Main Menu

Medication Reconciliation (MedRec) is an essential part of safe medication management and plays a key role in ensuring patient safety. This module presents basic information about the MedRec process.

This course includes:

- MedRec Basics
- Detailed MedRec Process

MedRec Basics

Introduction

This topic provides a general overview of the main principles of the MedRec process. The purpose and benefits of the process are also introduced.

This topic takes approximately **15 minutes** to complete.

Click **Next** to continue.

This topic includes the following content:

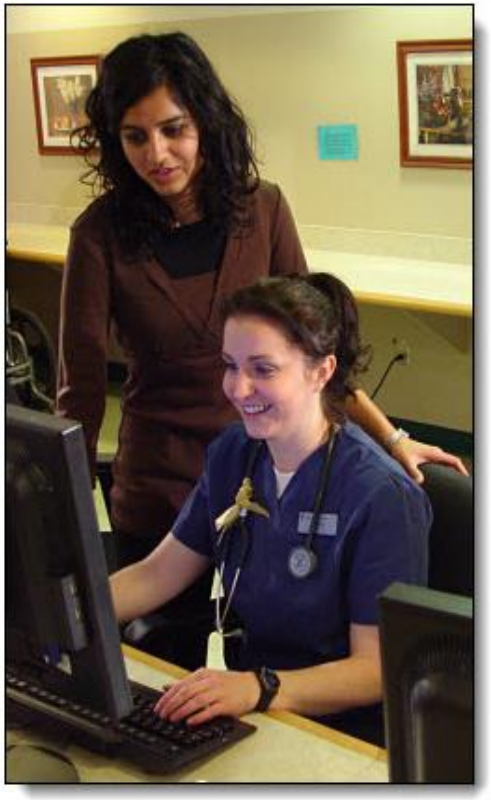
- Learning Objectives
- MedRec Overview
- The Benefits of MedRec
- MedRec Process
- Checkpoint 1
- Clinician Experiences
- Checkpoint 2
- Measuring Outcomes & Effectiveness
- Resources
- Wrap Up

MedRec Basics

Learning Objectives

Upon completion of this topic, you should be able to:

- state the rationale for performing MedRec
- recognize the three steps of the MedRec process
- list the transition points when MedRec should occur
- describe the measurement strategy involved for MedRec
- identify tools or organizations that are available as resources for MedRec
- identify who is involved in this collaborative process

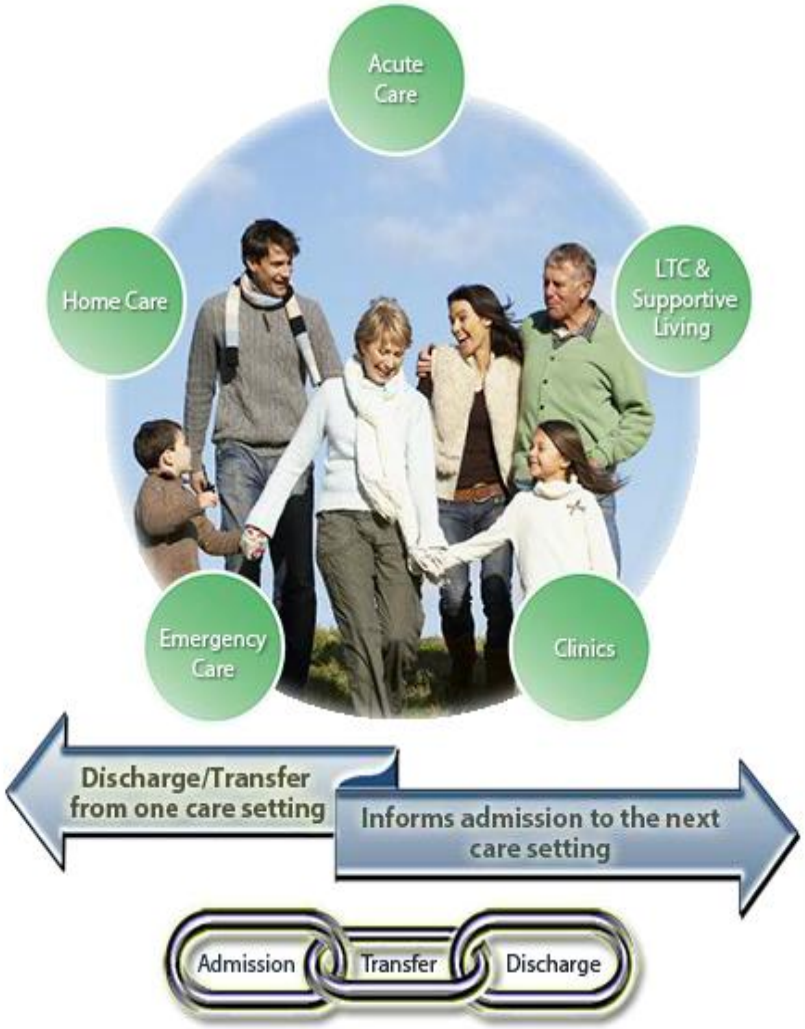


MedRec Basics

MedRec Overview

The MedRec process plays a significant role in optimizing patient health and safety by minimizing medication errors and adverse drug events.

MedRec is a patient-centered systematic process that is performed by an interdisciplinary team in collaboration with patients and families. The MedRec three step process results in accurate and complete medication information at all transitions in care.



MedRec Basics

The Benefits of MedRec

There are many reasons to do MedRec - a few reasons have been highlighted below. **Click the outer circle to view information that relates to you.**

MedRec Basics

The Benefits of MedRec

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Measurement

Baseline and ongoing audits will be done to ensure new MedRec processes and tools are consistent and effective in reducing medication errors and improving patient safety. Details of the auditing process will be available on the MedRec page on Insite (Insite can only be accessed within the AHS network).

MedRec Basics

The Benefits of MedRec

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Accreditation

MedRec is an Accreditation Canada Required Organizational Practice (ROP). The standards that sites will be surveyed on can be found in the ROP Handbook.

MedRec Basics

The Benefits of MedRec

There are many reasons to do MedRec - a few reasons have been highlighted below. **Click the outer circle to view information that relates to you.**

Organizations

Organizations, both nationally and internationally, recognize MedRec as a priority patient safety initiative and best practice. Examples include:

- WHO High 5s
- Safer Healthcare Now!

MedRec Basics

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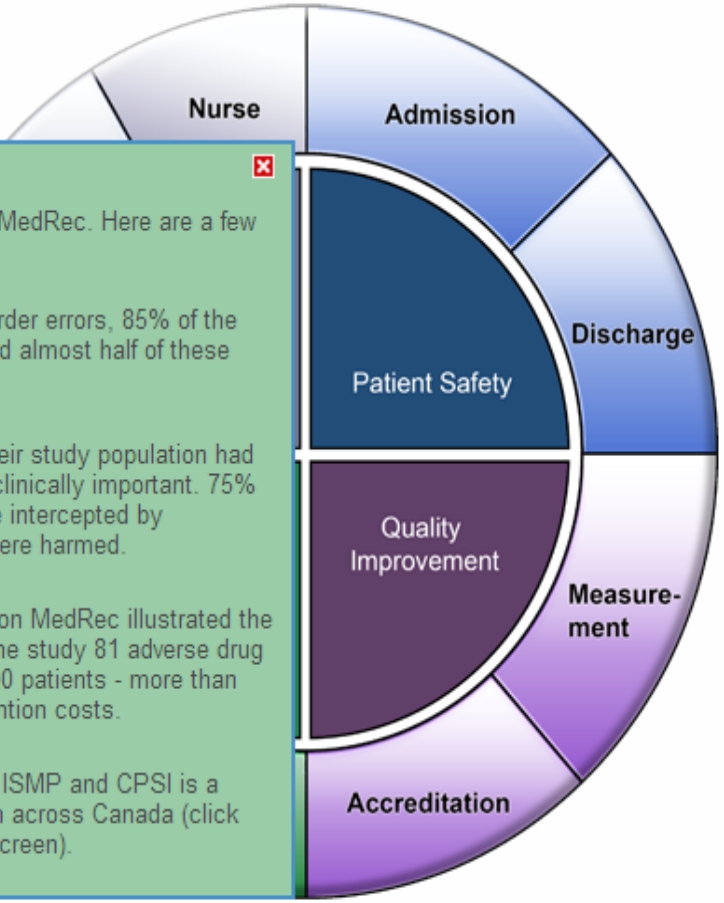

Research

There is a wealth of research on the merits of MedRec. Here are a few examples:

- A 2010 study found that for patients with order errors, 85% of the errors originated in medication histories and almost half of these were omissions.
- Research by Vira, et al. showed 60% of their study population had unintended variances, 18% of which were clinically important. 75% of these clinically important variances were intercepted by medication reconciliation before patients were harmed.
- A study of nurse-pharmacist collaboration on MedRec illustrated the cost effectiveness of the process. During the study 81 adverse drug events were potentially averted for every 290 patients - more than the 1 for every 290 needed to offset intervention costs.
- The National MedRec Check-Up Map from ISMP and CPSI is a great resource for finding MedRec research across Canada (click the *Research* button at the bottom of the screen).

MedRec Basics

The Benefits of MedRec

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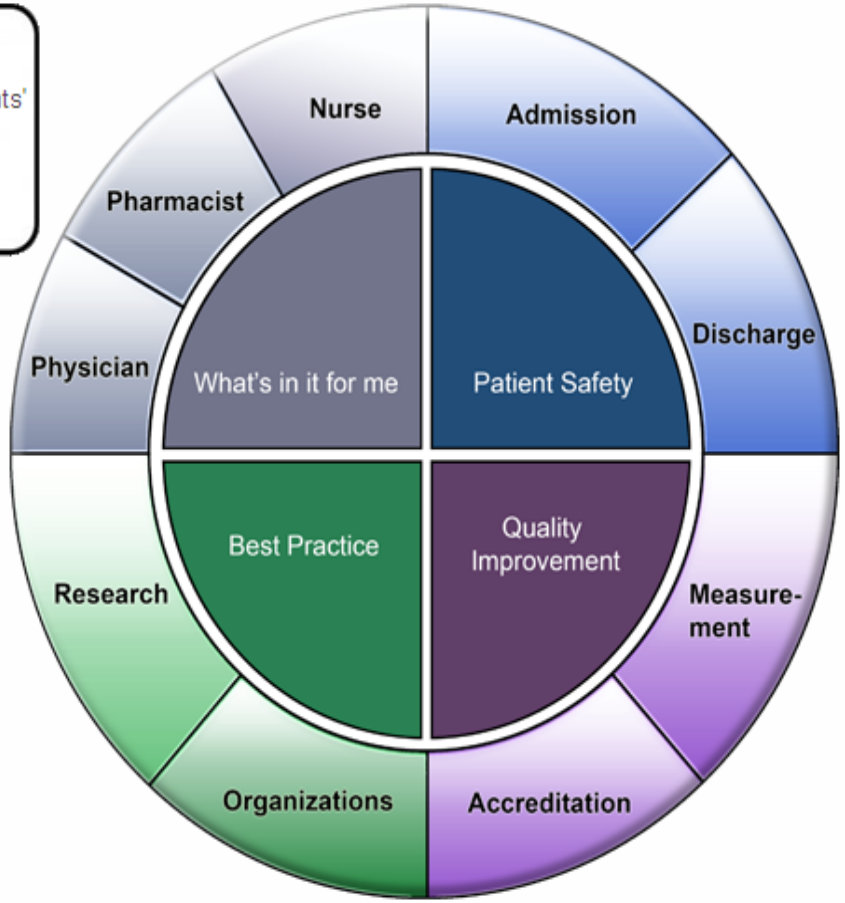
MedRec is a reliable and accessible source of patients' medication information that I can use when assuming care of a patient.



MedRec Basics

The Benefits of MedRec

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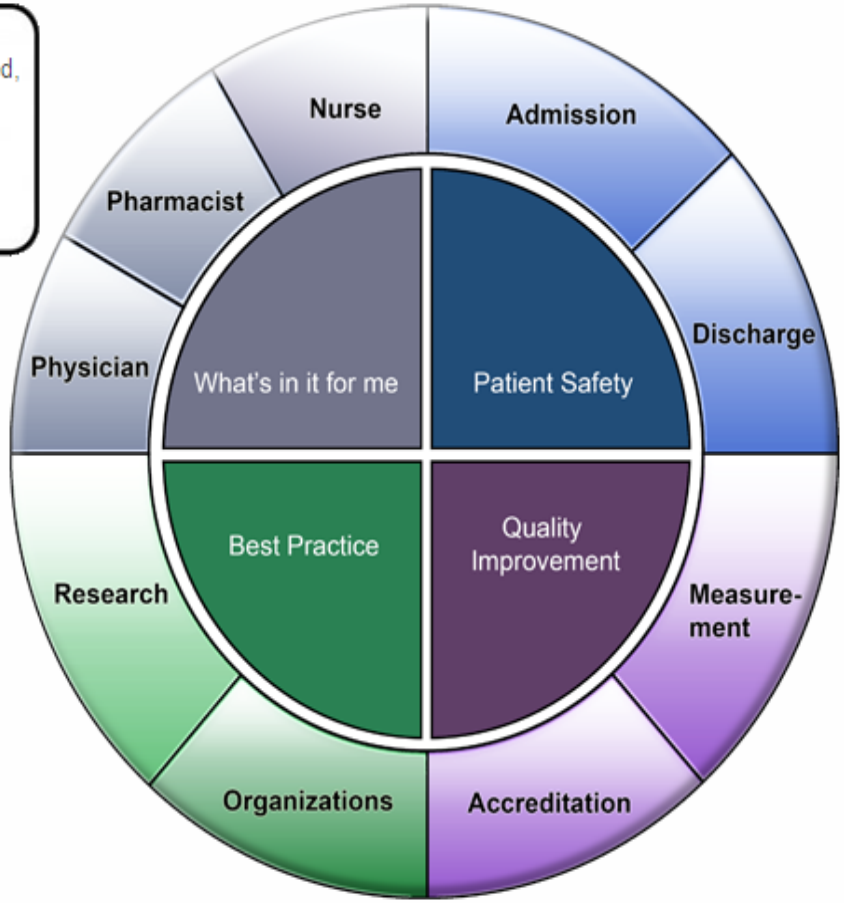
When MedRec is completed, as a pharmacist, I will have an accurate medication list for the patients across all sites over time.



MedRec Basics

The Benefits of MedRec

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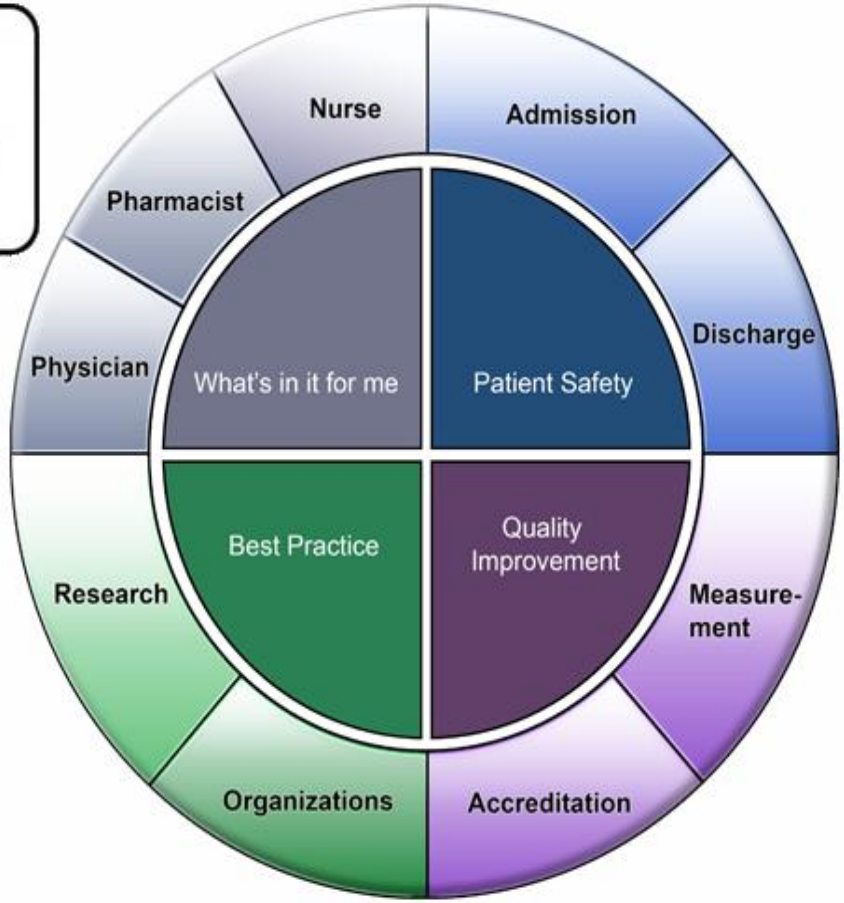
MedRec is a great tool to use when communicating with the patient and other members of the healthcare team.



MedRec Basics

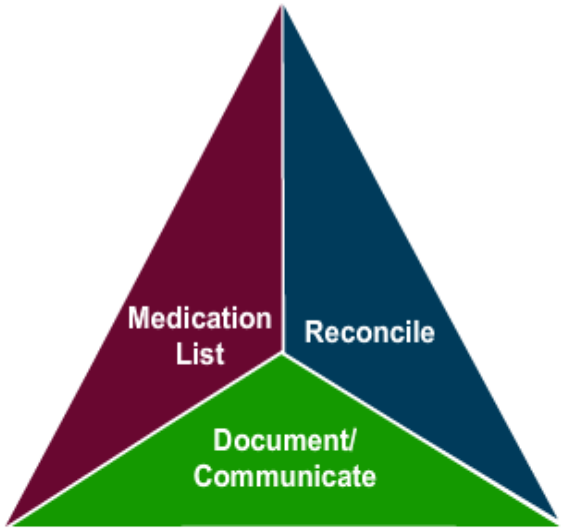
MedRec Process

This collaborative process includes participation with the patient and the interprofessional healthcare team.

MedRec is a three step process that is repeated at numerous transition points of care for all patients: create a medication list, reconcile the list to orders, and document and communicate differences and rationale.

Every care setting is unique in how their work flows; for example, community teams need to apply the MedRec process so it fits into their practice area.

Click the pyramid below to view details about the MedRec steps, then the audio buttons to hear more.



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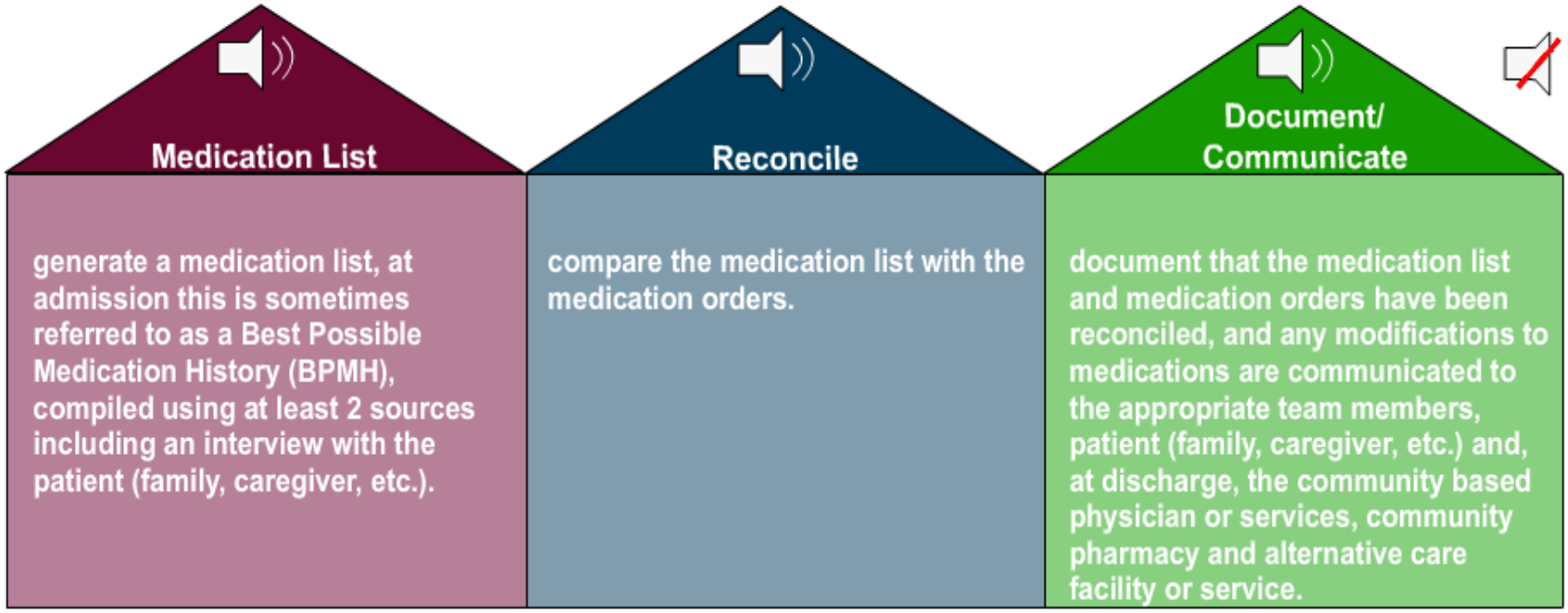

MedRec Basics

Checkpoint 1

This is an opportunity to check your understanding and recall of the information you have seen so far.

Click and drag each item and place it anywhere inside the correct bin.

Transfer

Emergency Care

Reconcile

Document/Communicate

Medication List

Discharge

Admission

Long-term Care & Supportive Living

Clinics

What are the MedRec Steps?	When would you perform MedRec?	What are some of the care settings that would benefit from MedRec?

MedRec Basics

Checkpoint 1

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What are the MedRec Steps?

- Reconcile
- Document/Communicate
- Medication List

When would you perform MedRec?

- Admission
- Transfer
- Discharge

What are some of the care settings that would benefit from MedRec?

- Emergency Care
- Clinics
- Long-term Care & Supportive Living

MedRec Basics

Clinician Experiences

As more clinicians use MedRec processes within their practice, they are able to share experiences that remind us why MedRec is important in patient safety.

Click the clinician below to hear his story.

Dr. Ronald Brisebois, MD, CD, shares a couple of stories about medication safety.

MedRec Basics

Checkpoint 2

There are several reasons why the MedRec process is important across the continuum of care.

Hover over each speaker's head and indicate if you agree or disagree with their statement regarding MedRec.

MedRec Basics

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Hover over each speaker's head and indicate if you agree or disagree with their statement regarding MedRec.

- ○ Agree?
- ○ Disagree?

Wow, MedRec really improves patient safety.

MedRec Basics

Checkpoint 2

There are several reasons why the MedRec process is important across the continuum of care.

Hover over each speaker's head and indicate if you agree or disagree with their statement regarding MedRec.

You're right! No matter how you look at it, MedRec improves outcomes by reducing medication errors.

- ○ Agree?
- ○ Disagree?

MedRec is going to increase my workload.

MedRec Basics

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Excellent! MedRec decreases workload by increasing staff efficiencies through fewer calls for clarification of med orders and less rework. It is NOT going to increase my workload.

Correct! MedRec will formalise and enhance your existing processes. It has been successfully implemented in all care settings.

You are right! MedRec is a great way to keep patients and providers informed about the patient's medications across all care settings.

- ○ Agree?
- ○ Disagree?

MedRec is a great communication tool.

MedRec Basics

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How did you get so smart? No matter the setting, patient, or care provider, MedRec is the ideal collaborative communication tool for current and accurate patient medication information.

MedRec Basics

Measuring Outcomes & Effectiveness

In order to support the success of MedRec, standardized measurement is vital to ensuring that new MedRec processes and tools are consistent and effective in reducing medication discrepancies and improving patient safety. The goals of the AHS Measurement Strategy are as follows:

1. **Process Measures:**
   - Percentage reconciled - goal: greater than 80% patients with MedRec completed on admission
   - MedRec Quality - goal: greater than 80% of the quality elements completed
2. **Outcome Measure:**
   - Percentage of patients with one or more outstanding discrepancies - goal: less than 10% of patients with one or more outstanding discrepancies

Hover over the image on the right to view various ways that we are all involved in evaluating MedRec.

MedRec Basics

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Discrepancy

A discrepancy is a difference between the medication list (e.g. BPMH) and the medication orders (e.g. admission orders).

MedRec Basics

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ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

Organization (Accreditation)

- Meet Accreditation Canada standards.
- Ensure AHS policy requirements are achieved and processes are monitored.

MedRec Basics

Measuring Outcomes & Effectiveness

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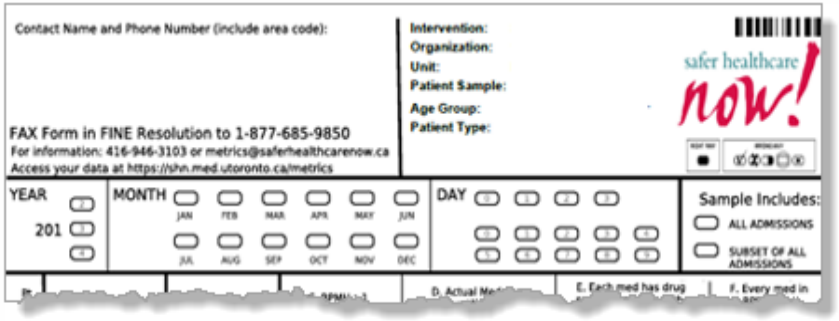

Team (Audits)

- Review unit-specific data to make changes to improve processes and reach goals.
- Conduct audits on a regular basis as outlined in the AHS Measurement Strategy.

MedRec Basics

Measuring Outcomes & Effectiveness

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Individual (RLS Forms)

- Enter near-misses or medication errors into the AHS Reporting and Learning System (RLS) for patient safety.

MedRec Basics

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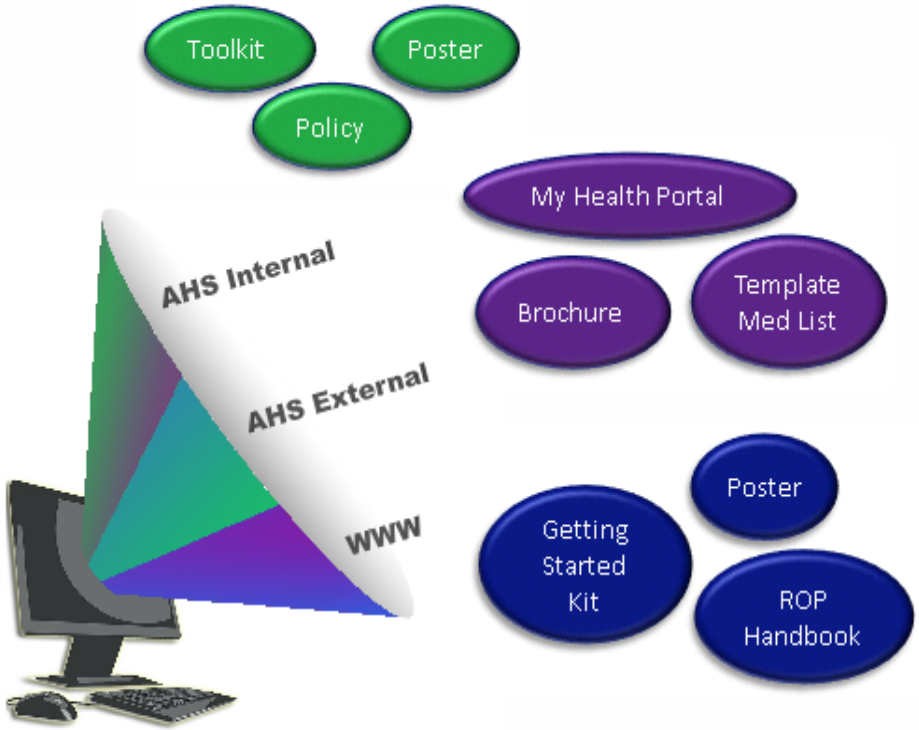

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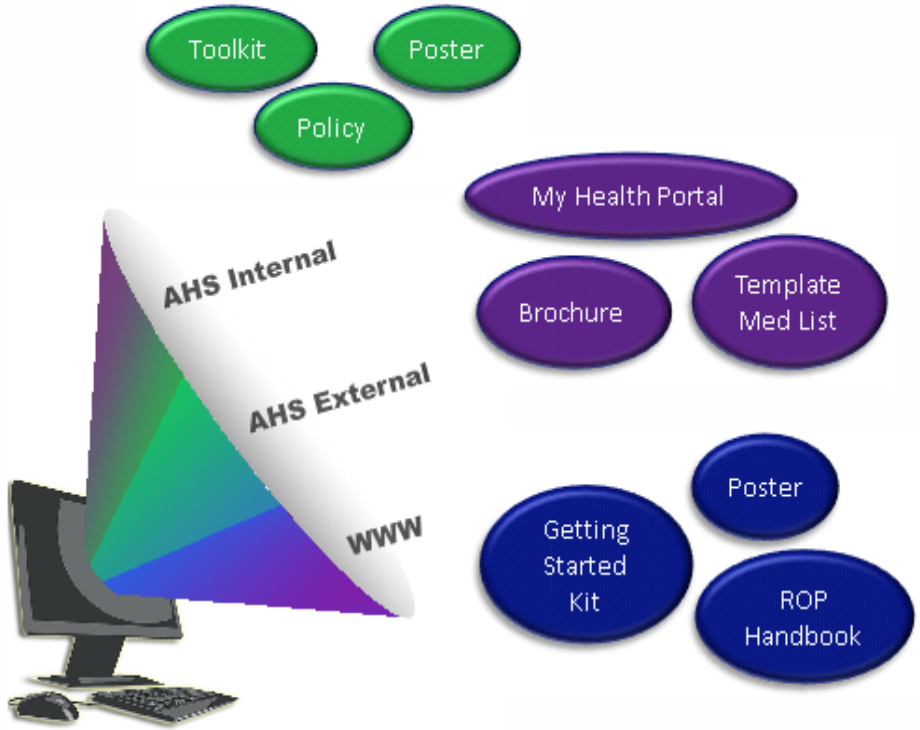

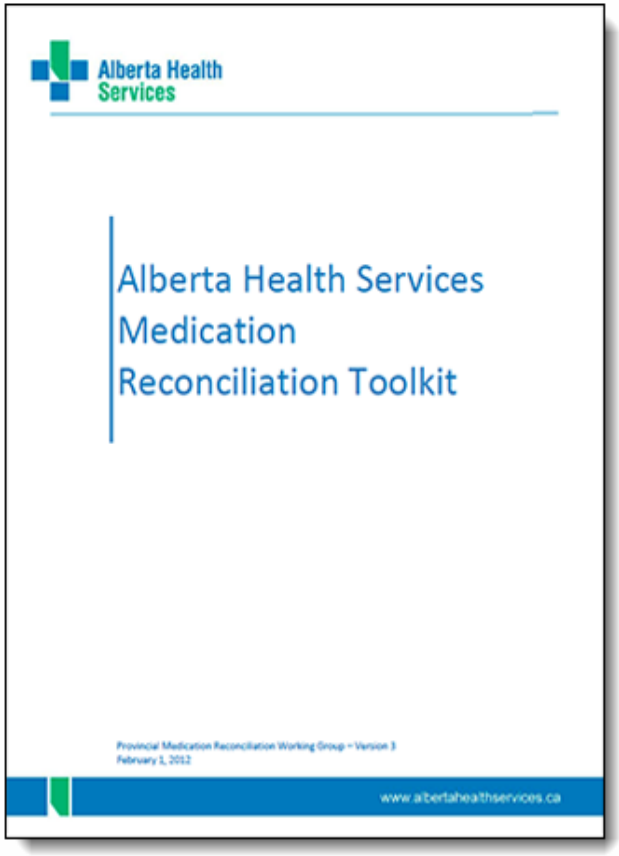

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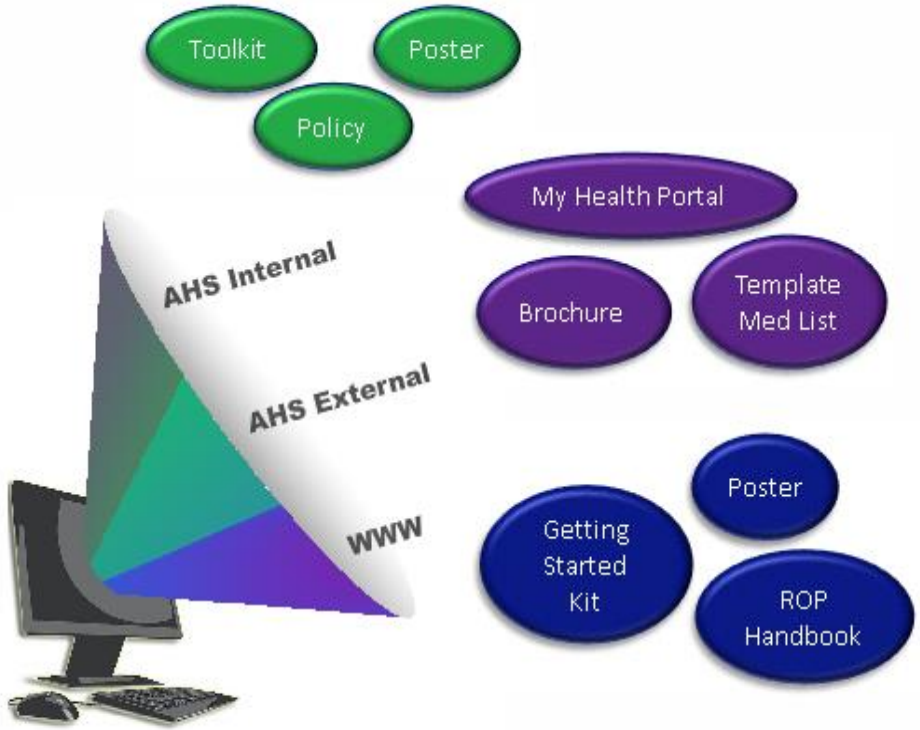

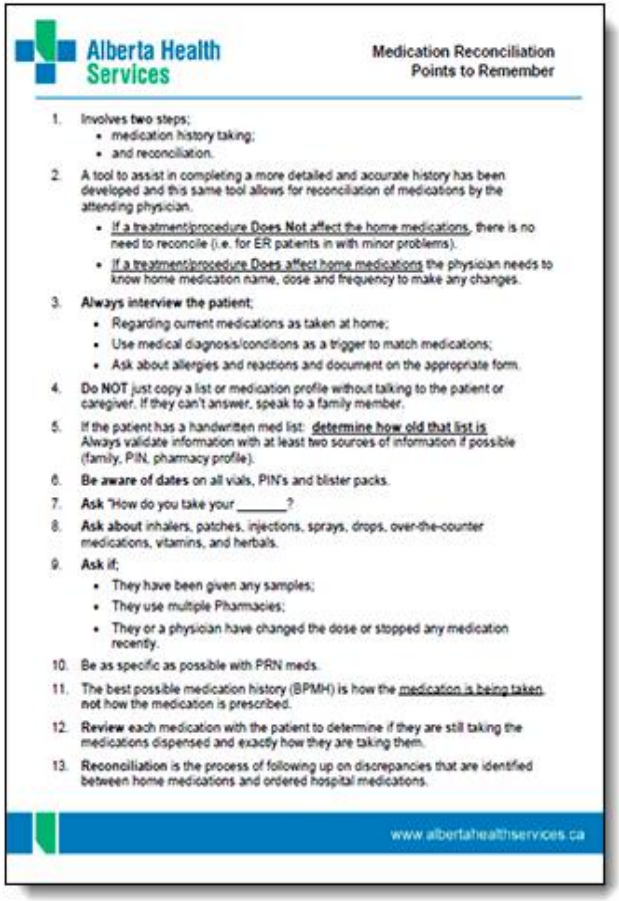

Alberta Health Services

Medication Reconciliation
Points to Remember

1. Involves **two steps**;
   - medication history taking;
   - and reconciliation.
2. A tool to assist in completing a more detailed and accurate history has been developed and this same tool allows for reconciliation of medications by the attending physician.
   - If a treatment/procedure **Does Not** affect the home medications, there is no need to reconcile (i.e. for ER patients in with minor problems).
   - If a treatment/procedure **Does** affect home medications the physician needs to know home medication name, dose and frequency to make any changes.
3. **Always interview the patient**;
   - Regarding current medications as taken at home;
   - Use medical diagnosis/conditions as a trigger to match medications;
   - Ask about allergies and reactions and document on the appropriate form.
4. **Do NOT** just copy a list or medication profile without talking to the patient or caregiver. If they can't answer, speak to a family member.
5. If the patient has a handwritten med list: **determine how old that list is**. Always validate information with at least two sources of information if possible (family, PIN, pharmacy profile).
6. **Be aware of dates** on all vials, PIN's and blister packs.
7. **Ask** "How do you take your _____?
8. **Ask about** inhalers, patches, injections, sprays, drops, over-the-counter medications, vitamins, and herbals.
9. **Ask if**;
   - They have been given any samples;
   - They use multiple Pharmacies;
   - They or a physician have changed the dose or stopped any medication recently.
10. Be as specific as possible with PRN meds.
11. The best possible medication history (BPMH) is how the medication is being taken, not how the medication is prescribed.
12. **Review** each medication with the patient to determine if they are still taking the medications dispensed and exactly how they are taking them.
13. **Reconciliation** is the process of following up on discrepancies that are identified between home medications and ordered hospital medications.

www.albertahealthservices.ca

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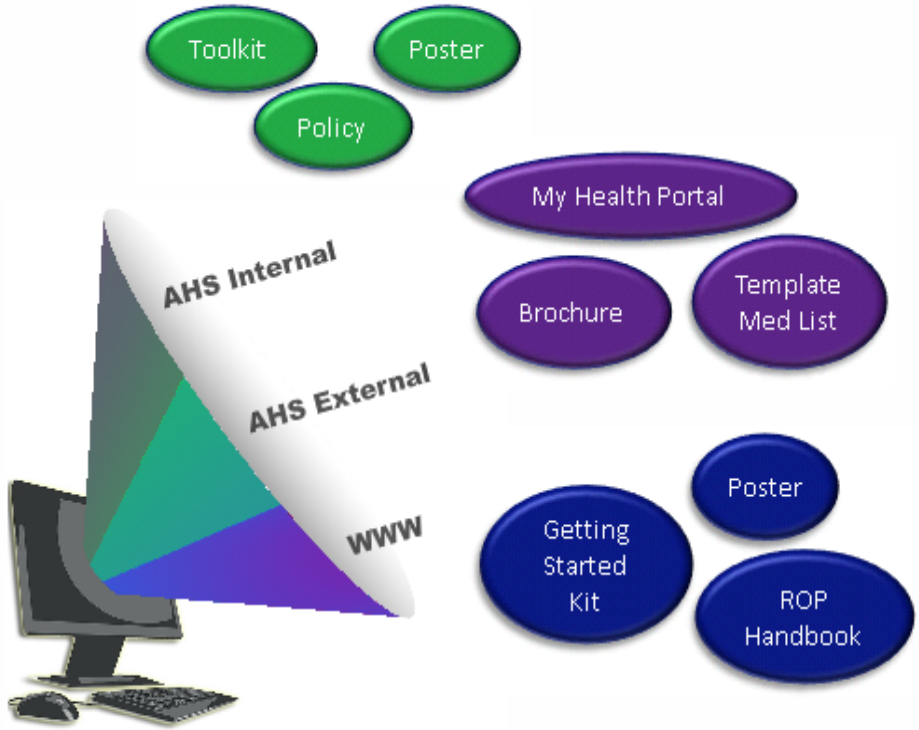

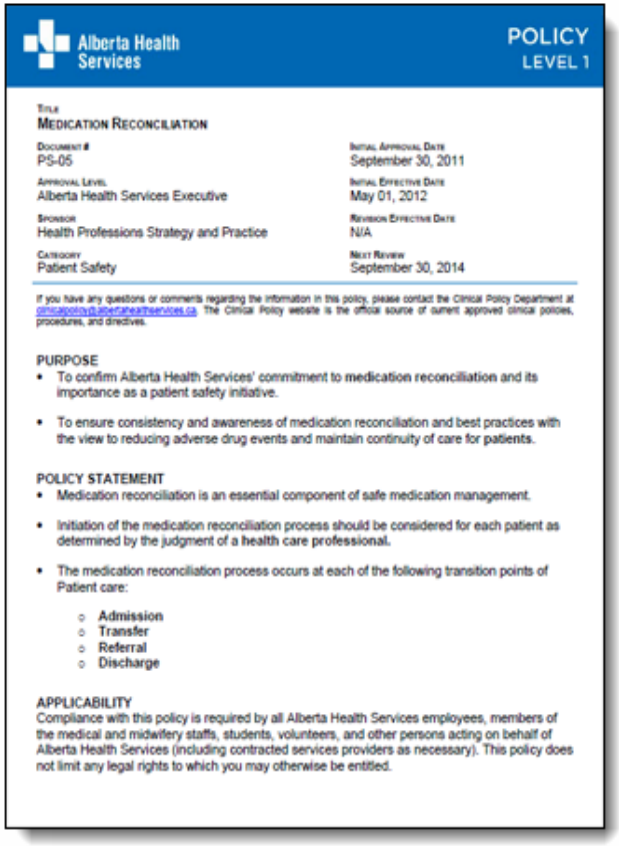

Alberta Health Services

POLICY
LEVEL 1

TITLE
MEDICATION RECONCILIATION

DOCUMENT #
PS-05

INITIAL APPROVAL DATE
September 30, 2011

APPROVAL LEVEL
Alberta Health Services Executive

INITIAL EFFECTIVE DATE
May 01, 2012

SPONSOR
Health Professions Strategy and Practice

REVISION EFFECTIVE DATE
N/A

CATEGORY
Patient Safety

NEXT REVIEW
September 30, 2014

If you have any questions or comments regarding the information in this policy, please contact the Clinical Policy Department at clinicalpolicy@albertahealthservices.ca. The Clinical Policy website is the official source of current approved clinical policies, procedures, and directives.

PURPOSE

- To confirm Alberta Health Services' commitment to **medication reconciliation** and its importance as a patient safety initiative.
- To ensure consistency and awareness of medication reconciliation and best practices with the view to reducing adverse drug events and maintain continuity of care for **patients**.

POLICY STATEMENT

- Medication reconciliation is an essential component of safe medication management.
- Initiation of the medication reconciliation process should be considered for each patient as determined by the judgment of a **health care professional**.
- The medication reconciliation process occurs at each of the following transition points of Patient care:
  - **Admission**
  - **Transfer**
  - **Referral**
  - **Discharge**

APPLICABILITY

Compliance with this policy is required by all Alberta Health Services employees, members of the medical and midwifery staffs, students, volunteers, and other persons acting on behalf of Alberta Health Services (including contracted services providers as necessary). This policy does not limit any legal rights to which you may otherwise be entitled.

MedRec Basics

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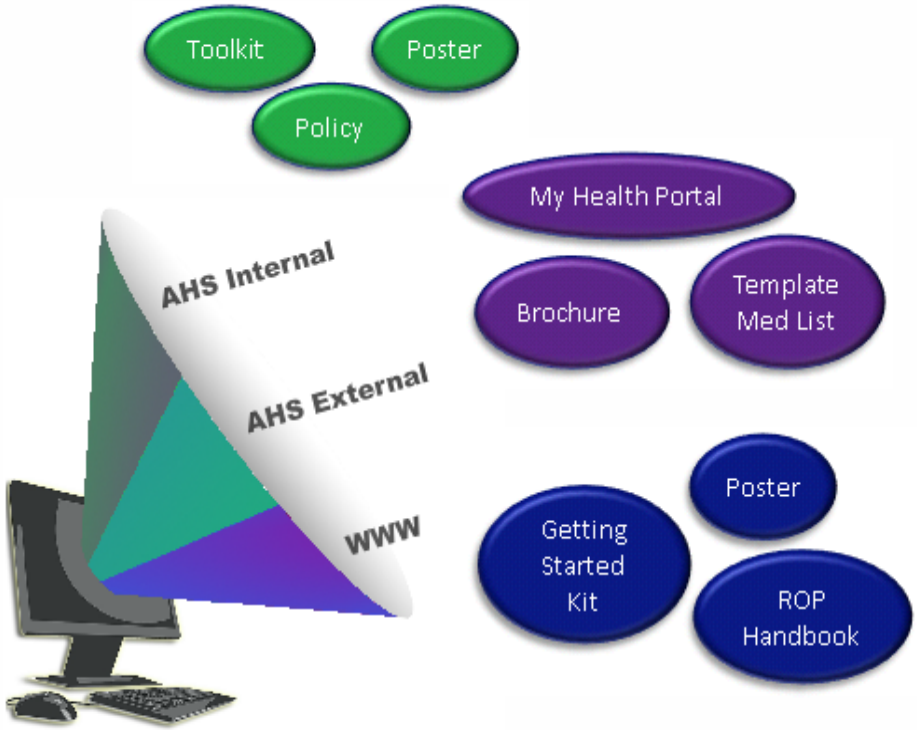

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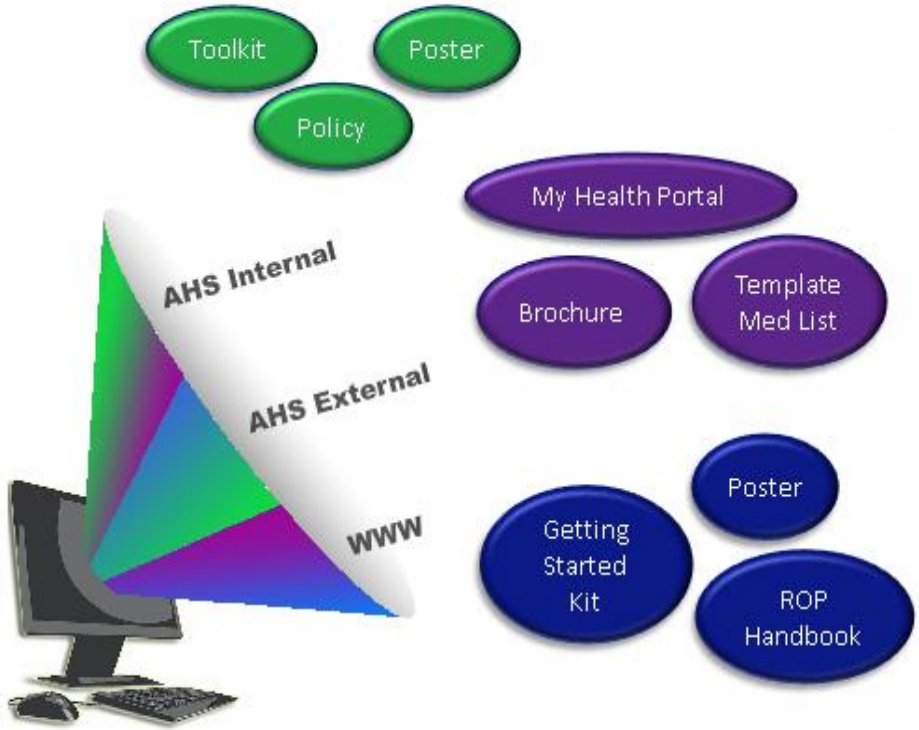

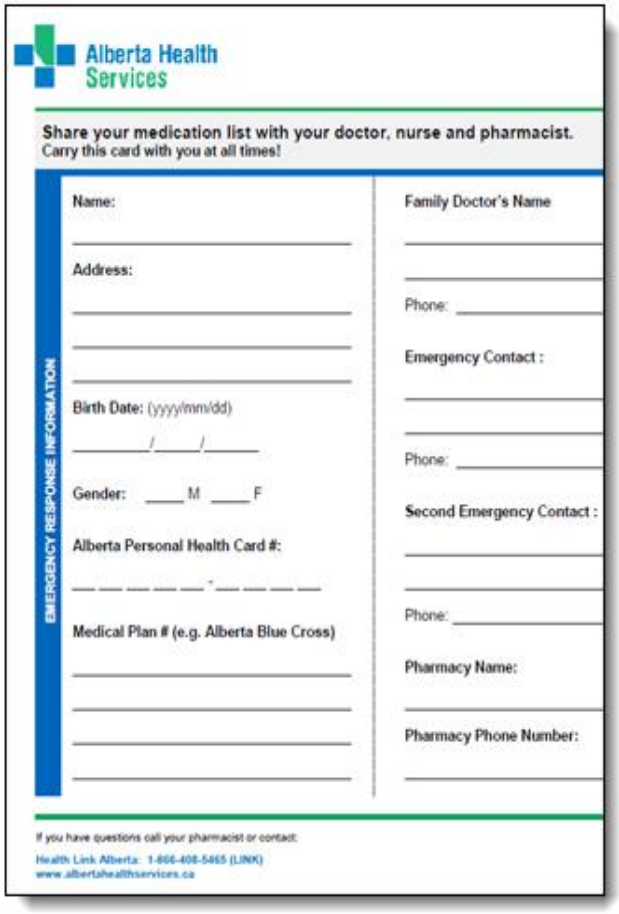

Alberta Health Services

Share your medication list with your doctor, nurse and pharmacist.
Carry this card with you at all times!

EMERGENCY RESPONSE INFORMATION

Name:

Address:

Birth Date: (yyyy/mm/dd)

_____/_____/_____

Gender: ____M ____F

Alberta Personal Health Card #:

Medical Plan # (e.g. Alberta Blue Cross)

Family Doctor's Name

Phone:

Emergency Contact :

Phone:

Second Emergency Contact :

Phone:

Pharmacy Name:

Pharmacy Phone Number:

If you have questions call your pharmacist or contact:
Health Link Alberta: 1-866-408-5465 (LINK)
www.albertahealthservices.ca

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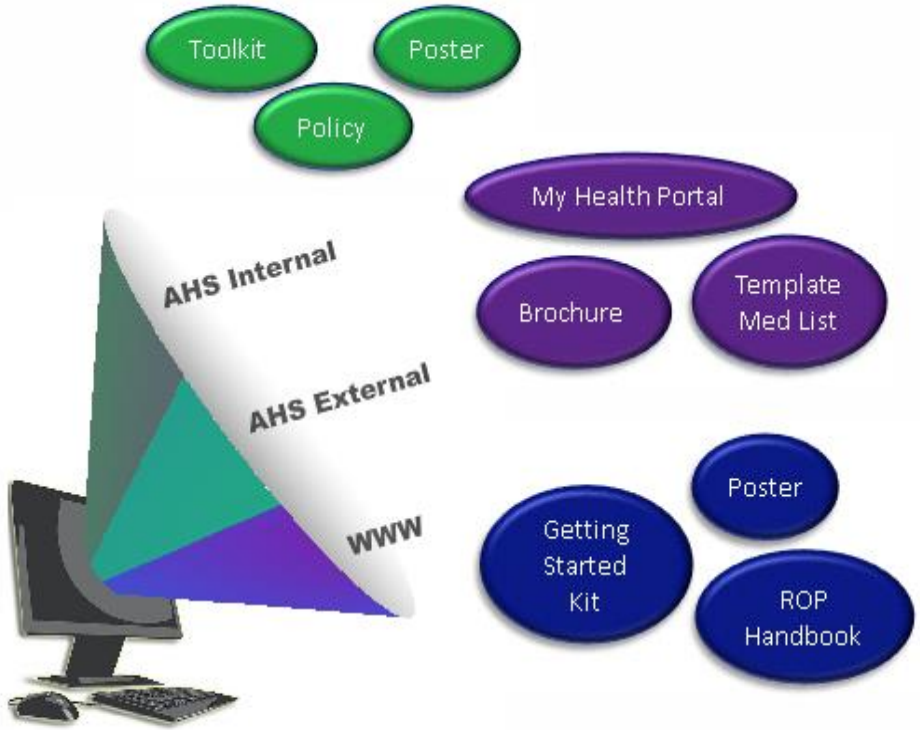

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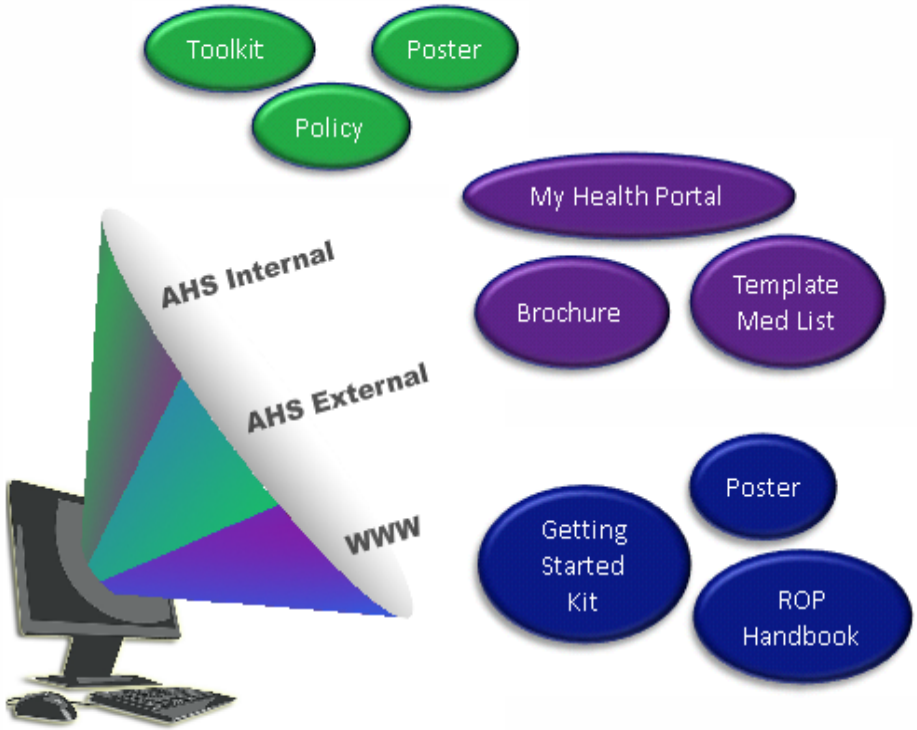
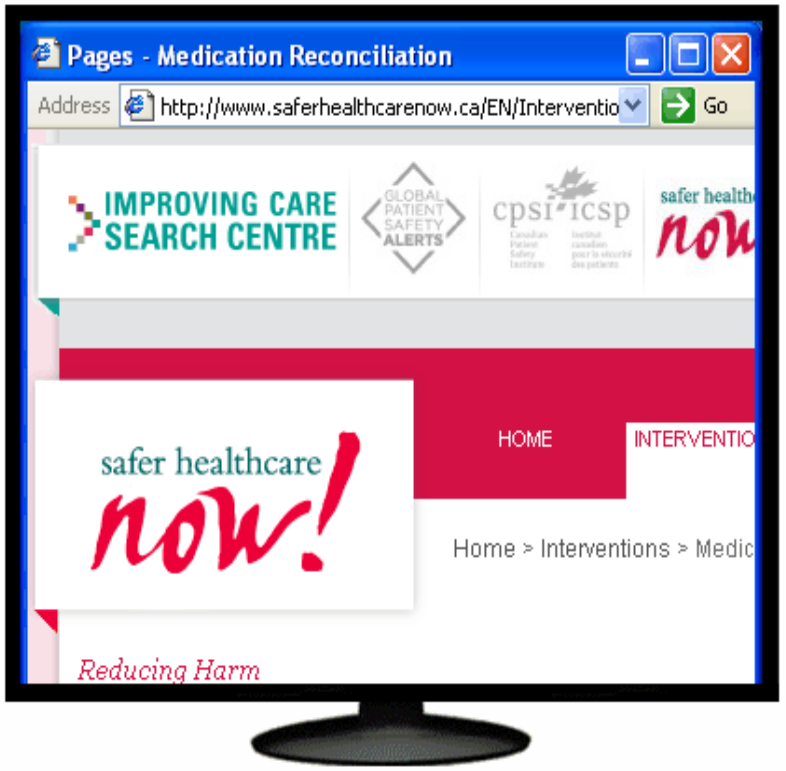




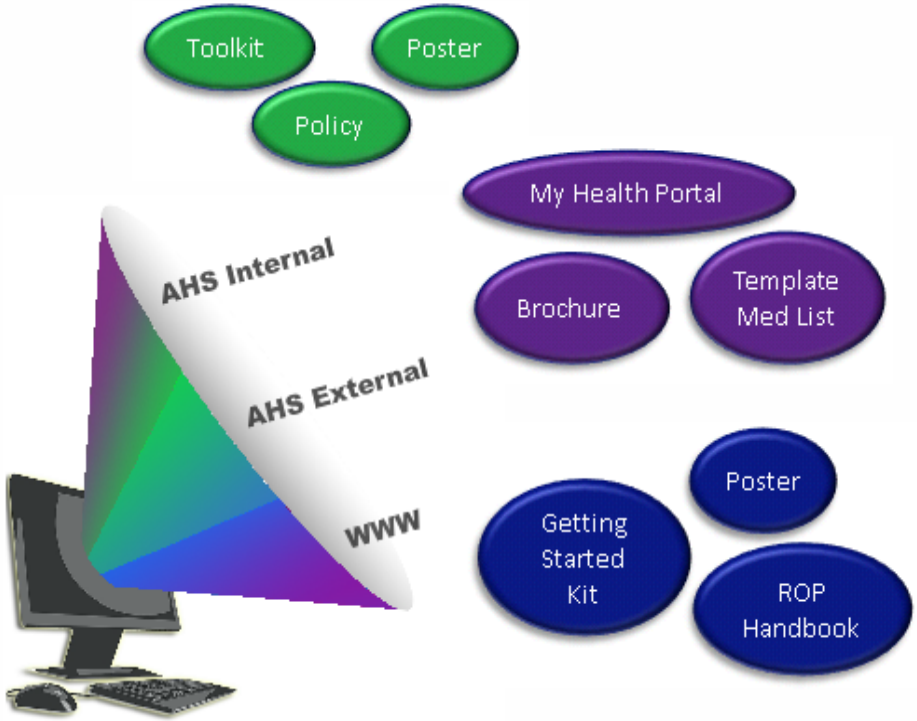
MedRec Basics

Resources

Several resources are available to support the MedRec process.

Click the items below to preview a few available resources.

Clicking on the preview image will open the resource. Some resources may only appear for learners within the AHS network.



MedRec Basics

Wrap Up

Having completed this topic, you've covered some important concepts. Some key points to remember are:

- MedRec is a structured interdisciplinary process to enhance communication about patient medications as they transition through care.
- the three steps of MedRec are designed to ensure a patient's complete medication list is considered, accounted for, and communicated at transition points.
- the ongoing success of MedRec processes and outcomes are optimized by using provincial measurement tools.
- MedRec is an internationally recognized patient safety initiative and an Accreditation Canada Required Organizational Practice.
- there are a number of resources both internal and external to AHS to support MedRec.

Click **Next** to return to the Main Menu.

AHS senior leadership supports MedRec as a patient safety initiative that is part of medication management. **Click to hear comments from Dr. Verna Yiu.**

Main Menu

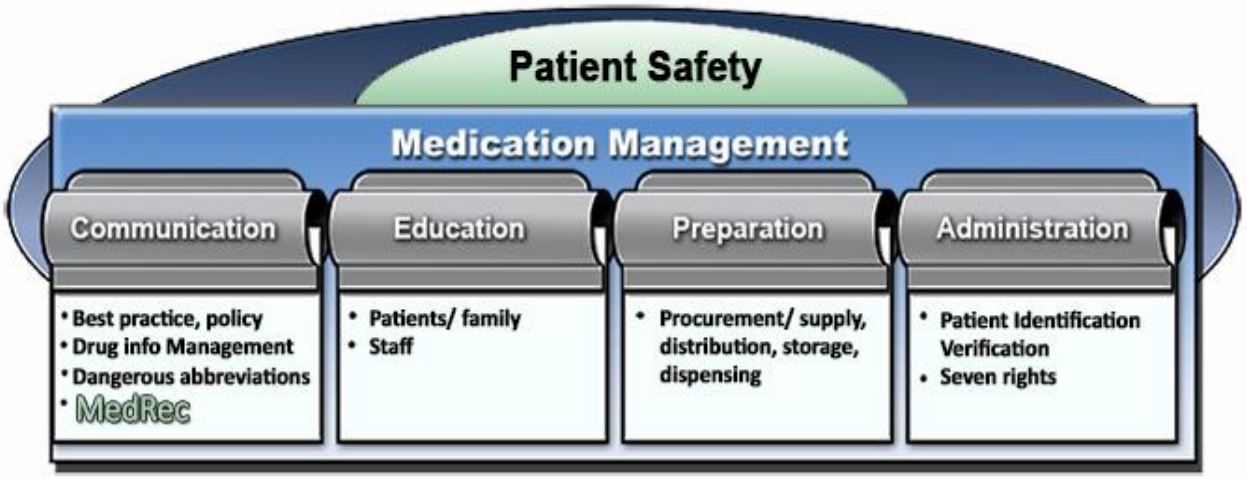
Medication Reconciliation (MedRec) is an essential part of safe medication management and plays a key role in ensuring patient safety. This module presents basic information about the MedRec process.

Congratulations! You have completed the MedRec eLearning module. You can return to this module at any time to refresh your learning.

Click **X** to close the module.

This course includes:

- [x] MedRec Basics
- [x] Detailed MedRec Process



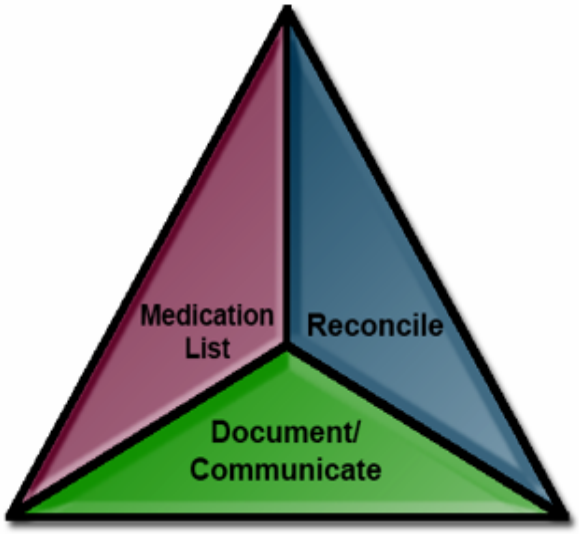
Detailed MedRec Process

Introduction

In this topic, each step in the MedRec process will be discussed in detail for the admission point of care. Then the three-step process will be discussed for the other transitions in care, such as transfer and discharge.

This topic takes approximately **30 minutes** to complete.

Click **Next** to continue.



This topic includes the following content:

- Learning Objectives
- Best Possible Medication History (BPMH)
- MedRec Tool
- Checkpoint 1
- Reconcile
- Document/Communicate
- Checkpoint 2
- Transfer MedRec Process
- Discharge MedRec Process
- Patient Scenario
- Wrap Up

Detailed MedRec Process

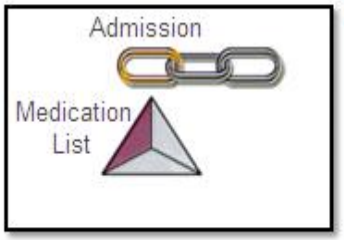
Learning Objectives

Upon completion of this topic, you should be able to:

- implement the elements of the BPMH
- compile the possible sources of information when creating a BPMH
- describe the key components of the MedRec tool
- complete the reconciliation process
- take appropriate action when discrepancies are identified
- adapt the MedRec steps to various transition points

Detailed MedRec Process

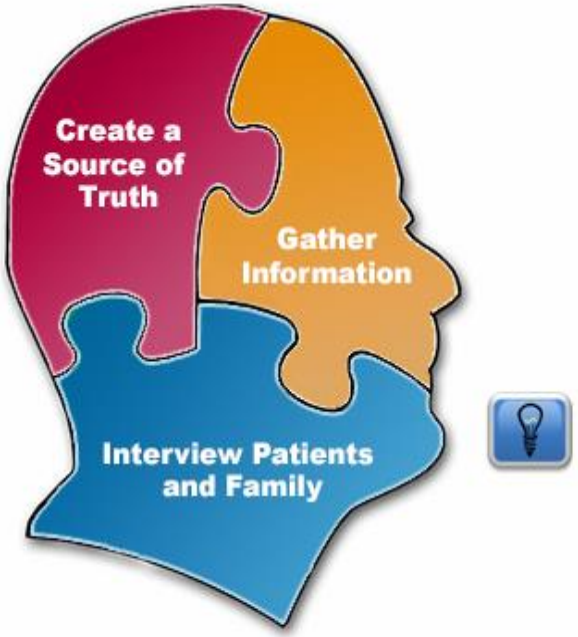
Best Possible Medication History (BPMH)



During the admission point of care, the medication list step is to create the BPMH. This is the most accurate and complete information that truly reflects how medications are being taken, not just how they were prescribed.

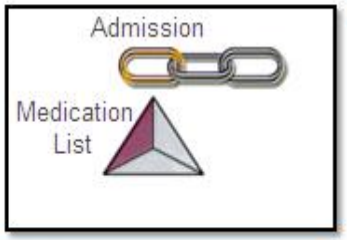
It is essential that at least two sources of information are used to create the BPMH. Whenever possible, the patient interview should be one of these sources.

Click each BPMH element below for detailed information.



Detailed MedRec Process

Best Possible Medication History (BPMH)



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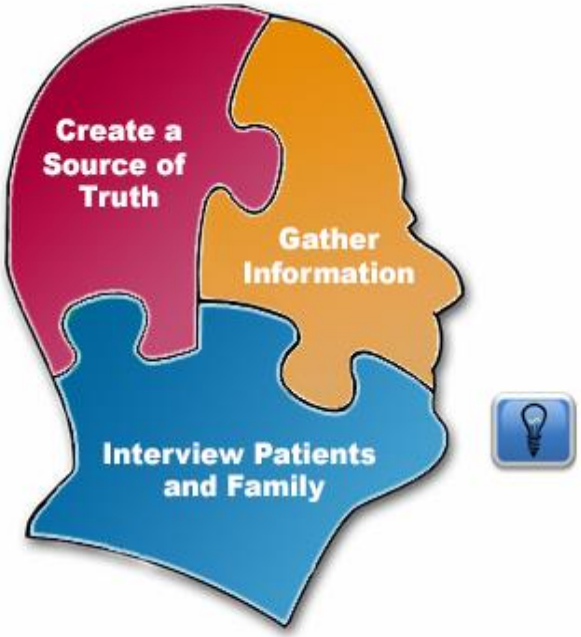


Create a Source of Truth

Compare two or more sources of information. Then, use clinical judgment to determine what is a true reflection of the patient's medication list, including drug, dose, and frequency. This list is the BPMH.

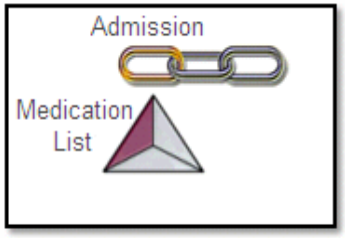
If there are differences between sources, they can be entered as notes if you are not able to resolve the difference.

Factors that can raise differences include:

- The reliability of the patient in terms of their medication history.
- Whether the patient is not taking the medication as prescribed or has stopped taking the medication completely.
- The accuracy of other sources of information and whether they are up to date.

Detailed MedRec Process

Best Possible Medication History (BPMH)



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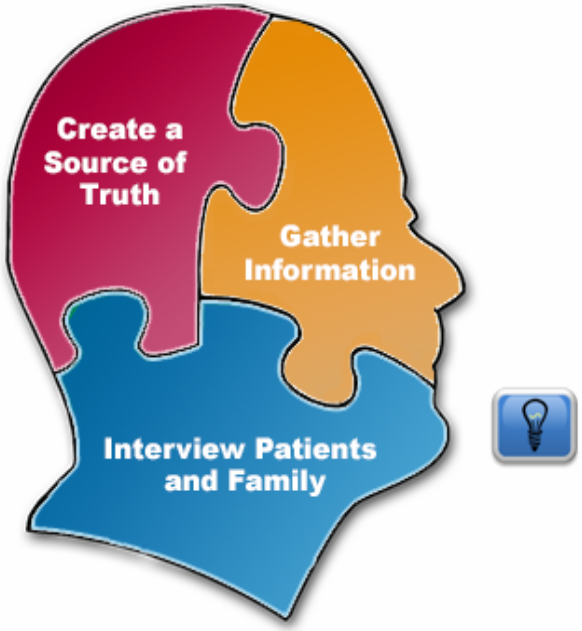


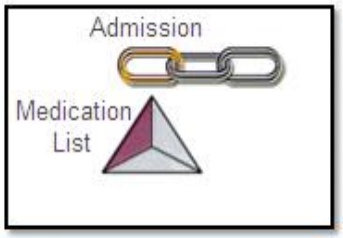
Gather Information

There are a number of sources of information that can be used:

- Patient's **list of current medications** (e.g., wallet card, smartphone, paper document).
- **Pill bottles / medication containers / blister packs**. Details to review from the containers include the name, date, dosage, route and frequency. Are these for this patient? Are they expired? Are there multiple bottles for the same medication?
- **Netcare PIN**. The Pharmaceutical Information Network lists information on prescribed and dispensed medications on an individual's Netcare electronic health record.
- **Medical Records**. Various types of medical records may be available from home care, long term care, family physician, ambulatory clinics, and specialty services. Examples of these documents include MAR, history, discharge/transfer letter, prescription.
- **Community Pharmacy Profile.**

Detailed MedRec Process

Best Possible Medication History (BPMH)



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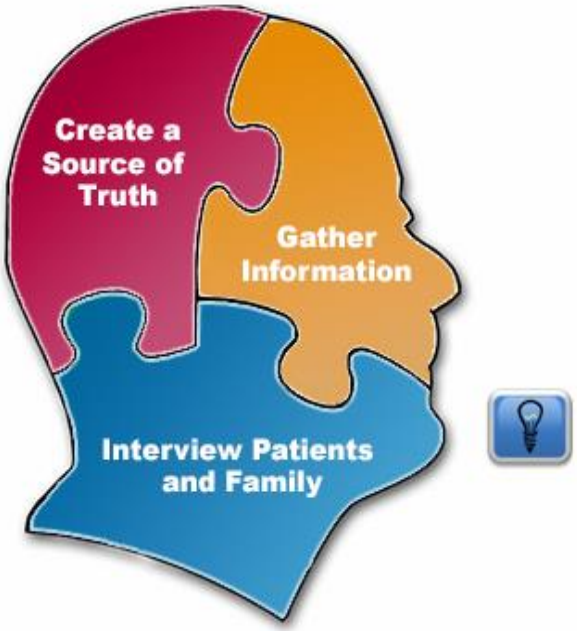


Interview Patients and Family

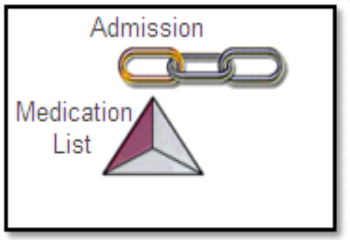
Interview the patient to clarify how and when medications are taken since this could differ from the way they were actually prescribed. Inquire about how current the patient's medication list is and discuss the details on the medication containers. This interview should occur as soon as possible given the patient's condition or availability of the family.

In addition to prescription medications, be sure to ask about any samples that were provided as well as the following:

- Forms of medication
- Over-the-counter (OTC)
- Vitamins/minerals/supplements
- Natural health products
- Traditional medicines
- Substances of abuse

Detailed MedRec Process

Best Possible Medication History (BPMH)



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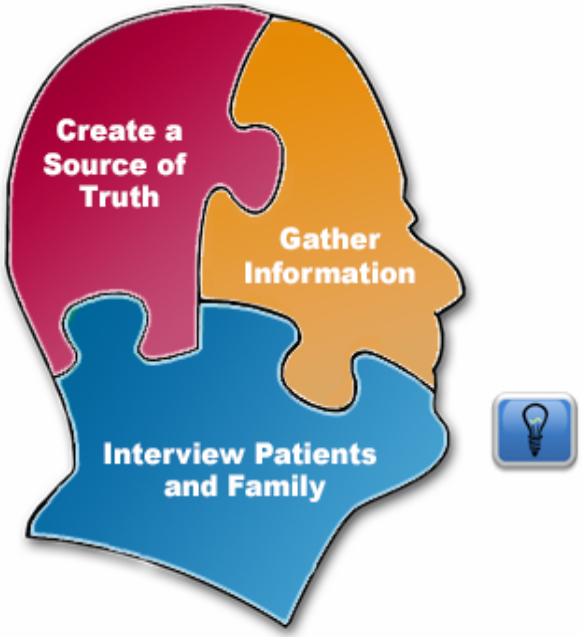

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Patient

The interview may also be conducted with the family or a care provider.

Detailed MedRec Process

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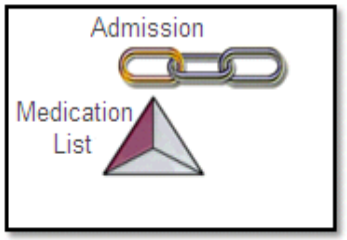

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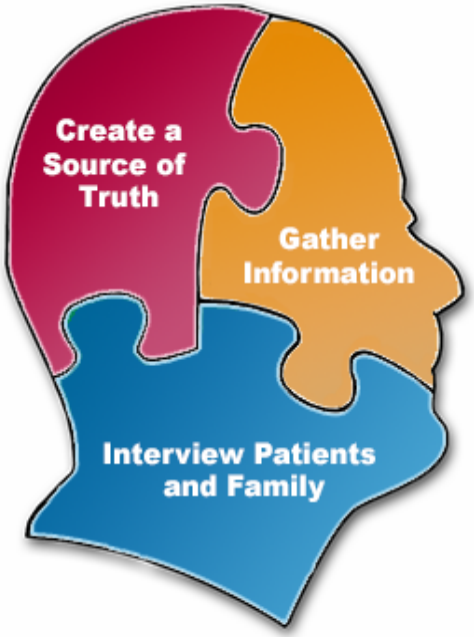

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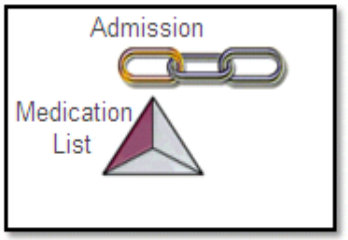
Forms of Medication

Different forms include: Tablets, Capsules, Liquids, Ear/Eye Drops, Inhalers/Puffers, Nasal Sprays, Patches, Injections, Creams/Ointments, Suppositories.

Detailed MedRec Process

Best Possible Medication History (BPMH)



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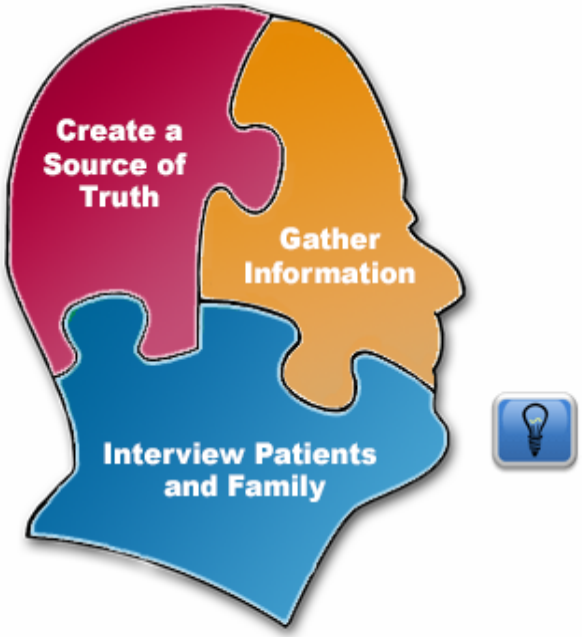

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Over-the-counter (OTC)

Over the counter medications include items such as allergy, cough and cold medicines.

Detailed MedRec Process

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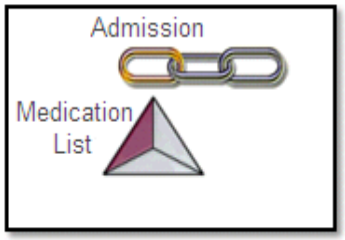

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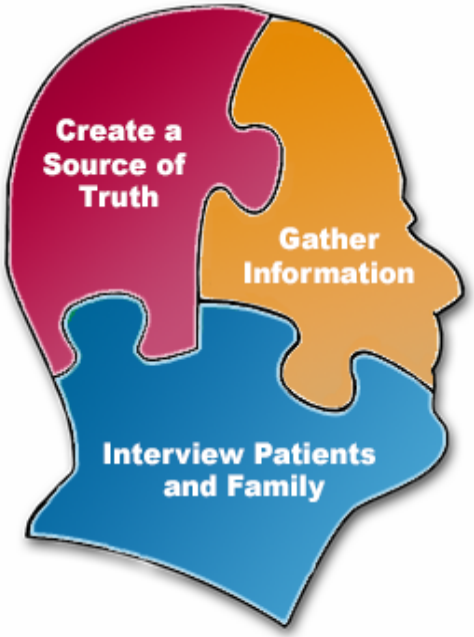

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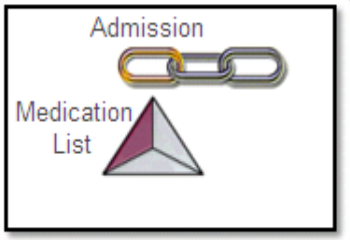
- Traditional medicines
- Substances of abuse

Natural Health Products

Includes products such as herbals and homeopathic medicines, e.g. Echinacea, Dandelion, Nettle and Chickweed.

Detailed MedRec Process

Best Possible Medication History (BPMH)



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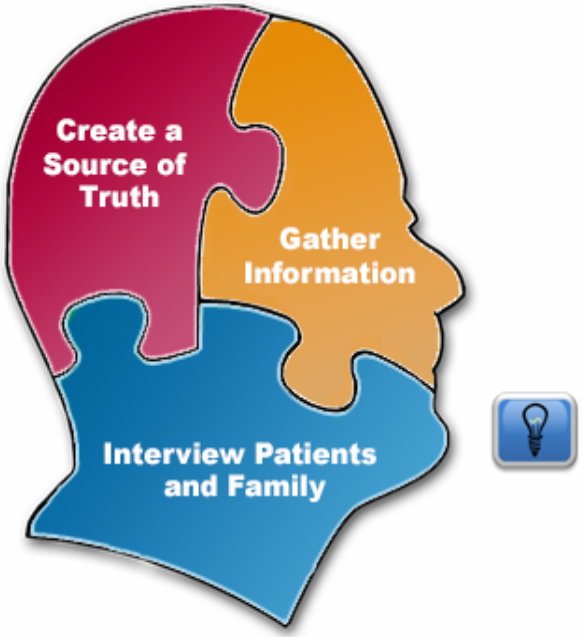

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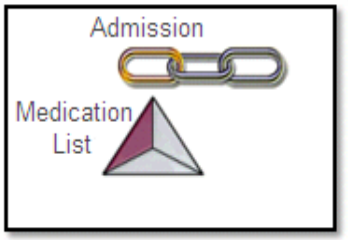
Traditional Medicines

Traditional medicines, or remedies influenced by culture or country, such as Chinese herbal and Indian ayurvedic medicines.

Detailed MedRec Process

Best Possible Medication History (BPMH)



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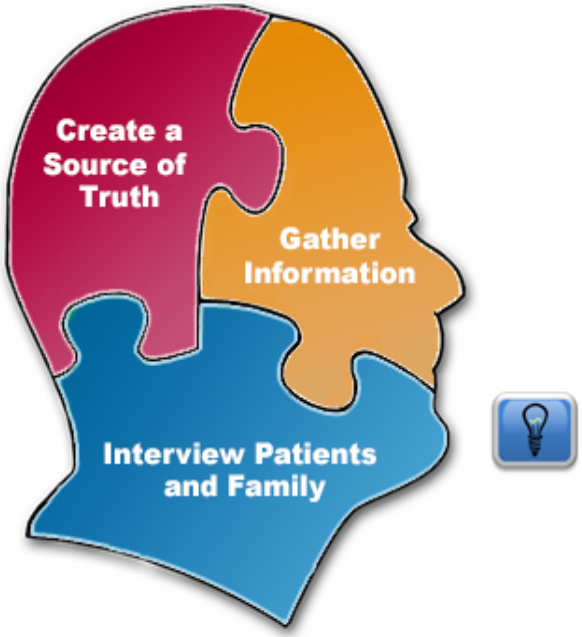

Tip!

Approach the review in a systematic way and use open-ended questions. Be sure to discuss:

- The duration of treatment
- The indication for treatment
- Recent changes to treatment
- Previous adverse drug reactions and allergies
- If they have any samples
- If they use multiple pharmacies
- If they or their physician has recently changed or stopped a medication
- Use medical diagnosis/conditions to trigger questions about medications
- Determine how old any medication lists are and be aware of dates on all vials, PINs and blister packs
- Be as specific as possible with PRN meds
- If they take prescriptions that were not prescribed to them
- If they have any prescriptions that have not been filled

Detailed MedRec Process

MedRec Tool

There are a variety of MedRec tools in use, both paper-based and electronic. They all should include the same essential elements.

The essential principle is that the tool is filled in with accurate and comprehensive data for all current medications being taken.

Click each number to learn more about key components.

Always remember to ask about OTCs and vitamin/herbal products! 3

MedRec Tool

Information Source-must use at least 2 sources 1

Patient Interview	Family Interview
Medication Vials	Patient Home Medication List
Bubble Pack/Dosette	netCARE PIN profile
MAR from other facility	Pharmacy Phone/Fax _____
Medication Discharge Plan	Other _____

Reconciliation

Please write new orders and changes on Prescriber Order form

2 Medication	Dose	Route	Frequency	Continue	Discontinue/ Hold	Change – see new order	Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

Prescriber *(Print Name)* _____

Signature _____

Date/Time _____

Copy to Pharmacy

Date _____ Time_____

Detailed MedRec Process

MedRec Tool

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The essential principle is that the tool is filled in with accurate and comprehensive data for all current medications being taken.

Click each number to learn more about key components.

1

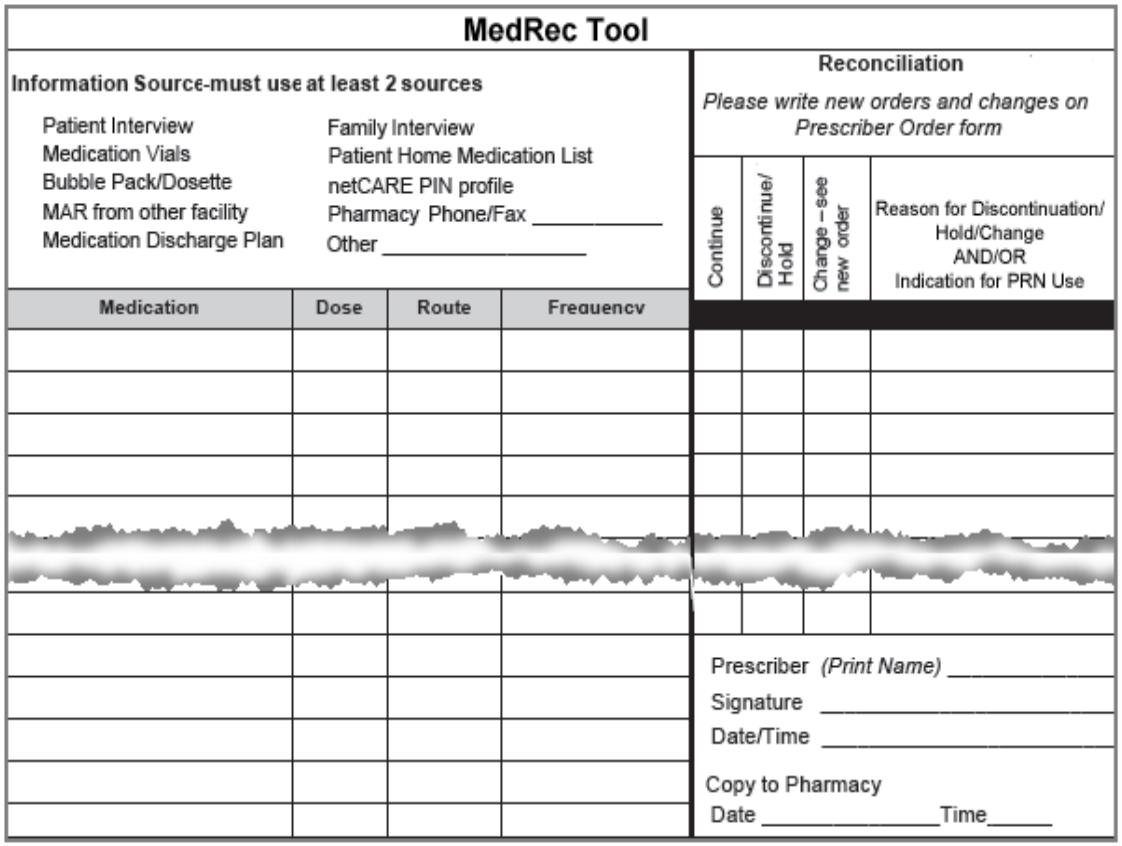
2

3

Variety of Tools

In addition to the essential elements, some forms may include local processes for documenting / communicating extra information, such as open areas for comments.

Always remember to ask about OTCs and vitamin/herbal products!



MedRec Tool

Information Source-must use at least 2 sources

Patient Interview
Medication Vials
Bubble Pack/Dosette
MAR from other facility
Medication Discharge Plan
Family Interview
Patient Home Medication List
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Detailed MedRec Process

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Click each number to learn more about key components.

1

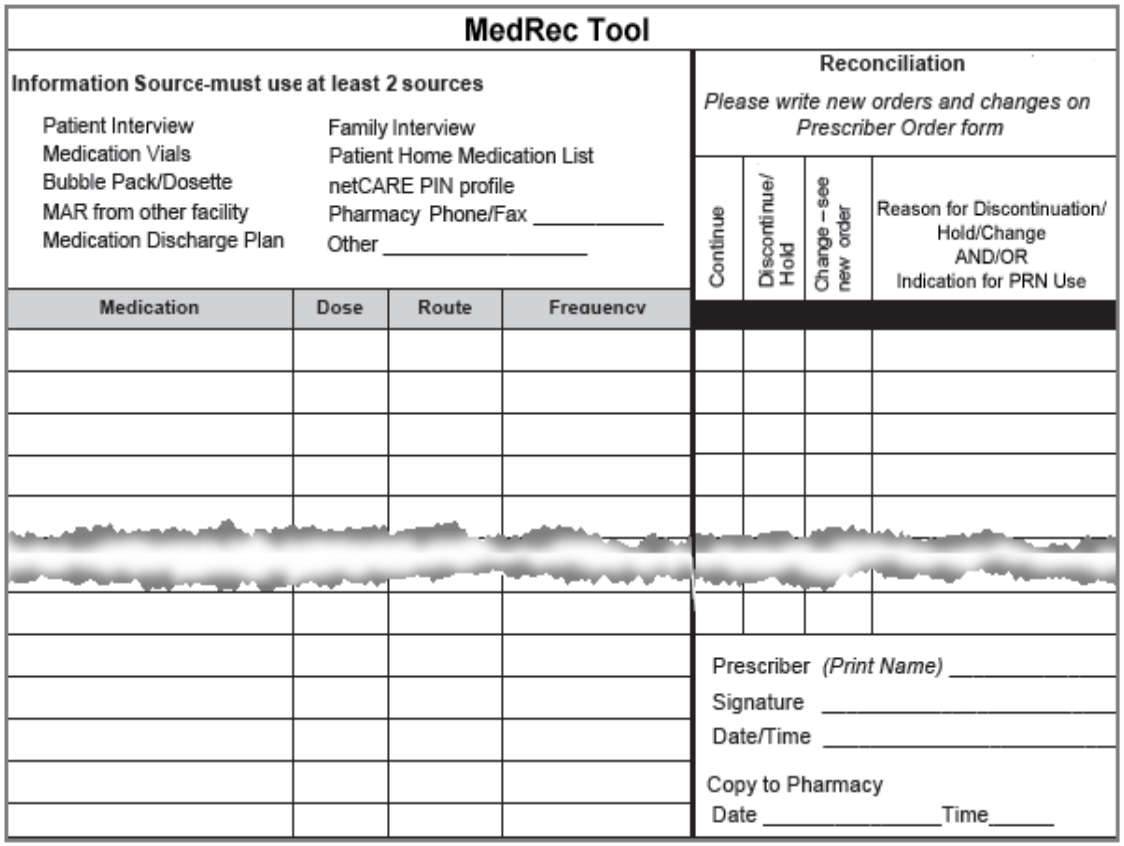
2

3

Tip!

Comments can be entered to capture differences in medications, recent antibiotic use, or immunizations, as well as recent dose changes.

Always remember to ask about OTCs and vitamin/herbal products!



MedRec Tool

Information Source-must use at least 2 sources

Patient Interview
Medication Vials
Bubble Pack/Dosette
MAR from other facility
Medication Discharge Plan
Family Interview
Patient Home Medication List
netCARE PIN profile
Pharmacy Phone/Fax _____
Other _____

Medication	Dose	Route	Frequency

Reconciliation

Please write new orders and changes on Prescriber Order form

Continue	Discontinue/ Hold	Change – see new order	Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

Prescriber *(Print Name)* _____
Signature _____
Date/Time _____

Copy to Pharmacy
Date _____Time_____

Detailed MedRec Process

MedRec Tool

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The essential principle is that the tool is filled in with accurate and comprehensive data for all current medications being taken.

Click each number to learn more about key components.

1

2

At least two sources of information need to be used for a BPMH, ideally including an interview with the patient, family or caregiver as one source.

Always remember to ask about OTCs and vitamin/herbal products!

3

MedRec Tool

Information Source-must use at least 2 sources

Patient Interview	Family Interview
Medication Vials	Patient Home Medication List
Bubble Pack/Dosette	netCARE PIN profile
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Medication	Dose	Route	Frequency	Continue	Discontinue/ Hold	Change – see new order	Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

Prescriber *(Print Name)* _____

Signature _____

Date/Time _____

Copy to Pharmacy

Date _____ Time_____

Detailed MedRec Process

MedRec Tool

There are a variety of MedRec tools in use, both paper-based and electronic. They all should include the same essential elements.

The essential principle is that the tool is filled in with accurate and comprehensive data for all current medications being taken.

Click each number to learn more about key components.

Always remember to ask about OTCs and vitamin/herbal products!

3

MedRec Tool

Information Source-must use at least 2 sources

Patient Interview	Family Interview
Medication Vials	Patient Home Medication List
Bubble Pack/Dosette	netCARE PIN profile
MAR from other facility	Pharmacy Phone/Fax _____
Medication Discharge Plan	Other _____

Reconciliation

Please write new orders and changes on Prescriber Order form

Medication	Dose	Route	Frequency	Continue	Discontinue/ Hold	Change – see new order	Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

Prescriber *(Print Name)* _____

Signature _____

Date/Time _____

Copy to Pharmacy

Date _____ Time_____

1

2

Only current medications are entered here. If the patient takes a medication differently than how it is prescribed, document how the patient actually takes it. OTC medications that are currently being taken are also entered here.

AHS has a policy (view on *Insite*) and list of dangerous abbreviations, symbols and dose designations which should not be used. For example, instead of documenting "QD", use "daily".

Ideally the BPMH is captured within 24 hours of an admission. As with any clinical documentation, make sure to capture date/time/initials.

Detailed MedRec Process

MedRec Tool

There are a variety of MedRec tools in use, both paper-based and electronic. They all should include the same essential elements.

The essential principle is that the tool is filled in with accurate and comprehensive data for all current medications being taken.

Click each number to learn more about key components.

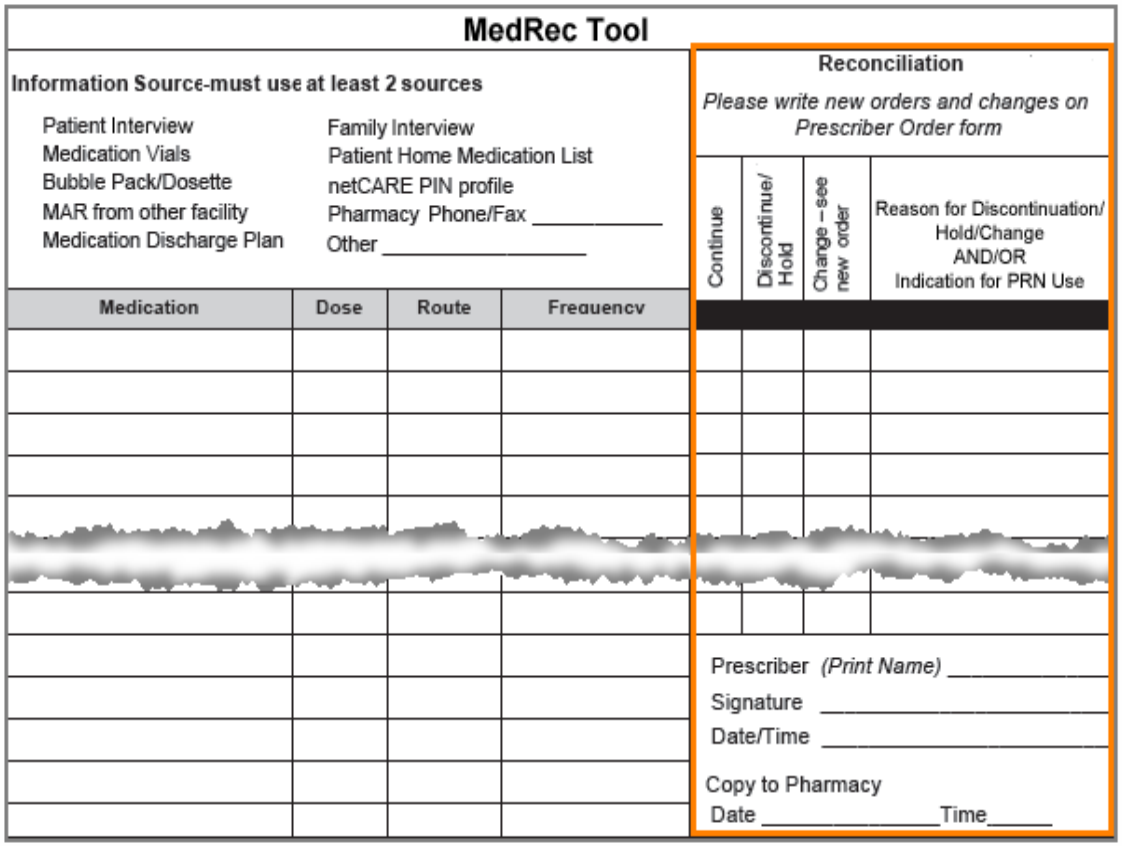
1

2

The Reconciliation section is the next step in the MedRec process and will be discussed on subsequent pages.

Always remember to ask about OTCs and vitamin/herbal products!

3



MedRec Tool

Information Source-must use at least 2 sources

Patient Interview
Medication Vials
Bubble Pack/Dosette
MAR from other facility
Medication Discharge Plan
Family Interview
Patient Home Medication List
netCARE PIN profile
Pharmacy Phone/Fax _____
Other _____

Medication	Dose	Route	Frequency

Reconciliation

Please write new orders and changes on Prescriber Order form

Continue	Discontinue/ Hold	Change – see new order	Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

Prescriber *(Print Name)* _____
Signature _____
Date/Time _____

Copy to Pharmacy
Date _____Time_____

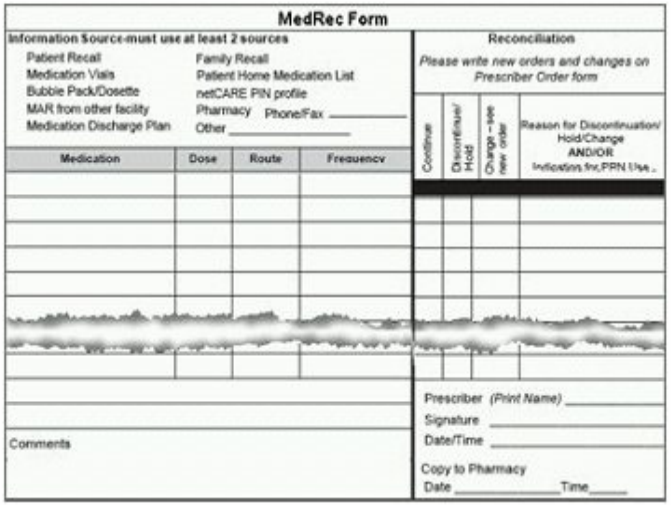
Detailed MedRec Process

Checkpoint 1

The most current Pharmaceutical Information Network (PIN) report for this patient shows that she is on the antidepressant citalopram. However, the patient's spouse stated that she had stopped taking the medication two weeks ago because it caused a lot of nausea.

What should you do about this medication when creating the BPMH?

- Make sure that the team knows that this medication was prescribed but the patient isn't taking it anymore because of side effects.
- Do not record anything about the medication.
- Record the patient's information from the PIN as this represents the patient's current medication list.



MedRec Form

Information Source-must use at least 2 sources

Patient Recall
Medication Vials
Bubble Pack/Dosette
MAR from other facility
Medication Discharge Plan
Family Recall
Patient Home Medication List
netCARE PIN profile
Pharmacy Phone/Fax
Other

Medication	Dose	Route	Frequency

Reconciliation

Please write new orders and changes on Prescriber Order form

Continue	Discontinue/ Hold	Change – see new order	Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

Comments

Prescriber (Print Name)
Signature
Date/Time

Copy to Pharmacy
Date Time

Detailed MedRec Process

Checkpoint 1

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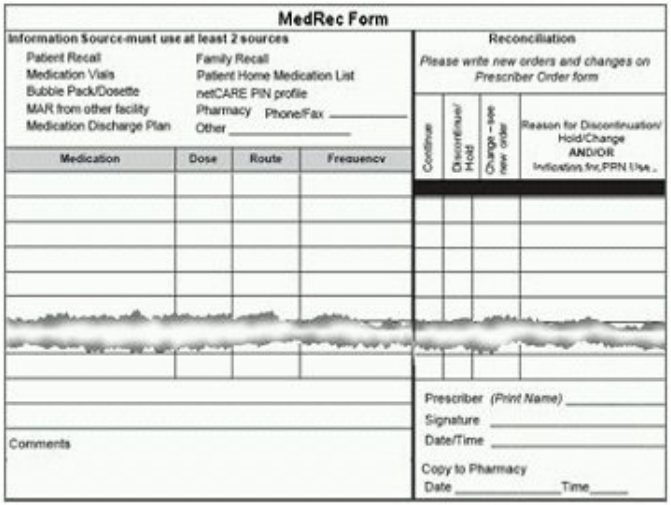
- Make sure that the team knows that this medication was prescribed but the patient isn't taking it anymore because of side effects.
- Do not record anything about the medication.
- Record the patient's information from the PIN as this represents the patient's current medication list.

PIN

The Pharmaceutical Information Network (PIN) is a separate drug information management system that has been seamlessly integrated into the Alberta Netcare EHR Portal to support access to prescribed drug and over-the-counter (OTC) drug information.

PIN provides authorized health service providers with the following information:

- Prescription information from physicians
- Prescribed dispensing information from pharmacies
- Drug-to-drug interaction alerts to avoid prescriptions that conflict
- Database of all available drugs and their common dosages



Detailed MedRec Process

Checkpoint 1

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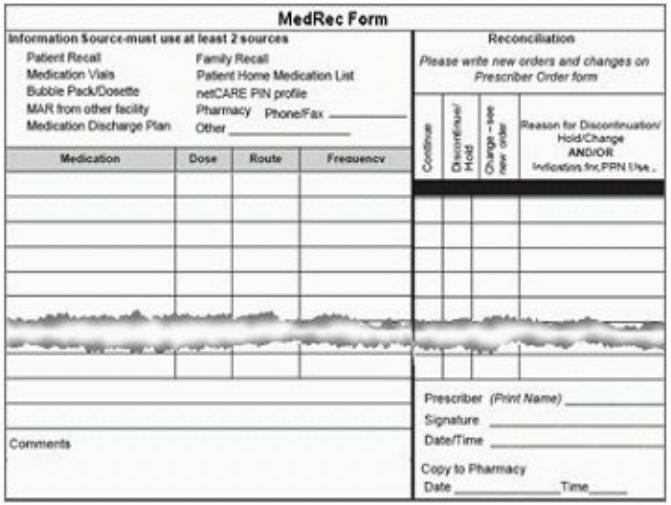
What should you do about this medication when creating the BPMH?

- (●) Make sure that the team knows that this medication was prescribed but the patient isn't taking it anymore because of side effects.
- ( ) Do not record anything about the medication.
- ( ) Record the patient's information from the PIN as this represents the patient's current medication list.

Correct. Communicating how the patient is actually taking their medication is vital, but so is communicating any differences of information between sources.


MedRec Form

Information Source-must use at least 2 sources

Patient Recall
Medication Vials
Bubble Pack/Dosette
MAR from other facility
Medication Discharge Plan
Family Recall
Patient Home Medication List
netCARE PIN profile
Pharmacy Phone/Fax
Other

Medication | Dose | Route | Frequency

Reconciliation

Please write new orders and changes on Prescriber Order form

Continue | Discontinue/ Hold | Change – see new order | Reason for Discontinuation/ Hold/Change AND/OR Indication for PRN Use

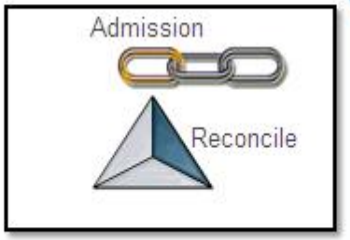
Comments

Prescriber (Print Name)
Signature
Date/Time

Copy to Pharmacy
Date Time

Detailed MedRec Process

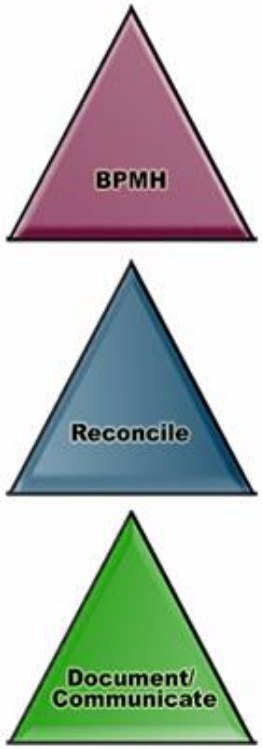
Reconcile



The reconciliation step involves comparing the BPMH to admission medication orders, to identify and resolve any discrepancies. In this step the prescriber determines if home medications need to be continued, discontinued, or modified at admission, and resolves any identified discrepancies.

Proactive Model

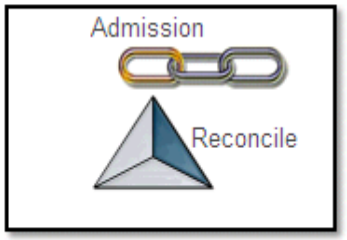
Retroactive Model



Recognizing that home and supportive living are unique practice areas, these guidelines describe the reconciliation process in these care settings.

Detailed MedRec Process

Reconcile



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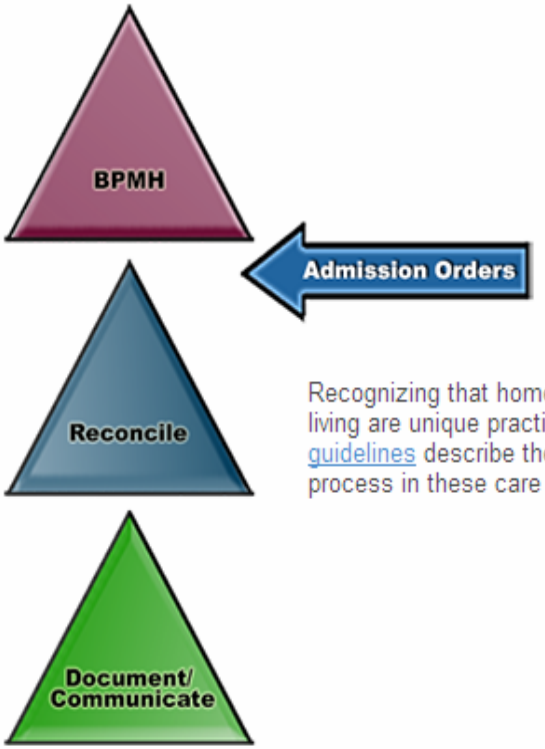
Proactive Model | Retroactive Model

Proactive Model

Ideally, the BPMH is created prior to medications being ordered. In this proactive model, the orders are based on the information in the BPMH to ensure that all of the medications have been assessed and any changes have been documented and communicated.

This approach minimizes potential adverse events by identifying discrepancies sooner.



Recognizing that home and supportive living are unique practice areas, these guidelines describe the reconciliation process in these care settings.

Detailed MedRec Process

Reconcile

The reconciliation step involves comparing the BPMH to admission medication orders, to identify and resolve any discrepancies. In this step the prescriber determines if home medications need to be continued, discontinued, or modified at admission, and resolves any identified discrepancies.

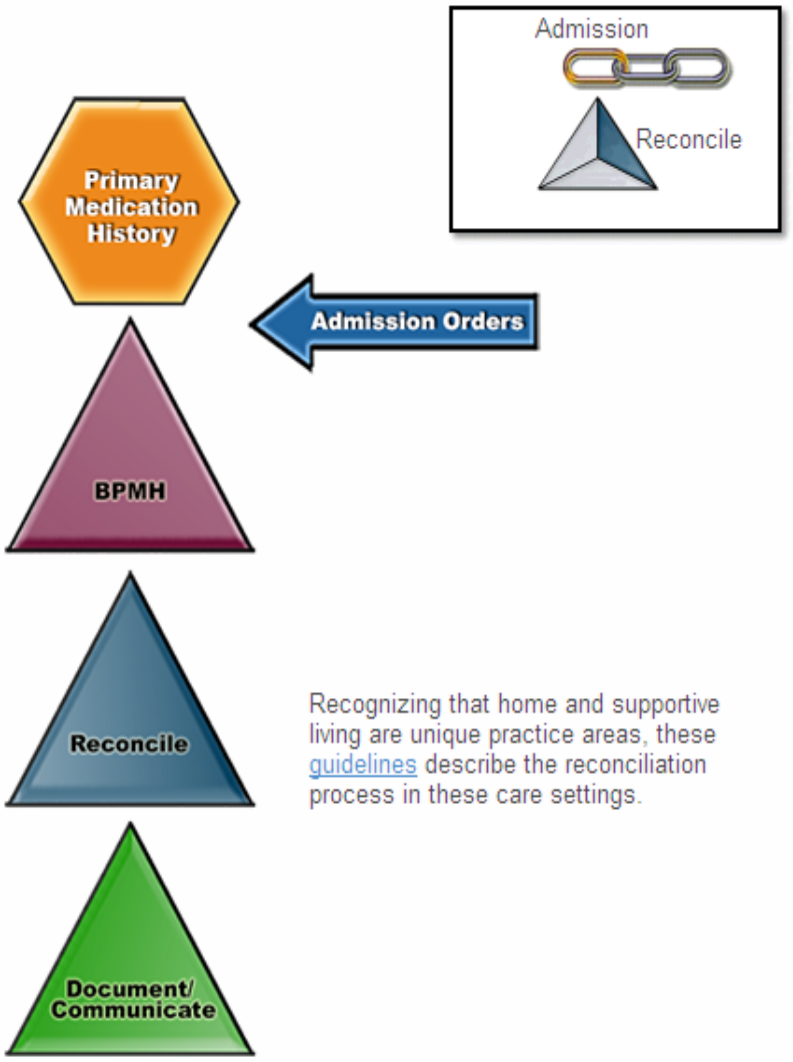
Proactive Model | Retroactive Model

Retroactive Model

There are influencing factors that might prevent the completion of a BPMH prior to the orders being determined, such as the patient's condition, limited resources and limited access to secondary sources of medication information.

In this retroactive model, admission medication orders are based on a primary medication history created when you are unable to create a BPMH. In a timely manner, create a BPMH and compare this to the admission medication orders to identify and resolve any discrepancies that are found. Ensure that all discrepancies are documented and communicated.

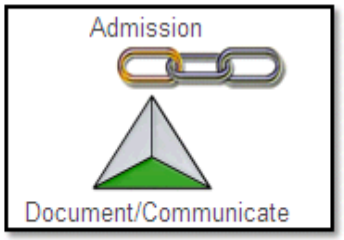
There is a greater chance with the retroactive model for discrepancies between the BPMH and admission medication orders.



Recognizing that home and supportive living are unique practice areas, these guidelines describe the reconciliation process in these care settings.

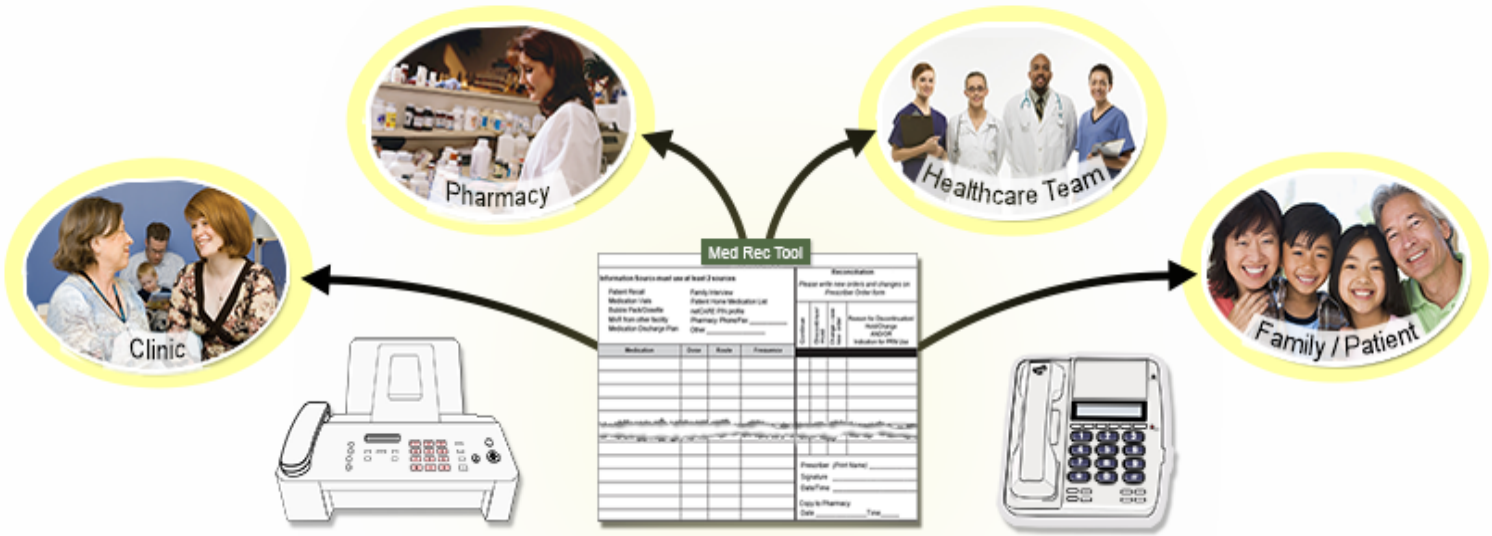
Detailed MedRec Process

Document/Communicate



Use the MedRec tool to document that the BPMH and admission orders have been reconciled, and communicate decisions about medications to the appropriate team members and patient (family, caregiver, etc.).

By using the MedRec tool, intentional changes to current medications can be easily identified. As well, this will assist with future points of care when the MedRec process is repeated and the overall medication plan is reassessed.



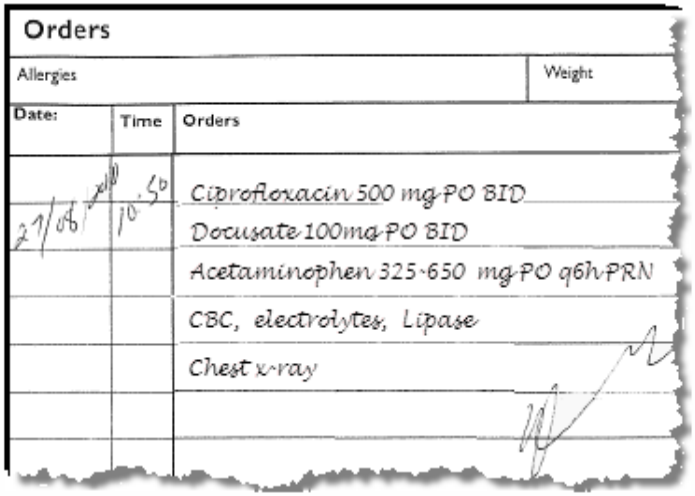
Detailed MedRec Process

Checkpoint 2

Medication orders were entered before the BPMH was created.

Select the true statement from the options below.

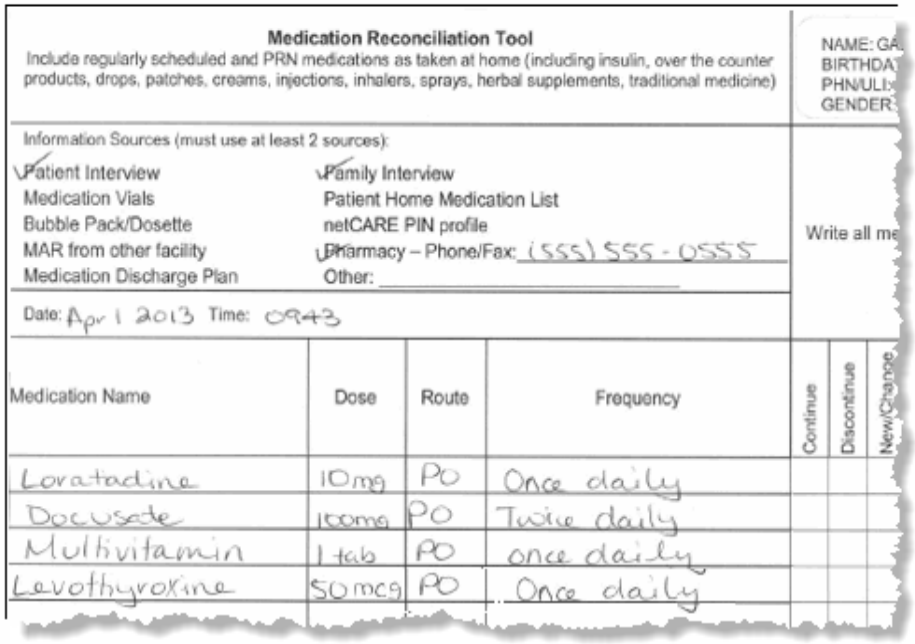
- ○ Since the orders have already been entered, information on the BPMH would not apply.
- ○ Ensure the BPMH is compared with the orders and all home medications have been addressed.



Orders

Allergies | Weight

Date:	Time	Orders
21/04	10:50	Ciprofloxacin 500 mg PO BID
		Docusate 100mg PO BID
		Acetaminophen 325-650 mg PO q6h PRN
		CBC, electrolytes, Lipase
		Chest x-ray



Medication Reconciliation Tool

Include regularly scheduled and PRN medications as taken at home (including insulin, over the counter products, drops, patches, creams, injections, inhalers, sprays, herbal supplements, traditional medicine)

NAME: GA
BIRTHDA
PHN/ULI
GENDER

Information Sources (must use at least 2 sources):

- ✓ Patient Interview
- Medication Vials
- Bubble Pack/Dosette
- MAR from other facility
- Medication Discharge Plan
- ✓ Family Interview
- Patient Home Medication List
- netCARE PIN profile
- ✓ Pharmacy – Phone/Fax: (555) 555-0555
- Other: _____

Write all me

Date: Apr 1 2013 Time: 0943

Medication Name	Dose	Route	Frequency	Continue	Discontinue	New/Change
Loratadine	10mg	PO	Once daily			
Docusate	100mg	PO	Twice daily			
Multivitamin	1 tab	PO	once daily			
Levothyroxine	50mcg	PO	Once daily			

Detailed MedRec Process

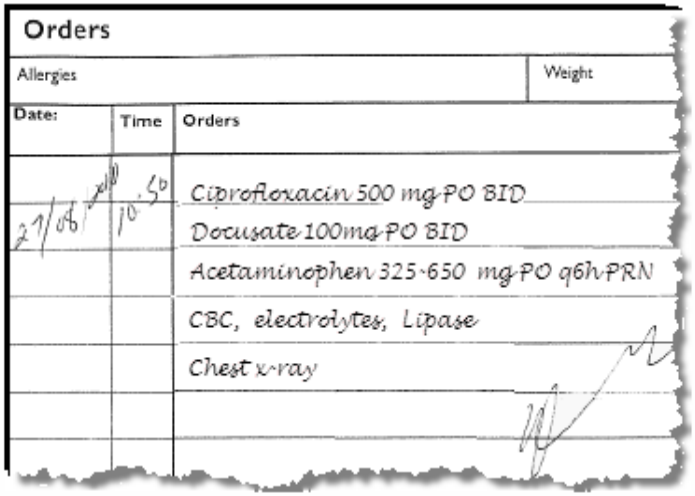
Checkpoint 2

Medication orders were entered before the BPMH was created.

Select the true statement from the options below.

- ○ Since the orders have already been entered, information on the BPMH would not apply.
- ◉ Ensure the BPMH is compared with the orders and all home medications have been addressed.

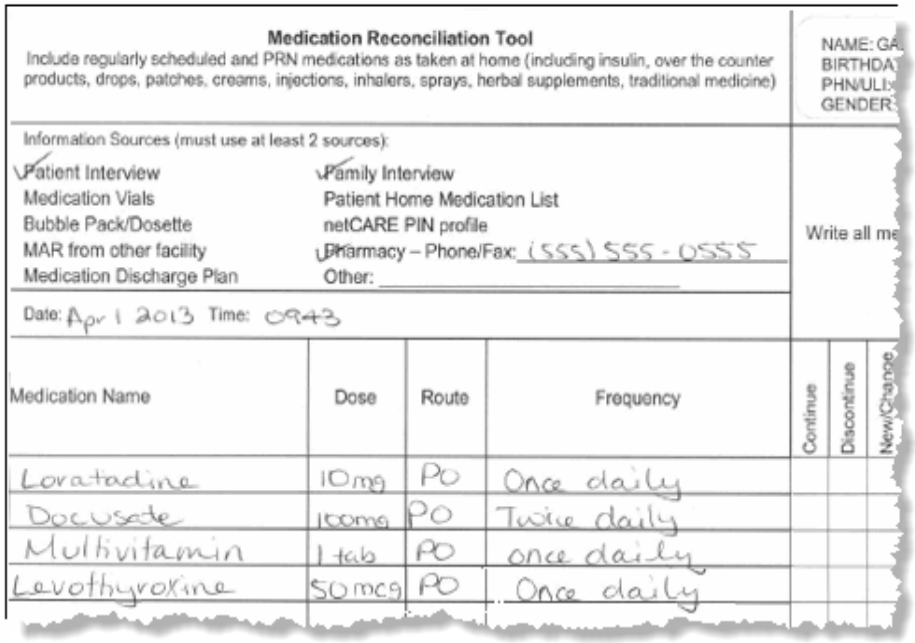
Correct. If the BPMH is completed later, after orders were entered, it is essential to reconcile the BPMH and the orders.



Orders

Allergies | Weight

Date:	Time	Orders
21/06	10:50	Ciprofloxacin 500 mg PO BID
		Docusate 100mg PO BID
		Acetaminophen 325-650 mg PO q6h PRN
		CBC, electrolytes, Lipase
		Chest x-ray



Medication Reconciliation Tool

Include regularly scheduled and PRN medications as taken at home (including insulin, over the counter products, drops, patches, creams, injections, inhalers, sprays, herbal supplements, traditional medicine)

NAME: GA
BIRTHDA
PHN/ULI
GENDER

Information Sources (must use at least 2 sources):

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- Bubble Pack/Dosette
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Write all me

Date: Apr 1 2013 Time: 0943

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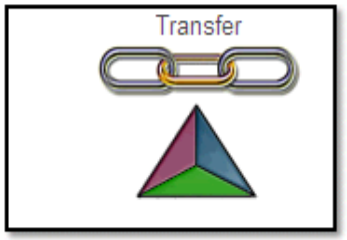
Detailed MedRec Process

Transfer MedRec Process



The MedRec process needs to be repeated at any transition of care when medications are changed, re-ordered, or where there is a risk of medication discrepancies. Some examples would include; a change from one clinic/service to another, a change in level of care, post-operatively, and/or a change in responsible medical services.

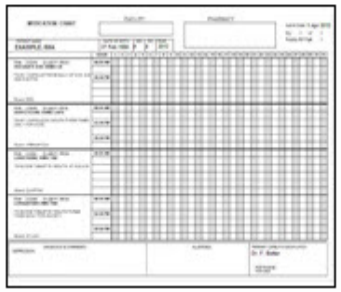
To ensure up-to-date information at transitions, compare the BPMH and the current medication list. Ideally the patient is involved in the process.

The reconciliation involves comparing the complete medication information with the transfer orders, and/or active medication orders to identify and resolve any discrepancies.

Document that the BPMH, complete medication list and medication orders have been reconciled, and any modifications of medications are communicated to the appropriate team members and patient (family, caregiver, etc.).

BPMH

+



Current Medication List

+

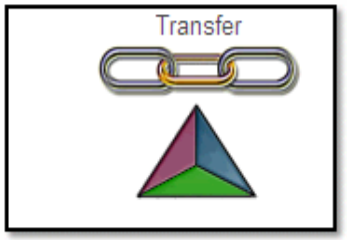
Orders

+

Patient Involvement

Detailed MedRec Process

Transfer MedRec Process



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The reconciliation involves comparing the complete medication information with the transfer orders, and/or active medication orders to identify and resolve any discrepancies.

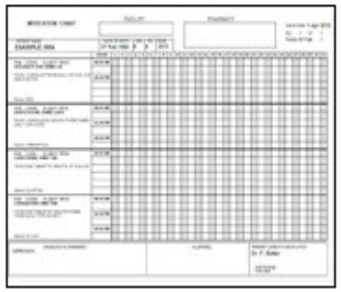
Document that the BPMH, complete medication list and medication orders have been reconciled, and any modifications of medications are communicated to the appropriate team members and patient (family, caregiver, etc.).

Current Medication List

Can also be an active medication list or Medication Administration Record (MAR).

BPMH

+



Current Medication List

+

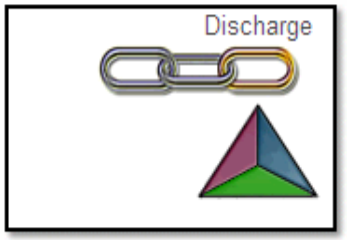
Orders

+

Patient Involvement

Detailed MedRec Process

Discharge MedRec Process



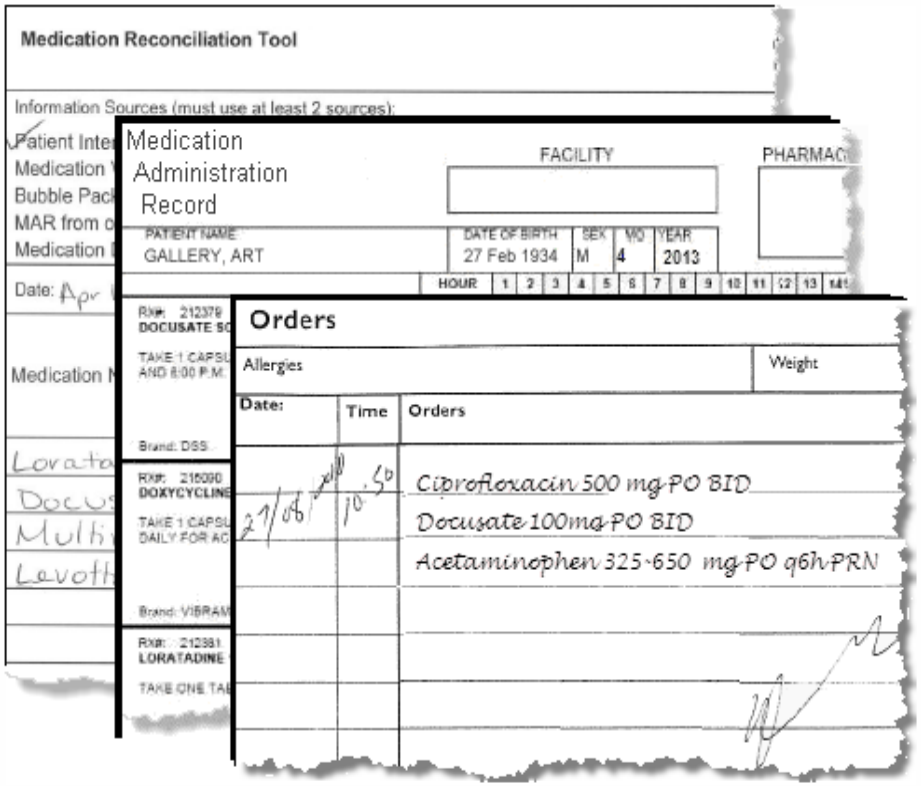
The discharge MedRec process reconciles the medications the patient was taking prior to admission and those initiated in hospital with the medications they should be taking post-discharge. When discharged, the patient is given a complete list of medications to take, information about what has changed and instructions on medication administration. This information should also be communicated to community care providers.

Generate a complete medication list using the BPMH and current medication list. The patient should be involved in the process.

The reconciliation step involves comparing the complete medication list with the discharge orders, and/or active medication orders to identify and resolve any discrepancies.

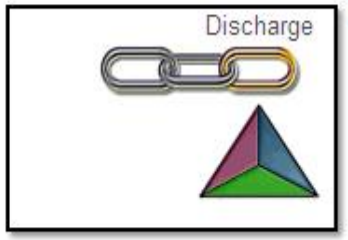
Document that the BPMH, complete medication list and medication orders have been reconciled, and communicate decisions about medications to the patient (family, caregiver, etc.) and next care provider(s).

View the MedRec steps at the time of discharge.



Detailed MedRec Process

Discharge MedRec Process



Patient Involvement

Patient involvement in their own medication safety is critical and can be encouraged in several ways:

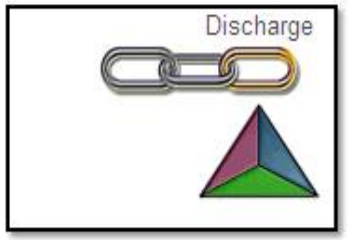
- Ensure patients have and understand the medication information they need. Provide tips to help them ask questions about medications.
- Encourage patients to maintain a current medication list. Advise them that there are resources and tools on the AHS external website.
- Recommend they bring a medication list or their medications when seeking care. Remind patients the list should include non-prescriptions, vitamins and minerals, creams, etc.

decisions about medications to the patient (family, caregiver, etc.) and next care provider(s).

View the MedRec steps at the time of discharge.

Detailed MedRec Process

Discharge MedRec Process



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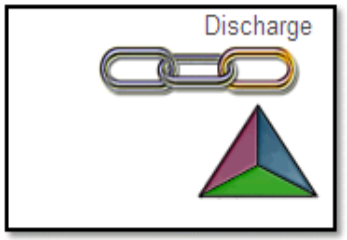
Detailed MedRec Process

Discharge MedRec Process



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View the MedRec steps at the time of discharge.

Medication Reconciliation Tool MedRec Tool

Information Sources (must use at least 2 sources):

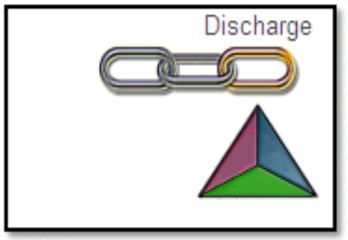
✓Patient Interview	✓Family Interview
Medication Vials	Patient Home Medication List
Bubble Pack/Dosette	netCARE PIN profile
MAR from other facility	✓Pharmacy – Phone/Fax: (555) 555 - 0555
Medication Discharge Plan	Other:

Date: Apr 1 2013 Time: 0943

Medication Name	Dose	Route	Frequency
Loratadine	10mg	PO	Once daily
Docusate	100mg	PO	Twice daily
Multivitamin	1 tab	PO	once daily
Levothyroxine	50 mcg	PO	Once daily

Detailed MedRec Process

Discharge MedRec Process



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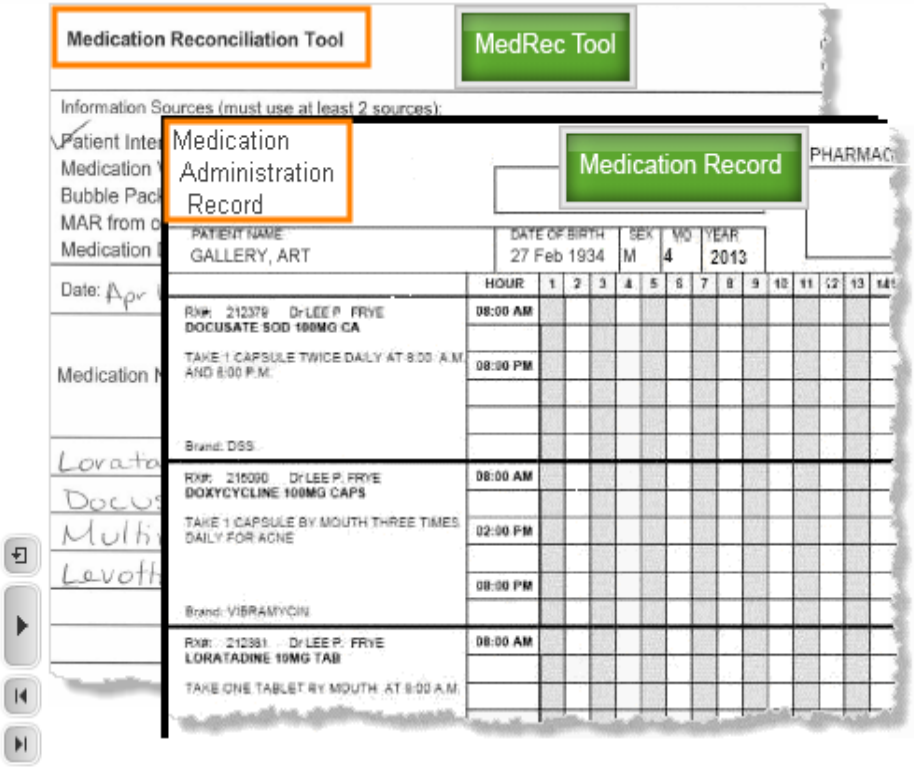
Generate a complete medication list using the BPMH and current medication list. The patient should be involved in the process.

The reconciliation step involves comparing the complete medication list with the discharge orders, and/or active medication orders to identify and resolve any discrepancies.

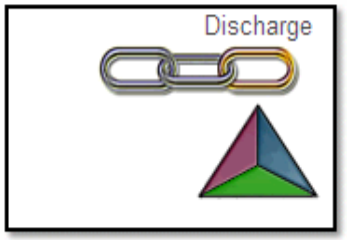
Document that the BPMH, complete medication list and medication orders have been reconciled, and communicate decisions about medications to the patient (family, caregiver, etc.) and next care provider(s).

View the MedRec steps at the time of discharge.



Detailed MedRec Process

Discharge MedRec Process



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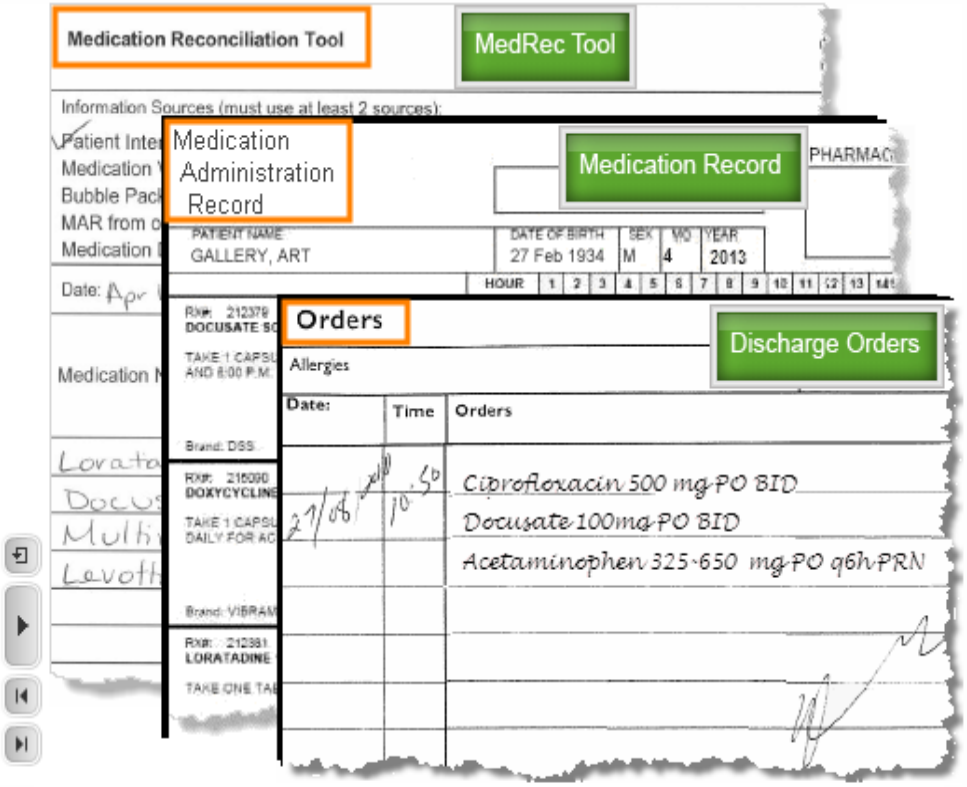
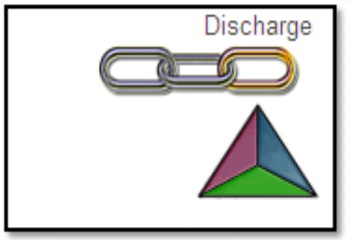


Detailed MedRec Process

Discharge MedRec Process



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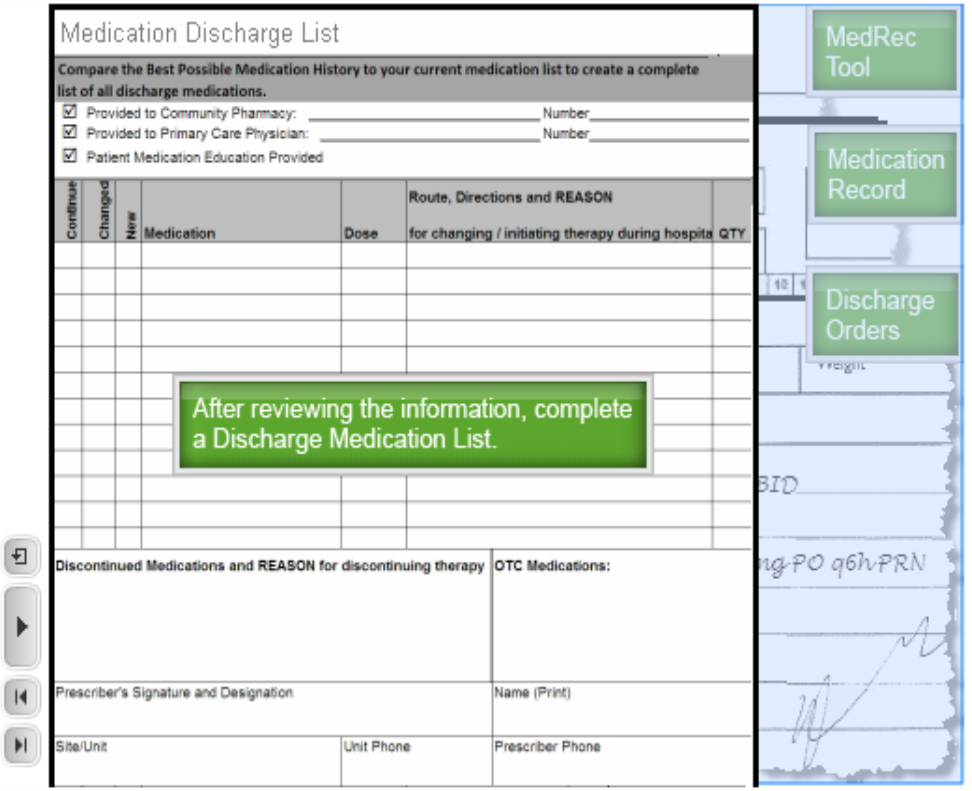


Patient Scenario

To navigate the scenario use the buttons at the top

Patient Scenario: Admission to Hospital

This is the story of Mr. North's admission to hospital. Your goal in exploring this patient scenario is to pursue the best pathway towards reducing the chance of medication errors during his admission. Although many pathways exist, your optimum choices will guide you through the three steps of MedRec and achieve maximum medication safety for Mr. North.

Click on the buttons at the bottom of the page ONLY if you want to exit the course or revisit another topic.

Patient Scenario

Background

Since his wife passed away 8 months ago, Mr. North has been finding it increasingly difficult to take care of himself. Last night he fell and had to be taken to the emergency department. He is now being admitted to an inpatient unit.

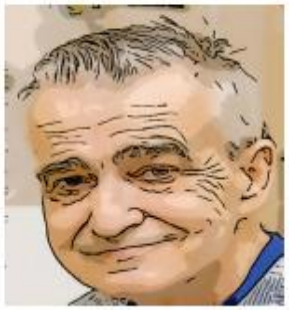
His daughter Mary West is out of the city travelling on business. She has been contacted and is on her way to the hospital.

Detailed MedRec Process

Patient Scenario

Good morning Mr. North. My name is Dr. Port and I am the physician who will be looking after you while you are in hospital. I would like to ask you a few questions. Can you tell me what happened last night? How did you fall?

Well Dr. Port. I was walking down the stairs and I suddenly felt quite dizzy.



Patient Scenario

Dr. Port goes through Mr. North's medical history with him

Thank you for all the details of your medical history. Now it is important for us to know what medications you are taking. Do you have a list?

Well, I don't have a list but I do have all my medicines in a bag right here by my bed.

Detailed MedRec Process

Patient Scenario

Of all these medications, can you please tell me which ones you are taking right now? And can you also tell me how you are taking them?

Oh, I don't remember any of the names. You will have to ask my daughter about that. She is the one who organizes them for me. She should be here in a few hours.

Patient Scenario

What Should Happen Next?

Dr. Port discusses the situation with Ricardo and Debra who are members of the care team. Ricardo is a pharmacist and Debra is the charge nurse who will help take care of Mr. North.

Since Ms. West can't be reached right away, in my opinion, while you are waiting to speak to her you should get Mr. North's medication history from his community pharmacy first.

Well, I think, you should also speak to Mr. North's family physician and maybe take a look at Netcare as well. It is always a good idea to gather information from more than one source of information before verifying the list of medications with patients or their family members.

Patient Scenario

The daughter

The pharmacist

The family physician

Alberta Netcare ELECTRONIC HEALTH RECORD

Sources of Information

Dr. Port compiles a medication list by writing down all of the medications that Mr. North brought in a bag from home. He then decides to contact Mr. North's family physician.

Patient Scenario

Comparison of Medication Lists From Patient and Family Physician

Medication list from patient

Drug Name	Dosage	Route	Frequency
Digoxin	0.125 mg	PO	Daily
Warfarin sodium	4 mg	PO	Daily
Metoprolol SR	100 mg	PO	Daily
Salbutamol MDI	1-2 puffs	inhaled	q6h PRN for acute symptoms of shortness of breath. Total dosage not to exceed 8 puffs/ day (1600 mcg total/day)
Trazodone hydrochloride	200 mg	PO	Daily at bedtime with food
Hydrochlorothiazide	25 mg	PO	Daily
Betahistine	12 mg	PO	BID

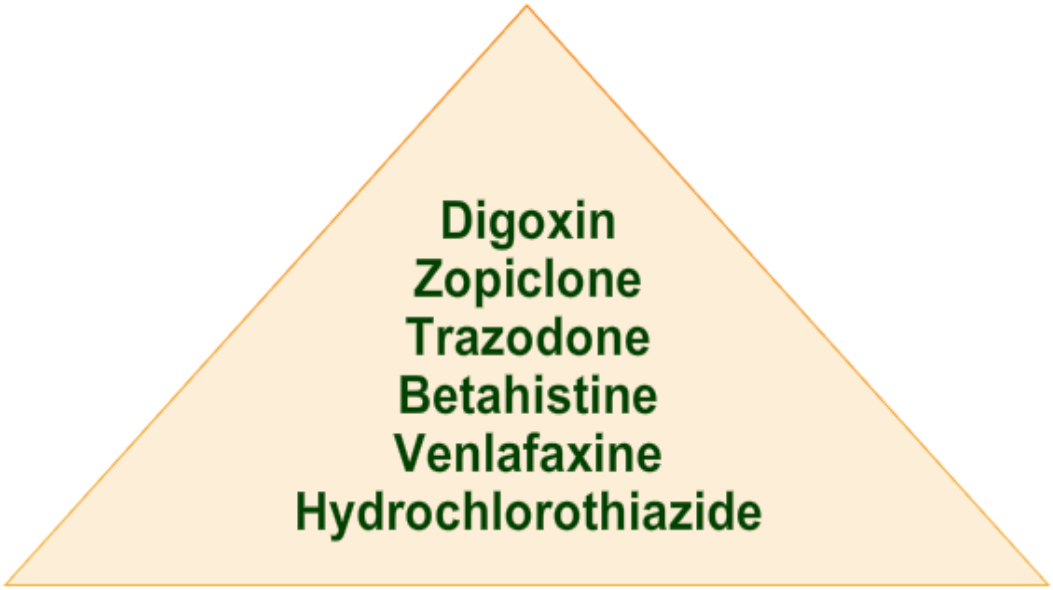
Medication list from family physician

Drug Name	Dosage	Route	Frequency
Digoxin	0.25 mg	PO	Daily
Warfarin sodium	4 mg	PO	Daily
Metoprolol SR	100 mg	PO	Daily
Salbutamol MDI	1-2 puffs	inhaled	q6h PRN for acute symptoms of shortness of breath. Total dosage not to exceed 8 puffs/ day (1600 mcg total/day)
Zopiclone	7.5 mg	PO	Daily at bedtime
Venlafaxine hydrochloride XR	75 mg	PO	Daily in the morning

● Differences in medications and/or their dosages in the lists

Detailed MedRec Process

Patient Scenario



The medications and/or dosages do not match on the lists you have now collected. Apply the principles of the first step in MedRec (BPMH) to create a verified list of Mr. North's medications.

Choosing Sources of Information

Choose your next source of information. In all there are 7 pathways to explore in this case scenario, with 2 outcomes where it is not possible to complete MedRec for Mr. North.

The daughter

click

The pharmacist

click

Alberta Netcare ELECTRONIC HEALTH RECORD

click

Detailed MedRec Process

Patient Scenario

So Ms. West. I think I have a complete list of the medications your father might be taking. Can you please take a look and let me know if this list is accurate?

OK. I would be happy to have a look and see if it matches what my dad has been taking.

Patient Scenario

He stopped taking the medications marked with a red circle months ago. Also, when I took him to the family doctor for a check-up a few days ago because he had been complaining of dizziness and palpitations, she examined him and changed the dosage of digoxin from 0.125 mg to 0.25 mg. He hasn't taken the new dose as of yet.

Drug Name
Digoxin
Warfarin sodium
Metoprolol SR
Salbutamol MDI
Trazodone hydrochloride
Hydrochlorothiazide
Betahistine
Zopiclone
Venlafaxine hydrochloride XR

Patient Scenario

Great. In addition, does your father use any ear drops, eye drops, patches, nasal sprays, other inhalers, creams, ointments or any other medications, including herbal medications? Or perhaps medicines that you can buy directly from the pharmacy without a prescription?

Well, we got some St John's Wort and Vitamin D gelcaps from the pharmacy a couple weeks ago. And every once in a while he takes some tylenol or ibuprofen for the pain in his knees and back. He isn't taking anything else.

Patient Scenario

Hover your mouse here to compare medication lists from your sources

Best Possible Medication History for Mr. North

Dose changed from 0.125 mg to 0.25 mg by family physician, but patient hasn't taken the new dose as yet.

Zopiclone added for sleep.

Trazodone discontinued and replaced with venlafaxine 6 months ago.

Over the counter herbal is a significant concern since patient is on warfarin.

These are over the counter medications. Ibuprofen is a concern since patient is on warfarin.

Drug Name	Dosage	Route	Frequency
Digoxin	0.125 mg	PO	Daily
Warfarin sodium	4 mg	PO	Daily
Metoprolol SR	100 mg	PO	Daily
Salbutamol MDI	1-2 puffs	inhaled	q6h PRN for acute symptoms of shortness of breath. Total dosage not to exceed 8 puffs/ day (1600 mcg total/day)
Zopiclone	7.5 mg	PO	Daily at bedtime
Venlafaxine hydrochloride XR	75 mg	PO	Daily in the morning
St John's Wort (0.3 percent hypericin content)	300 mg	PO	3 times daily
Vitamin D	400 units	PO	Daily
Acetaminophen	500 mg	PO	q8h as needed for joint pain not to exceed 4000 mg per day
Ibuprofen	200-400 mg	PO	q4h PRN for back pain. Daily dose not to exceed 1200 mg total.

Patient Scenario

Congratulations!

You have used multiple sources of information to create a Best Possible Medication History for Mr. North.

Some other sources of information that you could have used are Mr. North's community pharmacy or Netcare. Using multiple sources is important because in certain instances, when making reference to the family physician's list of medications, the list may not reflect prescriptions from a specialist, emergency department and/or hospital visits. Also, not every medication that is prescribed is necessarily always filled by patients.

Explore another path for patient scenario?

Move on to medication reconciliation?

Choosing Sources of Information

Choose your next source of information. In all there are 7 pathways to explore in this case scenario, with 2 outcomes where it is not possible to complete MedRec for Mr. North.

The daughter

click

The pharmacist

click

Alberta Netcare ELECTRONIC HEALTH RECORD

click

Detailed MedRec Process

Patient Scenario

Hello Dr. Port? I am faxing you the list that I have for Mr. North right now.

The pharmacist

Medication list from pharmacy
(to zoom in hover your mouse here)

Drug Name	Dosage	Route	Frequency
Digoxin	0.125 mg	PO	Daily
Warfarin sodium	4 mg	PO	Daily
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Zopiclone	7.5 mg	PO	Daily at bedtime
Trazodone hydrochloride	200 mg	PO	Daily at bedtime with food

Choose another source?

The daughter

click

Alberta Netcare ELECTRONIC HEALTH RECORD

click

Detailed MedRec Process

Patient Scenario

Medication list from pharmacy
(to zoom in hover your mouse here)

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Trazodone hydrochloride	200 mg	PO	Daily at bedtime with food

Detailed MedRec Process

Patient Scenario

And, here is the list from NetCare. Hmm, the list from the pharmacy and this list are a little bit different.

Medication list from Netcare
(to zoom in hover your mouse here)

Drug Name	Dosage	Route	Frequency
Digoxin	0.125 mg	PO	Daily
Diphenhydramine	25 mg	PO	q6h as required for pruritus
Warfarin sodium	4 mg	PO	Daily
Metoprolol SR	100 mg	PO	Daily
Salbutamol MDI	1-2 puffs	inhaled	q6h PRN for acute symptoms of shortness of breath. Total dosage not to exceed 8 puffs/ day (1600 mcg total/day)
Donepezil hydrochloride	5 mg	PO	Daily
Zopiclone	7.5 mg	PO	Daily at bedtime
Trazodone hydrochloride	200 mg	PO	Daily at bedtime with food
Venlafaxine hydrochloride XR	75 mg	PO	Daily in the morning

What should Dr. Port do next?

Speak to the daugher?

click

Proceed with generating a best possible medication history for Mr. North without speaking to Ms. West?

click

Detailed MedRec Process

Patient Scenario

Medication list from Netcare
(to zoom in hover your mouse here)

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Patient Scenario

One of the sources of information must include a patient/family or caregiver interview.

Click to see Mr. North's BPMH

- If Dr. Port had checked with Ms. West he would have realized that Mr. North isn't taking all his medications as prescribed.
- He is also taking some over the counter medications that his family physician is unaware of.
- This is not the best scenario.

Explore another path for patient scenario?

Click on the navigation buttons at the bottom of the page to exit the course or revisit another topic.

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Detailed MedRec Process

Wrap Up

Having completed this topic, you've covered some important concepts. Some key points to remember are:

- the key components of creating a BPMH are: gathering information, interviewing the patient and family, and creating a source of truth.
- there are different models of the reconciliation process; proactive and retroactive.
- an essential piece of the process is ongoing communication with the patient, family or caregiver as well as other providers involved in the patients' care.
- at each transition point there are differences in the details in carrying out each of the three steps, however the goal is to ensure complete and accurate sharing of medication information.
- although there are a variety of MedRec tools, there are essential elements to ensure complete information is shared at transitions of care.

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This certifies that

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January 30, 2014