LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER-SHREVEPORT

MEDICATION RECONCILIATION

Purpose:

To ensure timely and accurate medication information is captured and documented to compile a comprehensive list of the 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 all 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)

2. Comparing the list against admissions, transfer, and discharge orders.

3. Resolving any discrepancies.

4. Making necessary and appropriate medication changes based on the patient’s clinical condition.
5. Communicating the complete and updated list to the next provider of service whenever the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the hospital.

The medication reconciliation process shall be by the MD at each of the following points-of-care:

- Outpatient Clinic
- ECC
- Admission
- Intra-hospital transfer to another service or level of care (i.e. ICU to floor transfer) using the Net Access generated
- Discharge to home or transfer to another facility

a. Intra-hospital transfer to another service or level of care
   The physician shall review and reconcile the medication list prior to entering new orders.

b. Discharge to home or transfer to another facility
   Qualified personnel shall print the After Visit Summary (AVS) and educate patient/report to another facility. The AVS is given to the patient at discharge.

Process:

1. Obtain information to complete the list of the patient’s current medications and document this information in the electronic health record (EHR). Information sources may include:

   - Prescription medications
   - 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 the elements listed below, if unable to obtain this information, the nurse will document the reason:
• 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

2. The discharging physician shall review the admission Medication Reconciliation History prior to placing discharge orders.

3. The patient or caregiver should be given a copy the After Visit Summary (AVS) at the time of discharge and encouraged to partner with medical providers in keeping the list current.

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Administrator

7/20/12
Date

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