

**The Miriam Hospital  
Administrative Manual**

**Subject: Medication  
Reconciliation**

**File Under: MS-25 and PS-06**

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Administration

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**Rebecca Burke RN  
SVP, Patient Care Services & CNO**

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**R. William Corwin, MD  
VP Medical Affairs & CMO**

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**PURPOSE:** To define an interdisciplinary process for medication reconciliation to avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions, throughout the continuum of care.

To outline the tools and the processes that will allow us to become compliant with TJC standards for medication reconciliation. Reconciliation is the process by which we compile an accurate and complete home medication list at point of entry to the organization, compare these medications with those ordered by the organization, and at discharge provide a complete list of medications to the patient, and when appropriate to the next provider of care.

A medication is defined as any prescription, over-the-counter (OTC) or sample medication, herbal product, vitamin, alternative remedy, respiratory-related drug (i.e., inhaler), diagnostic/contrast agent or blood derivative given within the past seven days.

**POLICY:** ***At the point of entry to the organization,*** the medication reconciliation process begins. The Registered Nurse, or designee, will initiate gathering the patient's list of medications taken at home and document this information as appropriate to the setting, i.e. on an Interdisciplinary Home Medication History Form, in MedHost, and/or in Invision. This list will be obtained from the patient, a significant other or pharmacy. All efforts will be made to obtain a complete list of the patient's medication from the patient, family or significant other. If this is not possible there must be a documented reason as to why this was not achieved. This list will be utilized by the MD/LIP, or designee in outpatient areas, to compare with those medications being ordered while under the care of the organization. Any discrepancies, omissions, duplications or potential interactions, are resolved. If the patient presents urgently and the home medication list is not collected

immediately, it will be collected as soon as possible thereafter, not to exceed 24 hours.

**Upon discharge from an outpatient setting.** ED, ambulatory clinic, outpatient surgery, radiology, endoscopy, the patients medications are reconciled when there has been any change in regime or a new medication has been prescribed, and a complete list is provided to the patient and next provider of care.

**When a patient is admitted and when the patient is transferred from one level of care to another.** the MD/LIP will review the home medication list, and current medication list when applicable, and place orders into POM appropriately. The MD/LIP will confirm that all medications were reviewed and reconciled via a POM order “Active Orders Rev Meds Reconciled.” At that time any omissions, duplications, adjustments, deletions, additions or drug or disease interactions will be considered.

The admitting RN will clarify orders, as necessary with MD/LIP and enter the home med list into Lifelinks.

**Upon discharge from an inpatient setting.** all patients, inpatient and observation, must have a final medication reconciliation completed.

Medication reconciliation from an inpatient setting includes a review of home medications collected on admission, the active medication list and a revised medication regime to continue upon discharge. The MD/LIP reconciles medications and clearly notes any changes to medications, dosages or frequencies. This information is communicated electronically to the Patient Instruction Sheet.

The discharging RN will review, sign, date, and time final copy of “Patient Instruction Sheet” with patient/guardian. The Patient Instruction Sheet will clearly categorize for the patient, home medications to continue, home medications to discontinue, and new medications. On this sheet, patients are also provided the date and time of the last dose of medication received while in the hospital.

For patients being discharged/transferred to another facility, the on-line medication list will be communicated to the receiving facility, in addition to the patient. If the patient is unable to understand for reasons of confusion or cognitive impairment, the list is given to a family member or other advocate identified by family.

The on-line “Home Med List” will be kept as part of the permanent medical record within LifeLinks/NurseLinks for **each** encounter. When discharging or referring to the next provider, an updated medication list is communicated to the other providers with whom the patient has an established healthcare relationship or those for whom referrals have been made. If there is a POM downtime, the home med list will be documented by the RN on the Interdisciplinary Home Medication History form, and the Continuity of Care forms/Discharge form can be accessed by back up or emergency back up link.