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SUBJECT: RECONCILIATION OF MEDICATIONS		

PURPOSE:

To define the process for reconciling lists of medications at each transition point in the delivery of patient care, including admissions, emergency department visits, clinic visits, post operative care or procedural areas, all transfers in level of care, and at discharge.

DEFINITION:


Medication reconciliation is a cognitive process of identifying the most accurate list of all medications a patient is currently taking: prescriptions; sample medications; herbal remedies; vitamins; nutraceuticals; over-the-counter drugs; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, treat or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition of medication does not include enteral nutrition solutions, which are considered food products, oxygen and other medical gases.

- The medication reconciliation list(s) must include the name of the medication(s), concentration, dose, frequency, route and indication for use.
- Reconciliation involves comparing the patient’s current list of medications against the prescriber’s admission, transfer, post-op, and/or discharge orders.
- Who does medication reconciliation? Physicians, nurses and pharmacists share responsibility for medication reconciliation. Physicians perform medication reconciliation at the time of prescribing and nurses and pharmacists perform a double-check to make sure nothing was missed by reconciling new orders against previous orders or the home medication list and reporting any potential problems to the physician for correction.
- Point of Entry: Includes emergency department, inpatient/outpatient settings or any other patient care setting
- In urgent situations or when resulting delay would harm the patient, including situations in which the patient experiences a sudden change in clinical status, immediate care of the patient takes precedence. However, as soon as possible thereafter, medication information should be obtained and reconciled with physician orders.
- Next provider of care is that individual(s) with whom the patient has an established relationship for receiving healthcare services or, if there is not yet an established relationship, has accepted a scheduled appointment for follow-up care.

PROCESS:

The process involves four steps:

1. Verification: Creating of patient’s current medication list
2. Clarification: Ensuring that the medications and doses are appropriate
3. Reconciliation: Reviewing patient’s current medications when writing physician orders and making a medical decision to continue or discontinue each medication
4. Transmission: Send the discharge list to the next provider


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POLICY:


- 1) The Home Medication List (HML) is a medication history and is a complete list of all the patient’s current known prescribed and over-the-counter medications taken at home. While alternative medicines, herbals and supplements are NOT provided during inpatient hospitalizations, they must be listed as part of the home medications.
- 2) The list is initiated at first point of contact with CHRISTUS Santa Rosa Healthcare on each visit or admission. Fields on the form which cannot be filled due to poor history may be marked unknown (UKN) to designate the lack of available data.
- 3) The Home Medication List may be used as an order or just as a medication history. If a physician checks off each medication to continue and signs at the bottom it is a medication order. In this case, the physician is also performing the medication reconciliation as he/she goes down the list and decides which home medications to continue in the hospital. If the Home Medication List is not signed by a physician it is not a medication order but merely a medication history. In this case, the physician writes the medication orders on a Physician’s Medication Order form and nurses and pharmacists compare admission orders written on a Physician’s Medication Order form to the Home Medication List to detect possible problems. The physician is contacted if problems are identified. The Home Medication List must be completed by nursing, medical, or pharmacy staff within 24 hours of admission.
- 4) In ambulatory care areas including but not limited to emergency department, radiology, special procedures, catheterization lab, gastrointestinal lab, and COPS/KidStop, the nurse is responsible for completing the Home Medication List and reconciling it with the procedural medications used as well as educating the patient about medication use post-procedure at discharge.
- 5) The medication reconciliation process occurs at any change in level of care and across the continuum of care. Physicians, nurses, and pharmacists are responsible for reconciling all new orders created at any change in level of care. Potential problems identified by nurses or pharmacists are communicated to the patient’s physician and correction orders are obtained.
- 6) No orders to resume pre-op or prior medications are accepted.
- 7) At discharge a new Discharge Medication List is created and transmitted or otherwise made available to the next known provider and to the patient.

PROCEDURE:

- 1) Medication reconciliation in the Emergency Department
 - a) “Screening reconciliation” for all ED patients should include routinely obtaining from each patient at each ED visit a list of the patient’s current medication (usually done by the triage nurse).
 - b) “Focused reconciliation” as directed by the emergency physician, based on medical relevance, should include seeking additional information about the patient’s medications (exact drug list, dosage/route, ect) from the patient’s pharmacy, primary care physician, family, ect.
 - c) “Full reconciliation” for admitted patients should be completed by the receiving inpatient unit and pharmacist.
- 2) Reconciliation Upon Admission: Home Medication List (HML)

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- a) The first person taking a medication history (nurse, physician, or pharmacist) will initiate a List any medication, food or latex allergy information to include a brief description of the type of reaction.
 - b) The name, dose/concentration, route, frequency (scheduled or as needed), indication for use and last dose taken will be documented for each medication. Fields missing data due to poor information provided can be marked UKN. In the event all required information for a drug cannot be provided, the prescriber will be responsible for completing an order.
 - c) If orders have already been written by a prescriber, the Home Medication List must be reconciled with the ordered medications by the pharmacists.
 - d) If the Home Medication List is going to be used as a medication order, it is reviewed with or by the prescriber. This process may occur telephonically with the admitting nurse. Medications may be noted as “continue at admission” Yes or No by circling the appropriate letter. Any changed or new orders must be written on a physician’s order sheet. If the review has been completed telephonically, the nurse must indicate TOR or TORB as per policy # CO-PM-03-06.
 - e) All Home Medication Lists, whether as an order or as a medication history, must be scanned to pharmacy even if the patient is not on any medications. Indicate the page number and numbers of pages (e.g. page 1 of 2) at the bottom of the form.
 - f) The Home Medication List serves as an order sheet only on admission. Subsequent medication orders and any order clarifications must be written on a physician order sheet.
- 3) Intraoperatively
- a) Current medication list is reviewed by the anesthesia provider. The medication list information is taken into consideration when administering intraoperative medication.
- 4) Reconciliation upon Transfer or Post Surgical Procedure
- a) Meditech generated Transfer and Post-Operative Medication List (TML). Locate the pharmacy menu for nursing on the Meditech desktop. Select Patient Transfer and Post-operative Medication Order option, look up the patient and print the orders
 - b) If the prescriber elects to use the Transfer Post Op form as an order they must sign, date and time the document to initiate orders. They can also elect to handwrite the post surgical/transfer orders. This process may occur telephonically; the nurse must comply with policy #CO-PM-03-06.
 - c) If the surgeon(s) are not familiar with the home/current medication list, the primary care physician or the original prescribing physician will be contacted to review and act upon the medication list at transfer/discharge.
 - d) Once completed, scan orders to pharmacy. The pharmacist is responsible for reconciling the new orders against the pharmacy profile and communicating identified problems to the prescriber for correction.
- 5) Reconciliation Upon Discharge
- a) Inpatient Discharge Medication List (DML)
 - i) If the patient is admitted and orders are entered into Meditech pharmacy module then the Meditech Discharge Medication Report is used to identify which medications are to be taken by the patient at home. Locate the pharmacy menu for nursing on the Meditech desktop. Select Discharge Medication Report option,

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look up the patient and print the orders. Reconcile the discharge prescriptions with the medications actively being administered prior to discharge as well as against the Home Medication List.

- ii) Nurses ensure that patients leave the facility with a list of reconciled medications and knowledge about all newly prescribed medications.
- iii) A copy of the discharge medication list is transmitted to the next provider(s) if known at the time of discharge. Nurses work with case managers to accurately identify the PCP and/or specialist with whom the patient has an established relationship and/or a follow-up appointment.
- b) Outpatient Discharge Medication List (DML)
 - i) For outpatients including but not limited to emergency department visits, special procedures catheterization lab, and gastrointestinal lab, use the Home Medication List to indicate what the patient will take at discharge.
 - ii) Mark Yes or No in the “continue at discharge” column.
 - iii) *New prescriptions* are listed on the next available line and are denoted as new in the “last dose take/New Rx” column.
 - iv) If changes are made to the patient’s drug therapy, the nurse should re-write a list of all medications including the name, dose/concentration, frequency, route of administration and indication for each drug.

Discharge Medication List for All Areas

- a) Nurses/pharmacy/medical staff ensures discharge patient medication education is documented on the discharge instructions form.
- b) Nurses/pharmacy/medical staff ensures patients leave the facility with a list of current medications and knowledge about all newly prescribed medications.
- c) A copy of the discharge medication list is transmitted to the next provider(s) if known at the time of discharge.

RESPONSIBLE POSITION:

Director of Pharmacy
Chief Nurse Executive

HISTORY:


Started as ‘Home Medications Policy and form’ at CHRISTUS Santa Rosa Medical Center 2003.

REFERENCES:

IHI Medication Reconciliation ; American College of Radiology; The Joint Commission’s Sentinel Event Advisory Group; American Association of Emergency Medicine; ACEP; Emergency Nurses Association;

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The Medication Reconciliation Process

