

How we keep our patients safe



Fact:

Medication Reconciliation (Med Rec) — comparing an accurate list of medications that patients take at home to their in-hospital orders can reduce adverse drug events

See over for details >>>

What is Med-Rec in simple terms?

Medication Reconciliation starts with an accurate list of all medications taken at home (also known as the “Best Possible Medication History” or “BPMH”)

The medication list (home and inpatient medication orders) is checked and updated at admission, on transfer and at discharge.

It is a shared responsibility between the care team the patient.

Sources for obtaining an accurate home/ pre-admission list

- Patient / family interview
- Patient medication list or vials
- List completed in the ED – “Patient/Family Recorded Home Medication List”
- Patient’s pharmacy
- Previous hospital records
- Primary care physician’s office record
- Ontario Drug Benefit Profile Viewer system

More about home medications ...

- Should be documented in TED or the manual patient chart or new latrics software (implemented on 2E, 2C and CCC at Oakville and Pre-Admission clinics at all three sites ➤ coming hospital-wide!)
- Can be viewed in the EMR
- Should be compared and reconciled to current medication whenever patients are admitted, transferred or discharged. And discrepancies that are detected must be documented and brought to the attention of the physician (unless a reason for the discrepancy has already been documented in the patient chart)*