Medication Reconciliation - Inpatient

Administrative Policies & Procedures

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General Description

Purpose: To obtain a list of the medications the patient was taking at home prior to hospital admission and compare this home medication list with the Attending Physician/Licensed Independent Practitioner of Record's (AOR) admission, transfer and/or discharge orders.

To identify and address any discrepancies between the home medication list and the admission, transfer or discharge orders (i.e., omissions, duplications, potential interactions).

Scope: All inpatient clinical departments or patient care areas of Meridian Hospitals Corporation facilities.

Policy: Medication Reconciliation is defined as the process of obtaining the most accurate list of the patient's current home medications, and comparing that list with the AOR's admission, transfer, and/or discharge orders. This reconciliation is to be completed at every transition of care in which new medications are ordered or existing orders are rewritten or where current medications are discontinued to prevent medication errors (i.e., home to admission, change of level of care, and discharge to home or transfer to a rehabilitation or nursing home facility). Although nursing staff will assist in the medication reconciliation process, it is the ultimate responsibility of the AOR to make sure the patient's medication lists are up to date and appropriate for the patient's care and conditions.

As it is often difficult to obtain complete information or current medications from a patient, Meridian Hospitals Corporation facilities will make a good faith effort to obtain this information from the patient and/or other sources (i.e., family, rehabilitation or nursing home facility, etc.).
The Medication Reconciliation Process will be completed on any patient admitted to, transferred within, or discharged from a Meridian Hospitals Corporation facility. Specific processes are identified for admission, internal transfer, and discharge.

**Definition:** Home Medication List – A Home Medication List (HML) is the list of medications the patient was taking at home prior to admission to the acute care hospital. If the patient resided in an Assisted Living or Long-term Care facility prior to admission to the hospital, this is considered their home.

**Procedure: A. Admission**

1. Upon admission, a current home medication list (HML) will be obtained from the patient / family / referring facility by the nurse completing the admission history. The HML will be documented in the Home Medication Collection section of Soarian.

   The LPN may assist with the data gathering of the patient's current home medications, in which case, the RN will complete the admission assessment and enter the HML in the electronic chart.

2. The HML will be printed, stapled to the paper Medication Reconciliation Form and kept behind the "Med Rec/Medications" tab in the paper chart as long as a paper chart is maintained on the Unit.

3. If the patient comes in with a written home medication list, the nurse will review the list with the patient/family, clarify any medications as necessary and document all home medications in the Home Medication Collection section of Soarian. The nurse will put a patient label on the original source list and place it behind the printed HML in the "Med Rec/Medications" tab in the paper chart as long as the paper chart is in use.

4. If the patient / family / referring facility is unable to provide a complete HML upon admission, the nurse will make a good faith effort to complete the HML within 24 hours. The following steps may be used as a guide to help obtain the patient’s HML:
   - Review the home medications obtained by the Emergency Department
   - Review the home medications obtained by the physician / resident on the History & Physical
   - Request the patient’s family provide a list of the patient’s medications or bring the patient’s medications in
   - Check the patient’s Prescription History on-line via the importable medication database available
   - If the home medication list cannot be obtained within 24 hours, consult with the patient’s own Pharmacy

   If the nurse is unable to obtain the patient's home medication information, it
will be noted on the electronic home medication list.

5. The AOR will review the patient’s current home medications listed in the Home Medication Collection section in Soarian and compare the list to the admission orders to identify any discrepancies (i.e., omissions, duplications, contraindications, changes). Any discrepancies identified will be reconciled by the AOR and changes made to the admission orders accordingly, and as appropriate. It is the ultimate responsibility of the AOR to verify the accuracy of the HML at the time that they are doing their admission H&P/orders.

6. If additional home medications or corrections are identified after the HML is completed and reconciled by the physician/LIP, the nurse will document these changes in the Home Medication Collection section of Soarian and communicate the additions or corrections to the AOR.

B. **In-Hospital Transfer:**

1. All medication orders will be held, suspended or discontinued and must be reordered as appropriate by an authorized prescriber, when a patient:
   - Undergoes surgery and returns to post-operative care
   - Is transferred to the cardiovascular lab for interventional procedures
   - Is admitted to, or discharged from an intensive / critical care or telemetry unit
   (See current Meridian Medication Stop Order Policy, # MH-RX03-0010 for details)

2. The AOR will review the patient’s current medication record and the HML in Soarian, and compare them to new or rewritten orders to identify any discrepancies (i.e., omissions, duplications, contraindications, changes). Any discrepancies identified will be reconciled by the AOR and changes made to the orders accordingly, and as appropriate.

C. **Discharge**

1. The AOR will use either the Electronic Discharge Medication Reconciliation section in Soarian or the paper Medication reconciliation Form to document the discharge medication reconciliation process.

2. The AOR at the time of discharge will compare the current Medication Administration Record (MAR) with the HML to determine which medications should be continued, stopped, changed and/or prescribed for discharge.

3. If the AOR identifies any discrepancies (i.e., omissions, duplications, contraindications, changes), he/she will determine if changes to the discharge medication list are indicated. Any changes needed will be documented electronically in the Discharge Medication Reconciliation section of Soarian or on the paper Medication Reconciliation Form.

4. If the patient is to be discharged with no medications, and the Discharge Medication Reconciliation process was done electronically, the AOR at the
time of discharge will sign off on the blank electronic discharge medication list and mark this as complete in Soarian. If the discharge medication reconciliation process was done on the paper Medication Reconciliation Form, the AOR will document “no discharge medications” on the right hand side of the form and sign the form.

**Important Note:**
Under no circumstances will the electronically reconciled discharge medications be written on any form for transfer or discharge.

**D. Physician Discharge Responsibilities**

1. If the electronic discharge medication list is used, the AOR at the time of discharge will generate the list, which incorporates an electronic signature. The electronic discharge medication list will be automatically generated and imported into the electronic documentation once the Discharge Medication Reconciliation process is marked as “Complete”.

2. If the paper Medication Reconciliation Form is used, the AOR at the time of discharge will document the patient’s discharge medications and sign the form as detailed in the downtime procedure below.

3. If neither the electronic discharge medication process or Medication Reconciliation Form is able to be completed by the AOR at the time of discharge, the discharge medication reconciliation process will be completed with the AOR at the time of discharge via telephone order with the Discharge RN. After providing the patient’s discharge medication list via telephone, the physician will verify that the information read back by the Discharge RN is what was stated.

4. Consistent with other telephone orders, the AOR will then be prompted to electronically sign the telephone order indicating that the discharge medication list was obtained by telephone, read back and verified in accordance with the timeframes for authenticating telephone orders. If the paper Medication Reconciliation Form was used, the AOR will need to sign that form within the time frames for authenticating telephone orders.

**E. RN Discharge Responsibilities:**

1. When the AOR at the time of discharge completes the electronic discharge medication list, the Discharge RN will attach the printed electronic list to the Interdisciplinary Discharge Summary Form and provide it to the patient. No other medication lists, handwritten or typed, will be given to the patient at discharge except for patients being transferred to another facility (i.e., hospital, rehabilitation or nursing home facility) where the last day’s medication administration record (MAR) is provided to show the last dose taken for continuity of care.

2. If the AOR documents the discharge medication list on the paper Medication Reconciliation Form, the Discharge RN will attach the list to the
If the patient is discharged home with Home Care Services, the medication reconciliation process will be the same as for discharge except as follows:

The Discharge RN will complete a Universal Transfer Form (UTF) for the patient and fax the UTF form, as well as a copy of either the electronic or paper discharge medication list directly to the Home Care agency.

3. If the AOR at the time of discharge is in the hospital, whether on the patient’s Unit or not, it is their responsibility to complete the discharge reconciliation process electronically or in person. If the AOR at the time of discharge is not able to be physically present in the building to complete the discharge medication list electronically or on the paper Medication Reconciliation Form, the Discharge RN will contact the physician by telephone, obtain the discharge medication list and either document the discharge medication list electronically or on the paper Medication Reconciliation Form. As this is considered a telephone order, the Discharge RN will then read back the discharge medication list and any allergies/contraindications to the physician and get confirmation that the information read back is what was stated, documenting the read back electronically or using the check box on the paper form. Either the printed electronic form or paper Medication Reconciliation form will be attached to the Interdisciplinary Discharge form and given to the patient.

4. For Patients Discharged to Home with Home Care Services

If the patient is discharged home with Home Care Services, the medication reconciliation process will be the same as for discharge except as follows:

The Discharge RN will complete a Universal Transfer Form (UTF) for the patient and fax the UTF form, as well as a copy of either the electronic or paper discharge medication list directly to the Home Care agency. UTF Policy

5. For Patients Transferred to a Rehabilitation Hospital, Nursing and Rehabilitation Facility or Hospice Inpatient Program

If the patient is transferred to a Rehabilitation Hospital, Nursing and Rehabilitation Facility or Hospice Inpatient Program, the medication reconciliation process will be the same as for discharge except as follows:

- The Discharge RN will complete a Universal Transfer Form (UTF) and attach either the patient's electronic or paper discharge medication list along with a copy of the last day’s MAR to show the last dose taken for continuity of care. UTF Policy
- Patients transferred from RMC Acute Care Hospital to RMC Rehabilitation Hospital do not need to complete a Universal Transfer form as this is considered a intra-facility transfer.

6. For Patients Transferred to Another Acute Care Hospital

If the patient is transferred to Another Acute Care Hospital, the medication reconciliation process will be the same as for discharge except as follows:

- The Discharge RN will complete a Universal Transfer Form (UTF) and
If the patient is transferred to an Inpatient Psychiatric Hospital, the medication reconciliation process will be the same as for discharge except as follows:

- The Discharge RN will complete a Universal Transfer Form (UTF) and attach either the patient's electronic or paper discharge medication list along with a copy of the last day's MAR to show the last dose taken for continuity of care. **UTF Policy**
- Patients transferred from RMC Acute Care Hospital to RMC Inpatient Psychiatric Hospital do not need to complete a Universal Transfer form as this is considered an intra-facility transfer.
- Patients transferred from JSUMC Acute Care Hospital to JSUMC Inpatient Psychiatric Hospital do not need to complete a Universal Transfer form as this is considered an intra-facility transfer.

8. **Downtime Procedure**
   
   If there is a Soarian Downtime situation, the paper Medication Reconciliation Form will be used to track medication lists until Soarian is up and running. If there is a downtime situation upon discharge, the paper Medication Reconciliation Form will be completed by the AOR at the time of discharge. If the AOR is not in the building, the RN will assist in the discharge reconciliation process using the paper Medication Reconciliation Form. Afterward, a good faith effort will be made to adjust the medication lists electronically.

**Approvals**

Medication Reconciliation Subcommittee - August 2006
Medication Reconciliation Steering Committee - September 2006
Patient Safety Administrative Leadership Team - September 2006
Medication Reconciliation Subcommittee - September 2007
Patient Safety Administrative Leadership Team - September 2007
Medication Reconciliation Subcommittee - September 2009
Patient Safety Administrative Leadership Team - November 2010
Medication Reconciliation Subcommittee - October 2011
Patient Safety Administrative Leadership Team - October 2011
Clinical Excellence Committee - September 2012
BCH Medical Executive Committee - October 2012
JSUMC Medical Executive Committee - October 2012
OMC Medical Executive Committee - October 2012
RMC Medical Executive Committee - October 2012
SOMC Medical Executive Committee - October 2012
Nursing Congress - October 2012
Patient Safety Administrative Leadership Team - November 2012
Patient Safety Administrative Leadership team - April 2013
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Special Notes / Appendix

Attachments
UTF Policy MH-NUR-ADM-0050

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