

Policy

Medication Reconciliation

UW Hospital and Clinics

Policy Number: 7.60

Manual: Hospital Administrative

Section: Patient Support (Hospital Administrative)

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I. PURPOSE:

To accurately and completely reconcile medications across the continuum of care.

II. POLICY:

A complete list of a patient's current medications, allergies, and medication sensitivities will be obtained and documented upon admission to the organization in all relevant sites of care and all settings within UW Hospital & Clinics. This is updated at all visits whenever medications are administered, prescribed, or the response to the care or service provided to the patient could be affected by medications.

All new medications prescribed or administered will be reconciled against this list during the patient's care. Inpatients transferred between services or levels of care will have all medications reconciled. If a new medication is prescribed (or changes are made to the current regimen), the patient's electronic medication list is then updated and a copy of the updated list is provided to the patient.

A complete list of medications will be given to the patient upon discharge, and communicated to the next known provider or service when the patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.

III. FORMS:

Inpatient Medication Note (UWH #9171)

Discharge and Face Sheet Form #400552 or department specific form

WISCR Ambulatory Dataset (ADS)

Pharmacy Monitoring/Chart Documentation Form (UWH #SR300054).

IV. DEFINITIONS:

A. Medication

Includes any of the following: prescription medications; sample medications; herbal remedies, vitamins, or nutraceuticals; over-the-counter medications; vaccines; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions; and any product designated by the FDA as a drug. This definition does not include enteral nutrition solutions, which are considered food products, oxygen, and other medical gases.

B. Medication Reconciliation

Medication reconciliation is the process of identifying the most complete and accurate list of medications a patient is taking and using this list to provide correct medications for the patient anywhere within the organization. The process includes comparing prescriber's medication orders at the interfaces of care to that list, bringing discrepancies to the prescriber's attention, and if appropriate making changes to the orders including omissions, duplications, interactions and name/dose/route confusion. Other steps in medication reconciliation include updating the medication list as orders change during the episode of care and communicating the updated list to the patient and the next known provider of care

- C. Relevant sites of care
The relevant sites of care are all areas where the patient's response to the treatment or service could be affected by the medications the patient has been taking, particularly those areas where medications are prescribed or administered, including inpatient units, ambulatory clinics, emergency department, operating room, procedure areas and home health care services.
- D. Discharge medication list
The list of all medications the patient is to continue taking upon discharge. This is not an order, rather a complete list of continuing medications. This list should include all routine medications for the patient, including clinic-administered medications.
- E. Authorized personnel
The authorized personnel include nurses, physicians, physician assistants, nurse practitioners, pharmacists, medical assistants, radiology technicians, and other designated clinicians by location.

V. GENERAL PROCEDURE:

- A. A complete list of a patient's current medications, allergies, and medication sensitivities must be obtained and documented upon admission to the organization in all relevant sites of care and all settings within UW Hospital & Clinics. This list is updated at all visits whenever medications are used or the response to the care or service provided to the patient could be affected by medications.
- B. The only situations where a list of current medications does not need to be documented are those visits when a patient does not receive any prescriptions for medications, medications are not applied or administered, or when the care provided to the patient does not depend on the medications they are taking.
- C. If a list of the patient's medications cannot be obtained from the patient because of patient factors limiting their ability to provide this information at the time of the encounter, documentation of why this list could not be obtained should occur.
- D. In all settings, the patient's list of medications must be updated and provided to the patient whenever a new medication is prescribed or recommended for the patient. The list must also be provided directly either through documentation or other communication to the next known providers of care for the patient.
- E. The patient's list of medications should include all medications the patient will be taking after the encounter. This often includes medications not prescribed by the practitioner responsible for the encounter and does not signify that the practitioner of record for the encounter has ordered or reordered all of the medications.

VI. PROCEDURE FOR PATIENTS ADMITTED TO THE INPATIENT UNITS:

The following applies for all inpatients as well as outpatient short stay and observation patients.

- A. Admission
 - 1. Medication Histories
 - a. A complete and accurate medication history (see Appendix I) will be obtained for all patients admitted to the inpatient units and documented on the Medication History Note (UWH #9171) by a pharmacist as soon as possible after admission, no later than 24 hours after admission.
 - b. Patients may have their medication history obtained the day before a scheduled admission.
 - c. The source of the information will be documented on the note.
 - d. If no information can be obtained from any source, the pharmacist will document "Patient not able to be interviewed, no information available" on the Medication History Note.
 - e. In addition to the patient's medication history, the pharmacist will document the following:
 - i. Indication for use for each medication
 - ii. The patient's allergies to drugs, food, latex, contrast, and environmental allergies

- iii. The date and approximate time the last dose of the medication was taken, if known.
- iv. For doses of the medication taken on the day of admission, the nomenclature to be used is D = X, where X is the number of doses taken by the patient that day.
- v. The patient's preferred pharmacy.
- vi. Weight, height, age of the patient.
- vii. Food, latex, or contrast dye allergies.
- viii. Functional limitations and or barriers to learning apparent to the pharmacist.
- ix. Adherence of patient and/or caregiver to taking the medications as prescribed and if they are aware of the purpose of the therapy.
- x. Information about tobacco, alcohol, and recreational drug use, as obtained from the patient or as documented on the Adult Health Profile completed by the nursing staff.
- xi. History of treatment with chemotherapy
- xii. The pharmacist will identify non-formulary medications and work with other providers to develop a plan for providing these medications if necessary during hospitalization (e.g. use of patient's own order or non-formulary drug order, therapeutic interchange, or drug holiday).
- f. For patients transferred from another acute care facility:
 - i. The pharmacist will document both current and pre-admission home medications on the Medication History Note (UWH #9171).
 - ii. Medications new to the patient should be distinguished from those the patient was taking prior to admission to the other care facility.
 - iii. If patient is taking warfarin or low molecular weight heparin (LMWH) prior to admission and followed by the UWHC anticoagulation service, this will be documented in the designated section on Medication History Note (UWH #9171). The pharmacist should contact the outpatient anticoagulation service as indicated on the form to notify them of the admission.
 - iv. The Medication History Note will be filed in the patient's chart under the Progress Notes Section. A duplicate copy will be retained by the pharmacist for future reference during the patient's inpatient stay.
- g. Medication Reconciliation
 - i. Pharmacists will reconcile admission medication orders by comparing the orders to the patient's home medication history immediately upon receipt of both sources of information.
 - ii. The pharmacist will contact the prescriber for clarifications regarding discrepancies identified during the reconciliation. Discrepancies include when any home medication is not ordered upon admission without a documented reason, known therapeutic contraindication, or policy regarding their omission.
 - iii. Unless otherwise documented or explained, the pharmacist will document on the Pharmacy Monitoring/Chart Documentation Form the home medications not ordered upon admission and the reason on the monitoring form.
 - iv. The pharmacist will document that medication reconciliation is completed on the Pharmacy Monitoring/Chart Documentation Form, which is filed in the patient chart at discharge.
- h. Patient Transfers
 - i. Medication reconciliation will be performed whenever a patient transfers level of care or service.
 - ii. For inpatients, the patient's medication administration record (MAR) is available to all of the patient's care providers. This may occur through online access to the electronic MAR or through printing the MAR and placing it in the patient's chart prior to transfer.
 - iii. Pharmacists will reconcile the patient's new (transfer) medication orders versus their current inpatient MAR and their pre-hospitalization home medication list and contact the prescriber for any new

- discrepancies noted.
- iv. The pharmacist will document that medication reconciliation is completed on the Pharmacy Monitoring/Chart Documentation Form.
- i. Discharges
 - i. A physician or designated prescriber writes discharge medication orders (e.g.; the home discharge medication list) for the patient on the Discharge Order and Face Sheet Form (UWH #4005552 or service specific equivalent).
 - ii. A pharmacist will reconcile the patient discharge medication orders and discharge list against the current patient medication list and the patient's home medication list. She or he will document this verification step directly on the order form by initialing all orders under the RPh column on the left-hand side of the order form. The completion of the reconciliation will also be documented on the Pharmacy Monitoring/Chart Documentation Form (UWH #SR300054).
 - iii. The pharmacist will review the plan for discharge medications with the patient to determine if the patient has an adequate medication supply at home, determine time of estimated departure, review stored medications that the patient brought in with them at the time of admission, answer any questions and establish the pharmacy from which the patient wants to receive their medications.
 - iv. The pharmacist will document on the Face Sheet Form one of the following next to each order:
 - a. Has - patient has medication at home, no prescription needed
 - b. New or Rx - a prescription is needed
 - c. OTC - patient needs to purchase or obtain this medication over-the-counter
 - d. If the patient is going to another hospital, an extended care facility, or prison, the pharmacist will confirm that the facility is able to provide the necessary medications and document "facility transfer, no Rx's dispensed" on the face sheet.
 - j. For new prescription medications:
 - i. If the quantity to be dispensed is not indicated on the Discharge Order and Face Sheet Form (#4005552 or service specific equivalent) completed by the physician, a maximum of one-month supply may be ordered unless otherwise approved by the prescribing service. The pharmacist will document the amount to be dispensed on the Face Sheet Form for all controlled substances.
 - ii. The pharmacist may call the patient's pharmacy or provide written discharge prescriptions. If written discharge medication prescriptions are needed, the pharmacist may use the discharge face sheet as a prescription or chose to transcribe the medication orders onto prescription blanks (UWH #114).
 - iii. The attending physician's name and DEA number are to be recorded on the each transcribed prescription.
 - iv. All schedule II prescriptions must be signed by a physician with a valid DEA number.
 - v. The pharmacist must sign his/her name in the 'transcribed by' section of the prescription blank, since she or he is acting as the physician's designee.
 - k. If the patient wants the prescriptions sent to the UWHC Outpatient Pharmacy, the following information shall be provided on the prescription:
 - i. The patient's medical record and/or account number
 - ii. The patient's unit, time needed, total number of prescription orders being sent, allergies and adverse drug reactions, and the pharmacist's pager number.
 - iii. The patient will be provided with a copy of their discharge medication list and receive discharge medication teaching for each medication, including written patient information regarding the medication prescribed.

- iv. The medication list is also forwarded to the provider assuming care for the patient by the medical records department within 24 hours of discharge.

VII. PROCEDURES FOR NON-INPATIENT LOCATIONS:

- A. Ambulatory Clinics
 1. A complete and accurate medication history is obtained for each patient and documented in the electronic ambulatory data set (electronic medical record, WISCR ADS) by an authorized provider when a patient checks-in to a clinic. (See Appendix I).
 2. The medication list is reviewed and reconciled by the prescriber before any new medications are administered and/or prescribed.
- B. Procedure Areas (including Infusion Center, Cath Lab, Sedation Clinics, and Radiology).
 1. A complete and accurate medication history is obtained for each patient and documented in the electronic ambulatory data set (electronic medical record, WISCR ADS) or in the history and physical section of the medical record prior to the patient's procedure or surgery, or on the authorized medication reconciliation form by authorized personnel. [See Appendix 1]
 2. For inpatients, the MAR shall be used as the current medication list for reconciliation purposes.
 3. For most outpatients, this can occur through screening reconciliation by documenting the name of the patient's current medications during the triage or intake process.
 4. The medication list is reviewed and reconciled by the prescriber before any new medications are administered and/or prescribed.
 5. If a new medication is prescribed for the patient to take at home or in a clinic setting (or changes are made to the current regimen), the patient's electronic medication list is then updated and a copy of the updated list is provided to the patient and sent to the next known provider of care.
- C. Perioperative Areas (including Ambulatory Procedure Center, Outpatient Surgery Center, First Day Surgery, and Operating Room).
 1. A complete and accurate medication history is obtained for each patient and documented in the electronic ambulatory data set (electronic medical record, WISCR ADS), an authorized medication reconciliation form by authorized personnel, or in the history and physical section of the medical record prior to the patient's procedure or surgery.
 2. For inpatients, the MAR shall be used as the current medication list for reconciliation purposes.
 3. For most outpatients, this will occur through "screening" reconciliation by reviewing and documenting any changes to the list of patient's current medications during the triage process, or upon arrival to the location of the procedure or surgery.
 4. The medication list is reviewed and reconciled by the prescriber before any new medications are administered and/or prescribed.
 5. If a new medication is prescribed for the patient to take at home or in a clinic setting (or changes are made to the current regimen,) the patient's electronic medication list is then updated and a copy of the updated list is provided to the patient and sent to the next known provider of care.

VIII. Emergency Department:

- A. A complete and accurate medication history based on the information available at the point of care is obtained for each patient and documented on a home medication reconciliation form by an authorized provider. (See Appendix I).
- B. For most patients, this will occur through screening reconciliation by documenting the names of the patient's current medications during the triage process. A focused reconciliation to include exact dosage/routes and information from the patient's pharmacy or primary care physician may be directed by the emergency department personnel.
- C. The patient's list of medications should be obtained as soon as possible during the patient's encounter, after the management of emergent situations which may prohibit the ability to gather this information upon the initial contact.

- D. The medication list is reviewed by the emergency medicine physician or consulting physician as soon as possible after arrival before any non-emergent medications are administered and/or prescribed.
- E. If a new medication is prescribed (or changes are made to the current regimen), the patient's medication list is then updated and a copy of the updated list is provided to the patient and the next known provider of care.
- F. The list should include all known medications the patient will be taking, updated with changes as prescribed, and all new medications ordered.
- G. This list may include instructions to the patient to contact their primary care provider regarding medication concerns noted by the emergency department physician.
- H. If a patient is admitted to an inpatient unit through the emergency department, the medication history and reconciliation procedures will be performed by the pharmacist per procedures outlined above for inpatients.

IX. Home Health Care:

- A. Clinicians query patients about medication changes, use, new orders, errors, and/or compliance issues on admission and each home visit thereafter. (This includes looking at labels on ordered medication bottles and discussing dosages and frequency). Clinicians are also expected to review patient's use of over the counter medications and to maintain communication with the patient's physician about use of over the counter medications.
- B. Patients should be encouraged and assisted with keeping up-to-date lists of their medication orders.
- C. Clinicians teach and assist patients and caregivers in discussing newly prescribed medications with the ordering physician, to ensure an understanding of why the drug was prescribed and how it should be taken.
- D. A complete list of the patient's medications is sent to the next provider when patients are referred or transferred to another setting, service, practitioner or level of care within or outside the organization. This includes ED visits (if home care staff are aware when the pt seeks care in an emergency department), transfer to inpatient hospital, and discharge to other care providers such as clinic, hospice, nursing home, cardiac rehab, outpatient therapy, or other home health organizations. Home health office staff fax the medication list when patients are transferred or discharged
- E. Home health clinicians ensure that the patient is provided with a complete, updated list of medications upon discharge from the home health agency.

X. REFERENCES:

JCAHO, National Patient Safety Goals, Implementation Expectations and Frequently Asked Questions, Medication Management Standard 1.10, Element of Performance #2 and Patient Care Standards 15.20, Element of Performance #9 and 15.30, Element of Performance #1. Available at www.jointcommission.org and the JCAHO CAMPH Official Handbook, Update 2, September 2006. Wisconsin Hospital Association, Checkpoint Error Prevention Measurement Methodology, Version 7.0

XI. COORDINATION:

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Appendix I. Completing a Medication History

I. The medication history is the list of medications the patient is currently taking and any recent medication changes. It also includes the list of medications the patient can no longer take due to allergies or adverse drug reactions.

II. First determine what medications are already documented as being taken by the patient. Use the electronic health record to find the patient's outpatient medication list.

III. Ask the patient if they have a list of their medications or if they know the list from memory. Use open-ended questions to have the patient provide you with their list of medications.

- a. While the medication history is often obtained from the patient, other sources of information include the patient's parents, spouse, significant other, nursing home or other institution's MAR, local pharmacy, past discharge summary, and clinic visit transcription notes.
- b. It is recommended that the person be prompted and asked specifically about the use of ear drops, eye drops, creams, ointments, and herbal or over-the-counter medications.

IV. Use the list already documented in the patient's medical record to prompt the patient or their source regarding their medications. Ask specifically about medications which are documented in the health record and which may no longer be active. Remove from the active medication list the medications that are not current for the patient.

V. The following information should be documented in the medication history for all patients, when known and provided by the patient or his/her source:

- a. All current medications (see the definition of medication). The documentation of generic names is preferable.
- b. Specific dosage form, such as XL, SR, CD, etc, when applicable
- c. Dose and frequency,
- d. Route (not a required field, but should be indicated when not oral)
- e. Indication and duration of the medication

VI. Ask the patient about significant past medication history including prior exposure to chemotherapeutic agents, as applicable for his or her condition. For patients with chronic medical conditions, focus on the previous 6 months and discuss medications that have been tried for the patient's condition, and document the efficacy and toxicity as appropriate. Also document the indication for therapy and reason for discontinuation.

VII. Allergies or adverse drug reactions

- a. At each visit, ask the patient whether they have had any allergic reactions or adverse drug reactions to any medications.
- b. It is recommended patients are asked specifically about experience with or exposure to aspirin, penicillin and cephalosporins, sulfa-containing drugs, contrast dyes, latex, and tape.
- c. If the patient states that he/she has had problems with a medication, identify and document the drug and the reaction in the allergy/adverse drug reaction section of the electronic health record.
- d. When allergic reactions occur, it is also recommended to document the route of administration, type of reaction, date of the reaction, if the patient was rechallenged or followed up by an allergist, and treatment interventions, if any.