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## What is Medication Reconciliation (MedRec)?

MedRec is a 3-step process of working with patients, family, and other healthcare professionals to ensure accurate and comprehensive medication information, including over-the-counter or non-prescription medication, is communicated across transitions of care (CMPA, 2013).

The MedRec 3-Step Process:

- Step 1: Generate a Best Possible Medication History (BPMH)
- Step 2: Reconcile the BPMH at care transitions
- Step 3: Document and communicate the medication information

## Why is MedRec important?

Communicating effectively about medications is necessary to the delivery of safe care. Physicians should be familiar with their role and responsibilities relative to medication reconciliation (CMPA, 2013). Taking the time to review the patient's medications and reconcile medications improves patient safety, reduces the physician's risk for liability, and enables continuity of care via the family physician in the community. Visit [CMPA MedRec webpage](#) for more information.

## Who is responsible for each of the 3 Steps?

As per Alberta Health Services (AHS) [Medication Reconciliation Policy](#):

- **Step 1: Generate a BPMH**  
**Responsible:** When indicated, health care professionals who have medication management within their scope of practice and job duties
- **Step 2: Reconcile the BPMH at care transitions**  
**Responsible:** An **authorized prescriber**, who addresses and resolves any discrepancies or differences in medication therapy.
- **Step 3: Documenting and communicating**  
**Responsible:** Health care professionals, who document (digital and non-digital formats) and communicate the complete list of medications that the patient should be taking at care transitions (admission, transfer, and discharge).

## Who are Authorized Prescribers?

Authorized prescribers are health care professionals who are permitted by Federal and Provincial legislation, their regulatory college, Alberta Health Services, and practice setting (where applicable) to prescribe medications. Authorized prescribers include, but are not limited to: physicians; medical residents; Nurse Practitioners; pharmacists with additional prescribing authorization; midwives; and Registered Dietitians for parenteral nutrition if providing nutrition support and authorized to prescribe.

## How do I reconcile medications with which I am not familiar?

Patients may previously have been prescribed medications with which a physician may be unfamiliar. Multiple prescribers may be involved in the care of an individual patient. This may become a particular concern when patients transition from home to hospital and back or into residential care, and when the receiving physicians may be reluctant to alter an existing drug regimen (College of Physicians and Surgeons of Alberta (CPSA), 2015).

In both inpatient and outpatient settings, if any medications are unfamiliar, the physician has a professional responsibility to satisfy themselves that the full medication regimen is optimal for the patient's wellbeing. A physician may turn to resources such as pharmacists, other physicians, or published resources such as Lexicomp. The ordering physician should be contacted if there are any questions about the medication(s) ordered (CMPA, 2013). While the pharmacist is often an excellent resource, the final responsibility rests with the physician.

## I work in a variety of clinical settings. Is MedRec the same everywhere?

No. While MedRec always consists of 3 steps, not all 3 steps are executed the same way across settings because of differences in care requirements. The table below [highlights where MedRec applies](#). For additional instructions, see [AHS Policy and Process Overviews](#).

MedRec	Acute Care Inpatients, Long Term Care	Day Surgery, Day Procedures	Emergency Department, Urgent Care Centre	Ambulatory Care (Clinics)	Home and Community Care
<b>Step 1: Generate a BPMH</b>	✓	✓ if Med Management is a component of care and/or if home meds will change	✓ for patients with a decision to admit	✓ if Med Management is a component of care and/or if home meds will change. At subsequent visits, ask if meds have changed.	✓ if Med Management is a component of care
<b>Step 2: Reconcile</b>	✓	× Not Required	Can be completed on receiving inpatient unit	✓	✓
<b>Step 3: Document and communicate</b>	✓	✓	Can be completed on receiving inpatient unit	✓ at the last visit or upon discharge from the clinic	✓

## How can the Medication Reconciliation process be made more efficient?

Currently, a Netcare BPMH form is available pre-populated with Pharmaceutical Information Network (PIN) dispensed medication information. Benefits of using the Netcare BPMH form include increased legibility, reduced handwritten transcription, and improved documentation. Please note the limitations of the Netcare BPMH form. It may not reflect current medication use, does not include over the counter medications, and is to be used as a second source of information in addition to the patient or family interview.

Connect Care, when implemented, will promote efficiency in a variety of ways. The electronic health record will enhance documentation and communication as recording time and risk for transcription errors are reduced. Medication lists with date and time stamps will be easily accessible, serving as a potential secondary BPMH source (the ideal primary BPMH source remains an interview with the patient or family, if possible). As well, automatic prompts and alerts will support clinical decision-making.

## What changes have been made to the updated 2019 Policy?

The [Medication Reconciliation Policy](#) was reviewed and revised to clarify the content and responsibilities; **there are no changes to practice**. The intent of the policy remains unchanged. Key revisions to the policy include:

- Reorganization of the content according to the applicable step in the MedRec 3-step process (generate a Best Possible Medication History (BPMH); reconcile the BPMH at care transitions; and document and communicate the medication information)
- Clarification that the authorized prescriber is to resolve discrepancies in medication therapy (Step 2).

## Where can I get more information or specific assistance?

- CPSA offers valuable guidance to physicians on the role of medication reconciliation within their practice [Polypharmacy: Appropriate and Problematic \(2015\)](#).
- Medication Reconciliation AHS Policy and resources on [Insite](#):
- AHS [webpage](#) featuring:
  - Staff education tools
  - MedRec eLearning module
  - Implementation and engagement resources
  - Audit and improvement resources
  - Newsletters and webinars
  - Patient education tools
- Netcare BPMH Form support materials at [Alberta Netcare Learning Centre](#)
- [CMPA: Managing Risks - Medication Reconciliation](#)

Email [medrec@ahs.ca](mailto:medrec@ahs.ca) with any questions. Zone-specific assistance is also available.