

The following medication history script can be used when interviewing a patient about their medications.

### Medication History Script

#### Allergies

· *Do you have an allergy to, or avoid any medications due to side effects?*

#### Prescription and Non-prescription Medications

· *What prescription and over-the-counter medications do you take on a regular basis?*

· *When do you take them?*

#### Herbals, Supplements, Vitamins

· *What herbal, natural or homeopathic remedies do you take?*

· *What vitamins or minerals do you take?*

· *When do you take them?*

#### Additional prompting questions to ask:

Do you use any: eye drops? nose sprays? puffers? medicated lotions or creams? medicated patches?

Do you receive any: needles? samples from doctor's office? medications used for a study?

Do you take any medications on a regular basis for: sleep? your stomach? your bowels? pain?

### What can you do to improve patient safety?

Educate patients and clients on the importance of maintaining and carrying an up-to-date medication list with them at all times. There are a number of tools available that can be used to document this list.

Ensure each patient's medications prior to admission have been reconciled against the current inpatient medication orders when admitting, transferring or discharging a patient. Notify the physician of any discrepancies.

If seeing a patient at an outpatient visit, ensure that the list has been updated and that the patient is aware of any changes to be made to their medication regime.

For more information about Medication Reconciliation and Patient Safety, please contact:  
**The WRHA Patient Safety Office at 926-8058**  
and your call will be re-directed to the appropriate patient safety consultant.

Or visit the patient safety website at:

<http://home.wrha.mb.ca/patientsafety/index.php>



Winnipeg Regional  
Health Authority  
*Caring for Health*

Office régional de la  
santé de Winnipeg  
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# Medication Reconciliation

## For the health care provider



### What should you know?



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# Medication Reconciliation – Together we can improve patient safety

## What is medication reconciliation?

Identifying the most complete list of medications a patient is taking is crucial in reducing adverse events due to medications. Medication reconciliation (MedRec) is a process of ensuring that health care providers receive the most up-to-date list of medications a patient is taking and that the decisions to continue, modify, or discontinue medications is communicated to the next provider of service as the patient moves across the continuum of care.

## A MedRec story

An elderly male patient was admitted to a medical ward with a history of chronic arthritis and a new diagnosis of cancer. Upon admission, he was prescribed regular Tylenol that was soon changed to Tylenol #3 due to increasing pain. Several days later, upon talking to the patient's family about pain control, it was discovered that the patient was on Fentanyl patches at home. However, the patches had not been continued in hospital.



## Where and when does medication reconciliation occur?

A medication reconciliation process is to occur every time a patient moves between settings, services or providers. This is important to ensure that patient's home medications are reviewed and reconciled as the patient moves between levels of care. In the hospital setting, the reconciliation of medications taken at home is designed to occur at all transition points such as at admissions, during transfers between services (eg from intensive care unit to a medicine unit) and at discharge whereby the home medication list is compared to the current medication orders. In the outpatient care setting, the reconciliation of home medications occurs with each visit. Here the list previously collected is compared to what the patient is actually taking.

## How is the medication reconciliation process captured?

Tools are developed to aid in the medication reconciliation process. For example, at the point of admission into the hospital or personal care home, health care providers use a medication reconciliation form to document the home medication list in one area of the chart. This form is also designed to both serve as a physician's order and to enhance communication amongst health care providers, thus eliminating duplication.

## Who collects the home medication list?

Depending on the setting, a designated health care provider (physician, nurse or pharmacist) is responsible for collecting the medication history from the patient or client and documenting the information onto a tool to facilitate reconciliation.

## Why not just use DPIN for obtaining the medication history?

For several reasons, the DPIN (Drug Program Information Network) print out has several limitations and may not provide you with the most accurate medication list. For example, it only provides medications dispensed by the community pharmacy and not medications purchased over-the-counter. The dose and the frequency of the medication is also not included, but most importantly it does not confirm that the patient is actually taking the medication as prescribed or instructed. The DPIN however can be used as a tool to start collecting the medication history from the patient or patient's caregiver.

