DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
G.V. (SONNY) MONTGOMERY VA MEDICAL CENTER

Medical Center Policy Number: F-118-59 MAY 31 2011

MEDICATION RECONCILIATION

I. PURPOSE: To define the procedures at the G.V. (Sonny) Montgomery VA Medical Center for obtaining and maintaining a complete and accurate list of each patient's current medications. Patients are most at risk during transition in care across patient care settings, services, providers, and levels of care. Reconciliation and communication of a complete and accurate medication list throughout the continuum of care is essential in reducing the risk of transition related drug events. The compilation of the complete list of medications is the responsibility of the clinical staff including physicians, physician's assistants, nurse practitioners, nurses, pharmacists, and dieticians. Medications include all VA prescribed, non-VA prescribed, over-the counter, herbals, vitamins, nutraceuticals, and respiratory therapy-related drugs such as inhalers that the patient takes on a routine basis.

II. POLICY:

A. Medications reconciliation is an important component in avoiding medication errors and keeping patients safe. It is a key initiative in the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign and is one of Joint Commission's (JC) Patient Safety Goals. Medication Reconciliation helps to avoid medication omissions, duplications, dosing errors, or drug interactions. Medication orders such as "Resume pre-op medication" are never appropriate.

B. Medication reconciliation consists of:

1. Printing a list of all medications before the patient's appointments;

2. Asking the veterans to check off any medication still being taken, as well as to add any new medications to the list;

3. The provider discussing the list of medications (to include the dosing) with the patient and noting any appropriate changes in CPRS;

4. Ensuring the patient is provided with a revised medication list before leaving the medical center.

C. Training the staff to use the Medication Reconciliation templates will be an immediate and ongoing process as new employees are hired and new resident physicians and fellows rotate through the medical center. Care Lines, Service Lines, and Services will educate their current and new staff on the proper procedures and documentation in alignment with this policy.

D. Monitoring will be an effective tool to measure the progress of medication reconciliation. If it is determined that the medication reconciliation process is not being utilized effectively, action will be taken to improve the process.

III. DEFINITIONS:

A. Medication Reconciliation. Medication Reconciliation is a process to ensure maintenance of accurate, safe, effective, and, above all, patient centered medication information by:

1. Obtaining medication information from the patient, caregiver, or family members.

2. Comparing the information obtained from the patient, caregiver, or family member to the medication information available in the VA electronic medical record, including active medications, recently expired medications, medications given at other VA facilities (via remote data view), and non-VA medications, in order to identify and address discrepancies.

3. Assembling and documenting the medication information in the VA electronic medical record.

4. Communicating with and providing education to the patient, caregiver, or family members regarding updated medication information.

5. Communicating relevant medication information to and between the appropriate members of the VA and non-VA health care team.

B. Adverse Drug Event (ADE). An ADE is an injury from the use of a drug. Under this definition, the term ADE includes harm caused by the drug (adverse drug reactions and overdoses) and harm from the use of the drug including dose reductions and discontinuation of drug therapy.

C. Adverse Event and Close Call Reporting. Adverse event and close call reporting is the reporting, review, or analysis of incidents involving patients that cause harm or have the potential for causing harm.

D. Adverse Drug Reaction (ADR). ADR is a response to a drug which is noxious and unintended and which occurs at doses normally used in people for prophylaxis, diagnosis, or therapy of disease or for the modification of physiologic function. ADRs can be mild, moderate, or serious in nature; likewise, they can be observed or historical.

E. Brown Bag Inventory. Brown Bag Inventory is a term coined by the action of a patient bringing his or her medication containers, often in a brown paper bag, to an episode of care whereby the clinician reviews the patient's medication containers with the patient in an effort to compile an accurate list of the medications the patient is currently taking.

F. Local VA Medications. Local VA medications are medications ordered at the treating VA facility.

G. Medication Adherence. Medication adherence refers to the extent to which the use of a medication by a patient aligns with the stated medication use instructions.

H. Medication Discrepancy. Medication discrepancies are unintentional differences found in the patient's medication information when compared to the medication information available on the electronic health record. These discrepancies may be omissions, commissions, inappropriate duplications, changes, and/or additions. These discrepancies may be generated from the patient or the health care system.

I. Non-VA Medications. Non-VA medications are non-VA provider prescribed medications filled at non-VA pharmacies, VA provider prescribed medication filled at non-VA pharmacies, herbals, over-the counter-medications, nutraceuticals, and alternative medications.

J. Non-VA Providers. Non-VA providers are community providers including physicians, advanced practice nurses, physician assistants, and other health care professionals who provide health care to Veteran patients outside of VA. This includes services reimbursed by Fee-Basis, Department of Defense, Tri-Care, Medicare, private pay, and health insurance. Methods to communicate with non-VA providers include phone conversations, FAX, and correspondence by mail after compliance with patient privacy regulations.

K. Patient-focused Local Metrics. Patient-focused local metrics are metrics established at the local level. For example, discrepancy rates, the rates of unintentional differences found in the patients' medication information when compared to the medication information available on the VA electronic medical record, may be used.

L. Patient Medication Information. Patient medication information is information on all the medications taken by the patient, how they are taking it, any problems they may be having and/or have had in the past. This may be obtained by brown bag inventory, verbal history, or patient, caregiver or family member-furnished medication list.

M. Remote VA Medications. Remote VA medications means medications ordered at any other VA facilities (viewed or imported via remote data view).

N. VA Medication Reconciliation External Review Process (EPRP). EPRP is the process for chart review, including the minimum documentation requirements that provide evidence that Medication Reconciliation was performed at this episode of care.

O. VA Medication Reconciliation Performance Monitor. A VA Medication Reconciliation Performance Monitor includes two questions at the post discharge call process: "Did you receive an updated medication list when leaving this VA medical facility?" and "Do you know where to go to ask questions?"

P. VA Providers. VA providers are physicians, medical trainees, advanced practice nurses, physician assistants, and other health care professionals who provide primary care or specialty care within the limitations of their individual VA privileges or scopes of practice.

Q. Veterans Receiving Dual Care. Veterans receiving dual care refers to Veterans who receive ongoing health care in both VA and non-VA health care settings.

IV. RESPONSIBILITY:

A. Facility Director. The facility Director is responsible for:

1. Assigning a Facility Medication Reconciliation POC who can receive information and help disseminate new knowledge of Medication Reconciliation transferred from the VISN Medication Reconciliation POC as it is made available.

2. Ensuring that local policies conform to the following critical quality and safety elements:

a. Defines the roles, tasks, and steps of the Medication Reconciliation process;

b. Defines that Medication Reconciliation is initiated at every episode or transition in level of care where medications will be administered, prescribed, modified, or may influence the care given;

c. Outlines how care is coordinated with the appropriate members of the health care team, including non-VA providers, through effective communication mechanisms and in conformity with the most recent revision of VHA's National Dual Care Policy.

d. Defines the processes to be used when medications are outside of the scope of the health care team member performing components of Medication Reconciliation, such that the member has access to necessary resources and communication strategies to refer the patient to the appropriate provider in outpatient and inpatient settings;

e. Outlines strategies that enable adherence to minimum documentation requirements in the VA electronic medical record including:

(1) Patient, caregiver, or family member-provided medication information obtained at the episode of is represented in the VA electronic medical record

(2) Comparison of this patient, caregiver, or family member-provided medication information to the medication information available in the VA electronic medical record. This documentation includes active medications, recently expired medications, non-VA medications, and medications given at other VA facilities (remote medications) highlighting the discrepancies identified and addressed.

(3) Updated medication information at the end of the episode of care is represented in the VA electronic medical record (including changes relevant to the episode of care).

(4) Ensure discharge information in the VA electronic medical record is consistent with discharge instructions provided to the patient, caregiver or family member at the end of the episode of care.

f. Defines patient-focused local metrics to evaluate the quality and efficacy of the program.

(1) Ensuring processes exist which provide support to the patient, caregiver or family with being full and active partners in the Veteran's medication information management.

(2) Ensuring that the multidisciplinary health care team is knowledgeable about and accepts stewardship of the process by complying with local policies.

(3) Ensuring that local policy conforms with guidance from accreditation organizations where applicable.

(4) Ensuring that the facility monitors compliance as appropriate. ***NOTE****: Resources for monitoring are VA Medication Reconciliation EPRP and the VA Medication Reconciliation Performance Monitor (IPEC).*

B. The Chief of Staff and the Associate Director for Patient Care Services: will ensure that processes are established and maintained; and that the established processes are being administered and practiced properly by medical and nursing staff.

C. Quality Management: will monitor and track compliance with medication reconciliation monthly and report findings as needed. Any issues requiring immediate attention are to be reported to the Chief of Staff and Associate Director for Patient Care Services for review and action.

D. Each care line, service line, and service: is responsible for training and monitoring of staff for compliance with the procedures of this policy.

E. All providers (i.e. physicians, resident physicians, physician assistants, nurse practitioners), nurses, pharmacists, and dieticians are responsible for the procedures outlined in this policy to help ensure patient safety is enhanced through the avoidance of medication errors and unsafe drug interactions.

F. VA Provider. (Medication Discrepancies) The VA provider is responsible for:

1. Completing Medication Reconciliation in accordance with local policy including medications prescribed by, or secured outside of, the VA system to diminish the potential safety risk for the dual care patient.

2. Documenting a plan to address medication discrepancies that is commensurate with the severity of the discrepancy and the risk of patient harm. ***NOTE:***

Addressing a discrepancy does not always require managing a medication or changing the medication order.

3. Educating patients identified as dual care users as per VHA's National Dual Care Policy.

4. Documenting and reporting adverse events and close calls and reporting. All adverse drug events must be entered into the Computerized Patient Record System (CPRS) and the VA Adverse Drug Event Reporting System (ADERS) as defined by VHA policy regarding Adverse Drug Event Reporting and Monitoring. ***NOTE:*** *Employees becoming aware of adverse events or close calls report them to the medical center via VA Form 10-2633 Report of Special Incident Involving a Beneficiary or other locally approved channels. Current examples of adverse events, which require review and reporting, are included in VHA Handbook 1050.01.*

5. Assisting the Veteran patient, caregiver, or family member to maintain, update, and take ownership of the patient's medication information. Patients need to be encouraged to be active participants in the decision making of their treatment plan. As such, the patient, caregiver or family member should share with the patient's health care team:

a. The Veteran patient's goals of care;

b. Personal medication utilization;

c. Problems which affect medication adherence, such as:

(1) Allergies and/or ADRs,
(2) Difficulties with access to health care,
(3) Financial hardship,
(4) Recommended medication treatment plan declined, or
(5) Other health-system, condition, or therapy-related factors

6. Non-VA medication and provider information;

7. Any medication and provider information from other VAMC facilities; and

8. The patient's health care proxy, if there is one.

V. PROCEDURES:

A. Jackson VAMC providers with prescriptive authority will use the Computerized Patient Records System's (CPRS) order entry to prescribe all medications (except for those that are required to be handwritten (e.g. narcotics).

1. New prescriptions that are written using CPRS will automatically be integrated into the patient's list of current medications. Medications that will be stopped must be formally discontinued in CPRS. Providers must use CPRS appropriately to ensure the

medication list is updated accurately in regards to new medication orders, discontinued medication orders and renewal medications.

2. All non-VA medications and over-the-counter medication (including herbals, vitamins, nutraceuticals, and respiratory inhalers) must also be entered or discontinued in CPRS appropriately using the Non-VA medication tab in CPRS to ensure the medication reconciliation process is utilized effectively.

B. Providers will document medication reconciliation at the time of admission/hospitalization.

1. The provider responsible for the inpatient care will verify, clarify, and reconcile the patient's medication regimen using CPRS. Medication reconciliation should be accomplished as soon as clinically indicated, but must be documented no later than 24 hours after admission.

2. The provider will verify the patient's medication regimen by obtain a list of the medications the patient is actively taking to include those prescribed by non-VA providers, over-the-counter medications, herbals, vitamins, neutraceuticals, and respiratory inhalers. This list can be obtained from the patient or family as appropriate. The provider must note any deviations from the VA prescription medications due to side effects.

3. The provider will clarify the patient's medication regimen by reviewing all medications the patient is taking and by considering the patient's current medical condition to determine whether any medications should be discontinued because they would not be clinically appropriate due the change in the patient's condition.

4. The provider will reconcile the mediation regimen using CPRS. The provider will then document that the medication reconciliation process has occurred by using the appropriate template in CPRS. This must be done within 24 hours of admission/hospitalization.

5. Following the admission medication reconciliation process, any additions or deletions to the patient medication regimen will now be accurately listed in the patient's medication history.

C. Providers will document medication reconciliation at the time of transfer to a different provider, different location/ward/service, or different level of care where medication would be re-written. For all inpatient transfers, it is also required that the patient's list of home medications be reviewed to determine whether those home medications should be resumed or discontinued based on the patient's current condition or any noted changes.

NOTE: Medication verification, clarification, and reconciliation is NOT required when a patient moves to a different nursing care unit providing the same level of care and the patient remains with the same provider; or when a patient remains on the same nursing care unit, but transfers to the care of a different provider (i.e. changing staff attending). However, it is recommended that a list of the patient's home medications be reviewed to determine if any medications previously discontinued can now be resumed.

1. The provider responsible for accepting the care after the transfer will verify, clarify, and reconcile the patient's medication regiment using the appropriate template in CPRS. Medication reconciliation should be accomplished as soon as clinically indicated, but must be documented within 24 hours of the transfer.

2. The provider will verify the patient's medication regimen by reviewing the patient's active/current medication list in CPRS.

3. The provider will clarify the patient's medication regimen considering the patient's current medical condition to determine whether any medications should be discontinued because they are no longer clinically appropriate in the new patient care setting or level of care. The provider should also determine if any medication stopped upon admission can be resumed in regards to the new patient care setting/level of care.

4. The provider will reconcile the medication regimen using CPRS. The provider will then document that the medication reconciliation process has occurred using the appropriate template in CPRS. This must be completed within 24 hours of the transfer.

5. Following the transfer medication reconciliation process, any further additions or deletions to the patient's medication regimen will be accurately listed in the patient's medication history.

D. For Community Living Residents:

1. Medication reconciliation will be done upon admission, change in provider, and change in patient care setting/levels of care.

2. The provider responsible for accepting the care for the patient upon admission or transfer will verify, clarify, and reconcile the patient's medication regiment using the appropriate template in CPRS. Medication reconciliation should be accomplished as soon as clinically indicated, but must be documented within 24 hours of the transfer.

3. The provider will verify the patient's medication regimen by obtain a list of the medications the patient is actively taking to include those prescribed by non-VA providers, over-the-counter medications, herbals, vitamins, neutraceuticals, and respiratory inhalers. This list can be obtained from the patient or family as appropriate. The provider must note any deviations from the VA prescription medications due to side effects.

4. The provider will clarify the patient's medication regimen by reviewing all medications the patient is taking and by considering the patient's current medical condition to determine whether any medications should be discontinued because they would not be clinically appropriate due the change in the patient's condition.

5. The provider will reconcile the mediation regimen using CPRS. The provider will then document that the medication reconciliation process has occurred by using the appropriate template in CPRS. This must be done within 24 hours of admission or transfer for hospitalization.

6. Following the admission medication reconciliation process, any additions or deletions to the patient medication regimen will now be accurately listed in the patient's medication history.

E. Providers will document medication reconciliation at the time of discharge.

1. The provider responsible for the patient/resident care will verify, clarify, and reconcile the patient's medication regimen using CPRS. Medication reconciliation should be accomplished as soon as clinically indicated, but must be documented prior to the patient leaving the medical center.

2. The provider will verify the patient's medication regimen by obtaining from the patient and/or family (as appropriate) all home medications. This includes non-VA prescribed medications, over-the-counter medications, herbals, vitamins, neutraceuticals, and respiratory inhalers.

3. The provider will clarify the patient's medication regimen with consideration to the patient's current medication condition to determine whether any medications should be discontinued because they are no longer clinically effective or appropriate at home. The provider will also determine whether any medications that were stopped upon admission can be restarted when the patient goes home.

4. The provider will reconcile all medication regimes using CPRS. The provider will then document that the medication reconciliation process has occurred using the appropriate template in CPRS. This must be completed prior to the patient leaving the medical center.

5. Following the discharge medication reconciliation process, the patient will be given a current list of active medications. The provider must make any necessary changes to the outpatient medication list prior to printing the discharge instructions. The active list will contain all of the medications the patient will be taking in the outpatient setting, not just those prescribed to the patient upon discharge.

F. Providers will document medication reconciliation in the outpatient setting (Primary Care, Specialty Care) if the patient is new to that area and medications are prescribed. This includes new patients in primary care panel or established patients that have not been seen within previous years and may have been dropped from a panel.

NOTE: For follow-up visits to primary care or specialty care clinics, it should be expected that the active medication list will be reviewed, but does not require formal reconciliation unless the patient is undergoing an outpatient procedure that requires IV sedation or IV contrast media; new medications are being prescribed; or changes are made to existing prescriptions.

1. The provider responsible for the outpatient care will verify, clarify, and reconcile the patient's medication regimen using CPRS. Medication reconciliation should be accomplished during that visit and documented prior to the patient being release from the clinic.

2. The provider will verify the patient's medication regimen by obtaining from the patient and/or family (when appropriate) a list of all medications the patient is actively taking. This includes medications prescribed by non-VA providers, over-the-counter medications, herbals, vitamins, neutraceuticals, and respiratory inhalers. This also includes noting any deviations from VA prescribed medication due to side effects or failure to have medications refilled timely.

3. The provider will clarify the patient's medication regimen by reviewing all medications the patient is taking and by considering the patient current medical condition to determine if any medications should be discontinued because they would not be clinically appropriate based a change in the patient's condition.

4. The provider will reconcile the medication regimen using CPRS. The provider will then document that the medication reconciliation process has occurred using the appropriate template in CPRS. This must be done prior to the patient being released from the clinic.

5. Following the new outpatient medication reconciliation process, the patient will be given a list of active medications. The active list will contain all of the medications the patient will be taking in the outpatient setting, not just those prescribed to the patient upon release from the clinic.

G. Provider will document medication reconciliation in the Emergency Department if medications are prescribed, discontinued, or changed.

1. The Emergency Department provider responsible for the patient's care will verify, clarify, and reconcile the patient's medication regimen using CPRS. Medication reconciliation should be accomplished as soon as clinically indicated, but must be documented prior to the patient's release. If the patient is admitted/hospitalized and no medications are immediately prescribed in the Emergency Department setting, the responsibility for the medication reconciliation process will be the responsibility of the admitting provider..

2. The provider will verify the patient's medication regimen by obtaining from the patient and/or family (when appropriate) all medications the patient is actively taking. This includes medications prescribed by non-VA providers, over-the-counter medications, herbals, vitamins, neutraceuticals, and respiratory inhalers. This also includes noting any deviations from VA prescribed medication due to side effects or failure to have medications refilled timely.

3. The provider will clarify the patient's medication regimen by reviewing all medications the patient is taking and by considering the patient current medical condition to determine if any medications should be discontinued because they would not be clinically appropriate based a change in the patient's condition.

4. The provider will reconcile the medication regimen using CPRS. The provider will then document that the medication reconciliation process has occurred using the appropriate template in CPRS. This must be done prior to the patient being released from the Emergency Department.

5. Following the Emergency Department Medication Reconciliation process, the patient will be given a list of active medications. The active list will contain all of the medications the patient will be taking in the outpatient setting, not just those prescribed to the patient upon release.

VI. REFERENCES:

A. VHA Directive 2011-012, Medication Reconciliation, March 9, 2011;

B. Joint Commission National Patient Safe Goals, CAMH Update 1, March 2011

VII. RESCISSION: Center Policy F-118-59, Medication Reconciliation dated February 22, 2008.

Julie A. Catellier
Interim Center Director

ATTACHMENTS: None

EXPIRATION DATE: MAY 31 2014

RESPONSIBLE OFFICE: Patient Care Services (118)