How to obtain a BPMH in Long Term Care

Sources of Information to Use

Best Possible Medication History (BPMH)
is a ‘snapshot’ of the resident’s actual medication use story.
It is obtained using a **systematic process** of comparing sources of information.

Admission from COMMUNITY

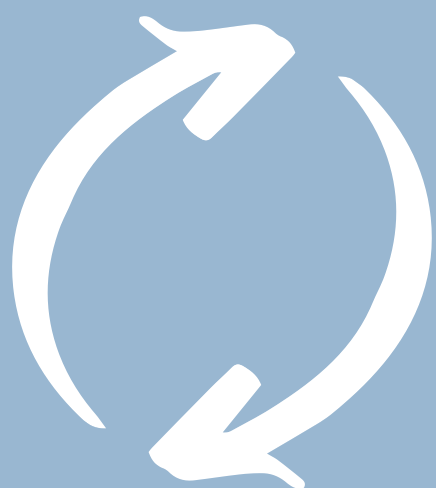
- Review “medication list" from resident
- Check medication vials/blister pack
- Review community pharmacy profile, provincial electronic health records
- See family physician records
- Community pharmacist medication review program (e.g., MedsCheck)

Compare With

- Interview resident/Substitute Decision Maker (SDM) (using BPMH Interview Guide or a checklist) to verify actual use

Admission from HOSPITAL

- Most current medication list (Medication Administration Record (MAR) or medication profile)
- Discharge summary/prescriptions
- Interview resident/SDM (using BPMH Interview Guide)
- Pre-acute medications if MedRec is not documented from acute care



Re-admission from HOSPITAL

- Resident’s long-term care MAR prior to hospital transfer

Compare With

- Interview resident/SDM to confirm changes,where possible
- Most current medication list (MAR or medication profile)
- Discharge summary/prescriptions

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For more information, visit www.ismp-canada.org/LTC

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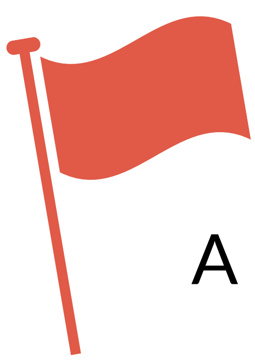
Step-by-Step Guide

1. Gather the relevant sources of information specific to the type of transfer. (See Sources of Information to Use Resource)
2. Document a preliminary BPMH along with indications using sources of information
3. Interview the resident/substitute decision maker (SDM) to confirm actual use. Use the BPMH Interview Guide/Checklist
4. Make revisions as needed, identify red flags that require clarification.
5. Organize a call with the prescriber to review orders. (nurse or pharmacist-led Medication Reconciliation)
6. Fax/email the BPMH to the prescriber, where possible.
7. Review each medication verbally with the prescriber to confirm therapeutic appropriateness and obtain authorization to fill and administer. Address any concerns and red flags.
8. Fax authorized medication list to the pharmacy.



Are there any red flags signaling a clarification is needed?

A red flag is any situation that requires clarification before prescriptions can be processed.

Examples:

- Is there a previously taken medication not appearing on the discharge prescription? (i.e. a discontinue order may be missing or an automatic substitution was made by the hospital)
- Is there a therapeutic duplication? (e.g. new bisoprolol and existing metoprolol)

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