

OFFICIAL PUBLICATIONS

Medication Reconciliation: Statement on the Role of the Pharmacist (2009)



Canadian Society of Hospital Pharmacists
Société canadienne des pharmaciens d'hôpitaux

Medication Reconciliation: Statement on the Role of the Pharmacist

Published by the Canadian Society of Hospital Pharmacists (CSHP), Ottawa, Ontario. 2009 edition. Use of this document was approved by CSHP Council in 2009.

Suggested citation:

Canadian Society of Hospital Pharmacists. Medication reconciliation: statement on the role of the pharmacist. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2009.

© Canadian Society of Hospital Pharmacists 2009

This paper was retired by the CSHP Board in April 2018. Though its content is considered outdated, the paper is made available so that readers have access to information that is suitable for referencing or conducting historical research.

If you are interested in a current version of this paper, please check CSHP's website: there is no guarantee that such a version exists.

All rights reserved. Publications of the Canadian Society of Hospital Pharmacists can be obtained from:

30 Concourse Gate, Unit 3
Ottawa ON K2E 7V7
Telephone: 613.736.9733
Fax: 613.736.5660
Internet: www.cshp.ca

An electronic copy of this document is available, for personal use, to:

- members of CSHP, at CSHP's website: www.cshp.ca
- non-members of CSHP at a cost, by contacting the Publications Administrator at the above address

Requests for permission to reproduce or translate CSHP publications – whether for sale or for non-commercial distribution – should be addressed to the CSHP Publications Administrator using the above contact information.

This publication represents the view of Canadian Society of Hospital Pharmacists and was approved after careful consideration of the evidence available. All reasonable precautions have been taken by the Canadian Society of Hospital Pharmacists to verify the information contained in this publication.

The Canadian Society of Hospital Pharmacists is not a regulation-setting organization.

This published material is being distributed without warranty of any kind, either expressed or implied. Although the intended primary application of this publication is stated in its introduction, it is important to note that it remains the responsibility of the user of the publication to judge its suitability for his or her particular purpose within the context of his or her practice and the applicable legislative framework. In no event shall the Canadian Society of Hospital Pharmacists or any persons involved in the development and review of this publication be liable for damages arising from its use.

CSHP Official Publications are subject to periodic review, and suggestions for their improvement are welcomed. Where more than one version of a publication exists, the most recent version replaces the former version(s). Users of the CSHP's publications are advised to check CSHP's website for the most recent version of any publication.

All inquiries regarding this publication, including requests for interpretation, should be addressed to the Canadian Society of Hospital Pharmacists using the above contact information.

RETIRED

Medication Reconciliation: Statement on the Role of the Pharmacist

THE CANADIAN SOCIETY OF HOSPITAL PHARMACISTS AND THE INSTITUTE FOR SAFE MEDICATION PRACTICES CANADA SUPPORT THE LEADERSHIP ROLE OF PHARMACISTS IN ENSURING COMPREHENSIVE AND TIMELY MEDICATION RECONCILIATION. PHARMACISTS ARE UNIQUELY QUALIFIED TO LEAD THE DEVELOPMENT, IMPLEMENTATION, EVALUATION, AND IMPROVEMENT OF MEDICATION RECONCILIATION PROCESSES.

Patients are at serious risk of medication errors during transitions in care, such as changes in the patient-care setting, service provider, or level of care. Medication reconciliation has been shown to reduce discrepancies between the medications that the patient was taking before admission and those prescribed at the transition points of admission, transfer, and discharge, and has the potential to improve patient outcomes. It provides an effective mechanism to communicate this information to the next healthcare provider at each key transition point, thus supporting the concept of seamless care. Effective medication reconciliation creates a basic foundation for pharmacists to provide comprehensive direct patient care.

The medication reconciliation process includes three main steps:

- a) On admission, obtain and document a complete history of the medications that the patient was taking before admission.
- b) At each transition point, identify and document the rationale for any discrepancies between medications prescribed during the hospital stay and the pre-admission medication history collected on admission. Reconcile any discrepancies identified.
- c) On discharge, provide to the patient and to the next healthcare provider the updated medication plan for the patient, including the generic name, dose, frequency, route of administration, reason for use, and duration of therapy for each medication.

Medication reconciliation is a shared responsibility of the patient, physicians, nurses, and pharmacy staff. It is best accomplished through the collaborative efforts of the interdisciplinary team to develop a model tailored to the practice environment, the resources available and the needs

of the patient. Pharmacists possess the unique knowledge, skills, and abilities to optimize the medication reconciliation process. Their knowledge about medications and pharmacy information systems helps to ensure that the medication history obtained from the patient is complete and accurately documented. Medication reconciliation is facilitated by partnerships with other members of the healthcare team, including pharmacy technicians and pharmacy students. The pharmacist is instrumental in providing education to other healthcare professionals about the various aspects of medication reconciliation, including eliciting the patient's medication history. Pharmacists are also well positioned to educate patients about their responsibility to know what medications they are taking and to have up-to-date medication information available for their healthcare providers. Pharmacists are vital in engaging the support of healthcare providers in other practice settings such as community practice, long-term care facilities, and primary care clinics to ensure that the patient's medication history and plan is up to date.

To improve patient safety and enhance the medication reconciliation process from admission through to discharge, healthcare facilities are encouraged to maximize the use of information technology whenever possible. Researchers have documented that manual transcription is associated with a high error rate. Therefore, designing and implementing effective information technology to reduce the need for manual documentation can significantly improve patient safety.

Pharmacists can fulfill a key leadership role in ensuring that medication reconciliation is fully integrated into daily practice. They can lead the

CSHP Mission:

CSHP is the national voice of pharmacists committed to the advancement of safe, effective medication use and patient care in hospitals and related healthcare settings.



development, implementation, evaluation, and improvement of interdisciplinary processes to enhance the quality of care provided.

This statement was prepared by the Medication Reconciliation Task Force of the Canadian Society of Hospital Pharmacists and the Institute for Safe Medication Practices Canada and approved by CSHP Council in March 2009.

BIBLIOGRAPHY

CSHP 2015 - a practice excellence initiative for pharmacists in hospitals and related healthcare settings [Internet]. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2007 [cited 2008 Jun 17]. Available from: http://www.cshp.ca/programs/cshp2015/index_e.asp

Safer Healthcare Now! [home page on the Internet]. Edmonton (AB): Canadian Patient Safety Institute; c2005 [edited 2008 Jul 10; cited 2008 Jul 10]. Available from: <http://www.saferhealthcarenow.ca/> (for information about medication reconciliation).

Statement on seamless care [monograph on the Internet]. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2005 [cited 2008 Jun 17]. Available from: http://www.cshp.ca/dms/dmsView/2_ST-SeamlessCare.pdf

Six countries endorse "high 5s" for safer care. PAHO Today Newslett Pan Am Health Organ [serial on the Internet] 2007 Dec [cited 2008 Jun 17]. Available from: http://www.paho.org/English/DD/PIN/ptoday16_dec07.htm