UMass Memorial Medical Center

SECTION: Guidelines

LOCATION:

SUBJECT: Preadmission Medication List Verification and Order Form (Medication Reconciliation Form)

PURPOSE:
The Preadmission Medication List Verification and Order Form (Medication Reconciliation Form) is intended to generate the most accurate medication list available especially at the transitions of care (home to admission, admission to discharge). Medication reconciliation is an interdisciplinary process designed to decrease medication ADE's and Potential ADE's on all nursing units. The form will be treated and filed as any other order sheet.

SCOPE:
The Medication Reconciliation Form will be completed on any patient admitted to a Medical/Surgical Acute Care floor by the admitting Licensed indepdenent practitioner (LIP—M.D., Physician's Assistant, Nurse Practitioner) and reviewed with the patient/family by the admitting RN.

RESPONSIBILITY:
The provider that completes the form is responsible for documenting all of the medications and doses that the patient was taking prior to admission on the Medication Reconciliation Form. The physician or midlevel provider takes responsibility for the medication history with their signature on the form.

SPECIFIC INSTRUCTIONS:
1) The Emergency Department Nurse/Triage Nurse should photocopy the patient's home medication list, if available, and this should kept with the patient's paperwork.
2) The provider is to document on the form all of the medications, dosages, frequency of medications that the patient was taking prior to admission. This does not need to be re-documented on the H&P (One can write "See Medication Reconciliation Form" in the medication section of the H&P).
3) The medication history may be obtained from the patient and/or family members who are present at the time of admission. An effort should be made to verify (by comparing with patient list, hospital discharge record, PCP record, and/or calling pharmacy) that the list is as accurate as possible.
4) Besides being a medication record, the form can be used an order form. Beside each medication in the "Continue on Admission" column, the provider should place a "C" to continue or a "DC" to discontinue.
    a) New medications (e.g. Ceftriaxone) to be initiated on admission should be written <u>on the admission order sheet</u>, not the medication reconciliation form.
    b) For medications that require a dosage change, please DC the medication on the Reconciliation Form and write the medication with new dosage on the admission orders.
    c) For medications with therapeutic interchanges, please DC the medication on the Medication Reconciliation Form and write the new one on the admission orders.
    d) Draw a line under the last medication listed on the Medication Reconciliation Form so that no additional medications can be written below.
5) The patient's floor nurse or the admission nurse should verify the medication list and document date/time of last dose in the appropriate column.
6) This form will then be scanned to pharmacy and should be treated and filed as any other order sheet.
7) On the admission orders, please write, "Please see Medication Reconciliation Form" to cue the pharmacist to review the Medication Reconciliation form as well.
8) When patient is being discharged, the provider should use the medication administration record and medication reconciliation form to generate the most accurate list of medications for the discharge paperwork. On the Medication Reconciliation form, in the "Continue on Discharge" column, write C to continue or DC to discontinue for each home medication. This will show the provider's conscious decision-making process.
9) Attention to insurer/formulary.

CHART PLACEMENT (PERMANENT CHART FORM) OR STORAGE (NON-CHART FORM):

Chart Placement

The Medication Reconciliation Form will be placed in the order section adjacent to the history and physical.

SUPERSEDES GUIDELINES:

Original Date of Issue:

Reviewed: _____ _____ _____ _____ _____ _____ _____
Revised: _____ _____ _____ _____ _____ _____ _____

CARITAS NORWOOD HOSPITAL

MANUAL Clinical Practice
SECTION ____ POLICY NO._
DATE WRITTEN 10/03
LAST REVIEW _____
LAST REVISION _____

TITLE: Medication Reconciliation

PURPOSE: Medication reconciliation is intended to maintain continuity of care for patients with regard to medication use on admission.

POLICY: All patients admitted to Caritas Norwood Hospital will provide as part of a nursing assessment a medication history. This medication history will be compared to admission orders to screen for omissions from or changes to the patients' home/LTCF medication regimen. A health care provider (nurse, pharmacist, physician) will reconcile differences between the two regimens at CNH.

PROCEDURE: Entry points for CNH admitted patients include the Emergency Department, Pre-Admission Testing, and Direct Admits. For each entry point, a procedure has been devised to complete the Medication Reconciliation Process. Specialty patient populations (OB and Behavioral Medicine) will follow the same procedure as Direct Admits.

The Medication Reconciliation Form is a two-sided document. Key data elements required on the form include the patient identification label placed in the upper right corner, allergy information (drug and reaction), medications taken prior to admission (Prescription [Rx] and over-the-counter [OTC]). These entries must include medication name, dose, route, and schedule. The reconciliation component of the form is to the right of the medication history. The back of the form provides space for documentation of Herbal products, additional comment, and documentation of how the medication history was obtained. Two signatures will be required on the Medication Reconciliation Form, one from the health care provider taking the history and one from the health care provider completing the reconciliation process. Any edits to the medication history by a health care provider must be initialed on the edited line and provide a full signature as noted on the back of the form. (See attachment A)

1. Patients entering through the Emergency Department represent the majority of admitted patients. A medication history will be obtained from the patient/family/referring facility. This medication history will be documented on the Medication Reconciliation Form. The medication reconciliation form will be placed in front of the Physician Order Sheets in the Medical Record.

2. Upon transfer to the inpatient unit, the admitting nurse shall compare the medication history from the Medication Reconciliation Form to the admission orders (written by the admitting

hospitalist or the attending). Differences between the medication history list and the admitting orders will require documentation by the admitting nurse explaining the discrepancy on the Medication Reconciliation Form (use the comments/changes column) or a follow-up telephone call to the physician.

3. Patients entering through Pre-Admission Testing (for planned surgical procedures with planned post-op admission) will have the medication history documented on the Medication Reconciliation Form during their pre-admission visit. The medication reconciliation form will be placed in the patient chart and will be available with the chart on the surgical day.

4. Upon transfer from PACU to the inpatient unit, post-operative orders will be reconciled with the medication history. Differences between the medication history list and the admitting orders will require documentation by the admitting nurse explaining the discrepancy on the Medication Reconciliation Form (use the comments/changes column) or a follow-up telephone call to the physician.

5. Specialty populations (OB and Behavioral Medicine) and direct admits will have both the medication history and the reconciliation completed by the admitting nurse. Differences between the medication history list and the admitting orders will require documentation by the admitting nurse explaining the discrepancy on the Medication Reconciliation Form (use the comments/changes column) or a follow-up telephone call to the physician.

6. Physician calls for medication reconciliation of chronic care medication will occur between 0800 and 2100. Physician calls for urgent or emergent patient care needs will be made as necessary 24 hours per day.

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