McLaren BAY REGION		Policy Title:	Medication Reconciliation
Effective Date:	9/13/19	Policy Number:	218
Review Date:	9/1/22	Department	Administration
Supersedes:	9/1/17	Owned by:	Gilbert Bowlby, DOP and Kayla Zaplitny

I. PURPOSE:

To create an interdisciplinary process to decrease medication errors by reconciling medications across the continuum of care. This will be accomplished by establishing the most accurate list possible and comparing this list with any new medications ordered at the time of admission, transfer and discharge.

II. POLICY:

Medication Reconciliation is designed to maintain and communicate accurate patient medication information. Any identified discrepancies will be brought to the attention of the prescriber and, if appropriate, changes are made to the orders. The process involves three steps: verification (collection of medication history), clarification (ensuring that the medications, doses and regimens are appropriate) and reconciliation (documentation of any necessary changes to the orders).

III. PROVISIONS

A. **Procedural Patients**

1. A verification of home medications will be performed on patients. Clarification and reconciliation by the physician will only be done if the patient is admitted after the procedure.

2. These areas include: Interventional Radiology, Cardiac Stress Tests, Cardiac Cath Lab, Emergency Department, Outpatient IV Therapy, and Ambulatory Surgery

B. **Upon Admission**

1. Upon admission the Medication History Specialist will create a complete electronic patient home medication list. Sources may include the patient, patient's family, previous history, physician, pharmacy, or medication bottles.

    a. The dose and frequency are to be documented.
    b. Time of last dose, if obtainable
    c. The indication for use should be documented for PRN medications

2. Once the medication listing is done, the physician is responsible to complete the electronic admission medication reconciliation.

a. Must be completed within 24 hours
b. If physician cannot access the electronic admission form he/she can request nursing verbal orders in CPOE for 24 hour supply of scheduled medications until he/she can complete the electronic medication reconciliation.

3. Physician processing of the electronic admission medication reconciliation includes the following functions:

    a. Continue- continue as taking at home
    b. Defer- not to be continued in patient but available at discharge (i.e. all herbals)
    c. Modify- change dose or frequency
    d. Discontinue- intended not to be continued at time of discharge

4. The pharmacist at order entry will review medications profiled against medications the patient took at home to identify any discrepancies. The pharmacist will also perform clinical screenings for allergies, drug interactions, duplicate therapy, fall risk, etc. All discrepancies will be clarified with the patient and physician prior to profiling the medication order.

C. **Upon Transfer**

1. A re-evaluation and reordering of medications is required for any patient who experiences a transfer involving a change in level of care (i.e. into or out of an intensive care unit, into or out of a monitored care unit or after undergoing a surgical procedure).

2. The physician primarily responsible for the patient's care, or his/her designee, must complete an electronic transfer medication reconciliation which addresses home medications and current inpatient medication orders.

D. **Upon Discharge**

1. A re-evaluation and reordering of medications is required for any patient prior to discharge from the medical center.

2. The physician primarily responsible for the patient's care, or his/her designee, must complete the discharge medication reconciliation. (preferably electronically) This will create a final list of medications, both previous home and new orders, that the patient is to continue at home.

3. Physician processing of the electronic discharge medication reconciliation includes the following functions:

    a. Continue- continue taking med at home
    b. Modify- change dose or frequency
    c. Discontinue- patient will not continue taking this medication at home

d. Replace- used for alternate therapies
e. Aware- physician is acknowledging patient is taking this medication at home
f. Add- add new medications to home med profile

4. The electronic home medication profile will be updated to reflect the complete list of medications the patient will be taking after discharge from the hospital. This electronic list will be printed and provided to the patient as the discharge medication instruction form.

5. Nurse will review printed list for accuracy before giving to patient (i.e. therapeutic substitutions and duplications). Nurse will call Medication History Specialist for any changes that need to be made, including discharge medications.

6. The electronic medical record is the source to view the patient discharge medication list for subsequent providers.

Approvals:

Pharmacy and Therapeutics Committee: 9/13/19
Patient Safety Committee:
Nursing Management Council:
Nursing Practice Council:
Medical Executive Committee: 10/14/19
Professional Affairs Committee: 10/28/19

Approved:

Name	**Title**	**Date**
Gilbert Bowlby	Director of Pharmacy	9/13/19
Ellen Talbott	Vice President	9/13/19
Clarence Sevillian	President	9/13/19