POLICY TITLE: MEDICATION RECONCILIATION

DEVELOPED BY: Medical Reconciliation Committee

EFFECTIVE DATE: February 2014

POLICY DISTRIBUTION: General Manual, Emergency Department Manual, OR Manual, Clinic Manual

PURPOSE: To ensure as much as possible the list of home medications appearing in the patient’s electronic chart is accurate and complete. This process must occur at every point of contact with the patient throughout the continuum of care. This process is intended to facilitate medication prescribing and promote patient safety.

PROCEDURE:

1. Emergency Department
	1. At the time of admission to the ED, the nurse will obtain a complete list of the patient’s home medications to the best of his/her ability.
		1. Educate the patient on the importance of having a medication list with them at all times if possible.
		2. RN/staff member may utilize other available sources of information such as the patient’s pharmacy, clinic, reliable family member, etc.
	2. The home medication list must include prescribed medications as well as over the counter medications, vitamins, homeopathic medications and nutritional supplements. Documentation should include the name of the medication, dose, frequency and last dose taken. If information regarding the preferred pharmacy, this can also be documented.
		1. If the ED nurse is unable to complete the process, he/she must document that the patient’s home medication list was not reconciled and for what reason (ED too busy, information not available, etc.).
		2. This information must be communicated to the ED physician.
		3. This information must be communicated to the Med-Surg nurse if the patient is to be admitted to the hospital.
		4. If the patient is transferred to another facility, the RN/Ward Clerk must send or fax a copy of the ED summary report and a copy of the patient’s home medication list with a note indicated reconciliation was not completed.
	3. Notations regarding the patient’s home medication list should be documented as follows:
		1. If the patient confirms that the medication currently documented in the home medication list is accurate in every detail, the nurse will click “reviewed”.
		2. If the nurse needs to add a new medication not already in the patient’s home medication list, the nurse will click “reported”. This option only appears when a new medication is added.
		3. If something has been added to the medication list in error, the nurse will click “cancel.”
		4. If the medication is something the patient is no longer taking, the nurse will click “discontinue”. This includes antibiotics, one time, or limited prescriptions that have been completed. Etc.
		5. If the patient is not taking the medication the way it was prescribed by the provider (or not taking a prescribed medication at all), the nurse should click “discontinue” and then enter the medication as the patient stated they are taking it and then click “reported”.
	4. A copy of the reconciled home medication list may be sent home with patients who may be at risk for a medication adverse event following discharge. These patient may include:
		1. Patients taking more than 5 medications
		2. Patients with multiple changes in their home medication regime
		3. Patients on high-risk medication (i.e. warfarin, cardiac medication, insulin, etc.)
		4. Patients lacking adequate support at home
		5. Patients with a principle diagnosis of cancer, COPD, stroke, heart failure, diabetes, depression, etc.
2. Medical-Surgical-OB Unit
	1. Admission:
		1. At the time of admission to the unit, the nurse will obtain a complete list of the patient’s home medications to the best of his/her ability.
			1. Educate the patient on the importance of having a medication list with them at all times if possible.
			2. RN/staff member may utilize other available sources of information such as the patient’s pharmacy, clinic, reliable family member, etc.
		2. The home medication list must include prescribed medications as well as over the counter medications, vitamins, homeopathic medications and nutritional supplements. Documentation should include the name of the medication, dose, frequency and last dose taken. If information regarding the preferred pharmacy, this can also be documented.
			1. If the nurse is unable to complete the process, he/she must document that the patient’s home medication list was not reconciled and for what reason (unit too busy, information not available, etc.).
			2. This information must be communicated to the admitting physician.
			3. This information must be communicated to the nurse on the next shift in order for the process to be completed.
		3. If any outside facility discharge summary or outside physician notes are received the medication list must be reconciled and updated to reflect the changes in medication including- dose, route, quantity and discontinuation.
	2. Notations regarding the patient’s home medication list should be documented as follows:
		1. If the patient confirms that the medication currently documented in the home medication list is accurate in every detail, the nurse will click “reviewed”.
		2. If the nurse needs to add a new medication not already in the patient’s home medication list, the nurse will click “reported”. This option only appears when a new medication is added.
		3. If something has been added to the medication list in error, the nurse will click “cancel.”
		4. If the medication is something the patient is no longer taking, the nurse will click “discontinue”. This includes antibiotics, one time or limited prescriptions that have been completed. Etc.
		5. If the patient is not taking the medication the way it was prescribed by the provider (or not taking a prescribed medication at all), the nurse should click “discontinue” and then enter the medication as the patient stated they are taking it and then click “reported”.
	3. Discharge;
		1. At the time of discharge or transfer from the hospital, the patient’s home medication list must be reconciled to include the home medications as detailed in the physician’s discharge/transfer orders.
		2. If the patient is transferred to another facility (hospital, home health, nursing home, etc.) the RN/Ward Clerk will send a list of the patient’s home medications as well as a copy of the MAR.
		3. The nurse/physician/pharmacy should review the plan for discharge medications with the patient to determine if the patient has an adequate supply at home and answer any questions.
		4. The nurse assigned to the patient at the time of discharge will provide medication education including a copy of discharge instructions that details a list of home medications.
3. Surgery/OR
	1. At the time of the PRT appointment or on admission to the surgery department, the RN will obtain a complete list of the patient’s home medications to the best of his/her ability.
		1. Prior to the PRT appointment, patients will be directed to bring their home medications or a current list of medications to the appointment to help ensure accuracy.
		2. RN/staff member will call the patient/s pharmacy/clinic/reliable family member if medications or a current list is not available.
		3. Educate the patient on the importance of having a medication list with them at all times if possible.
	2. The home medication list must include prescribed medications as well as over the counter medications, vitamins, homeopathic medications and nutritional supplements. Documentation should include the name of the medication, dose, frequency and last dose taken. If information regarding the preferred pharmacy, this can also be documented.
	3. Notations regarding the patient’s home medication list should be documented as follows:
		1. If the patient confirms that the medication currently documented in the home medication list is accurate in every detail, the nurse will click “reviewed”.
		2. If the nurse needs to add a new medication not already in the patient’s home medication list, the nurse will click “reported”. This option only appears when a new medication is added.
		3. If something has been added to the medication list in error, the nurse will click “cancel.”
		4. If the medication is something the patient is no longer taking, the nurse will click “discontinue”. This includes antibiotics, one time, or limited prescriptions that have been completed. Etc.
		5. If the patient is not taking the medication the way it was prescribed by the provider (or not taking a prescribed medication at all), the nurse should click “discontinue” and then enter the medication as the patient stated they are taking it and then click “reported”.
	4. A copy of the reconciled home medication list may be sent home with patients who may be at risk for a medication adverse event following discharge. These patient may include:
		1. Patients taking more than 5 medications
		2. Patients with multiple changes in their home medication regime
		3. Patients on high-risk medication (i.e. warfarin, cardiac medication, insulin, etc.)
		4. Patients lacking adequate support at home
		5. Patients with a principle diagnosis of cancer, COPD, stroke, heart failure, diabetes, depression, etc.
4. Clinics
	1. Medication reconciliation may happen with physician visits, and nurse encounters.
	2. Patients will be requested to bring their medication bottles and/or their medication list with them to their visit to support compiling as complete a medication history and medication list as possible.
	3. The medical assistant or nurse will obtain a complete list of the patient’s home medications to the best of his/her ability. The goal is to have as complete of a list as possible to support providers in the prescribing process.
	4. Medical Assistants and RN are encouraged to utilize other available sources of information such as the patient’s pharmacy, other clinics, referral forms, reliable family member, or other sources to complete the reconciliation process.
	5. The home medication list must include prescribed medications as well as over the counter medications, vitamins, homeopathic medications and nutritional supplements. Documentation should include the name of the medication, dose, frequency and with as needed prescriptions the reason for taking the medication.
		1. Preferred pharmacy and allergies will be reviewed and updated with encounters.
		2. If the clinic nurse is unable to complete the process, he/she must communicate that the patient’s home medication list was not reconciled and for what reason (information not available, etc.) to the provider.
		3. This information must be communicated to the ED or Med-Surg nurse if the patient is to be admitted to the hospital.
	6. Notations regarding the patient’s home medication list should be documented as follows:
		1. If the patient confirms that the medication currently documented in the home medication list is accurate in every detail, the nurse will click “medications reconciled” button on the Intake screen. This will put a time stamp on the header and communicate to the provider the process is completed.
		2. If the nurse needs to add a new medication not already in the patient’s home medication list, the nurse will complete the steps to Add a new medication and complete the fields as directed.
		3. If something has been added to the medication list in error, the nurse will click “cancel.”
		4. If the medication is something the patient is no longer taking, the nurse will click “discontinue”. This includes antibiotics, one time, or limited prescriptions that have been completed. Etc.
		5. If the patient is not taking the medication the way it was prescribed by the provider (or not taking a prescribed medication at all), the nurse should click “discontinue” and then enter the medication as the patient stated they are taking it as a “New” medication.
		6. If any sample medications are provided to the patient, the medication list will reflect the medication given, the lot number, expiration number, and manufacturer. The medication log will also have documentation of the patient receiving the medication, in the event of a possible manufacturer recall.
		7. If the physician gives any verbal or task orders to the nurse, the medication list will be updated and reconciled at that time.
		8. If any outside facility discharge summary or outside physician notes are received the medication list must be reconciled and updated to reflect the changes in medication including- dose, route, quantity and discontinuation.
	7. A copy of the reconciled home medication list may be sent home with patients who may be at risk for a medication adverse event following discharge. These patient may include:
		1. Patients taking more than 5 medications
		2. Patients with multiple changes in their home medication regime
		3. Patients on high-risk medication (i.e. warfarin, cardiac medication, insulin, etc.)
		4. Patients lacking adequate support at home
		5. Patients with a principle diagnosis of cancer, COPD, stroke, heart failure, diabetes, depression, etc.