SAFETY PRACTICE

MEDICATION RECONCILIATION (MEDREC)

LET'S PREVENT MEDICATION EVENTS

KEEP PATIENTS SAFE: MAKE SURE MEDREC IS DONE AT CARE TRANSITION

See your site/program guidelines or protocols

Note: Patient/Client/Resident used interchangeably

Prevent Patient Harm

Performing MedRec at care transitions will reduce preventable patient injury or death due to harmful medication events. The steps below describe the MedRec process

(1) Best Possible Medication History (BPMH)

- BPMH is a medication list which includes a history of current medications the patient is taking
- Trained health care workers collect BPMH using at least two reliable sources - one of which is the patient or caregiver. Other sources may include community pharmacy, patient health records, or patient's medication containers

(2) Reconciliation

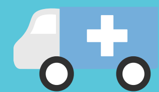
- Using the BPMH to create medication orders OR comparing the BPMH with the current medication list
- Resolving discrepancies with prescriber / most appropriate person
- Ensuring pre-admission medications are considered at care transitions

(3) Communication & Documentation

- Document the reconciliation using standardized forms
- Communicate at care transitions, the reconciled medication instructions / orders to the next health care provider & pharmacy
- Provide the patient or caregiver/family with a complete & updated list of their medications

Examples of Care Transitions

*Admission/ Intake/ Initial Assessment
*Internal Transfers
*Transfer to another Facility
*Discharge Home



Need more information?

See procedure section of your MedRec Policy

Contact your coordinator /supervisor /manager or quality safety lead.

Shared health Soins communs Manitoba