form
  - The current MAR
  - New medications to be started upon discharge
- All scheduled and routinely used PRN medications should be recorded onto the "Discharge Medication Plan and Prescription" under the appropriate headings provided.
- The "Discharge Medication Plan and Prescription" is to be reviewed by the prescriber (if he/she did not initially create the list).
- All changes require a rationale in the comment section of the form including new medications to be started upon discharge and those that have been discontinued. The unchanged medications that were listed from the original BPMH do not require a rationale.
- Once reviewed the acute care facility prescriber signs the "Discharge Medication Plan and Prescription" which then becomes the PCH admission orders for the client. A photocopy of the original signed order is to be sent to the receiving PCH with rest of the transition documentation.
- Once signed, the white copy (original) is provided to the pharmacy responsible for servicing the PCH facility the client is being sent to. If the normal procedure with the facility is to fax a copy to the pharmacy in advance to expedite filling, continue this practice.
- The yellow copy is to be stamped "Physician Copy" and is forwarded to the primary care provider by Health Information Services. Where there is no primary care provider within the chart, the yellow copy will remain in the chart.
- The pink copy remains on the chart.
- If the prescriber providing the PCH admission orders is not the prescriber responsible for the regular care of the client while in the PCH facility, the responsible PCH prescriber will review the orders at the earliest possible opportunity.
- Any order changes are to be written on the PCH's "Physician/Prescriber Orders" form.

<u>Transition from PCH to home</u>

- Patients leaving PCH to home are assumed to have a community based care provider (e.g. Homecare). The sending PCH will provide a copy of the most recent MAR to the community based care provider. This should be sent at least 2 business days in advance of the client being transitioned. Order changes occurring in the interval after the MAR is sent will have to be communicated to the community based care provider.
- The community based care provider will utilize the most recent MAR to determine if any pertinent changes have been made and will liaise with the primary care prescriber for new prescriptions if required.

Transfer Reconciliation:

Transition from one unit of an acute care facility into another unit of the same facility

- This procedure will be followed wherever the transfer medication orders for the new unit are being written (either the sending or receiving unit). Transfer reconciliation is required only in facilities that have more than one type of care unit (ex. Regional sites)
- The most appropriate HCP, a nurse, pharmacist or prescriber; or the most appropriate administrative personnel, a unit assistant or ward clerk; will transcribe the current MAR onto the "Transfer Reconciliation and Order Form".
- Prescriber reviews the "Transfer Reconciliation and Order Form" and makes a conscious decision to "Continue", "Change", or "Do Not Order" each medication listed and document this by checking the appropriate box on the form.
- The prescriber must document what the change is and the rationale for all changes to the transfer medication list. This is completed in the "Change to Transfer Medications and Reason" column.
- After completion the prescriber will sign and date the form including time of completion. The "Transfer Reconciliation and Order Form" then becomes the medication orders for the client. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the *"Physician/Prescriber Orders"* form.
- Fax/Scan the "Transfer Reconciliation and Order Form" to pharmacy following standard facility processes.
- Process and transcribe medications ordered onto the *Medication Administration Record* (MAR)

Transition from one unit of an acute care facility into another unit of the same facility (when available from pharmacy operating when using BDM's Med Reconciliation Transfer Profile

- The most appropriate HCP, a nurse, or prescriber; or the most appropriate administrative personnel, a unit assistant or ward clerk; will notify the pharmacy of a request for a Transfer Medication Reconciliation Report
- Pharmacist or delegated pharmacy staff member will access Patient Profile Reports in BDM and create the report titled SH-SS Transfer Med Rec Report for the requested patient visit and print or fax the generated report to the appropriate unit
- The most appropriate HCP, a nurse, a pharmacist, or prescriber will verify the generated report with the current MAR to identify any additional or omitted medication orders. If required, the missing orders should be communicated back to pharmacy who will update the profile and reprint the report or additional/missed medications can be included on a separate Transfer Reconciliation & Order Form
- Prescriber reviews the "Med Reconciliation Transfer Profile" and makes a decision to continue, "Yes", or "No" for each medication listed and documents this by circling the appropriate option on the form.
- The prescriber must document any changes to medication orders by crossing out the old order and rewriting any new medication orders on the Med Reconciliation Transfer Profile

- After completion the prescriber will sign and date the Med Reconciliation Transfer Profile form including time of completion. File the form in the Orders section of chart once the orders are processed.
- All further orders shall be written on the *"Physician/Prescriber Orders"* form.
- Fax/Scan the "Med Reconciliation Transfer Profile" to pharmacy following standard facility processes.
- Process and transcribe medications ordered onto the *Medication Administration Record* (MAR)

Home Care:

<u>On Initiation or Resumption of Home Care</u>

- The most appropriate qualified HCP, a nurse, pharmacist or prescriber, overseeing care of the home care client will obtain the BPMH on all clients admitted to care. The most appropriate HCP will be determined within the site and may vary between sites and within a site depending on availability.
- The HCP will utilize appropriate resources in generation of the BPMH. It is important to capture and confirm what, when, and how the client takes their medications. Appropriate resources could include the DPIN/e-Chart medication list, consultation with the client or caregiver, bottles/blister packs, clinic record, MAR from another facility, etc.
- The HCP will document the medications identified on the Home Care BPMH and Physician Confirmation Form.
- The completed form is sent to prescriber for verification except in the following circumstances:
    - If the client is starting or resuming homecare directly after a discharge from a hospital, the completed "Home Care BPMH and Physician Confirmation Form is compared with the "Discharge Medication Plan and Prescription". The Home Care BPMH and Physician Confirmation Form has to be sent to the prescriber for verification if there are differences between the two documents. If there are no differences, then the form does not have to be sent to the prescriber for verification, it should be filed in the clients chart.
    - If the client is starting or resuming homecare directly after a discharge from a PCH, the completed Home Care BPMH and Physician Confirmation Form is compared with the MAR provided by the PCH. The Home Care BPMH and Physician Confirmation Form has to be sent to the prescriber for verification if there are differences between the two documents. If there are no differences, then the form does not have to be sent to the prescriber for verification, it should be filed in the clients chart.
- Prescriber sends back form with any changes and new prescriptions as required.

Transition from Home Care to PCH

- The following process shall be initiated before client is admitted to PCH. The prescription is to be provided to the pharmacy at least 2 business days in advance of the client being transitioned. Order changes occurring in the interval after the prescription is sent will also have to be communicated to the pharmacy.
- The most appropriate qualified healthcare professional (HCP), a nurse, pharmacist or prescriber, overseeing care of the home care client will prepare the medication list using the following resources
  - Home Care BPMH and Physician Confirmation Form
- All scheduled and routinely used PRN medications should be recorded onto the "Discharge Medication Plan and Prescription" under the appropriate headings provided.
- The "Discharge Medication Plan and Prescription" is to be reviewed by the prescriber (if he/she did not initially create the list).
- All changes require a rationale in the comment section of the form including new medications to be started upon discharge and those that have been discontinued. The unchanged medications that were listed from the original BPMH do not require a rationale.
- Once reviewed the prescriber is to sign the "Discharge Medication Plan and Prescription" which then becomes the PCH admission orders for the client. A photocopy of the original signed order is to be sent to the receiving PCH with rest of the transition documentation.
- Once signed, the white copy (original) is provided to the pharmacy responsible for servicing the PCH facility the client is being sent to. If the normal procedure with the facility is to fax a copy to the pharmacy in advance to expedite filling, continue this practice.
- The yellow copy is to be stamped "Physician Copy" and is forwarded to the primary care provider by Health Information Services. Where there is no primary care provider within the chart, the yellow copy will remain in the chart.
- The pink copy remains on the chart.
- If the prescriber providing the PCH admission orders is not the prescriber responsible for the regular care of the client while in the PCH facility, the responsible PCH prescriber will review the orders at the earliest possible opportunity.
- Any order changes are to be written on the PCH's "Physician/Prescriber Orders" form.

2. Obstetrical Care:

- Follow the Admission Reconciliation: Transition from home to an acute care facility Procedure above utilizing the Obstetrical Best Posible Medication History (BPMH) and Reconciliation at Admission and Discharge Form CLI.6010.PL.009.FORM.05

3. ***Emergency Department (ED)****:*
   - An admission medication reconciliation will be conducted on any patient that is being admitted to the hospital from the ED, and any patient with a stay or anticipated stay in the emergency department of 8 hours or more.
   - For applicable sites, a column in the EDIS Status Board, titled BPMH STS, located between the Nurse and 1:1 columns, to identify and communicate when the BPMH is overdue, in progress or completed.
   - The BPMH STS column will allow healthcare providers to quickly identify patients that are in need of a BPMH. The BPMH STS column will be triggered by the LOS column to provide a visual alert to staff to complete the BPMH at the 8-hour mark (yellow cell) and again at the 24- hour mark (red cell). The user will manually select IP-In progress or Complete which will be visible for staff to see that the BPMH is initiated or completed or left blank with the color alert if not initiated.

4. ***Ambulatory Care Services (Dialysis unit and Cancer Care units):***
   The medication reconciliation process in the ambulatory care services, which include the dialysis units at Boundary Trails Health Centre (BTHC) and Portage District General Hospital (PDGH), and the Cancer Care units at BTHC, PDGH and Bethesda Regional Health Centre (BRHC) will follow the policies of Manitoba Renal Program and CancerCare Manitoba respectively.

SUPPORTING DOCUMENTS:

CLI.6010.PL.009.FORM.01	Best Possible Medication History (BPMH) and Admission Reconciliation & Order Form
CLI.6010.PL.009.FORM.02	Discharge Medication Plan and Prescription
CLI.6010.PL.009.FORM.03	Transfer Reconciliation & Order Form
CLI.6010.PL.009.FORM.04	Home Care Best Possible Medication History (BPMH) & Physician Confirmation Form
CLI.6010.PL.009.FORM.05	Obstetrical Best Posible Medication History (BPMH), and Reconciliation at Admission and Discharge
CLI.6010.PL.009.FORM.06	Addendum/Therapeutic Substitution Order from Pharmacy
CLI.6010.PL.009.SD.01	Medication Reconciliation: Quick Reference Guide
CLI.6010.PL.009.SD.02	Med Reconciliation Transfer Profile**:** BDM Form example
CLI.6010.PL.009.SD.03	Med Reconciliation and Discharge Order Form BDM example

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