Disclaimer: the information contained in this document is for educational purposes only. Any PRINTED version of this document is only accurate up to the date of printing. Always refer to the Policies and Procedures Intranet site for the most current versions of documents in effect.

POLICY	**Manual:** Clinical	**Section:** Interdisciplinary Clinical	**Code No.:** I B009	**Old Code No.:**
Title: Best Possible Medication History (BPMH)			**Original Effective Date:** Feb 08, 2016	
			Review/Revised Effective Date: Feb 05, 2020	
			Next Review Date: Feb 01, 2023	
Cross Index: I M015, I I002	**Authoring Committee/Program/Dept:** Medication Safety Committee		**Approved By:** SLT	

As an exception, SLT has approved the use of combined policy and procedure in this document, notwithstanding accepted practice to have policy and procedure as separate documents.

POLICY

Patients of Southlake Regional Health Centre shall have a Best Possible Medication History (BPMH) completed in accordance with the timeframes and processes outlined in the Procedure below.

The BPMH and Medication Reconciliation form is a history form until such time as the prescriber carefully reviews the information, assesses the prescriptions against the current clinical picture, checks the appropriate box for each medication, and signs the form which makes it an order.

PROCEDURE

Purpose:

- To outline the process for completing the BPMH.
- A complete, timely, and accurate BPMH is required to complete medication reconciliation.

Roles and Responsibility:

- **Registration staff** in the Emergency department – ensure the medication list from DPV/Connecting Ontario is printed and placed with the chart.
- **Certified Medication Reconciliation Pharmacy Technicians and Pharmacist Students** – collect a BPMH for the patient, and enter it into the Meditech Home Medications module. The prescriber is alerted to any discrepancies and/or the need to convert the BPMH to active orders as soon as the BPMH is completed.
- **Pharmacists** - monitor for BPMH completion and initiate if not yet done. Assist the Pharmacy Technicians and students as needed. Alert prescribers for BPMH signature and communicate any required clarifications or concerns.

- **Nurses** – initiate the BPMH as needed, work with Pharmacy staff if there are any concerns or questions, clarify discrepancies with prescribers, alert prescribers of the need to convert the BPMH to active orders as soon as the BPMH is completed; enter BPMH's into the Meditech Home Medications module.
- **Prescribers** - initiate the BPMH on the blue BPMH and Medication Reconciliation form when necessary and indicate when Pharmacy is to be consulted for follow-up and clarification of the medication regimen. Proactively ensure the BPMH is **SIGNED** within 24 hours of admission and that discrepancies are reconciled. The prescriber is responsible for the completeness of the order information when the order is signed.

Equipment:

- Meditech Home Medications Module
- Ontario Drug Benefit information through Connecting Ontario
- Patient vials/lists; community pharmacy profiles; primary care provider medication lists
- BPMH and Medication Reconciliation (form #SL0185)
- Medication Reconciliation pamphlet (form #SL0505)

Method:

1. When completing the BPMH, inquire about patient allergies, other adverse drug events and the nature of the events. Enter the drug allergies and the nature of the events in Meditech. If using the paper based form (SL0185) list the allergies on the form.
2. Provide the Southlake pamphlet 'Medication Reconciliation' (form #SL0505) for the purpose of engaging the patient and family in the importance of this safety initiative and to provide a page for the patient to use as a medication list (this may not be necessary if the patient/family already have a thorough understanding and approach to the importance of maintaining an accurate list of medications).
3. A minimum of 2 sources of medication information shall be used for the BPMH.
    - The patient/family/caregiver shall always be consulted as a source of information.
    - Family and caregiver consultation is always necessary when the patient is confused or unable to provide accurate information.
4. Other possible sources of information include but is not limited to:
    - Connecting Ontario/Drug Profile Viewer record for ODB eligible patients (those over 65 years of age or receiving social assistance through Ontario Works or Ontario Disability Support program and those under 25 years of age with no private insurance),
    - Patient medication list,
    - Patient medication vials,
    - Community pharmacy medication profile,
    - Family physician medication list,
    - May consult the patient's previous health record medication list, but it **MUST BE VALIDATED** with the patient,
    - Medication Administration record from another facility (i.e. Nursing home).

INPATIENTS:

The BPMH will be:

- Initiated as soon as possible by a certified Pharmacy Technician, nurse, pharmacist, or MRP,
- Completed within 24 hours of admission,
- Initiated at the preoperative clinic visit and **RE-VERIFIED** carefully on the day of admission to the hospital as the medication information may have changed.

For an accurate BPMH:

- Assess if the patient or family/caregiver is a reliable historian, how current the information is, and if there are other possible sources of medication information.
- Never assume that the patient's medication list is up-to-date, complete or accurate.
- Never assume that the patient takes the medications as stated on the label.
- Record the medication history exactly according to how the patient was using the medication, not the way it was prescribed.
- If there is a significant difference between the medication prescription and how the

patient actually takes the medication, make note of that in the comment column of the BPMH form or enter into the comments box in Home Medications. Consult with the pharmacist if required.

- Gather information about:
  - Prescription medication use,
  - Natural/over the counter - complementary/herbal therapies, vitamins, antacids,
  - Recreational Drugs - any street drugs, smoking, alcohol, cannabis,
  - Always ask about non oral medications such as inhalers, eye/eardrops, nasal sprays, topical creams/patches, injections, vaginal/rectal preparations,
  - Ask about other sources of medication such as physician samples or study drugs,
  - Influenza vaccine history especially from October to April or longer depending on the influenza season.
- Probe for more information - ask open ended questions to obtain details about drugs, doses, dosage forms, adherence and any problems or concerns with the therapies, i.e.:
  - Who ordered the medication? What dose/dose form? When do you take it?
  - Why do you take it? Have you missed any doses recently? Do you have any problems with your medications? When did you last take it?
  - Is there anything else you would like to tell me about your medications that I have not asked?

If all of the information required is not immediately available, request the patient/family obtain the information, or contact outside resources to clarify (patient's usual outpatient pharmacy or their physician office).

For Ontario Drug Benefit patients, ensure a copy of the ODB Viewer profile is on the chart and that the medication history is verified against such information as the ODB profile provides.

Note the ODB medication list ONLY reflects those drugs that have been covered by ODB; the patient may be on other medications.

Where the medication history is difficult to obtain, or the information is unreliable or incomplete, please contact the Pharmacy staff for assistance. Page the clinical pharmacist for the department, or a Pharmacy Technician at pager #1902, or #1308, check 'Pharmacy Consult required' on the BPMH form, or write in the chart that Pharmacy follow-up is required.

For further information on how to complete the history, view the BPMH - Safer Healthcare Now BPMH interview guide med card.

The BPMH Information and Meditech:

- Enter the home medication history into the ‘Home Medications Module', including if the patient takes no medications. View the Meditech - BPMH How to Enter Home Meds Powerpoint for further information.
- Enter treatments that the hospital doesn't provide, such as herbals, homeopathy, naturopathic medicines, supplements (e.g.non-prescribed vitamins) in the ‘herbals/supplements' section of the Home Medications module.
- When the Best Possible Medication History (BPMH) report prints, attach the Post-it note “blue flag” (Grand and Toy product #680-2) to the upper right hand corner for easier identification in the paper chart, and **place the form at the front of the ‘orders' section of the chart.**
- The BPMH form remains in the orders section of the chart until it is completed by a prescriber and scanned to Pharmacy.
- **After it is completed and scanned, remove the blue flag from the form and place the form in the ‘Medications' tab of the paper chart (for easier locating and assessment at transfer or discharge).**

Paper process:

- Prescribers who initiate their own medication history will document on the"BPMH and Reconciliation of Medications" pre-printed order form (#SL0185 or the 'blue form').
- Prescribers will use this form for admission orders.

Transfers from other Acute Care facilities

- The current medication history of patients transferred FROM OTHER ACUTE CARE SETTINGS, **will NOT be entered into the Meditech Home Medications module** - use paper orders for admission orders.
- Home meds will be entered in Meditech only if a BPMH interview occurs and home medication use is verified.

Documentation of BPMH Completion:

- Pharmacy staff document their work and workload in the PCS 'BPMH-Med Rec' Intervention.
- Nurses document in the PCS Admission Assessment Intervention.

AMBULATORY CLINICS

The BPMH:

- Will be completed in specified ambulatory clinics where medication management is a focus of the care provided by the clinic (refer to Medication Reconciliation and Southlake Ambulatory Care Services Clinics schedule and Medication Reconciliation policy and procedure).
- Will be entered into Meditech 'Home Meds Module' where possible.
- Will be documented on an appropriate paper record (i.e. form SL0185, SL1445, or SL1942) if the clinic is paper-based.

Special Considerations:

Not Applicable.

References:

- Edward G. Tessier, Pharm.D.,MPH, CPS, Pharmacy-nursing intervention to improve accuracy and completeness of medication histories, Am J Health-Syst Pharm-VOl 67, Apr 15, 2010, pp 607-611
  Sunnybrook
- Safer Healthcare Now! (2007). Getting Started Kit: Medication Reconciliation Prevention of Adverse Drug Events – How-to Guide. Retrieved from http://www.ismpcanada.org/download/MedicationReconciliationGettingStartedKit-Version2.pdf
- Cornish PL, Knowles SR, Marcheso R, Tam V, Shadowitz S, Juurlink DN, Etchells EE. Unintended medication discrepancies at the time of hospital admission. Arch Intern Med. 2005;165:424-29.
- Vira T, Colquhoun M, Etchells EE. Reconcilable differences: correcting medication errors at hospital admission and discharge. Qual Saf Healthcare. 2006;1-6.
- Forster AJ, Clark HD, Menard A, et. Al. Adverse events among medical patients after discharge from hospital. Can Med Assoc J. 2004;170(3):345-9
- American Medical Association (2007). The physician's role in medication reconciliation. Retrieved from: www.ama-assn.org/resources/doc/cqi/med-rec-monograph.pdf
- American Society of Hospital Pharmacists (AHSP) SP) SP) Council on Pharmacy Practice. (2013). ASHP statement on the pharmacist's role in medication reconciliation. Am.J.Health.Syst.Pharm., 1: 453-6.
- Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Drug Events (Medication Reconciliation). Retrieved from: www.ihi.org/knowledge/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx
- Institute for Healthcare Improvement (2008). Reconcile medications at all transition points. Retrieved from: www.ihi.org/knowledge/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx
- MARQUIS Investigators. (2011). MARQUIS Implementation Manual: A guide for medication reconciliation quality improvement. Philadelphia, PA: Society of Hospital Medicine. http://tools.hospitalmedicine.org/resource_rooms/imp_guides/MARQUIS/marquis.html (registration required)
- World Health Organization Collaborating Centre for Patient Safety Solutions (2007). Assuring Medication Accuracy at Transitions in Care. Report No.: Solution 6.

Copyright ©1997 - 2021 Southlake Regional Health Centre