

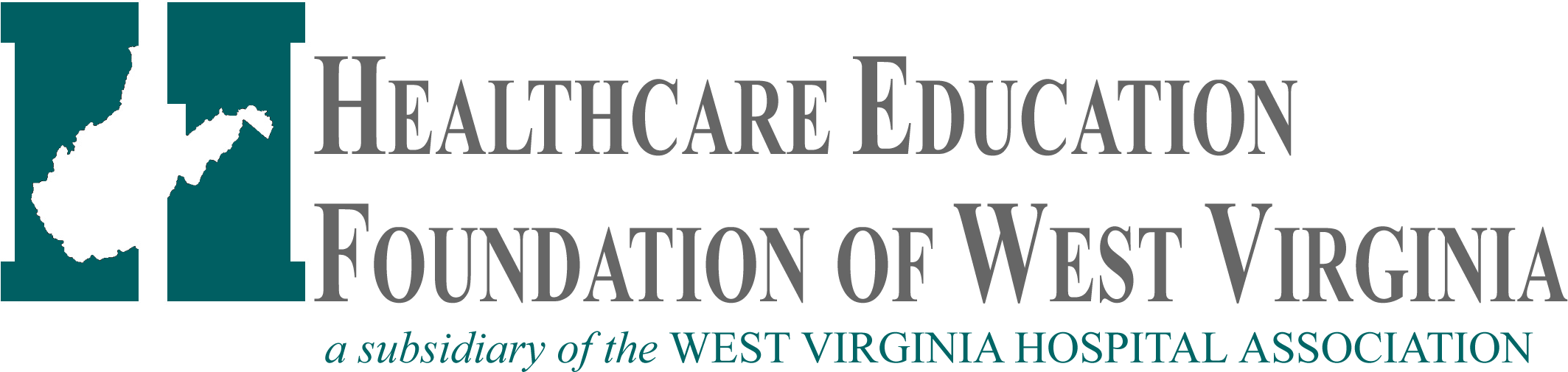
DATE: 2-16-09

**WVHA Patient Safety Council**

**Medication Verification**

**Monitoring Program**

**Toolkit**



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The purpose of this project is to provide necessary tools for an organization to create or update their existing medication verification programs. The task force compiled a multitude of example policy and procedures, forms and educational materials related to medication verification. The task force does not endorse any one method or document to be included in a medication verification policy, but merely hopes to provide examples that the organizations may use to draft the policy and procedure that best fits the needs of their organization. All of the documents have been formatted using Word to enable the organization to make changes to fit their needs without the need to re-create the document.

**A Joint Commission Note Just Issued February 5, 2009**

**Subject:** Medication reconciliation National Patient Safety Goal to be reviewed, refined

**Medication reconciliation National Patient Safety Goal to be reviewed, refined**

Medication errors continue to be one of the most frequent causes of preventable harms in health care. The Joint Commission is committed to helping organizations prevent medication errors, as evidenced by our National Patient Safety Goal on medication reconciliation, which highlights a critical problem that poses significant risk to patients. However, since the Goal on medication reconciliation was instituted in 2005, many organizations have struggled to develop and implement effective and efficient processes to meet the intent of the Goal.

Today, The Joint Commission Accreditation Committee determined that effective January 1, 2009, survey findings on National Patient Safety Goal 8 (Accurately and completely reconcile medications across the continuum of care) will continue to be evaluated during the on-site survey. However, given the difficulties that many organizations are having in meeting the complex requirements of NPSG 8, the Accreditation Committee agreed that The Joint Commission should evaluate and refine the expectations for accredited organizations. While this evaluation is being conducted, survey findings from NPSG 8 will not be factored into the organization’s accreditation decision. In addition, survey findings on NPSG 8 will not generate Requirements for Improvement (RFIs) and will not appear on the accreditation report.

Recognizing that medication reconciliation problems continue to put patients at risk, The Joint Commission expects organizations to continue to address medication reconciliation within their organizations. During the on-site survey, Joint Commission surveyors will evaluate the organization’s medication reconciliation processes, discuss opportunities for improvement, and collect information on the progress organizations are making in meeting NPSG 8.

In 2009, The Joint Commission will evaluate and further refine NPSG 8. As part of this process, The Joint Commission will consult with health care organizations, physicians, pharmacists, nurses, surveyors, and other stakeholders. Through these discussions, an improved NPSG 8 will be crafted that both supports quality and safety of care and can be more readily implemented by the field in 2010.

**Points You May Want to Consider as You Work on Your Organization’s Medication Verification Process**

* Define the Process for medication reconciliation after initial list has been completed
* Keep the steps minimal
* Include an MD champion when developing a process
* Be sure to have a process to ask the patient if the MD gave them scripts
* Develop a process that will assure the MD discharge summary list of meds matches the nurses discharge summary.
* Consider discontinuing all herbal, OTC etc meds on admission unless MD specifically orders them
* Use the med list either as a med collection list only or as the process for collection and MD signature DO NOT PERMIT BOTH PROCESSES

**INTRODUCTION**

*Background Information*

Across the United States, approximately 1.3 million people become ill or have adverse side effects from medical therapy each year. In a continuing effort to improve patient safety, in West Virginia a task force of volunteers has came together to develop tools to assist facilities a patient safety effort to improve medication reconciliation. Medication reconciliation requires that a complete and current list of a patient’s medications be obtained upon admission, updated during the course of care, and communicated to the next care provider. Medication reconciliation involving the patient should occur at all interfaces of care (handoffs) and on admission to and discharge from ambulatory, emergency and urgent care, long-term care, home, or inpatient services. The Joint Commission mandates the process at every care transition if new medications are ordered or existing orders are written. This is not just a Joint Commission National Patient Safety Goal it is a patient safety issue.

Medication reconciliation helps avoid transcription errors, omissions in a patient’s chart, and works to prevent duplication of therapy as well as drug interactions. These benefits are accomplished by comparing all prescribed medications with those listed on a patient provided list of medications. Upon discharge or transfer hospitals are required to communicate a list of prescribed medications their patient is taking to the next healthcare provider, ensuring a continuum of care.

*Facts on Medication Reconciliation*

* It includes over-the-counter medications, vitamins, herbals, nutriceuticals, and others
* It helps avoid transcription errors, omissions, in a patient’s chart, and dosing errors.
* It prevents duplication of therapy, as well as drug interactions
* It asks patients to provide a list of current medications
* It requires physicians to communicate with the health care provider about specific medications at transfer or discharge, ensuring a continuum of care.
* It allow and encourages the involvement of other, authorized people if the patient is too ill, injured, young or disabled to participate actively in the process, or if the patient is overwhelmed by his or her condition, speaks or reads poorly or has health literacy challenges.

*Accountability*

Medication reconciliation is an ongoing responsibility, and it cannot be assigned to one specific point in the health care continuum. When providers receive a list of discharge medications from a facility, they must invoke the reconciliation process despite the fact that the originator already should have performed medication reconciliation. Medication reconciliation is one area where the goal is to increase rather to decrease redundancy. The patient should be encouraged to carry the list with him or her and to share the list with any providers of care, including primary care and specialists, nurses, pharmacists, and other caregivers.

Some have called medication reconciliation a glorified medication history; it is much more than that. At its heart, medication reconciliation attempts to optimize drug therapy while reducing adverse drug events at transition points across the continuum of care. This reconciliation is a three step process to:

1. Obtain and document a complete list of the patient’s medications upon entry into the system.
2. Compare this list with any new medication orders to detect and avoid omissions, duplications, interactions, and other errors.
3. Communicate the complete list of the patient’s medications to the next provider of service (inside or outside of your organization) and to the patient.

The core purpose of medication reconciliation is the reduction of transition-related adverse drug events, reconciliation provides additional benefits, including decreasing initial work and rework at the time of both admission and discharge. Medication reconciliation requires employees to gather mediation information in a standard and centralized manner, which in turn, reduces the amount of clarification and rework needed in relation to incomplete or potentially problematic orders. Another significant benefit is the potential to reduce the number of times patients are asked about their home medications. Lastly, having up-to-date and accessible patient home and current medication profiles should decrease the amount of time prescribers require to access needed information.

It is recognized that all patients may not know their entire list. The expectation is that clinicians at minimum ask the questions related to all medications, both prescription and OTC’s that a patient may take.

*Whose Job is it?*

There are two common models for who performs medication reconciliation. In some cases the prescribing provider performs medication reconciliation when the orders are written or prescriptions given to the patient. This process provides a streamlined and more efficient method for medication reconciliation.

The second method is for nurses and/or pharmacists to perform the medication reconciliation. This model creates a more complex reconciliation process. When discrepancies are found, the ordering practitioner must be contacted to clarify the orders.

*When should Medication Reconciliation Occur?*

Medication reconciliation should occur whenever medications are prescribed or administered to the patient. When medications are to be administered, there is a potential for drug interactions and adverse events. Medication reconciliation must occur upon exiting the health care system. A list of the patient’s current medications must be provided to the patient, and can be done on a discharge instruction sheet, as well as sent to the next provider of care. The next provider of care can be problematic. The next provider of care is defined as the practitioner with whom the patient has an established relationship for receiving health care services or if there is not yet an established relationship, has accepted a scheduled appointment for follow up care. The expectation is that the clinician speaks directly with the next provider of care. The patient cannot be used as an intermediary or messenger. The medication verification process should start as soon as the patient presents to the healthcare facility. The extent of the process carried out depends upon whether the patient is admitted as an inpatient.

**Strategies and Tips**

*Medication Card*

A medication card is a form for tracking medication information that is provided to patients at discharge. This can be pre-populated for patients, who are encouraged to keep it updated so that they are able to communicate their current medications to any future healthcare providers. Although medication information will be sent to the patient’s primary care provider upon the patient’s discharge, if the patient visits and urgent care or another emergency department, or another provider this information is vital to their treatment plan.

The West Virginia Center for Patient Safety (WVCPS) created a Universal Medication form to be carried on the person of WV health care consumers. The ultimate goal for the project was to get the consumer involved and responsible for their health care. The Universal Medication Form is a tool developed for consumers to track prescription and over-the-counter medications, as well as the herbal supplements and vitamins, they take at home. Health care providers are encouraged to keep copies of this form and to distribute them to patients upon discharge or upon request from patients and/or families. You may also wish to distribute the forms at community health fairs, senior organization meeting, etc. Consumers should be encouraged to complete the form and give copies to their doctors, pharmacist and dentist. These health care providers can then help the patient update the form as needed. The toolkit, “Universal Medication Forms” is available on the WVHA website: [www.wvha.org](http://www.wvha.org).

The *“About the Universal Medication Form”* Pamphlet

*The* consumer pamphlet, “About Your Universal Medication Form,” encourages use of the Universal Medication Form. Hospitals may wish to produce copies of the brochure for themselves and affiliated physicians to share with patients. We have also enclosed some pamphlets for your use.

**The Joint Commission National Patient Safety Goal 8**

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| --- | --- |
| Requirement 8A | There is a process for comparing the patient’s current medications with those ordered for the patient while under the care of the organization. |
| Implementation Expectation for 8A | The organization, with the patient’s involvement, creates a complete list of the patient’s current medications at admission/entry  The medications ordered for the patient while under the care of the organization are compared to those on the list and any discrepancies (e.g., omissions, duplications, potential interactions) are resolved. |
| Requirement 8B | A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization. The complete list of medications is also provided to the patient on discharge from the facility. |
| Implementation Expectations for 8B | The patient’s accurate medication reconciliation list (complete with medications prescribed by the first provider of service) is communicated to the next provider of service, whether it be within or outside the organization.  The next provider of service should check over the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered/prescribed.  The complete list of medications is also provided to the patient on discharge from the facility. |

**STEPS IN THE PROCESS**

Step 1

*Complete the patient’s home medication profile*

Medication reconciliation begins with obtaining a complete list of medications that the patient is taking upon entry into the healthcare system. This process should involve both the patient and the family. This process is referred to as the “Home Medications”

The list of Home Medications is one of three pieces of documentation that will be required to complete medication reconciliation for a patient entering a health care facility. This document should be accessible while the patient is in the healthcare facility so that it can be used in the medication reconciliation process when the patient is transferred and, in all cases, when the patient is discharged.

Step 2

*Reconcile the Home Medication list with new medications*

When a patient enters the healthcare system, he or she is assessed and treated, and/or diagnostic decisions are provided. So the next step in the process is for clinicians to compare the patient’s Home Medications list with any new medication orders. The purpose of this reconciliation is: 1) to help avoid omissions and duplications of home medications; 2) to evaluate for the potential of drug-drug interactions; and to compare the patient’s admission orders and timing of administration against what the patient may have already received at home or at a prior facility.

The Joint Commission does not require documentation that the reconciliation has occurred. Some organizations have developed forms to help with this process and, by their own policy, require a signature to indicate that this step was performed. While this provides proof that medication reconciliation has occurred, non-compliance with their own policy have been a major reason for receiving a “Requirements for Improvement” by surveyors. If the organization does not require a signature by their own policy, the Joint Commission surveyors will assess compliance by direct observation and clinician interviews. Surveyors will also ensure that the Home Medications list is available and used by those performing medication reconciliation.

Step 3

Reconcile the home medication list and current medication list when the patient is transferred to another level of care within the organization.

Step 4

*Communicate complete medication list to patient, new provider and next level of care*

The complete list of medications should be provided to the patient upon discharge. This is simply a list of medications and not a physician’s order sheet. A complete list of the patient’s medications should always be communicated to the next provider of service, inside or outside of the healthcare organization. At this point, medication reconciliation involves comparing the patient’s discharge medication orders with both the Home Medications list and the current medication profile or MAR. The purpose is to assess the medications prescribed at the time of discharge and to reevaluate the appropriateness of the medications that the patient was taking prior to entry into the healthcare system. After reconciliation, the goal is to provide a complete and accurate discharge medication list to both the patient and the next provider of care. This list is not a summary of what the patient took while in the facility, but rather a summary list of what the patient should be taking upon exit from the healthcare system, essentially this becomes the patient’s new Home Medication List.

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The complete list of medications is also provided to the patient on discharge from the facility.** | | Goal 9 | | Reduce the risk of patient harm resulting from falls. | | 9B | | Implement a fall reduction program including an evaluation of the effectiveness of the program. | | Goal 13 | | Encourage patients’ active involvement in their own care as a patient safety strategy. | | 13A | | Define and communicate the means for patients and their families to report concerns about safety and encourage them to do so. | | Goal 15 | | The organization identifies safety risks inherent in its patient population. | | 15A | | The organization identifies patients at risk for suicide. [Applicable to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals—NOT APPLICABLE TO CRITICAL ACCESS HOSPITALS) | | Goal 16 | Improve recognition and response to changes in a patient’s condition. | | | | | | |  |

Or Best Effort

Medication Reconciliation Process

**PROCEDURES**

**Example 1**

**PROCEDURE**

A. Medication Reconciliation at Admission

1. Upon hospital entry, the nurse will record the patient’s current home

medication regimen on the Medication Profile section as part of the admission history. Enter home medication as Medications by History. If the patient is not taking any medications at home, note this as “no home meds.”

1. A variety of sources and methods shall be used to accurately identify the patient’s current home medication regimen. Not all sources and methods have to be used for every patient. Examples of sources and methods that can be used to identify the current medication regimen are:
2. Interviewing the patient
3. Interviewing the caregiver
4. Interviewing family members
5. Direct observation of the patient’s medication bottles
6. Contacting the pharmacy
7. Contacting the primary healthcare provider
8. Contacting other healthcare systems in which the patient may be enrolled, such as, home healthcare. When sources are other than the patient, indicate which information sources you used to obtain the current home medication regimen in the Comments section.
9. A medication regimen profile of a patient shall include the drug name, dosage, frequency, route, and indication. The time and date of the last dose taken by the patient should be noted if available in the order entry detail section. Examples of medications shall include:
10. Prescription medications
11. Non-Prescription medications
12. Herbal medications
13. Alternative medications
14. Vitamins and other dietary supplements
15. Respiratory, rectal, vaginal, and topical medications

2. When a patient has a return visit, the nurse should review the

medication profile and update the information on the home medications section. This may include, adding new home medications by history, deleting medications no longer being taken or modifying the home medications with the most recent last dose date and time.

3. An admission medication reconciliation form should be printed for the prescriber to review. The prescriber/designee shall indicate on the Medication Reconciliation Form which medications are to continue in the hospital. The prescriber/designee signs, dates, and times the form as “*Ordering Physician*” to note that the medication has been reconciled. The physician/designee is accountable to assure that all required order entry details are complete and correct on the form. This form acts as a reconciliation form. The physician/designee will document admission orders on a physician order sheet.

4. The registered nurse is accountable to review the

completed/signed Medication Reconciliation Report of Admission Form and the admission orders and then once the reconciliation is completed signs the form in the “Reconciled By” section.

5. Keep the signed original Medication Reconciliation Report of

Admission Form in the chart under the PHYSICIAN’S ORDER tab with the discharge instructions.

6. If discrepancies between the home medication regimen and the

prescriber’s orders exist, call the prescribing provider.

1. If it is discovered that a patient was using a medication not listed initially on the ***admission medication profile***, update the medication profile to add this medication.
   1. The nurse shall notify the attending physician of the newly discovered medication.
   2. It is important to record the newly discovered medication on the ***medication profile*** in order to optimize the patient’s medication regimen while in the hospital and at discharge.

8. The accurate current medication regimen (Medications Being

Given) will be maintained by the pharmacy while in the hospital system. Nursing will complete medications by history only.

\*For admissions occurring in the Labor and Delivery area, the medication profile shall be initiated at delivery and completed in the Mother/Baby Unit.

B. Medication Reconciliation at Transfer:

1. When transferring the patient to a different level of care (to or from a special-care unit, i.e. ICU, TCU), before a surgical procedure, from an overflow status, or to another facility, hospital personnel will reconcile medications. This form, once completed and signed by the physician/designee, serves as physician orders for medications at the time of transfer.
2. The prescriber/designee shall review the medications presented on the Transfer Medication Reconcile Form, indicate which of these medications are to continue, and/or order new medications as warranted. The prescriber/designee shall then sign and date the form. A verbal order may be obtained and shall be signed, dated, and timed by the RN along with checking the verbal order verification box as appropriate.

C. Medication Reconciliation at Discharge

1. As the patient prepares to exit the care of the hospital, hospital personnel will print a Medication Reconciliation Form. The prescriber/designee shall indicate which medications should be continued upon discharge by marking the appropriate box on the Medication Reconciliation Form. The physician will continue to also write prescriptions to be sent home with the patient and these will be transcribed onto the Medication Reconcile Discharge Report. \* Confirm that the patient has not been given additional prescriptions by the Healthcare Provider.
2. The RN will review the completed Medication Reconciliation Form and clarify any questions related to the physician’s intended orders. The RN will sign the form in the “Reconciled By” section.
3. The physician shall complete the final progress notes instructions listing medications ordered upon discharge or indicate on the transfer/discharge current medication list the medications to be taken upon discharge.
4. The patient shall receive a copy of the final progress note instructions and transfer/discharge sheet (if applicable) and will be encouraged to share the list with any providers of care. If applicable, a copy of the Medication Reconciliation Form may also be sent with the patient. The original document will remain in the Medical Record as a physician’s order sheet.

END OF SECTION

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| Example 2 |  |
| MANUAL | Administration |
| SECTION | Medication Management |
| SUBJECT | Medication Reconciliation |
| JC STANDARD | National Patient Safety Goal |

**POLICY**

Upon entry into the hospital, a list of the patient’s current medications will be obtained and documented with the involvement of the patient and family. The current medication list will be compared to the admission orders. The admitting/attending provider will reconcile any differences. The list of medications shall be communicated to the next provider at the time of transfer to a different level of service or discharge, within or outside the organization. The patient will receive a copy of the list at the time of discharge.

**RESPONSIBILITY**

Physicians, Allied Health Professionals, RNs, Pharmacies, Designated Ancillary Staff, Patient/Family.

**PROCEDURE**

* + - 1. The “Continue on Admission” column is only to be used when the Medication List Verification/Order Form is a physician order. By circling “Y” or “N” in this column, home medications to be continued or not continued are identified by the provider. The form is to be signed according to policy.
      2. If the “Medication List Verification/Order Form” is not used as a physician order on admission, the RN will place “N/A” (not applicable) in the space provided for the admitting physician’s signature.

1. Admission:
2. Medication List:
   * A current (patient routinely take in the past 30 days) pre-admission medication list will be collected at the time of admission, except in emergency situations. The list will include antibiotics, over-the-counter (OTC), chemotherapy and herbal medications. The information should be written in laymen’s terms.
   * The source of the information will be indicated.
   * The pharmacy name and family physician may be noted on the form.
   * The medication detail will be as complete as possible. If the patient takes a medication PRN, the box under “As Needed” is checked. An indication for how often and the reason the medication is needed must be included.
   * If a patient is unreliable, the information must be verified with at least one other source. The nurse will mark “unknown” and place a question mark or an “X” in the block when the information is incomplete.
   * The nurse will “X” out unused lines in that section of the form.
   * The person who records the information will sign and date on the “Medication History Recorded By” line.
   * The caregiver will review the form and verify that the information is complete and sign his/her name on the “Medication History Recorded By” line next to the patient’s signature and date/time.
   * If Pre-Admission Testing (PAT) obtains the history, the last date/time will be left blank. The interviewing nurse will complete the list with the last dose information and sign his/her name on the “Medication History Recorded By” line next to the PAT nurse’s signature and date/time.
3. Clarification:
   * Clarifications will be made on the Clarification Form
   * The number of the medication will be written in the clarification form in the “Order Number” column.
   * The RN will ensure that all the medication details for the order are complete as above.
   * The clarifier will “X” out the unused line(s) in the clarification section of the form.
   * The clarifier will sign his/her name on the clarifier’s signature line.
   * If an RN/R.Ph. is unable to clarify a medication by the end of the shift, it will be passed on to the oncoming shift.
   * All medications should be clarified within 24 hours of admission. Every reasonable attempt should be made to obtain clarification.
   * Later clarifications should be put on a new form
4. Reconciliation: The current medication list will be compared to the admission orders. The admitting/attending provider will be contacted to reconcile any differences.
   * Reconciliation must occur within 24 hours of admission.
     + If the admission orders have already been written:
       - The RN will compare the current pre-admission medication list to the admission list.
       - The nurse will place a checkmark in the column “on Physician Order Sheet” if the admission medication and the current medication are the same or if the provider has made it clear the admission medication is a change from the pre-admission list.
       - The RN will contact the provider to review the list of medication, which have not already been addressed in the admission orders or with any questions.
     + If the admitting/attending provider is not present and the admission orders have not been written:
       - The RN will contact the physician to obtain medication orders. The RN will review the list of pre-admission medications with the provider and circle “Y” or “N” on the form to indicate which medications are continued or not continued (reconciliation process) on admission, as ordered by the physician.
       - The RN will sign the order on the admitting physician line according to the policy.
     + If the admitting/attending provider is present and the admission orders have not been written:
       - He/she will review the re-admission medication list.
       - The provider will indicate on the form which medications are to be continued or not to be continued on admission.
       - The provider will sign and date the form on the line for the admitting physician.
5. Any herbal or dietary supplements that the physician considers therapeutically necessary to be given while the patient is in the hospital will require use of the patient’s own medication. (See the policy “Patient’s Use of Own Herbals and “Natural” Remedies)
6. **ALL NEW MEDICATION ORDERS OR CHANGES MUST BE WRITTEN ON A SEPARATE PHYSICIAN ORDER SHEET**.
7. Order will be faxed to the Pharmacy.
8. Orders will be signed off per policy. Orders will be placed in the chart in the Physician’s Orders section of the chart.
9. Any additional medications reported by the patient and/or family after the admission process is complete will be placed on a new form as above and placed with the other pre-admission medication lists.
10. Pharmacy will enter the pre-admission medications that will be continued on admission into the Pharmacy patient profile so that they will appear on the electronic MAR

* Pharmacy will not file any order needing clarification with the completed orders until the medication has been clarified.

1. Pharmacy will enter the pre-admission medications information on the medication profile (Med Profile tab) within 24 hours of receiving the form.
   * After the pharmacist has entered the pre-admission medications into the medication profile, the order will be filled with other pre-admission medication lists.
2. Post Procedure/Transfer:
3. As per hospital policy, all orders will be discontinued and

appropriate orders rewritten by the physician when the patient transfers to a different level of care (e.g., from ICU to 6th floor, 5th Med to CCU, or Labor and Delivery to Post-Partum) or to the Operating Room or Cath Lab.

1. Consideration should be given to pre-admission medications that may need to be restarted or held, based on the level of care.
2. For patients going to a procedure, the Active Order Report will be printed and placed on the chart at the time of transport so the report is available post procedure for the provider’s review.
3. At the time of transfer, the active ordered medications will be printed and used as a preprinted order sheet.
4. This report will be used by the physician to indicate which orders are continued and/or discontinued. Indicate discontinued medications by putting a line through the order.
5. New orders or modified orders can be written on a separate physician order sheet on the active order report.
6. Any orders to “continue” or “resume” will be clarified with the provider.
7. If the provider signs the report at the time the orders are placed, it will serve as a written order.
8. The signed active ordered medications will be faxed to the Pharmacy.
9. Implement the Transfer/Cancel Process. See the Transfer Policy.
10. Discharge:
    1. The pre-admission medication list and current medications will be reviewed prior to discharge.
    2. If the provider is present:

* He/she will review the pre-admission medication list and current medications.
* He/she may indicate on the Medication List which home medications should be continued or discontinued on discharge.
* He/she will sign and date the Medication List on the line for the discharging physician.
* When giving prescriptions to the patient he/she will confirm that the medications are included in the discharge medication list.
  1. If the provider is not present:
* The nurse will review the pre-admission medication list and current medications.
* The nurse will contact the provider to review both lists.
* The nurse will indicate on the Medication List which pre-admission medications are continued or discontinued (reconciliation process) on discharge.
* The nurse will sign the order on the Medication List on the discharging physician line, according to the verbal order policy.
  1. The nurse will compare the pre-admission medication list, current medications and the discharge medication(s). The nurse will contact the provider if there are any discrepancies or concerns.
  2. New medication orders or changes can be written on a separate physician order sheet or on the bottom of the medication list.
  3. For inpatients, the nurse will list the re-admission medications to be continued, any new medications, and discontinued home medications on the discharge medication sheet.
  4. For outpatients who come for a test, a procedure, a surgery, or an infusion with the intention of being discharged from that area (e.g., Ortho Center, SurgiCare, Infusion Center, Cath Lab, ED, and Radiology) a copy of the medication list will be given to the patient at discharge.

1. List to Next Provider at Discharge
2. The medication list will be sent by the Medical Records Department staff to any provider(s) indicated in the dictated discharge summary.
3. When a patient is transferred to another facility, the medication list will be copied and included in the discharge chart.

END OF SECTION

|  |  |
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| Example 3 |  |
| MANUAL | Administration |
| SECTION | Medication Management |
| SUBJECT | Home Meds – What the Pharmacist Can Do |
| JC STANDARD | National Patient Safety Goals |

**POLICY**

With the intent of accurately and completely reconciling the patient’s home medications against those ordered while under our care, the medical staff authorizes the pharmacist to:

1. Assess the patient’s home med list and write orders per policy to discontinue any herbal remedy, vitamin, over-the-counter (OTC) drug, or nutraceutical that is not on the hospital formulary;

AND

1. Write orders per policy to discontinue any ***Incomplete*** (*defined as a medication order where the drug name is unclear (BP pill) and/or one or more of the following components are missing: strength, dose, route of administration, or frequency of administration*) home medication order that cannot be clarified once the pharmacist has made attempts to do so.

**RESPONSIBILITY**

Pharmacist, Physician

**PROCEDURE**

|  |
| --- |
| PHARMACIST’S GUIDELINES TO FOLLOW WHEN CLARIFYING ***INCOMPLETE*** HOME MEDICATION ORDERS FROM THE MEDICATION RECONCILIATION ORDER FORM |

1. Speak with patient to obtain additional information including pharmacy where medication was filled and/or physician who ordered the medication; or
2. Speak with patient’s family for above information if patient is not a reliable historian;
3. Call pharmacy where medication was filled, according to patient or family;
4. Call physician who prescribed the medication, according to patient or family.

END OF SECTION

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| Example 4 |  |
| SUBJECT | Out-Patient Medication Reconciliation Policy |
| DEPARTMENT | Out-Patient |

**POLICY**

If medications are given during a patient visit, a list of the patient’s current medications must be obtained and compared to (reconcile) any medications that will be given during the visit.

**PROCEDURE**

1. On initial visit to out-patient services, record patient’s medications on Out-patient Medication Reconciliation Sheet.
2. Review medications for any possible reaction with medication to be given.
3. After medication given, document medication on Out-patient Medication Reconciliation Sheet.
4. Sign, date, and copy Out-patient Medication Reconciliation Sheet and give a copy to patient prior to discharge from department.
5. If patient has a repeating medication order, file original med reconciliation sheet in out-patient services.
6. When patient returns for next medication, pull med reconciliation sheet and ask patient if any changes to medication. Revise med list as necessary.
7. If revisions have occurred, then date, sign and copy list for patient.
8. If no changes, in med list since last visit, document date of review and re-file for next visit.

END OF SECTION

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| Example 5 |  |
| SUBJECT | Policy and Procedure for Medication Reconciliation |
| DEPARTMENT | General Nursing |

**PURPOSE**

A process for reconciling patient medications will provide for an accurate and complete medication list for patients across the continuum of care. The inaccuracy of medication lists has been documented to cause medication errors often with serious adverse outcomes. The admission medication list should be used as a basis of comparison for medications prescribed upon admission, and reevaluated as the patient changes levels of care.

**DEFINITION**

Reconciling medications is the process of obtaining a list of a patient’s current home medications, and them comparing that list against one or more other sources; including, but not limited to, the physician’s admission orders, pharmacy record, prescription vial review, physician office records, and/or medication administration record from a transferring facility. The nurse must clarify any unclear admission orders to assure patient safety.

**POLICY**

Upon entry into the healthcare system, a complete list of the patient’s current medications will be obtained, verified, and documented with the involvement of the patient or caregiver. A complete list of medications shall also be communicated to the next provider of service when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

**PROCEDURE**

1. A medication history should be obtained from the patient and/or family members who are present at the time of entry into the hospital system. Emergency room nurses will document medications and source of information on the ER Triage Sheet.
2. Medications should be recorded on the Medication Reconciliation Form during the nursing admission process. If medications are brought in with the patient, they should be reviewed at this time. All medications should be recorded, including over-the-counter (OTC) herbal, respiratory medications, and oxygen. The source of the medication information should be documented by placing a checkmark in the appropriate boxes. Allergy information is also included on the form.
3. The admitting nurse or physician will be responsible for reconciling the medication list during the admission process. Home medications that are not to be continued should be recorded as a “no” in the order column for clarity. Home medications that are to be continued can be recorded as “yes”. If changes in dosage or frequency are made a new order must be written. The completed medication reconciliation form will be faxed to pharmacy when the order column is completed.
4. When a patient moves to a different level of care within the hospital, the medications should be reviewed and reconciled by the transferring and accepting caregivers.
5. At the time of discharge or transfer out of the facility, discharge orders should be compared to the most current medication administration record. Discharge medication orders will be written in the discharge order column of the Medication Reconciliation Order Form. It is the responsibility of the nurse to clarify any unclear orders prior to discharge or transfer.
6. A pharmacy consult should be considered for medication lists that include ten (10) or more medications.

END OF SECITON

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| Example 6 |  |
| SUBJECT | Medication Reconciliation |
| DEPARTMENT | Nursing |

**PURPOSE**

To ensure timely and accurate capture and documentation of a comprehensive list of a patient’s medications.

* Communication of this information across the continuum of care
* To reduce medication-related errors
* Improve patient safety and outcomes

**POLICY**

The medication reconciliation process includes these steps:

1. Obtaining and documenting the most complete and accurate list possible of current medications for each patient

For the purposes of reconciliation, the term “medication” includes:

* prescription medications
* over-the counter (OTC) medications
* sample medications
* investigational/study medications
* vitamins and other supplements
* herbal remedies
* eye, ear, skin preparations or patches
* dietary or nutritional supplements
* parenteral nutrition
* inhaled medications and respiratory treatments
* diagnostic, contrast, and radioactive agents
* vaccines
* blood derivatives
* intravenous solutions (plain, with electrolytes or drugs)
  1. Comparing the list against admissions, transfer, and discharge orders.

2a. Patients entering through the Emergency Department represent the majority of admitted patients. A medication history will be obtained from the patient/family/referring facility. This medication history will be documented on the Medication Reconciliation Form. The **medication reconciliation form will be placed in front of the Physician Order Sheets** in the outpatient and inpatient Medical Record. The Home Health and Hospice Medication Reconciliation Form will be placed under the Medication tab.

2b. Upon transfer to inpatient unit, the admitting nurse shall compare the medication history from the Medication Reconciliation Form to the admission orders (written by the admitting or the attending). If discrepancies are noted, notify the provider. After contacting the physician for clarification make appropriate changes as a new written order.

**PROCEDURE**

1. Obtain information to complete the list of the patient’s current medications and document this information on the Medication Reconciliation List/Admission/Triage Note. Information sources may include:
   * Medications provided in original containers (check contents against name on label)
   * List provided by the patient or surrogate
   * Patient/family recall
   * Primary care physician or other medical service providers
   * Medication Administration Record (MAR) from an outside facility or agency
   * Discharge summary or discharge medication list from a previous hospitalization (providers are discouraged from using a recent discharge summary as the sole data source)
   * Current hospitalization MAR
   * Contacting patient’s pharmacy provider

Reasonable efforts should be made and resources used to obtain medication information in situations involving a poor historian, literacy, language, cultural, or cognitive status barrier, or other patient vulnerability.

A complete medication entry will include:

* Medication or product name
* Dose (including concentration for liquid medications (ex. mg/mL)
* Route or site
* Frequency (schedule)
* Last dose
* Reason or indication for use
  1. The prescriber shall document the reconciliation process on the Medication Reconciliation List.

Document in the “Comments” section:

* Any deviation from labeled instructions (dose, frequency, etc.) reported by the patient, family, or facility/agency.
* Any other pertinent medication-related information.
  1. The patient or surrogate should be given a copy of their current medication list at the time of discharge and encouraged to partner with medical providers in keeping the list current.
  2. A copy of the list of Patient Medications upon Discharge will be distributed to the patient’s primary care provider.
* A copy of the Patient Medications upon Discharge will be placed in each physician’s mail box in the Admissions Office each morning **or**
* A copy of the Patient Medications upon Discharge will be faxed to the physician’s office when the medical record is separated for Medical Records.

END OF SECTION

|  |  |
| --- | --- |
| Example 7 |  |
| TITLE /DESCRIPTION | Medical Reconciliation |
| STANDARD | Medication Management / Patient Safety |

**I. PURPOSE:**

The Preadmission Medication List Verification and Order Form (Medication Reconciliation Form) is intended to generate the most accurate medication list available especially at the transitions of care (home/nursing home to admission, admission to discharge). Medication reconciliation is an interdisciplinary process designed to decrease medication adverse drug reoccurrences and potential adverse drug occurrences on all nursing units and to maintain continuity of care for patients with regard to medication use on admission. The Preadmission Medication List Verification and Order Form will be treated and filed as any other order sheet.

**II. POLICY:**

The Medication Reconciliation Form will be completed on all patients admitted to inpatient status at the organization.

**III. RESPONSIBILITY:**

The nurse and/or physician obtaining the medication history are responsible for documenting all of the medications and doses (including over the counter and herbal medications) that the patient was taking prior to admission on the Medication Reconciliation Form. The **physician** takes responsibility for the completion of the medication history with their signature on the form.

**III. PROCESS**

**A. PROCEDURE:**

1) **At the entry point of admission, the Emergency Department Nurse/Triage Nurse or Direct Admission Nurse** should photocopy the patient’s home medication list (if available) and attach to the Preadmission Medication List Verification and Order Form (Medication Reconciliation Form). However, the nurse and physician **must still complete** the Preadmission Medication List Verification and Order Form (Medication Reconciliation Form)

2). The medication history may be obtained from the patient and/or family members who are present at the time of admission. An effort should be made to verify (by comparing with patient list, hospital discharge record, Primary Care Provider record, and/or calling pharmacy) that the list is as accurate as possible.

3). **Patients entering for planned surgical procedures with planned post-op admission** will have the medication history documented on the Preadmission Medication List and current home medication list and will be updated during their pre-admission visit or during the pre-operative assessment time period by the physician and/or outpatient/surgical Nurse. This form will be placed with the physician order section to be utilized by the physician when writing post-operative physician orders.

4) The Emergency Department nurse/Triage Nurse, Direct Admission Nurse Outpatient Nurse and/or Physician is to document on the Preadmission Medication List Verification and Order Form (Medication Reconciliation Form), all of the medications, dosages, frequency of medications, and last dose that the patient was taking prior to admission. This medication information **does not** need to be re-documented on nursing flow sheets or on the H&P. Instead, one can write “See Medication Reconciliation Form” in the medication sections of these forms.

5) **This medication record is then used as an order form for reconciliation of home and inpatient medications.**

a). Beside each medication in the “Continue on Admission” column, the physician should circle a “C” to continue or a “DC” to discontinue.

b) **New medications** (e.g. Ceftriaxone) to be initiated on admission should be written on the designated physician order sheet, **not** the medication reconciliation form.

c) For medications that require a **dosage change**, discontinue (DC) the medication on the Medication Reconciliation Form and write the medication, new dosage, frequency and route of administration on the admission orders.

d) **For medications with therapeutic interchanges,** discontinue (DC) the medication on the Medication Reconciliation Form and write the new medication on the physician admission orders.

e) Draw a line under the last medication listed on the Medication Reconciliation Form so that no additional medications can be written below. If additional medication reconciliation pages are needed, then please indicate at the bottom of this form, that this is one of two pages, etc.

6) The charge nurse and/or admission nurse should verify/sign off the orders on the Preadmission Medication List Verification and Order Form (Medication Reconciliation). The attending and/or ordering physician shall be notified regarding any discrepancies or incompleteness.

7) This form will then be scanned to pharmacy and shall be treated and filed as any other physician order sheet. Before faxing the medication reconciliation form to pharmacy, the physician signature and/or a verbal order written by an RN from physician must be present. If a verbal order is obtained from a physician by an RN and verified via the read-back protocol, the ordering physician/attending physician must review the form and sign upon the next patient visit.

8) On the admission orders write, “Please see Medication Reconciliation Form” to cue the pharmacist to review the Medication Reconciliation Form as well.

9) **When the patient is being discharged,** the Physician and Registered Nurse should use the inpatient Medication Administration Record (MAR) **and** Medication Reconciliation Form to generate the most accurate list of medications for the discharge paperwork. On the Medication Reconciliation form, in the “Continue on Discharge” column, circle C to continue or DC to discontinue for each home medication. This will show the provider’s conscious decision-making process. Physician must sign the discharge area of the medication reconciliation form.

**B. CHART PLACEMENT**

The Medication Reconciliation Form will be placed in the physician order section.

END OF SECTION

|  |  |
| --- | --- |
| Example 8 |  |
| SUBJECT | Medication Reconciliation Admission and Intrahospital Transfer |
| DISTRIBUTION | Nursing Policy and Procedure Manual |
| REGULATORY AUTHORITY/REFERENCE | JC, NPSG, IHI, ISMP |

**PURPOSE**

It is the policy of this facility to reconcile patient’s medications across the continuum of care

to facilitate communication of the health care team in order to prevent medication errors and to optimize the patient’s potential for recovery.

**PROCEDURE**

*Admission and discharge of patient*

1. The admitting RN will complete the home medication list within 24 hours of admission. If a home medication list cannot be obtained, the RN will notify the physician.
2. After completion, the home medication list is compared to the admitting/attending physician’s orders. If the home medication is ordered correctly, the RN will check “yes” in the admission order column on the left side of the form. If the home medication is not ordered, this will necessitate reconciliation by contacting the physician and asking if this medication should be continued, and a separate order must be written and added to the discharge instructions upon admission. If the physician would like the medication ordered, check “yes” on the left column of the form and write a verbal order

for this medication. If the physician does not want the medication ordered, check “no.”

1. At this time, the home medication list is considered reconciled and this form will be placed with the nursing admission history on the chart.
2. At the time of discharge, this form will be utilized to compare against the physician’s discharge instructions. If the physician has continued the medication at discharge, check “yes” in the discharge order column on the right side of the form. The patient’s current MAR will also be compared during this process. If the medication is not continued upon discharge, this will again necessitate reconciliation with the physician. If the physician would like the medication continued, add this to the patient’s discharge instruction sheet. If not, check “no” in the right column of the form.
3. When the discharge orders are reconciled, the medication reconciliation process is complete. The form remains with the nursing section of the medical record.

*Transfer of patient, intrahospital*

1. Upon receiving the order to transfer, the RN will compare the patient’s current MAR with the home medication list and the transfer orders. NOTE: PATIENTS TRANSFERRED FROM MEDSURG TO CCU WILL HAVE THE MEDICATION RECONCILIATION PERFORMED BY THE CCU NURSE UPON RECEIVING THE PATIENT.
2. If a medication which is currently being administered is not continued to the next level of care, this will need to be reconciled by contacting the physician for clarification to prevent errors of omission.
3. The MAR will then be updated after the medication reconciliation is complete.
4. At times of emergent transfer, this process will be coordinated by the transferring and receiving RNs to ensure an accurate reconciliatory effort.

END OF SECTION

**FORM SAMPLES**

**MEDICATION RECONCILIATION FORM**

***(Medication Assessment History/Physician Order Form)***

**ADM. NURSE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE & TIME**:\_\_\_\_\_\_\_\_\_\_\_

**NURSE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE & TIME**:\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HEIGHT**:\_\_\_\_\_ **ft.** \_\_\_\_\_\_**in.** **WEIGHT**:\_\_\_\_\_\_\_\_\_\_**lbs.** \_\_\_\_\_\_\_\_\_\_**oz.**

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| --- | --- | --- | --- | --- | --- |
| **Home Med. Dose/Route/Frequency/Time**  Include Herbal/OTC/Vitamins) | Reason | Last Dose Taken  “?” if Unknown | Con-tinue Same Med. | Discon-tinue Med. | **Changes**  (record changes in dose, route, frequency, or time) |
| Patient takes no medication |  |  |  |  |  |
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| MD REVIEW:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***(I have reviewed home meds, orders previously written. This does not constitute order.)*** | | | | | |
| ***Information Obtained***: Patient/Family Bottles/List Old records Retail Pharmacy  Universal Medication Form  Meds send to: N/A Hospital Pharmacy    Home with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **NEW MEDICATION ORDERS** | | | | | |
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**PHYSICIAN ORDER SIGNATURE**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE & TIME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATION RECONCILIATION**

***Medication Assessment History/Physician Orders*** PATIENT ADDRESSOGRAPH

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Nurse Signature Date & Time

|  |  |
| --- | --- |
| **IN HOSPITAL** | **AT DISCHARGE** |
| At time of admission, please check which medications should be continued and sign below to authenticate order. | At time of discharge, please check which medications should be continued and sign below to authenticate order. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Home Medication/Dose/Route/Frequency/Time**  (include Herbal/OTC/Vitamins, ALL Medications) | Last dose taken ? = unkn. | Give med. during hospital | Do **not** give med. | Continue at discharge | Do **not** give at discharge |
| Patient takes no medications  Does this patient take insulin injections? |  |  |  |  |  |
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| **Information obtained from:**  Universal Medication Form Patient/Family Bottles/List  Old Records Retain Pharmacy MD Office Records  ED Records  Meds sent to: Home with:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hospital Vault N/A  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ----------------------------------------------------------------------------------------------------  **CHECK BOX BELOW AND SIGN**  Medications addressed by physician, appropriate boxes checked.  Physician contacted and verbal received for each medication  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician Signature Date & Time | Please list new medications prescribed for patient at discharge:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician Signature Date & Time |

NAME OF HOSPITAL

**Patient Medication History**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Admitting Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_

Expected date of admission:\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for admission:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All Allergies and the reaction experienced:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill all medications you are currently taking and review with your physician, surgeon, practitioner, or pharmacist for accuracy prior to admission:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **Dose** | **Frequency** | **Used For** | **Date of last dose** | **Resume after discharge** |
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| NAME OF HOSPITAL  Address  **OUTPATIENT HOME MEDICATION RECONCILIATION** |
| Patient home medication recorded on admission:  Documented by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **MEDICATION/HERBAL/VITAMINS/CONTRAST/OVER-THE-COUNTER**  **NAME DOSE REASON LAST TAKEN**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Allergy or Adverse Reactions TYPE SEVERITY DATE**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Reviewed by Attending of Record or Designee:**  On Admission:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time\_\_\_\_\_\_\_\_\_  Change in Level of Care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time\_\_\_\_\_\_\_\_\_  On Discharge:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date & Time\_\_\_\_\_\_\_\_\_\_ |

This tool is being used for data collection in order to audit our medication reconciliation processes.

**Admission Data Documentation:**

1. Medication list obtained within 24 hours of admission? \_\_\_\_\_Yes \_\_\_\_\_No
2. Was patient NPO? \_\_\_\_\_Yes \_\_\_\_\_No
3. Inpatient Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service: \_\_\_\_\_\_\_\_\_\_\_\_\_
4. Number of home medications listed on admission form: \_\_\_\_\_\_\_\_\_
   * Number of prescription medications \_\_\_\_\_\_\_\_\_
   * Number of over-the-counter medications \_\_\_\_\_\_\_\_\_
   * Number of herbal supplements \_\_\_\_\_\_\_\_\_
   * Number of supplements \_\_\_\_\_\_\_\_\_
5. Number of home medications recorded \_\_\_\_\_\_\_\_\_
6. Number of home medications changed \_\_\_\_\_\_\_\_\_
   * Dose change \_\_\_\_\_\_\_\_\_
   * Frequency change \_\_\_\_\_\_\_\_\_
   * Route change \_\_\_\_\_\_\_\_\_
7. Number of home medications clarified: (please check correct box and the number of medications clarified):

Omitted \_\_\_\_\_\_\_ Wrong Dose \_\_\_\_\_\_\_

Duplication \_\_\_\_\_\_\_ Missing Information \_\_\_\_\_\_\_

Wrong Drug \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Number of home medications with documented reason to hold \_\_\_\_\_\_\_\_\_
2. Number of medications clinically appropriated to hold \_\_\_\_\_\_\_\_\_
3. Number of medications not reconciled within 24 hours \_\_\_\_\_\_\_\_\_
4. Allergies documented? \_\_\_\_\_\_Yes \_\_\_\_\_No
5. Interventions made by R.Ph.: (please check box and indicate number of interventions):

Drug-drug interactions \_\_\_\_\_\_\_ Incomplete list of medication \_\_\_\_\_\_\_

Drug-disease interactions \_\_\_\_\_\_\_ Dose changes \_\_\_\_\_\_\_

Duplication of therapy \_\_\_\_\_\_\_ Route changes \_\_\_\_\_\_\_

Lab monitoring \_\_\_\_\_\_\_ IV to PO \_\_\_\_\_\_\_

Adverse effects \_\_\_\_\_\_\_ Formulary changes \_\_\_\_\_\_\_

Incomplete list of medications \_\_\_\_ Patient education \_\_\_\_\_\_\_

|  |
| --- |
| Please provide additional comments or notes here: |

This tool is being used for data collection in order to audit our medication reconciliation processes. Please document the following elements for patients who have transferred to your unit.

**Transfer Data Collection:**

Pt MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Inpatient Unit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Unit Pharmacist to Document the following Information** |

1. Patient transferred

Level of Care (ICU to IMC or general care)

Services of care (ex. CCS to GM1)

1. Number of current inpatient medications clarified: (please check correct box and indicate the number of medications clarified)

Omitted \_\_\_\_\_\_\_ Wrong Dose \_\_\_\_\_\_\_

Duplication \_\_\_\_\_\_\_ Missing Information \_\_\_\_\_\_\_

Wrong Drug \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Number of home medications re-ordered: \_\_\_\_\_\_\_\_\_\_\_\_
2. Number of home medications clarified: (please check correct box and indicate the number of medications clarified)

Omitted \_\_\_\_\_\_\_ Wrong Dose \_\_\_\_\_\_\_

Duplication \_\_\_\_\_\_\_ Missing Information \_\_\_\_\_\_\_

Wrong Drug \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Interventions made by R.Ph. (please check box and indicate number of interventions)

Drug-drug interactions \_\_\_\_\_\_\_ Incomplete list of medication \_\_\_\_\_\_\_

Drug-disease interactions \_\_\_\_\_\_\_ Dose changes \_\_\_\_\_\_\_

Duplication of therapy \_\_\_\_\_\_\_ Route changes \_\_\_\_\_\_\_

Lab monitoring \_\_\_\_\_\_\_ IV to PO \_\_\_\_\_\_\_

Adverse effects \_\_\_\_\_\_\_ Formulary changes \_\_\_\_\_\_\_

Incomplete list of medications \_\_\_\_ Patient education \_\_\_\_\_\_\_

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| ***\*\*\* STOP HERE\*\*\**** The following information will be completed by auditor |

1. Number of home medications listed on admission history note \_\_\_\_\_\_
2. Number of scheduled medications listed in e-mar: \_\_\_\_\_\_
3. Number of medications clinically appropriate to hold \_\_\_\_\_\_
4. Number of home medications with documented reason to hold \_\_\_\_\_\_
5. Number of current inpatient medications ordered upon transfer \_\_\_\_\_\_
6. Documentation of reconciliation on monitoring sheet \_\_\_\_\_YES \_\_\_\_\_NO

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| Please provide additional comments or notes here: |

This tool is being used for data collection in order to audit our medication reconciliation processes. Please document the following elements for TWO patients being discharged on your shift for this unit.

**Discharge Process Data Collection**

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| **Unit Pharmacist to document the following information** |

Patient MRN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Estimated time trial (minutes) – this is to provide us with a rough estimate of how long it takes to complete a patient discharge-remember it is estimated
   1. Actual Time when face sheet completed by physician (if known) \_\_\_\_\_
   2. Actual time R.Ph. receives face sheet \_\_\_\_\_
   3. Time spent for R.Ph. to complete reconciliation of face sheet \_\_\_\_\_
   4. R.Ph. time spent completing discharge counseling \_\_\_\_\_
2. Total number of medications listed on the face sheet \_\_\_\_\_
3. Number of interventions/clarifications made to face sheet \_\_\_\_\_
4. Types of interventions made by R.Ph. (please check correct box and indicate the number of medications clarified)

Wrong Drug \_\_\_\_\_\_\_ Duplication \_\_\_\_\_\_\_

Wrong Dose \_\_\_\_\_\_\_ Missing Medication \_\_\_\_\_\_\_

Wrong Route \_\_\_\_\_\_\_ Allergy \_\_\_\_\_\_\_

Wrong Frequency \_\_\_\_\_\_\_ Adverse drug reaction \_\_\_\_\_\_\_

Adverse effects \_\_\_\_\_\_\_

I Insurance issue (prior authorization required or therapeutic interchange)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Number of home medications clarified (please check correct box and indicate the number of medications clarified)

Omitted \_\_\_\_\_\_\_ Wrong Dose \_\_\_\_\_\_\_

Duplication \_\_\_\_\_\_\_ Missing Information \_\_\_\_\_\_\_

Wrong Drug \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did the patient receive an electronic medication list: \_\_\_\_\_YES \_\_\_\_\_NO

Medication Chart \_\_\_\_\_\_\_

Self-administration sheet \_\_\_\_\_\_\_

1. Complete teaching documentation? \_\_\_\_\_YES \_\_\_\_\_NO

|  |
| --- |
| Please provide additional comments or notes here: |

This tool is being used for data collection in order to audit our medication reconciliation processes.

**Non-inpatient care areas using paper documentation**

1. Medication list documented in patient chart? \_\_\_\_YES \_\_\_\_NO
2. Medication list obtained by:

Nurse Physician Pharmacist

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Was an updated medication list provided to patient? \_\_\_\_YES \_\_\_\_NO
2. Was this communicated to next provider of care? \_\_\_\_YES \_\_\_\_NO

***Evaluation of the accuracy of the medication list***

1. Missing information? (please check appropriate boxes and document # of missing items)

Drug name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Strength \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Route \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Use of banned abbreviations? \_\_\_\_YES \_\_\_\_NO
2. Any misspellings \_\_\_\_YES \_\_\_\_NO

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Logo | | | |  | | | | |
| MEDICATION RECONCILIATION ORDER FORM | | | |
| List all patient medications prior to assessment. Include OTCs & alternative meds (herbals). (Alternative meds will not be continued on admission).  Before an outpatient receives any medication as part of their test or procedure, list all of their current home medications looking for allergies, interactions, duplications, or other concerns. A complete reconciliation is required only if the patient is to be admitted to the hospital.  Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| DO NOT USE UNAPPROVED ABBREVIATIONS: .#, .0, IU, MS, MgSO4, QD, QOD, U, etc... | | | | | | | | |
| Information Source:\_\_\_\_\_\_\_\_Patient \_\_\_\_\_Family \_\_\_\_\_Primary Care Physician  \_\_\_\_Patient’s Pharmacy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_MAR from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Check her if patient is not currently on any   medication. | | | | | Last Dose | | Physician Decision:  Continue? Circle One | |
| Medication Name | Dose | Route | Frequency | | Date | Time |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
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|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
|  |  |  |  | |  |  | Y | N |
| On the lines below, enter order for new medications that the patient isn’t currently taking or changes to their current regimen | | | | | | | | |
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Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nurse Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time \_\_\_\_\_\_\_\_\_\_\_

I have reviewed this list of patient medications and to the best of my knowledge, the additional medications I have ordered will not result in any adverse reaction(s).

Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Provider Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time \_\_\_\_\_\_\_\_\_\_\_

Faxed/Given to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date/Time \_\_\_\_\_\_\_\_\_\_\_

Sheet \_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Allergies/Reactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient’s Community Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| HOME MEDICATION LIST  IF ADDITIONAL SPACE IS NEEDED, PLEASE USE A SECOND COPY OF HOME MEDICATION LIST | | | | | | | | | | | | | | |
| Continue in Hospital?  (Orders Must Be Written) | | | NO HOME MEDICATIONS  PRESCRIPTION MEDICATIONS/ OVER-THE- COUNTER/VITAMIN SUPPLEMENTS | | | DOSE | | ROUTE | FREQUENCY  Do Not Use “Unsafe” Abbreviations | DISCHARGE MEDICATIONS | | | | |
| Yes | Ordered | No | Resume at Same Dose | | | DO NOT Resume at Discharge to Home | |
|  |  |  | 1. | | |  | |  |  |  | | |  | |
|  |  |  | 2. | | |  | |  |  |  | | |  | |
|  |  |  | 3. | | |  | |  |  |  | | |  | |
|  |  |  | 4. | | |  | |  |  |  | | |  | |
|  |  |  | 5. | | |  | |  |  |  | | |  | |
|  |  |  | 6. | | |  | |  |  |  | | |  | |
|  |  |  | 7. | | |  | |  |  |  | | |  | |
|  |  |  | 8. | | |  | |  |  |  | | |  | |
|  |  |  | 9. | | |  | |  |  |  | | |  | |
|  |  |  | 10. | | |  | |  |  |  | | |  | |
|  |  |  | 11. | | |  | |  |  |  | | |  | |
|  |  |  | 12. | | |  | |  |  |  | | |  | |
|  |  |  | 13. | | |  | |  |  |  | | |  | |
| Admission Nurse Signature | | | | Date | | Discharge Nurse Signature | | | | | | Date | | |
|  | | | |  | |  | | | | | |  | | |
| SIGNATURE BELOW INDICATES MEDICATION HAVE BEEN RECONCILED | | | | | | | | | | | | | | |
| Admission PHYSICIAN SIGNATURE | | | PHYSICIAN # | | DATE | | | DISCHARGE PHYSICIAN SIGNATURE | | | PHYSICIAN # | | | DATE |
| **THIS IS NOT A PHYSICIAN ORDER FORM** | | | | | | | | | | | | | | |
| **Patient Identification Here** | | | | | | | **Facility Name Here** | | | | | | | |

|  |  |
| --- | --- |
|  | FACILITY LOGO  IMAGING SERVICES  MEDICATION RECINCIATION |
| For your safety, please list any Allergies: | |
|  |  |
|  |  |
|  |  |
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|  |  |

For your safety, please list all medications including prescriptions, over-the-counter and herbal supplements, etc…you are currently taking.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dosage** | **Frequency** |
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***The Imaging Services Medication Reconciliation list must be updated at each visit.***

|  |
| --- |
| It is important for you to wait 48 hours before resuming the following medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,   but we advise you to contact your physician for specific instructions |
| Stop taking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_until you follow-up with your primary medical physician. |
| Continue all your medications as prescribed. |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient or Designee Signature Time/Date Witness Date/Time

Updated with no changes noted

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Patient or Designee Signature Time/Date Witness Date/Time

**Current Medication Reconciliation Form   
 (ALL** information must be completed (drug, dose, route, frequency).

|  |
| --- |
| * The medication **will NOT** be processed until a written order has been received. * **Home Meds must not be edited or medications added. Any CONTINUATION or additions to medications MUST be made to routine Physician Order Form. The purpose of this form is to “RECONCILE patient’s current and or home medications as listed ONLY!** |

🞏 No History Available 🞎 Will obtain from MD Office or Patient’s Pharmacy 🞏 Patient Takes No Medications

**PATIENT ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s Current Pharmacy/Pharmacies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Prescription / OTC/ Vitamins/Herbals | Dose | Route | Frequency | Last  Dose | Indication |
| **1** |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |
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| **11** |  |  |  |  |  |  |
| **12** |  |  |  |  |  |  |
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| **14** |  |  |  |  |  |  |
| **15** |  |  |  |  |  |  |
| **16** |  |  |  |  |  |  |
| **17** |  |  |  |  |  |  |
| **18** |  |  |  |  |  |  |

**Nurse Obtaining Med. Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_Time:\_\_\_\_\_\_\_\_\_**

***This form goes with Example Policy Number 7  
PREADMISSION MEDICATION LIST***

***VERIFICATION AND ORDER FORM***

***(Medication Reconciliation)***

LIST BELOW ALL OF THE PATIENT’S MEDICATION CHANGES ***PRIOR TO ADMISSION*** INCLUDING OTC AND HERBAL LMEDS

NEW MEDICATIONS OR MEDICATION CHANGES SHOULD BE WRITTEN ON ADMISSION ORDERS

Source of Medication List (Check all that apply):

Patient medication bottles/list CHECK HERE IF THIS IS AN ADDENDUM TO OR REVISION OF PREVIOUSLY

Patient/Family recall COMPLETED MEDICATION LIST

Pharmacy

Patient takes no home medications

MEDICATION HISTORY RECORDED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE RECORDED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Circle “C” to continue OR “DC” to discontinue** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | | | | **PHYSICIAN ORDER** | | |  |  |
| HOME MEDICATION NAME  (WRITE LEGIBLY) | | | | | DOSE  (mg, mcg, ) | | | ROUTE  (PO, GT, SC, IV) | FREQUENCY | | LAST DOSE  DATE/TIME | | **Continue**  **on**  **Admission** | | |  | **COMPLETE**  **On**  **Discharge** |
|  | | | | |  | | |  |  | |  | | C DC | | |  | C DC |
|  | | | | |  | | |  |  | |  | | C DC | | |  | C DC |
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| **ADMISSION** Date: | |  | | | | Time: |  | | | **DISCHARGE** Date: | | | |  | | Time: |  |
| Reviewed: | see orders above | | | see admission orders | | | | | | Reviewed: | | see orders above | | | | see discharge orders | |
| Physician Signature: | | | |  | | | | | | Physician Signature | | | | | |  | |
| Orders Verified / signed off: | | | | RN | | | | | | Orders Verified / signed off: | | | | | | RN | |
| DATE: | | | TIME: | | | | | | | DATE: | | | | | TIME: | | |

**Medication Reconciliation Form**

|  |
| --- |
| HOME MEDICATION LIST |

## Information obtained from: patient family pharmacy doctor

## other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home medications, OTC, Herbals**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ALLERGIES:** | | | | | |
| **Date\_\_\_\_\_\_\_**  **admission order** | | **medication** | **dose** | **how often** | **route** | **Date/Time of last dose** | **Date\_\_\_\_\_\_\_\_**  **Discharge order** | |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |
| **yes** | **no** |  |  |  |  |  | **yes** | **no** |

**CHECKING “NO” INDICATES THAT THE PHYSICIAN HAS CONFIRMED THAT THE MED IS NOT ORDERED  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RN obtaining medication information/time/date RN reconciling medication on discharge/time/date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RN reconciling medication on admission/time/date**

**Medication Reconciliation**

**From ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergy History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Active Report of Home Medications – Last Verification Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Drug Name** | **Dose** | **Route** | **Frequency** | **Comment** | **Continue** | **Discontinue** | **Start Date** |
|  |  |  |  |  |  |  |  |
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**IV Medications**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Order #** | **Drug Name** | **Dose** | **Infusion Rate** | **Start Date** | **Continue** | **Discontinue** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Acct: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: F M Admit Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN: \_\_\_\_\_\_\_\_\_\_\_\_**

**Medication Reconciliation**

From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Medication Order**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug Name | Dose | Route | Frequency |
|  |  |  |  |
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Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Order/Reconciliation Sheet**

|  |  |  |
| --- | --- | --- |
| **Home Medications**  (include herbal, OTC, respiratory & O2)  Name/dose/frequency | Admit Medications  Yes No  Or write in changes/additions | Discharge Medications |
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Signature of nurse Signature of ordering physician Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date/Time Date/Time Date/Time

The source of medication reconciliation is the patient unless otherwise stated below:

Family recall\_\_\_\_ Pharmacy\_\_\_\_ phone\_\_\_\_\_\_\_  
MAR or transfer record from facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medication bottle\_\_\_\_   
Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies/Reactions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Home Medications  
N/A\_\_\_\_ Sent to pharmacy \_\_\_\_  
Sent home with family\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Admitting Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Facility Information**

**LIST BELOW ALL OF THE PATIENT’S MEDICATIONS FRIOR TO ADMISSION INCLUDING ANTIBIOTICS, OTCS AND HERBALS**

**NEW MEDICINES OR MEDICATION CHANGES SHOULD BE WRITTTEN ON ADMISSION ORDERS**

**Medication Reconciliation Form**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Source of Medication List: (check all that apply)** | | | | | | | | | |
|  | **Patient recall** |  | **Family recall** |  | **Patient medication list** |  | **MAR form outside facility** | | |
|  | **Previous discharge documents** |  | **Medication bottles** |  | **Pharmacy** |  | **Dr:** |  | **Other:** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Continue on Admission** | **Medication Name**  **(Print Legibly)** | **Dose** | **Route** | **Frequency** | **Last Dose**  **Date/Time** | **Indication (PRN required)** | **DISCHARGE ORDER** | **Continue on Discharge** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |
| **Y N** |  |  |  |  |  |  | **Y N** |

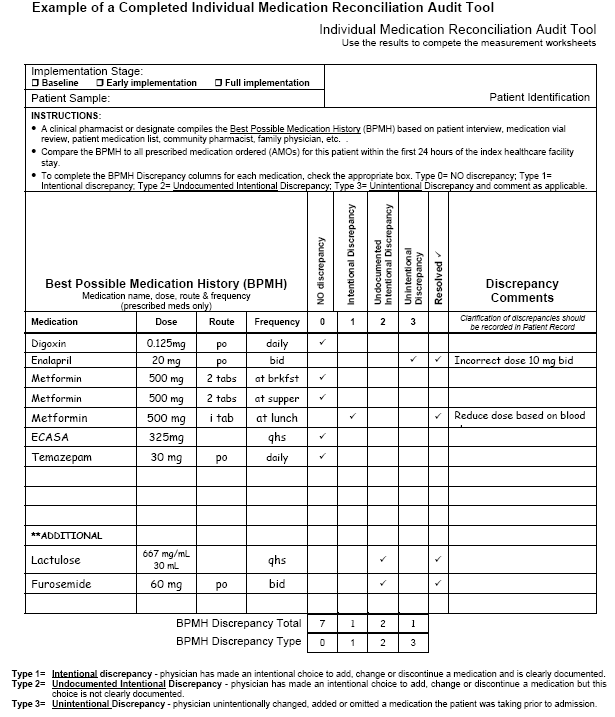
Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

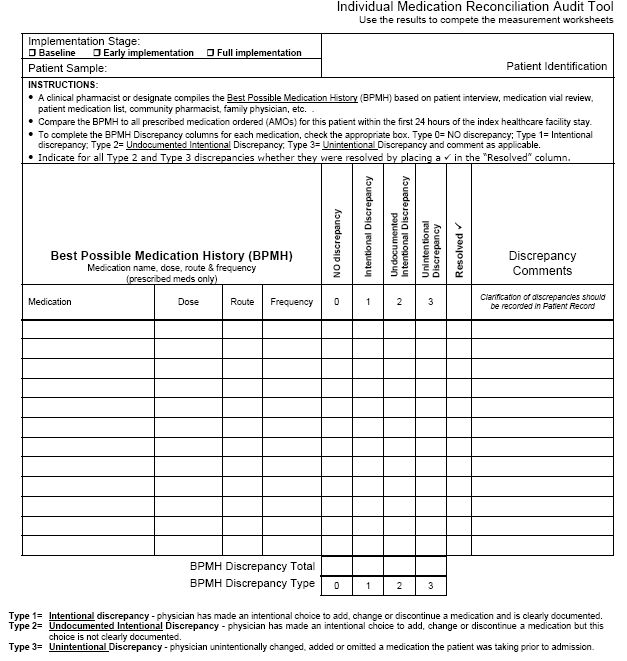
Medication History Recorded By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was IV contrast given in the last 48 hours? YES NO Date/Time Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Admitting Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



**Individual Medication Reconciliation Audit Tool**



**Instructions for Use of Addendum to Medications Prior to Admission – Reconciliation and Order Form**

**Guidelines:**

This is a form for clarifying medications taken prior to admission after a patient has been admitted and the medications prior to admission have already been reconciled and ordered.

**Procedures:**

1. List all new information about prescriptions and over-the-counter (OTC) medications taken prior to admission used on a scheduled and/or PRN basis in the left-hand column labeled “Clarification of Medications taken prior to admission.”
2. Check off the appropriate box indicating the reason for clarifying each medication
3. Sign section marked “medication history taken by” and record the date and time.
4. Check off the section “physician notified” once the physician is informed of the new information.

**Physicians:**

1. Review each medication and check off the appropriate box
   1. Check “do not order” if the medication is to be discontinued or changed. Write new orders in the regular physician order sheet applicable
   2. Check off “continue as prior to admission” if the medication is to be continued and write new order in the regular physician order sheet.
   3. Check off “continue as written in hospital” if the medication is to be continued as written.
2. Complete “physician signature” once new information is reviewed.

**ADDENDUM**

**Medications Prior to Admission-**

**Reconciliation and Order Form**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Clarification of Medications taken prior to Admissions**  **Regularly scheduled and PRN Medications**  Write all new medication information in the blank space and check off reason for the clarification | Medication History taken by (initials) Date & Time | Physician Notified | PHYSICIAN’S Review of Medication  Do Not Continue Continue  Order as prior to as written  Admission in  (write new hospital  order) | | | Physician Signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Omission No Longer Taking  Dose Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Omission No Longer Taking  Dose Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Omission No Longer Taking  Dose Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Omission No Longer Taking  Dose Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Omission No Longer Taking  Dose Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Omission No Longer Taking  Dose Other\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |

|  |
| --- |
| **DO NOT REMOVE OR THIN FROM THE CHART**  **Please place with the “Medication Prior to Admission-Reconciliation and Order Form”** |

**Instructions for Use**

**Guidelines:**

This is a physician order form for medications taken prior to admissions to be completed on all patients on admission.

**Procedure:**

1. Complete the “Allergies / Intolerances & Reactions” section. Check the appropriate box if there are no known allergies or if you were unable to obtain this information
2. List all prescriptions and over-the-counter (OTC) medications used on a scheduled and/or PRN basis including does, route and frequency in the left-hand column labeled “Medications Taken Prior to Admission.”
3. Use a second form if there is insufficient space and indicate the page number in the bottom right-hand corner.
4. Check the appropriate box if patient is on no home medications or if you were unable to obtain the medication history.
5. Check all applicable boxes in the section labeled “Information Source.”
6. Sign section marked “Medication History Taken By” and record the “Date and Time.”

**Physicians:**

1. Review each medication and check the appropriate box.
   1. Check “continue” if the medication is continued at the same does, route and frequency.
   2. Check “change” if the medication does, route, or frequency is changed and indicate the reason for change in the “Reason for Changing or Not Ordering” column. Write the changed order in the section “PHYSICIAN’S Changed Orders.”
   3. Check “do not order” if the medication is discontinued or held and indicate the reason for not ordering.
2. Complete “Physician Signature,” “Physician Printer Name,” and “Date and Time.”
3. Fax or copy the form to be sent to pharmacy and check the box “Orders Faxed/Sent to Pharmacy” and enter “Date and Time” sent.
4. Transcribe ONLY orders that are checked in the box marked “continue” and any changed orders written in the “PHYSICIAN’S changed Orders” section.
5. Indicate transcription and verification of order processed according to established procedures.

**MEDICATIONS PRIOR TO ADMISSION-**

**RECONCILATION AND ORDER FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Allergies / Intolerances & Reactions**  **None Known Unable to Obtain** | | | | |
| **No Home Medications Unable to Obtain Medication History** | | | | |
| **Medications Taken Prior to Admission**  List all regularly scheduled and PRN medications  (including prescription, OTC, drops, patches, creams, injections, inhalers)  **Medication, Dose, Route & Frequency** | **PHYSICIAN’S Review & Order**  Review each medication and check off appropriate box | | | | |
| Continue | Change  (see below) | Do Not  Order | **Reason for Changing or**  **Not Ordering** | |
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|  |  |  |  |  | |
| **PHYSICIAN’S Changed Orders**  Write changes to medications prior to admission (ie: medications listed above) | | | **Information Source:** | | |
|  | | | Bubble Pack Medication  Administration  DPIN Record  Family Recall Mediation Vials  HOME Patient Recall  Medication List  Pharmacy | | |
| **Physician Signature: Physician Printed Name: Date: Time:** | | | | | |
| **Medication History Taken By: Date: Time:** | | | | | |
| **Orders Faxed/Sent to Pharmacy Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **Page \_\_\_\_\_ of \_\_\_\_\_** | |
| **DO NOT REMOVE OR THIN FROM THE CHART**  **Please place Reconciliation Forms in the Orders Section** | | | | | |

**HEALTHCARE PROVIDER**

**EDUCATIONAL**

**MATERIALS**

**Appendix I Completing Medication History**

1. The medication history is the list of medications the patient is currently taking and any recent medication changes. It also includes the list of medication the patient can no longer take due to allergies or adverse drug reactions.
2. First determine what medications are already documented as being taken by the patient. Use the electronic health record to find the patient’s outpatient medication list.
3. Ask the patient if they have a list of their medications or if they know the list from memory. Use open-ended questions to have the patient provide you with their list of medications.
   1. While the medication history is often obtained from the patient, other sources of information include the patient’s parents, spouse, significant other, nursing home or other institutions MAR, local pharmacy, past discharge summary, and clinic visit transcription notes.
   2. It is recommended that the person be prompted and asked specifically about the use of ear drops, eye drops, creams, ointments, and herbal or over-the-counter medications.
4. Use the list already documented in the patient’s medical record to prompt the patient or their source regarding their medications. Ask specifically about medications which are documented in the health record and which may not longer be active. Remove from the active medication list the medications that are no current for the patient.
5. The following information should be documented in the medication history for all patients, when known and provided by the patient or his/her source:
   1. All current medications (see the definition of medication). The documentation of generic names is preferable.
   2. Specific dosage form, such as XL, SR, CD, etc. when applicable.
   3. Dose and frequency.
   4. Route (not required field, but should be indicated when not oral).
   5. Indication and duration of the medication.
6. As the patient about significant medication history including prior exposure to chemotherapeutic agents, as applicable for his or her condition. For patients with chronic medical conditions, focus on the previous 6 months and discuss medications that have been tried for the patient’s condition, and document the efficacy and toxicity as appropriate. Also document the indication for therapy and reason for discontinuation.
7. Allergies or adverse drug reactions
   1. At each visit, ask the patient whether they have had any allergic reactions or adverse drug reactions to any medications.
   2. It is recommended patients are asked specifically about experience with or exposure to aspirin, penicillin and cephalosporins, sulfa-containing drugs, contrast dyes, latex, and tape.
   3. If the patient states that he/she has had problems with a medication, identify and document the drug and the reaction in the allergy/adverse drug reaction section of the electronic health record.
   4. When allergic reactions occur, it is also recommended to document the route of administration, type of reaction, date of the reaction, if the patient was re-challenged or followed up by an allergist, and treatment interventions, if any.

END OF SECTION

|  |
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| **MEDICATION RECONCILIATION EDUCATION PACKET** |

**Medication Reconciliation Education Objectives**

Purpose

The following learning objectives will be presented and evaluated with regard to the process of medication reconciliation. The goal is to provide non-pharmacy staff with the tools on how to obtain an accurate medication list from patients.

Scope

This document applies to, but is not limited to, the following individuals:

|  |  |
| --- | --- |
| * Physicians | * Radiology technicians |
| * Physician assistants | * Medical, nursing and pharmacy students |
| * Nurses | * Any healthcare personnel who will be |
| * Nurse practitioners | responsible for obtaining a medication |
| * Pharmacists | list from patients |
| * Medical assistants |  |

Learning Objectives

1. Describe the National Patient Safety Goal 8a and 8b
2. Define medication reconciliation
3. Describe the process of medication reconciliation within your area
4. Define the term “medication” as described by The Joint Commission
5. Describe and apply “best practices” when obtaining a medication list
   1. Documentation of allergies (medications, food, latex) including a description of the reaction
   2. Document the name of the pharmacy where the patient has their medication filled
   3. For each medication listed, document the following information:
      1. Drug name (generic)
      2. Strength or concentration
      3. Dose
      4. Route
      5. Frequency
      6. Indication
6. Describe the potential barriers to obtaining an accurate medication list
7. Describe how to resolve or address these identified barriers
8. Describe potential errors encountered when documenting a medication list
9. Discuss the role of patient education related to medication safety

**National Patient Safety Goals 8a and 8b**

Goal: Accurately and completely reconcile medications

across the continuum of care.

8a

Process exists for obtaining and documenting a complete list of current medications upon admission to the organization and with the involvement of the patient. Compare the medications the organization provides to those on the list.

8b

A complete list of the patient’s medication is communicated to the next provider of care when a patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. The complete list of medication is provided to the patient on discharge.

Most medication errors result from miscommunication between providers at transition of care. The literature demonstrates that over 50% of all hospital medication errors and 20% of adverse drug events are due to poor communication at these transitions.

**What is Medication Reconciliation?**

Medication reconciliation is the process of identifying the most complete and accurate list of medications a patient is taking and using this list to provide correct medications for the patient anywhere within the organization. The process includes comparing prescriber’s attention, and if appropriate making changes to the orders including omissions, duplications, interactions, and name/dose/route confusion. Other steps in medication reconciliation include updating the medication list as orders change during the episode of care and communicating the updated list to the patient and the next known provider of care.

The purpose of reconciliation is to avoid errors of transcription, omission, duplication of therapy, drug-drug interactions, and drug-disease interactions.

**Process of Medication Reconciliation in Your Area**

Your manager or supervisor will provide you with the specific process within your area. The individual steps may vary from clinic to clinic, but the overall goal is the same.

Know your role for medication reconciliation in your patient care area:

* Identify who is responsible for obtaining the medication list
* Describe where the form is located within the patient chart
* Describe how to identify and resolve any medication discrepancies found
* Describe when is the list updated and who is responsible for making these changes
* Describe who provides the updated list to the patient at the end of the visit
* Describe how the updated medication list is communicated to the next provider of care if applicable

In general, here is what you should be able to describe for the process:

* When the patient arrives, a current list of all medications being taken must be documented or updated in the medical record
* Before any new medication is administered, ordered, or prescribed to the patient, the home medication list must be reconciled to check for duplications, omissions, interactions and allergies
* All discrepancies must be brought to the attention of the prescriber and resolved
* Any changes to the patient’s medication list must be updated and given to the patient at the end of the visit or at discharge
* This updated medication list must be communicated to the next known provider of care

**What is the Definition of Medication?**

As defined by The Joint Commission, a medication includes prescription medications, sample medications, vaccines, intravenous medications, blood derivatives, respiratory treatments such as inhalers, parenteral nutrition, diagnostic and contrast agents used on or administered to persons to diagnose, treat or prevent disease, and radioactive medications.

**How Do I Obtain a Medication List?**

Although there is not a specific one size fits all approach to obtaining an accurate medication list, there are key elements that should be included.

Allergies

This may be the most important piece of information you document on the medication list! Always ask the following questions to assess for patient allergies:

* “Do you have any allergies to medications?”
* “What happens when you take this medication?”
* “Do you have and allergies to latex?”
* “Do you have any allergies to IV contrast dye?”
* “Do you have any allergies to foods?”

Patient’s Preferred Pharmacy

Ask the patient where they usually have their medications filled. This is helpful when you have a question or need to have a specific medication clarified. It is also helpful to have this information updated when the patient requests a refill of their medication to be phoned into the pharmacy.

Medications

As it is helpful when the patient brings in their medication bottles, or an updated medication list, this generally is not the case. To get your conversation started, begin by asking:

* “What medications do you take every day?”
* “Do you take any over-the-counter (OTC) medicines?”
* “Do you take any medications for allergies?”
* “Do you take any medications to help with breathing?”
* “Do you take any medications to help with pain?”
* “Do you take any multi-vitamins or herbal supplements?”
* “Have you recently taken any antibiotics within the last 2-3 weeks?”
* “Are you wearing any medication patches?”
* “Is there anything else your take that has not been mentioned?”

Be very specific when asking for medication lists. Most patients do not associate things such as multi-vitamins or herbal supplements as a medication. You may need to ask specifically about eye drops, ear drops, inhalers, and topicals.

As the patient begins to list each medication, document the following pieces of information:

* Drug name: Generic name is always preferred; however do not get caught up in the detail. If the patient states the brand name and you do not know the generic, just write down the brand name
* Strength or concentration
* Patient dose – always write this as “mg,” avoid writing “tablets” or “mL”
* Route
* Frequency
* Indication – ask the patient what they are treating if you are not sure why they are taking a specific medication

The following are examples of complete medication information:

* Gabapentin 600 mg po BID for neuropathic pain
* Ranitidine soln 15 mg/mL – 5mg po daily
* Amoxicillin 500 mg po TID for 10 days. Started on 5/25 for infection
* Fentanyl 75 mcg patch applied every 72 hours (next patch due 5/27)
* Metoprolol XL 50 mg po qhs
* Insulin asparte 8 units subQ TID with meals
* Warfarin 2.5 mg po daily on Mon, Wed, Fri and 5 mg Sat, Sun, Tues, Thursday

This medication list will become part of the permanent medical record! DO NOT USE ANY BANNED ABBREVIATIONS!!!!

**Potential Barriers to Obtaining an Accurate Medication List**

1. Patient does not know what medications they are currently taking
   1. Examples of questions:
      * “I take a pink pill for my heart”
      * “My wife always takes care of my medications”
      * “My doctor just changed my medicines around and I don’t know what I am taking”
      * “Here is my pill box-this is what I take everyday”
2. Not enough time to speak with the patient to obtain the medication list – Example in an emergency situation.
3. Patient does not speak English
4. “Don’t you already have this information?”
5. The patient states they take a medication that has multiple dosage forms, yet they are unsure what the dosage form is. For example, the patient states they take calcium for the bone health.

**Recommendations on How to Address These Potential Barriers**

1. Patient does not know what medications they are taking

* Ask a family member or caregiver present for the information
* Contact their local pharmacy and determine what medications are active on their profile
* Review the patient’s medical record in available – go through the current medication list with the patient. This may trigger them to remember some of the information they need
* Use electronic resources available such as MicroMedex® or eFacts™. MicroMedex® has a tool that will identify a tablet on the color, size, shape and inscription on the tablet

1. Not enough time to speak with the patient

Acknowledge the increase in workload that staff is faced with, it is important to remember that the goal of medication reconciliation is to increase patient safety. A recent report in the *Archives of Internal Medicine* found that the number of reported serious adverse drug events has increased 2.6 fold between 1998 and 2005.

1. Patient does not speak English

Request the assistance of an interpreter. Hospital Policy 7.53 states interpreters shall be used in any situation where clear and effective communication is necessary. Situations in which the presence of an interpreter for deaf, hard-of-hearing, or limited English-speaking patients is necessary to ensure thorough and accurate communication include but are not limited to:

* Obtaining a medical history
* Informed consent
* Explaining a diagnosis and plan for medical treatment
* Explaining any change in regimen, environment of condition
* Procedures/surgery
* Medication instructions and explanation of possible side effects
* Discharge planning
* Legal issues (advance directives, guardianship, etc.)

1. “Don’t you already have this information??”

Patients and their caregivers may become frustrated when they are asked to produce a medication card or update their medication list at each visit. Respectfully remind them of the importance of medication safety and that the reason we ask is to e sure we do not give them a medication that will cause harm.

**Potential Errors Encountered While Documenting the Medication List**

1. Paper Form

* Legibility of the person who documents the medication history
* Use of banned abbreviations
* Medication not listed
* Medication listed, by the patient no longer taking
* Missing information such as dose, route, frequency
* Look-alike-sound-alike medication – especially problematic when using the brand name of the medication

1. Electronic Form

* The medication pick-list may not contain the specific dose you need
* Product confusion within the pick-list
  + Metoprolol *succinate* vs. Metoprolol *tartrate*
  + Bupropion *IR* vs. Buproprion *SR* vs. Bupropion *XL*
* The full name of the product may not be visible on the screen
* Use of banned abbreviations
* Missing Information
* Look-alike-sound-alike medications
* Errors in data entry – human factor

END OF SECTION

|  |  |
| --- | --- |
| Opportunities for Patient and Family Involvement | Potential Barriers |
| * Provide information to patients about their medical condition and treatment care plan in a way that is understandable to them. * Make patients aware of their prescribed medications, doses, and required time between medications. * Inform patients who the responsible provider of care is during each shift and who to contact if they have a concern about the safety or quality of care. * Provide patients with the opportunity to read their own medical record as a patient safety strategy. * Create opportunities for patient and family members to address any medical care questions or concerns with their health-care providers. * Inform patients and family members of the next steps in their care, so they can if necessary communicate this to the care provider on the next shift, or so they are prepared to be transferred from one setting to the next, or to their home. * Involve patients and family members in decisions about their care at the level of involvement that they choose. | * Resistance of caregivers to change behaviors. * Time pressures from patient care needs and other responsibilities. * Training and time cost of implementing new processes. * Cultural and language differences among patient population and workforce. * Low health literacy. * Lack of financial resources and staffing shortages. * Lack of knowledge about how to improve systems. * Failure of leadership to require implementation of new systems and behaviors. * Lack of information technology infrastructure and interoperability. * Insufficient generally accepted research, data, and economic rationale regarding cost-benefit analysis or return on investment (ROI) for implementing these recommendations. |

**Pharmacy Listings in our Area**

|  |  |
| --- | --- |
| Pharmacy Name  Address  Phone Number | Pharmacy Name  Address  Phone Number |
| Pharmacy Name  Address  Phone Number | Pharmacy Name  Address  Phone Number |
| Pharmacy Name  Address  Phone Number | Pharmacy Name  Address  Phone Number |
| Pharmacy Name  Address  Phone Number | Pharmacy Name  Address  Phone Number |
| Pharmacy Name  Address  Phone Number | Pharmacy Name  Address  Phone Number |
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**HEALTHCARE CONSUMER INFORMATION**

|  |  |
| --- | --- |
| C:\Documents and Settings\Jean.WVHA\Local Settings\Temporary Internet Files\Content.IE5\2XCDIHAD\MPj04305010000[1].jpg | The prescription for a Healthy Community:  Understanding Medication Safety |
| For many, daily medicines are an important part of staying healthy. By carrying a list of your medicines with you at all times, you and your care providers can together manage your health in the safest manner.  Local community members and Your Hospital Name have partnered to improve the health of Your County to encourage safe practice of medicines.  *Be an active partner in your health with three simple steps:*  C:\Documents and Settings\Jean.WVHA\Local Settings\Temporary Internet Files\Content.IE5\ATUNA1IJ\MCj04398220000[1].png  **• Come Prepared!**  Bring your medicines or personal medicine list with you  each time you visit your doctor, nurse or pharmacist.  **• Ask Questions!**  Talk with your pharmacist, doctor or nurse if there  is something you don’t understand about your  medications.  **• Share Your Information!**  Tell your family what medicines you are  taking and when you take them.  Visit an Aurora Health Center or Aurora  Pharmacy for a FREE personal medicine | |
| YOUR FACILITY LOGO HERE | |

**POSTER**





* Bring your medicines and a list of your medicines each time you see your doctor, nurse or pharmacist.
* Ask questions! Talk with your pharmacist, doctor or nurse if there is something you don’t understand about your medicines.
* Share with your family what medicines you are taking and when you take them.

What

Can

**YOU**

Do

Logo Here Website Here

**APPENDIX**

**The Model for Improvement**

In order to implement Medication Reconciliation, *Safer Healthcare Now!* recommends using the Model for Improvement. Developed by Associates in Process Improvement, the Model for Improvement is a simple yet powerful tool for accelerating improvement that has been successfully used by hundreds of health care organizations to improve many different health care processes and outcomes.

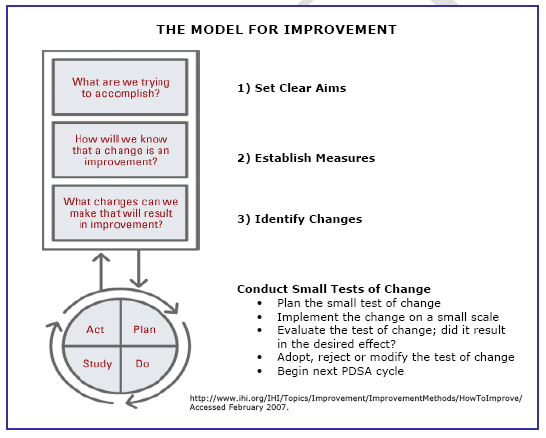
The model has two parts:

* Three fundamental questions that guide improvement teams to 1) set clear aims, 2) establish

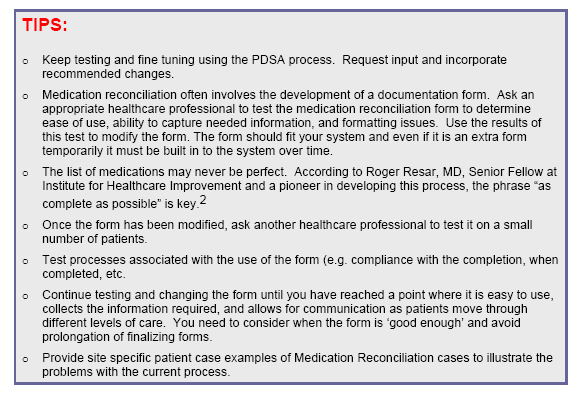
measures that will tell if changes are leading to improvement, and 3) identify changes that are

likely to lead to improvement.

* The Plan-Do-Study-Act (PDSA) cycle to conduct small-scale tests of change in real work settings— by planning a test, trying it, observing the results, and acting on what is learned. This is thescientific method used for action-oriented learning. (Available at: http://www.ihi.org/ihi).



Implementation: After testing a change on a small scale, learning from each test, and refining the change through several PDSA cycles, the team can implement the change on a broader scale — for example, test medication reconciliation on admissions first.



Learn more about the Model for Improvement from Institute for Healthcare Improvement

Link: <http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>

The Massachusetts Coalition created a worksheet for testing change based on the PDSA form Link: http://www.macoalition.org/Initiatives/RecMeds/PDSA.doc.

**Keys to Successful Implementation of Medication Reconciliation**



**Tips to remember when interviewing patients:**

**(OSF St. Francis Medical Center, Peoria, Illinois)**

* When asking about all medications, be sure to **get the name, dosage form, dosage, dosing schedule, and last dose taken** – be as specific as possible about prn (as needed) medications.
* **Use open-ended questions** (what, how, why, when) and balance with yes/no questions.
* Use nonbiased questions which do not lead the patient into answering something that may not be true.
* **Pursue unclear answers** until they are clarified.
* **Ask simple questions**, avoid using medical jargon, and always invite the patient to ask questions.
* Let the patient know the **importance of using one central pharmacy/pharmacist**.
* **Educate the patient** on the importance of using a medication wallet card and bringing their medications to the healthcare facility, physician’s office, etc.
* **Prompt the patient** to try and remember patches, creams/ointments, eye/ear drops, inhalers, sample medications, shots, herbals, vitamins, and minerals.
* When discussing allergies, educate **the patient on the difference between a side effect and a true allergy**—e.g., rash, breathing problems, hives.
* **Have patients describe how and when they take their medications**, and if they ever have difficulty taking their medications or remembering to take their medications. Vague responses may indicate non-compliance.

***Steps to take if the patient cannot remember a medication or if clarification is needed:***

* **Obtain a detailed description of the medication** from the patient or a family member—dosage form, strength, size, shape, color, markings.
* **Talk to any family members** present or contact someone that could possibly bring in the medication or read it over the phone.
* **Call the patient’s pharmacy** to obtain a list of medications the patient has been regularly filling.
* **Contact the patient’s physician/physicians** to get an accurate listing of their current medications.
* **Obtain previous medical records**.