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MANITOBA RENAL PROGRAM

SUBJECT ▪ Medication Reconciliation	**SECTION**	80.10 Guidelines – Manitoba Renal Program, General
	CODE	80.10.02
AUTHORIZATION ▪ Professional Advisory Committee, Manitoba Renal Program ▪ Nursing Practice Council, St. Boniface Hospital	**EFFECTIVE DATE**	November 2012
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PURPOSE:

1. To describe the responsibilities of Manitoba Renal Program (MRP) Health Care Providers in regards to:

a. Creating the Best Possible Medication History (BPMH)
b. Reconciliation of the Client's Medications

2. To identify the Client groups that will require Medication Reconciliation.

3. To ensure Medications are accurately and completely reconciled at Transitions of Care (new dialysis starts, Transfer between sites or modalities, End of Service), that all Medication changes are intentional, and any Medication Discrepancies identified are resolved.

4. To ensure that the Client has a complete up-to-date list of Medications to communicate with their Health Care Provider.

DEFINITIONS:

1. Best Possible Medication History (BPMH): Is a Medication list obtained by a Prescriber or designated Health Care Provider which includes a history of all current Medications. A minimum of two reliable Information Sources shall be used, one of which should include the Client/Client's caregiver as appropriate. It shall include: the Medication name (generic name preferred for single active ingredient products), dose, route of administration, and frequency of administration.

2. Client: Any individual receiving dialysis provided by the Manitoba Renal Program.

3. Discrepancy/Discrepancies: Indicates a difference between what the Client is actually taking versus the information obtained from other sources. These differences in Medications shall include Medications that Client is no longer taking, omission of a Medication, or conflicting Medication directions.

4. Drug Program Information Network (DPIN): Connects all retail pharmacies in Manitoba to a central database and allows for direct on-line submission of prescription drug claims to Pharmacare. As an Information Source, it provides the Health Care Provider with a dispensing history.

5. Electronic Kidney Health Record (eKHR): Refers to the electronic Client record of the Manitoba Renal Program.

6. End of Service: Refers to the discharge of a Client from the MRP (e.g. moved to another province, or discontinuation of dialysis).

7. Health Care Provider: May include nephrologists, physician assistants, nurses, pharmacists, pharmacy assistants/technicians or any individuals providing and supporting these professions (e.g. students, residents).

8. Information Source(s): Are used in collecting the Best Possible Medication History. It may include but not limited to: Client, Client's caregiver, Client Medication list, Drug Program Information Network (DPIN), Medication containers, community pharmacy, Medication Administration Record (MAR), Electronic Patient Record (EPR), and primary care provider.

9. Medication Reconciliation: Is a formal structured process in partnership with the Client/Client's caregiver in identifying the most accurate list of all the Medications a Client is taking and using this list to include instructions (e.g. orders) regarding their disposition at Transitions of Care. It is a process to verify and communicate accurate Client Medication information at transition points to reduce/prevent adverse Medication events.

10. Medication(s): Includes prescription drugs, over-the-counter drugs (including vitamins, supplements and herbal Medications), and sample drugs. Recreational drugs shall be documented where appropriate in Patient's health record.

11. Prescriber: Refers to a Health Care Provider who is permitted to prescribe Medications as defined by Provincial and Federal legislation, his/her regulatory college or association, and practice setting.

12. Site(s): For the purpose of this document Site refers to a dialysis unit where health care services are delivered within the Manitoba Renal Program.

13. Transfer: For the purpose of this guideline, refers to the permanent relocation of a Client to a Facility/ Site or change in dialysis modality within the Manitoba Renal Program. It is an interface of care where Medication Orders need to be reviewed, reconciled and modified as necessary for the next phase of care.

14. Transitions of Care: Refers to the movement of Clients from one Manitoba Renal Program Site to another.

GUIDELINES FOR MEDICATION RECONCILIATION:

1. Medication Reconciliation is *not* required for:

a. Manitoba Renal Program Clients who are admitted to hospital:

A current Medication list shall be provided from eKHR or the paper chart when sending the Client from the unit to the Emergency department.

Rationale: Clients often present to Emergency departments between visits and may be admitted without the program knowing. Some Emergency departments have access to eKHR to obtain the most current Medication list on file. The responsibility falls on the admitting service to contact the renal program if the Client is unable to provide their current Medication list.

b. Clients with non-dialysis dependent Chronic Kidney Disease.

Rationale: These Clients are followed less frequently than Clients receiving dialysis and the Manitoba Renal Program does not assume primary care of these Clients. However, communication with the Client/Client's caregiver, Client's primary care, and other specialty providers does occur when changes are made to their Medications.

c. Clients who are temporarily relocated to another dialysis Site but will return to their original dialysis unit (e.g. transients, temporary Transfers).

Rationale: Procedures are very similar between MRP Sites. In most of these incidences, Medication changes are not made.

d. Death of a Client.

2. The final shared responsibility for Medication Reconciliation shall lie with the Prescriber. There is a shared

accountability of the various Health Care Providers who assist in accurate Medication Reconciliation. In the MRP, pharmacists hold the primary responsibility for the Medication Reconciliation procedures outlined below. However, pharmacy assistants/pharmacy technicians, physician assistants and nurses may also reconcile Clients' Medications and communicate and resolve any Discrepancies with the Prescriber(s) if a pharmacist is not available.

3. The Medication Reconciliation process shall be completed by the MRP pharmacist in a timely manner at the following Transitions of Care:

a. Within 2 weeks of Clients for new outpatients starting dialysis treatments in the Manitoba Renal Program.

b. Within 2 weeks of Clients permanently transferred from one dialysis Site to another who have not had a change in dialysis modality (e.g. in-centre hemodialysis to another in-centre hemodialysis Site or peritoneal dialysis to another peritoneal dialysis Site).

c. Within 2 weeks of Clients permanently transferred from one dialysis modality to another (e.g. in-centre hemodialysis to Home Hemodialysis, hemodialysis to peritoneal dialysis, etc.).

d. Within 2 weeks of Discharge from an acute care Facility for existing Manitoba Renal Program dialysis Clients.

e. Every 6-12 months for Clients receiving chronic in-centre hemodialysis.

f. At every clinic visit for Clients receiving home hemodialysis and peritoneal dialysis.

g. End of Service.

PROCEDURE:

The following procedures apply to all MRP dialysis Sites. The MRP pharmacist shall perform the following:

1. Best Possible Medication History (BPMH):

a. Collect the BPMH within 2 weeks of beginning dialysis or hospital discharge with the involvement of the Client and/or Client caregiver. At least one other Information Source shall be used.

b. Multiple Information Sources shall be considered where the Client and/or Client caregiver are not considered reliable historians or where the Client and/or Client caregiver are not available within the 2 week time period (e.g. Clients receiving evening shift dialysis will have a preliminary Medication history generated from other Sources within 2 weeks of beginning dialysis or hospital discharge and a BPMH will be generated with the Client and/or Client caregiver within 1 month).

c. If the BPMH cannot be obtained from the Client/Client's caregiver and/or other Information Sources, the reason shall be documented in the Client's dialysis chart and subsequent attempts to obtain the information shall be documented.

d. Best practice shall be to include the source(s) of information used and document on the Pharmacist Medication Review sheet or in the Integrated Progress Notes (IPN).

2. Discrepancies:

a. Identify any Discrepancies between the Medication list documented in the Client's dialysis chart and what the Client is actually taking.

b. If the Medication is prescribed and monitored by the Manitoba Renal Program:
Inform the Prescriber of the Discrepancy. Document the decision and provide appropriate prescriptions once the Discrepancy is resolved.

c. If the Medication is prescribed by another Health Care Provider outside of the Manitoba Renal Program:
Discuss the Discrepancy with the nephrologist and the Client/Client Caregiver; document in the

Medication list how the Client is currently taking the Medication; advise the Client to follow up with the Prescriber and/or pharmacy if deemed necessary and document the actions to be taken.

3. Documentation:

a. Write the new or changed Medication order(s) on the Physician Order Sheet or MRP Outpatient Prescription as appropriate.

b. The dialysis unit clerk or pharmacist will enter the Medication order(s) into eKHR or the Renal Medication Flowsheet for Sites without eKHR.

- Enter Medication(s) into eKHR as per the eKHR Medications Manual. Available at: : http://www.kidneyhealth.ca/wp/wp-content/uploads/ekhr/eKHR%20Medications%20Module%20v1.pdf

- Enter Medications on the Renal Medication Flow Sheet FORM #NS01708 (60.20.05a *Renal Medication Flow Sheet*) as per MRP Standard 60.20.05. *Renal Medication Flow Sheet Standard: Non Electronic Kidney Health Record Sites*

c. Verification that the Medication order(s) were entered correctly by the unit clerk is done by the dialysis nurse.

d. The Renal Medication Flow Sheet represents the up-to-date Medications list as of the date indicated.

e. Home Hemodialysis or Peritoneal Dialysis Medication Changes made *outside of Clinic* visits:
The dialysis nurse will phone the Client or Client's Caregiver informing them of the medication change and which pharmacy the prescription was faxed to. The dialysis nurse will document that the Client was contacted on the Manitoba Renal Program Outpatient Prescription.

4. Communication to the Client/Client's Caregiver:

a. The unit clerk or pharmacist will generate either:

- a new Medication Card from eKHR
  OR
- the Medication Change Form (Appendix A 80.10.02a *Medication Change Form*)

b. The nurse or pharmacist will document in the appropriate box on the MRP Outpatient Prescription that the written (MRP Medication Change Form or Medication Card) instructions were provided.

c. The Client shall be encouraged to carry and share an up-to-date Medication list that includes all pertinent Medication information (Medication name, dose, route, and frequency) with their Health Care Providers.

MEDICATION RECONCILIATION ON PERMANENT TRANSFER *within* THE MANITOBA RENAL PROGRAM:

1. Transfer between in-centre Hemodialysis or Peritoneal Dialysis Sites with *no* change in dialysis modality.

a. Best Possible Medication History (BPMH):
The dialysis nurse will complete the "Transfer of Renal Patients between Renal Sites Checklist" located in 70.10.04 *Protocol for Patient Transfer*

70.10.04 Appendix A *Transfer Checklist* specifies that the current Medication list and all PRNs and single dose Medications within the last month are sent to the receiving dialysis unit by sending the Renal Medication Flowsheet, MAR, and PRN Med Lists.

b. Discrepancies:
A review of the Transfer Medication list is performed within the first 2 weeks by the pharmacist.

Discrepancies are resolved as outlined in procedure section 2.

c. Documentation:
Any new or changed Medication order(s) is/are written on the Physician Order Sheet or MRP Outpatient prescription and entered into eKHR.

The pharmacist will document in the Integrated Progress Notes (IPN) that the Transfer Medication list was reviewed.

d. Communication to the Client/Client's Caregiver:
Either a new Medication Card is generated from eKHR and provided to the Client or Client's caregiver *OR* the Medication Change Form (Appendix A 80.10.02a *Medication Change Form*) is completed by unit clerk or pharmacist and provided to the Client/Client's caregiver. Document in the appropriate box on the MRP Outpatient Prescription that the written (MRP Medication Change Form or Medication Card) and verbal instructions were provided.

2. Transfer to Peritoneal Dialysis from another modality (e.g. Renal Health Clinic, Hemodialysis):

A BPMH is performed and documented as outlined in "Medication Reconciliation at the Beginning of Service" during the Client's first week of training before they go home.

3. Transfer to Home Hemodialysis from another modality (e.g. Renal Health Clinic, in-centre hemodialysis, peritoneal dialysis):

A BPMH is performed and documented as outlined in "Medication Reconciliation at the Beginning of Service" during the Client's first 2 weeks of training.

4. In-centre Hemodialysis Transfer from and to Long-Term Care Facilities:

Follow 60.20.06 *Documentation Standard for Manitoba Renal Program & Long Term Care Communication Record* .

Complete the appropriate Manitoba Renal Program and Long-Term Care Communication Record (Form W-00273 – 60.20.06a, Form WR-16 for Riverview Health Centre – 60.20.06b, or Form CL0065-5 for Deer Lodge Centre 60.20.06c) so that the Long-Term Care Facility is aware of the Medications that were administered in dialysis.

MEDICATION RECONCILIATION AT END OF SERVICE:

- The Client's Renal Medication Flowsheet and the most recent Case Summary are provided to the accepting service provider(s).
- eKHR Sites: The Client is provided with a copy of their Medication Card generated from eKHR by the unit clerk or pharmacist.
- Paper chart Sites (i.e. no eKHR): The Client is provided with a copy of the MRP Medication Card by the unit clerk or pharmacist (80.10.02b *Medication Card*).

REFERENCES:

Accreditation Canada Ambulatory Care Required Organizational Practices 2016. Available at: www.accreditation.ca

WRHA Medication Reconciliation Policy (draft May 25, 2014)

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