

TITLE: RECONCILIATION OF MEDICATIONS ACROSS THE CONTINUUM		
FACILITY: St. Vincent's East	FUNCTION: Medication Management	ORIGINATING DEPT: Pharmacy
HOSPITAL SHARED POLICY? _X_ Yes ___ No		EFFECTIVE DATE: 10/01/2006
DOCUMENT NUMBER: 42-7171-169		LAST REVIEW DATE: 2/01/2009
ORIGINATION DATE: 10/01/2006		LAST REVISION DATE: 2/01/2009
APPROVAL DATE:		RETIREMENT DATE:

SCOPE: All areas of St. Vincent's East
PURPOSE: To establish a process for comparing the patient's current medications with those ordered for the patient while under the care of the organization.
DEFINITIONS: Reconciliation is the process of comparing the patient's current medications with those ordered for the patient while under the care of the hospital.
POLICY: I. A medication reconciliation list should be collected for <u>every patient given medication anywhere</u> in the St. Vincent's East Organization. II. The medication reconciliation list for each patient should be analyzed to determine: A. <u>For inpatients</u> , should the drugs be stopped, continued, and/or medications added. B. <u>For outpatients</u> , does the patient's home medication list conflict with planned treatments in the outpatient setting? III. Copies of the medication list should be provided to: A. The receiving unit for an intra-hospital transfer between levels of care,

*The contents of this document rescind any previous document covering similar material.
The online version of this document is deemed current.*

- such as into or out of an ICU.
- B. A receiving health organization if the patient is transferred there
 - C. The patient at the time of discharge from the inpatient setting
 - D. The patient at the time of discharge from a procedural area if the list has changed due to the prescribing of a new chronic medication or requiring the patient to stop one or more of their existing medications.
 - E. The patient's primary care physician or next provider of care if the medications that the patient has been taking has changed.
 - F. Document all such occurrences as described in A – D above.
- IV. The reconciliation process should include the following:
- A. Reviewing the patient's personal medications to determine:
 - 1. If they are to be continued while the patient is in the hospital
 - 2. To look for duplicate therapy or possible symptoms related to the admission diagnosis.
 - 3. To determine if any dosages or frequencies should be changed
 - 4. If any of the medications might affect care being rendered such as surgical procedures
 - B. Each medication should be checked either to continue or stop while the patient is in the hospital. It should be demonstrated an intentional decision was made to continue or stop each of the patient/s personal medications. The absence of prescribing on the order sheet is not sufficient documentation to demonstrate that there was not an error of omission.
 - C. Any Schedule II or Schedule III home medications require a new and separate order and will not be permitted as part of continuation of home medication orders as documented on the History and Assessment/Home Medication Record/Physicians Orders Form (#42-NADM-700).
 - D. Whenever a patient changes level of care such as post surgery or is transferred into or out of an ICU, the previous list of medications that the patient was receiving before the change in level of care should be reviewed and a decision made to continue, change or stop any of the medications. This process should occur each and every time the patient changes level of care.
 - E. Before the patient is discharged, the following reconciliation process should occur:
 - 1. The medications that the patient was taking when admitted should be compared to the medications the patient is taking prior to discharge.
 - 2. A decision should be made which medications should be continued

3. A final discharge list should be created and copies of that list provided as appropriate as outlined in III above.
- V. In settings where medications are used minimally, or prescribed for short duration, a modified medication reconciliation process may be performed. This includes but is not limited to the ER, outpatient radiology, ambulatory care such as GI lab, and short stay procedural areas.
- A. The hospital obtains and documents an accurate list of the patient's current medications and allergies. This list is used to access potential allergic or adverse drug reactions related to medications given to the patient during the procedure.
 - B. When the patient is discharged from the procedural area, if no changes are made to the patient's original medication list or if only short-term medications (for example a pre-procedural medication or a short-term course of an antibiotic is prescribed), the patient/family is provided with a list containing only the short-term medication that the patient will take following discharge.
 - It should be noted that this short-term medication is not considered to be a part of the original, known patient medication list.
 - A list of the original, known, and current medications does not need to be provided unless the patient is assessed to be confused or unable to comprehend adequately.
 - C. A complete, documented medication reconciliation process is used when:
 1. Any new long term (chronic) medication(s) are prescribed.
 2. There is a change in the patient's original medications that he/she was taking prior to the procedure
 3. The patient is required to be subsequently admitted to the hospital or to another health organization from the procedural area for ongoing care.
 4. The complete list is provided to the patient/family as needed, and to the patient's known primary care provider or original referring provider, or a known next provider of service.

PROCEDURE:**REFERENCES:**

Joint Commission National Patient Safety Goal 8; Joint Commission FAQs related to National Patient Safety Goal 8

ATTACHMENTS:

*The contents of this document rescind any previous document covering similar material.
The online version of this document is deemed current.*

APPROVAL ROUTING: Pharmacy and Therapeutics Committee; Medical Staff Executive Committee
REVIEW HISTORY:
REVISION HISTORY: