The PSW/WHA Medication Reconciliation Project Team has identified and listed below some key components to consider as a part of the Medication Reconciliation process at your institution. This list is not meant to be inclusive, but rather as a guide to assist you in developing your Medication Reconciliation procedure.

Transition Point: Admission

1. Identify who is excluded from Medication Reconciliation in your policy
    a. If admitted and will receive medications, need reconciliation
    b. All others still get medication history
2. Identify health care discipline involved at key steps in process (flow chart) - documentation
3. Engage Physicians
4. Patient/caregiver interaction to develop medication list
5. Process/method to update original history
6. Identify how each discrepancy will be addressed
    a. Order
    b. Medicine reconciliation form (enhance intra-professional communication)
    c. Difference between how written and how taken
    d. Additional Notes
7. What medications to include
    a. All prescription meds
    b. Hospitals need policy regarding herbals, O-T-Cs, etc.
8. What specifics to include
    a. Required
        i. Name
        ii. Dose
        iii. Frequency
        iv. Route
    b. Optional
        i. Indication
        ii. how patient takes medication
9. Signatures
    a. Require 2 signatures from 2 different disciplines
    b. Recommend 1 signature be from physician
10. The more accurate you admission information, the more accurate your discharge process

11. Sources of information – may need more than one
    a. Patient
    b. Family/significant other
    c. MD office
    d. Care facility
    e. Pharmacy
12. Evaluate the "reliability" of information received
    a. Patient
    b. Non-patient source
13. All discrepancies should be addressed by the doctor
    a. Include hold or not written orders
    b. Don't include substitutions within class by therapeutic protocol
14. Identify standard location of form in patient's chart

Transition Point: Unit Transfers

1. Compare medications from one unit to the next. May want to review home medications when transferring out of Intensive Care Unit.

Transition Point: Discharge

1. Review 3 lists
    a. Home Medications
    b. Current medication administration record
    c. Discharge medication orders
2. Doctor writes discharge orders, someone else should check (Nurse, Pharmacist)
3. Discharge medication form should include:
    a. Medications to take
    b. Medications to discontinue
4. Patient should be educated about their responsibility to maintain and distribute their medication record to the:
    a. Pharmacy
    b. Primary Physician
    c. Nursing home
    d. Hospital
    e. Others
5. Need to address hospital formulary changes at discharge
6. System should identify who is responsible for patient and patient questions after discharge