DEPARTMENT OF VETERANS AFFAIRS HEALTHCARE SYSTEM Long Beach, California

HEALTHCARE SYSTEM POLICY 03-10

ISSUE DATE: September 17, 2014

MEDICATION RECONCILIATION

1. **MAJOR POLICY CHANGES:** The policy was substantially changed to meet the Joint Commission's National Patient Safety Goal on Reconciling Medications (NPSG 03.06.01) effective January 2014. The policy allows for good faith effort from providers or designee to obtain medication history, adds responsibilities for staff and patient, and addresses the patient's role in medication safety. Procedures/guidance was added for medication reconciliation in Inpatient and Long Term Care settings; and for full medication reconciliation and limited medication reconciliation in both Outpatient Primary Care and Specialty Care areas. The inpatient transfer procedure was removed. Patient-focused local metrics, external review process, and performance monitor were added.

2. **PURPOSE:** To set forth policies and procedures for the development, reconciliation and communication of an accurate medication list throughout the continuum of care at VALBHS.

3. **POLICY:** All patients cared for within the VALBHS will receive well-coordinated, safe, appropriate, and patient-centered medical care at all levels of the health care continuum as it pertains to the management of patient medication information. This policy outlines a standardized method for obtaining, documenting, and communicating an accurate patient medication list for inpatient and outpatient care settings.

4. **DEFINITIONS:**

   a. **Adverse Drug Event (ADE).** An ADE is an injury resulting from the use of a drug. ADE's 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).

   b. **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.

   c. **Adverse Drug Reaction (ADR).** ADR is a subset of an ADE. An ADR is an unintended harm directly caused by a drug occurring during normal use (therapeutic, prophylactic or diagnostic) and at normal doses. ADRs can be mild, moderate, or serious in nature; likewise, they can be observed or historical.

   d. **Brown Bag Inventory.** Brown bag inventory is the process in which the patient presents at an episode of care with their current prescribed and over the counter (OTC) medications (vitamins, supplements, topical products, herbals) in their original containers. This process facilitates obtaining an accurate inventory of current medications, assists in the education of the patient and or surrogate about their medication, allows for discontinuing medications no longer needed and compiling an accurate list of the medications the patient is currently taking.

   e. **Medication.** Medication includes any product designated as a drug by the FDA, investigational drugs, OTC medications (vitamins, supplements, topical products, herbals), recreational drugs and vaccinations.

      (1) **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, OTC medications, nutraceuticals**,** and alternative medications.

(2) **Remote VA Medications.** Remote VA medications are medications ordered at any other VA facilities (viewed or imported via remote data view).

(3) **Local VA Medications.** Local VA medications are medications ordered at the treating VA facility.

f. **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.

g. **Medication Discrepancy.** Medication discrepancies are differences noted in the patient's actual medication regimen when compared to the medication information available on the electronic health record (CPRS). These discrepancies may be omissions, commissions, inappropriate duplications, changes, and/or additions. Discrepancies may originate from the patient and or the health care system.

h. **Medication List.** An accurate and complete list of a patient's current medications located in the VA electronic record (CPRS) after medication reconciliation has been completed.

i. **Medication Object.** A list of medications available in the electronic health record (CPRS) generated by a Veterans Health Information Systems Technology and Architecture (VISTA) data query of a patient's electronic medical record. VISTA queries can be configured to output Medication Objects that contain the following: inpatient and outpatient medications, supplies, active, expired, and discontinued medications and supplies, non-VA medications and remote medications.

j. **Medication Reconciliation.** Medication Reconciliation is a collaborative process of maintaining accurate patient centered medication information by:

(1) Obtaining medication information from the patient and or surrogate;

(2) Comparing the information obtained from the patient and or surrogate 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 (e.g. discontinuing or modifying medication orders);

(3) Assembling and documenting the medication information in the VA electronic medical record;

(4) Communicating the corrected medication information to the patient or surrogate and providing updated medication information; and

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

Full Medication Reconciliation encompasses the elements included in section j (1-5) and involves reconciling all the patient's medications. Full medication reconciliation may be appropriate in areas such as primary care, inpatient admission and discharge, etc.

Limited Medication Reconciliation encompasses the elements included in section j (1-5), but is limited to reconciling the patient's medications with only those ordered or prescribed. Limited medication reconciliation may be appropriate in minimal use areas such as emergency department, urgent care, specialty ambulatory care, radiology, outpatient procedures, diagnostic areas, etc. where medication administration and prescribing may be

minimal or none.

k. 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.

l. 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.

m. 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/surrogate furnished medication list.

n. Specialty Care. An outpatient episode of care (excluding primary care) that is focused on a specific patient problem or medical condition. Specialty care settings include areas such as the emergency department, urgent care, specialty ambulatory care, radiology, outpatient procedures and surgeries, diagnostic settings, etc.

o. 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.

p. VA Medication Reconciliation Performance Monitor. A VA Medication Reconciliation Performance Monitor includes questions after an episode of care such as: "Did you receive an updated medication list when leaving this VA medical facility?" and "Do you know where to go to ask questions?"

q. VA Providers. VA providers are physicians, medical trainees, advanced practice nurses, physician assistants, pharmacists, and other health care professionals including contracted personnel who provide patient care within the limitations of their individual VA privileges or scopes of practice.

r. 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.

5. PROCEDURES:

a. Patient Centered Medication Reconciliation Process. Patients and or surrogates are strongly encouraged to actively participate in the decision process of their treatment plan. Furthermore, it is incumbent upon every member of the care team to accept stewardship for the process of medication reconciliation. The primary provider for each service line or clinical care area is responsible for medication reconciliation. The provider should identify which members of the team are best positioned to complete this task. The physician, nurse, pharmacist, mid-level practitioner, or allied healthcare provider (e.g. medical assistant, pharmacy technician) is equally capable of capturing and documenting this information.

(1) A complete list of the patient's current medication, which includes prescriptions, OTC medications (vitamins, supplements, topical products, herbals), and any product designated by the Federal Drug Administration (FDA) as a drug, is obtained with involvement of the patient or surrogate. A good faith effort will be made to obtain as complete a list as possible. Please refer to Attachments A-E which outlines the procedures in different settings

and the key steps required for creating and communicating an accurate list of the patient's medication at the time of admission, discharge, and at other episodes of care, when full medication reconciliation is required, when limited medication reconciliation is required and when no medication reconciliation is required to be performed.

(2) Patients will be encouraged and reminded to bring ALL medications including prescribed medications (both local VA, remote VA and non-VA), OTC medications (vitamins, supplements, topical products, herbal, etc.) for the purpose of the "Brown Bag" inventory to appropriate episodes of care.

(3) The complete and current "list" of a patient's medications (name, dose, route, frequency, and, if appropriate, purpose) will be maintained and documented in the CPRS "Meds" tab. The medication list generated from the CPRS will accurately list the patient's outpatient prescriptions, inpatient orders; remote and Non-VA medications after discrepancies have been addressed. Providers will use the facility's designated "Medication Objects" in their progress notes to assist in the documentation of the medication reconciliation process.

(4) The medication information to be collected when medications are changed will be the name of drug, dose of drug, route to be given, the frequency, and, if appropriate, the purpose. The provider making adjustments to the medication(s) ordered for the patient will compare the medication information the patient is currently taking with the medications ordered for the patient to identify and resolve discrepancies. Discrepancies include omissions, duplications, contraindications, unclear information, and changes. For inpatient admissions, the computerized medication list is updated automatically with order entry and upon verification. The discharge medication list should include not only the medications that are prescribed at the time of discharge, but any other medications the patient should be taking. Patients will be provided an up-to-date list of their medications at the time of discharge.

(5) With order entry of new or changed VA or non-VA medications into the CPRS computer system, the CPRS medication record automatically updates to include all active medication orders and can be printed for patients at the end of the episode of care. An updated medication list will be available to the next provider of service, across the continuum of care, as documented in the CPRS "Meds" tab. If a patient is discharged to a fee basis or a non-VA facility, a copy of all current medications will accompany the patient.

(6) Provide the patient or surrogate with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, and if appropriate, purpose). Note: When only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications.

(7) Explain the importance of managing medication information to the patient or surrogate when discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including OTC medications) are added; and to carry medication information at all times in the event of emergency situations.

(8) When the patient is being treated by a non-VA provider, the patient is offered a Release of Information (ROI) form to allow the ROl department of Health Information Management Service (HIMS) to mail the reconciled medication list to the non-VA provider.

6. RESPONSIBILITES:

a. **Facility Director** is responsible for:

(1) Assigning a Facility Medication Reconciliation Point of Contact (POC);

(2) Ensuring a medication reconciliation process has been developed and implemented; and

(3) Ensuring medication reconciliation is performed consistent with applicable VHA Directives, policies, and accreditation standards.

b. **Associate Director, Patient Care Services/Nurse Executive** is responsible for:

(1) Ensuring that Veterans are provided optimal and safe patient care; and

(2) Ensuring overall implementation of this policy and associated medication reconciliation procedures as they pertain to nursing practice.

c. **Chief of Staff** is responsible for ensuring that Veterans are provided optimal and safe patient care. The Chief of Staff standardizes, establishes, and maintains the medication reconciliation processes throughout VALBHS. This includes the following critical quality and safety elements:

(1) Defining the roles, tasks, and steps of the medication reconciliation process;

(2) Ensuring that medication reconciliation is initiated at every episode of care where medications will be administered, prescribed, modified, or may influence the care given;

(3) Outlining 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;

(4) Defining the processes to be used when medications are outside 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;

(5) Ensuring that the facility monitors compliance as appropriate by defining patient-focused and local metrics to evaluate the quality and efficacy of the program; and

(6) Outlining strategies that enable adherence to minimum documentation requirements in the VA electronic medical record including:

(a) Patient or surrogate-provided medication information obtained at the episode of care is represented in the VA electronic medical record; and

(b) Comparison of this patient or surrogate-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. 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).

d. **Clinical Service Chiefs** are responsible for compliance with this policy and for monitoring compliance as it pertains to their service. They are responsible for ensuring:

(1) Medication reconciliation is initiated at every episode of care in their respective areas where medications will be administered, prescribed, modified, or may influence the care given;

(2) VA providers are adequately trained and educated on the medication reconciliation process and understand its importance in the scope of quality patient care and patient safety;

(3) VA providers are knowledgeable about their lead role and responsibilities with respect to medication reconciliation;

(4) VA providers are following a consistent and uniform process for documenting medication reconciliation within their service/section; and

(5) Staff responsibilities for conducting medication reconciliation are delineated within their respective services and in accordance with this policy and applicable VHA Directives.

e. **Medication Reconciliation Point of Contact (POC)** is responsible for facilitating the medication reconciliation processes at all levels of care and at all transitions of care in order to improve patient safety and clinical outcomes.

f. **Attending Physicians** in all settings are responsible for appropriate resident supervision in medication management. This includes:

(1) Educating house staff, students, and residents on the correct medication reconciliation process;

(2) Ensuring consistent documentation for reconciling medication across the continuum of care; and

(3) Ensuring discharge information in the VA electronic medical record is consistent with discharge instructions provided to the patient or surrogate at the end of the episode of care.

g. **VA Provider(s)** are 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;

(a) Providers may elect to designate a clinician surrogate to obtain medication history. In such instances, the provider is responsible for reviewing the content of said data.

(b) Providers are responsible for reconciling medication discrepancies.

(c) When medication falls outside the scope of practice of the provider they should communicate discrepancies to the most appropriate prescriber. ***NOTE:*** *Addressing a discrepancy does not always require managing a medication or changing the medication order.*

(2) Documenting and reporting adverse events and close calls. All adverse drug events must be entered into the ADR/allergy field in the CPRS;

(3) Providing appropriate clinical justification when prompted by critical alerts. Justification for any overrides must be documented in the CPRS override comments field;

(4) Document a plan to address medication discrepancies that is commensurate with the severity of the discrepancy and the risk of patient harm;

(5) Reconciling when medications are altered and as outlined in this policy (see Attachments A – E). Physicians performing procedures (e.g., cardiac cath, interventional radiological

procedures) are responsible for reconciling the medication list prior to any procedures in which medications will be administered or when current medications may affect the outcome of the procedure;

(6) Educating patients identified as dual care users as per VHA's National Dual Care Policy;

(7) Assisting the patient or surrogate 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 or surrogate should share with the patient's health care team:

(a) The patient's goals of care;

(b) Personal medication utilization;

(c) Problems which affect medication adherence, such as:

i. Allergies and/or ADRs,

ii. Difficulties with access to health care,

iii. Financial hardship,

iv. Recommended medication treatment plan declined, or

v. Other health-system, condition, or therapy-related factors.

(d) Non-VA medication and provider information;

(e) Any medication and provider information from other VAMC facilities; and

(f) The patient's health care proxy, if applicable.

h. **Pharmacists** (without scopes of practice) are responsible for assisting VA providers with medication reconciliation and ensuring medication reconciliation is completed in accordance with this policy. This includes:

(1) Reconciling medication on inpatient admissions, discharges, and other episodes of care;

(a) Reviewing the patient medication history:

i. Comparing with existing medication data artifacts (e.g. lists, notes, electronic profiles); and

ii. Identifying clinically relevant discrepancies.

(b) Communicating findings to responsible prescribers. The mechanism used to contact the provider may be dependent upon the context of the encounter and may include but not be limited to verbal communication, forwarding of electronic charting materials, input of medication renewal requests, or use of other telecommunication modalities.

(2) Documenting and reporting adverse events and close calls. All adverse drug events must be entered into the ADR/allergy field in the CPRS;

(3) Furnishing patients with medication counseling and/or documentation as appropriate upon departure from a care setting (e.g. hospital discharge); and

(4) Assisting providers with urgent discrepancies identified at the point-of-care.

i. **Allied Health Care Personnel** (e.g. pharmacy technicians, medical support agents [clerks], medical secretary, nursing assistant, and patient services assistant) are responsible for administrative support of the medication reconciliation process including:

(1) Assisting with gathering medication and allergy history from the patient or surrogate;

(2) Assisting with providing an updated medication list to the patient, surrogate, or next provider of care; and

(3) Assisting with providing paperwork, assisting patients or surrogates with self-directed questionnaires (e.g. printouts, handouts, or kiosk software).

j. **Nurses (LVN and RN)** are responsible for assisting VA providers with medication reconciliation in accordance with this policy. This includes but is not limited to:

(1) Obtaining a current list of medications and a medication adherence history from the patient or surrogate (VA and non-VA prescriptions, OTC medications, dietary supplements or herbal products);

(2) Communicating findings to responsible prescribers. The mechanism used to contact the provider may be dependent upon the context of the encounter and may include but not be limited to verbal communication, forwarding of electronic charting materials, input of medication renewal requests, or use of other telecommunication modalities;

(3) Documenting and reporting adverse events and close calls. All adverse drug events must be entered into the ADR/allergy field in the CPRS; and

(4) Assisting with providing an updated medication list and instructions to the patient, surrogate, or next provider of care.

k. **Patient Safety Committee** is responsible for:

(1) Reviewing medication reconciliation performance data to track facility compliance;

(2) Reporting data to patient care areas for the purposes of feedback and quality improvement;

(3) Delivering feedback to the Chief of Staff and Service Chiefs;

(4) Issuing consultative expertise on medication reconciliation for the purposes of supporting facility change management, policy development, or metric validation;

(5) Ensuring that local policy conforms with guidance from accreditation organizations where applicable; and

(6) Reporting findings and recommendations to the P&T Committee.

l. **Quality Management** is responsible for:

(1) Ensuring that the facility participates in ongoing monitoring program such as the VA Medication Reconciliation External Peer Review Process (EPRP) and the VA Medication Reconciliation Performance Monitor; and

(2) Furnishing EPRP and other relevant medication reconciliation performance data to the Patient Safety Committee for review and action.

m. **Pharmacy and Therapeutics Committee (P&T)** is responsible for:

(1) Facilitating the medication reconciliation processes at all levels of care and at all transitions of care in order to improve patient safety and clinical outcomes; and

(2) Assisting with establishing the metrics to evaluate the quality and efficacy of the medication reconciliation process.

n. **Clinical Information Officer (CIO) and Clinical Application Coordinators (CACs)** are responsible for the timely implementation of the CPRS enhancements/tools (e.g. reminder dialogues, templates, order sets, data objects, and health factors) to facilitate an efficient and accurate patient centered medication reconciliation process under the guidance of the P&T Committee.

o. **Office of Information Technology (OIT)** is responsible for providing necessary computer software support and technical assistance to facilitate and enhance the medication reconciliation process under the guidance of the P&T Committee. This includes CPRS enhancements and third party software solutions.

p. **Patients** are responsible for:

(1) Participating in the decision making of their treatment plan and inform the health care provider and/or team of any changes in their medicine regimen;

(2) Sharing with the health care team information such as:

(a) The Veteran patient's goals of care;

(b) Personal medication use;

(c) Problems which affect medication adherence, such as: allergies and/or ADRs, difficulties with access to health care, financial hardship, recommended medication treatment plan declined, other health-system, condition, or therapy-related factors;

(d) Non-VA medication and provider information;

(e) Any medication and provider information from other VAMC facilities; and

(f) The patient's health care proxy, if there is one.

7. REFERENCE:

a. VHA Directive 2011-12, Medication Reconciliation, March 9, 2011. VHA Directive 2011-012 "Medication Reconciliation".

b. Joint Commission on Accreditation of Healthcare Organizations, current edition.

c. Joint Commission National Patient Safety Goal on Reconciling Medication Information (NPSG.03.06.01), available at: http://www.jointcommission.org/standards_information/npsgs.aspx

d. National Patient Safety Goal VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011

e. VHA Directive 2009-038, VHA National Dual Care Policy, dated August 25, 2009.

8. RESCISSION: HSP 03-10 Medication Reconciliation, dated May 31, 2007.

9. REVIEW AND FOLLOW UP RESPONSIBILITY: This policy will be reviewed annually by the Policy Coordinator and the Medical Executive Council. This policy will be recertified and reissued on or before September 17, 2019.

10. POLICY COORDINATOR: The Chair of the Pharmacy and Therapeutics Committee is responsible for the contents of this document.

/s/ Anthony DeFrancesco
For Michael W. Fisher
Medical Center Director

Attachments:
A. Outpatient Full Medication Reconciliation Process – Primary Care Quick Reference
B. Outpatient Limited Medication Reconciliation Process – Specialty Care Quick Reference
C. Specialty Care – No Medication Reconciliation if Required to be Performed if No Change in Medications
D. Inpatient Medication Reconciliation Process for Admission – Quick Reference
E. Long Term Care Medication Reconciliation Process for Discharge – Quick Reference

OUTPATIENT FULL Medication Reconciliation Process - Primary Care Quick Reference **Attachment A**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Primary Care or other Specialty Care Area (e.g. Psychiatry, Renal, Cardiology, Spinal Cord Injury, etc.)	Primary Care Provider or other Specialty Care Providers who are acting as the patient's Primary Care Provider	Every outpatient Primary Care Provider visit or other Specialty Care visit where the provider is acting as the patient's Primary Care Provider	1. The provider will document the outpatient medication list using the medication list in the CPRS (comparing the list against what the patient or surrogate reports [non-VA, remote VA medications, OTC, herbals, and dietary supplements] including identifying and resolving discrepancies with prior outpatient prescriptions, such as, omissions, duplications, contraindications, and unclear information). Providers are encouraged to use a "Brown Bag" inventory to facilitate this process.
			2. If the assessment and plan for the patient is to order or change a medication during the visit, document the comparison of and/or the actions taken on old and new medications in the CPRS progress note.
			3. Review and update drug allergies and/or adverse drug reactions in the CPRS prior to ordering new medications in the CPRS or administering a new medication.
			4. When medications are outside the scope of the health care team performing components of medication reconciliation, use resources and communication strategies to refer the patient to the appropriate provider when indicated.
			5. If the patient has not previously received an active medication list or the medications have been changed since the last visit, then provide written information on the medications the patient should be taking at the end of an outpatient encounter.
			6. Review outpatient medication list with patient or surrogate (including non-VA, remote VA medications, OTC, herbals, and dietary supplements). Counsel patients on new and changed medications which include regimen, potential side effects and purpose, and provide medication information sheets as needed as part of the medication teaching process.
			7. Instruct the patient how to properly dispose of medications which are no longer needed.

OUTPATIENT LIMITED Medication Reconciliation Process - Specialty Care Quick Reference **Attachment B**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Specialty Care and Minimal Use Areas (e.g. Emergency Department, Same Day Surgery, Dental Service, Infusion Clinics, Bronchoscopy, etc.)	Specialty Care Provider or designee	Prior to medications being administered, prescribed, or modified. 1) Only change in medications is new short term prescriptions (e.g. antibiotics or pain medications), or a temporary supply or bridge of a medication prescribed in anticipation of a follow up appointment with the originating or Primary Care Provider. 2) Where the care provided is focused on a specific patient problem and any change in medication(s) is limited to treating that condition or specific to that clinical setting. 3) Where medications are prescribed, ordered, or administered as part of a procedure.	1. The provider will: a. Document the outpatient medication list using the medication list in the CPRS, comparing the list against what the patient or surrogate reports (non-VA, remote VA medications, OTC, herbals, and dietary supplements). Providers are encouraged to use a "Brown Bag" inventory to facilitate this process. b. Document review of outpatient medication list against new medications prescribed or administered during the episode of care in a CPRS progress note.
			2. Review and update drug allergies and/or adverse drug reactions in the CPRS prior to ordering new medications in the CPRS or administering a new medication.
			3. When medications are outside the scope of the Specialty Care encounter, use resources and communication strategies to refer the patient to the appropriate provider when indicated.
			4. Review outpatient medication list with patient or surrogate (including non-VA, remote VA medications, OTC, herbals, and dietary supplements). Counsel patients on new and changed medications which include regimen, potential side effects and purpose and provide medication information sheets as needed as part of the medication teaching process.
			5. Provide information on newly prescribed medications to the patient at the end of the episode of care.
			6. Instruct the patient how to properly dispose of medications which are no longer needed.

Specialty Care - NO Medication Reconciliation is Required to be Performed if NO Change in Medications **Attachment C**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Specialty Care	Specialty Care Provider or designee	No change in medications.	No medication reconciliation is required to be performed.

INPATIENT Medication Reconciliation Process for ADMISSION – Quick Reference **Attachment D**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Hospital / Acute Inpatient	Admitting Provider or designee	Admission - prior to prescribing inpatient medications and / or within 12 hours of admission	1. Document the outpatient medication list using the medication list in the CPRS (comparing the list against what the patient or surrogate reports [non-VA, remote VA medications, OTC, herbals, and dietary supplements]).
			2. Document comparison of outpatient medication list with inpatient medication list in a CPRS progress note (including identifying and resolving discrepancies with prior outpatient prescriptions, such as, omissions, duplications, contraindications, and unclear information).
			3. Review and update drug allergies and/or adverse drug reactions in the CPRS prior to ordering new medications in the CPRS or administering a new medication.
			4. Respond promptly to communications from the inpatient medical/pharmacy staff when any unresolved discrepancies found when reviewing admission medication orders and as compared to outpatient medications.
Hospital / Acute Inpatient	Inpatient Pharmacist	Admission - as part of verifying prescribed inpatient medications	1. Verify the inpatient admission medication orders and compare these orders against the current outpatient medication list.
			2. Communicate with the provider any unexplained discrepancies between the inpatient medication orders and the outpatient medication list.
			3. Review and update drug allergies and/or adverse drug reactions in the CPRS prior to ordering new medications in the CPRS or administering a new medication.
			4. If available, upon consultation: a) Document the outpatient medication list using the medication list in the CPRS (comparing the list against what the patient or surrogate reports [non-VA, remote VA medications, OTC, herbals, and dietary supplements]). b) Document comparison of outpatient medication list with inpatient medication list in a CPRS progress note (including identifying discrepancies with prior outpatient prescriptions, such as, omissions, duplications, contraindications, and unclear information).

INPATIENT Medication Reconciliation Process for DISCHARGE – Quick Reference **Attachment D (cont.)**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Hospital / Acute Inpatient	Provider, in conjunction with the Pharmacist	At the time of discharge	1. Review all inpatient medications, nutritional supplements, and supplies to determine the patient's discharge regimen and to resolve any discrepancies with outpatient prescriptions, such as, omissions, duplications, contraindications, and unclear information.
			2. The provider will discontinue undesired prescriptions (medication(s), nutritional supplements, and supplies).
			3. Document the treatment plan in the discharge progress note in the CPRS including the documentation of inpatient orders that will be continued upon discharge and new medications and/or dosage/schedule changes that will be added to the patient's medication regimen.
			4. Communicate the medication regimen to the patient or surrogate. A discharge instructions sheet containing the medication regimen information will be provided to the patient or surrogate.
			5. Upon discharge document the discharge medication list in the discharge note.
			6. If a patient is discharged to a non-VA facility, a copy of the current medication list will accompany the patient or surrogate.
Hospital / Acute Inpatient	Pharmacist	At the time of discharge	1. Compare the discharge prescriptions with the active inpatient medication regimen (including nutritional supplements and supplies) and active outpatient medication list and communicate discrepancies to the provider(s) for clarification.
			2. Review provider Discharge Instructions note and compare against new discharge prescriptions as well as existing outpatient prescriptions: i. Communicate with the prescriber any discrepancies detected including need for discontinuation of any undesired medications; ii. Document any medication reconciliation discharge discrepancies in the Pharmacy Discharge Medication note with the prescriber as an additional signer. iii. Adjust medication discharge orders per provider.
			3. Provide discharge medication counseling to the patient or surrogate at the bedside or at the Pharmacy. Give the revised medication printout list to the patient or surrogate during the counseling session.
Hospital / Acute Inpatient	Nurses (LVN or RN)	At the time of discharge	Instruct/remind the patient or surrogate of his/her responsibility to wait for discharge prescriptions, pharmacist counseling and updated medication list prior to leaving the facility. Provide supplemental medication education and or training to patients or surrogate as requested.

Long Term Care Medication Reconciliation Process for ADMISSION - Quick Reference **Attachment E**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Long Term Care / Community Living Center (CLC) and Blind Rehab Center (BRC)	Admitting Provider or designee	Admission - prior to prescribing inpatient medications and / or within 12 hours of admission	1. Document the medications the patient is receiving at his/her current location, comparing the list against what the patient or surrogate reports (non-VA, remote VA medications, OTC, herbals, and dietary supplements).
			2. Document comparison of the medication list with the newly ordered inpatient medications in a CPRS progress note (including identifying and resolving discrepancies with prior outpatient prescriptions, such as, omissions, duplications, contraindications, and unclear information).
			3. Review and update drug allergies and/or adverse drug reactions in the CPRS prior to ordering new medications in the CPRS or administering a new medication.
			4. Respond promptly to communications from the inpatient medical/pharmacy staff when any unresolved discrepancies found when reviewing admission medication orders and as compared to outpatient medications.
			5. Discontinue, edit and or add new medication(s) as necessary.
			6. Review delayed medication orders and reconcile them with current medication needs. This is to assure that orders made after delayed orders are considered and addressed upon admission.
Long Term Care / Community Living Center (CLC) and Blind Rehab Center (BRC)	Pharmacist	Admission - as part of verifying prescribed inpatient medications	1. Verify the inpatient admission medication orders and compare these orders against the current medication list prior to admission.
			2. Communicate with the provider any unexplained discrepancies between the inpatient medication orders and the most recent medication list.
			3. Review and update drug allergies and/or adverse drug reactions in the CPRS prior to ordering new medications in the CPRS or administering a new medication.
			4. If available, upon consultation: a. Document the most recent medication list using the medication list in the CPRS (comparing the list against what the patient or surrogate reports [non-VA, remote VA medications, OTC, herbals, and dietary supplements]). b. Document comparison of most recent medication list with inpatient medication list in a CPRS progress note (including identifying discrepancies with most recent prescriptions/orders, such as, omissions, duplications, contraindications, and unclear information).

Long Term Care Medication Reconciliation Process for DISCHARGE - Quick Reference **Attachment E (cont.)**

Setting / Specific area	Who is responsible?	When is it done?	What is required?
Long Term Care / Community Living Center (CLC) and Blind Rehab Center (BRC)	the Provider, in conjunction with the Pharmacist	At the time of discharge	1. Review all inpatient medications, nutritional supplements, and supplies to determine the patient's discharge regimen and to resolve any discrepancies with outpatient prescriptions, such as, omissions, duplications, contraindications, and unclear information.
			2. The provider will discontinue undesired prescriptions (medication(s), nutritional supplements, and supplies).
			3. Document the treatment plan in the discharge progress note in the CPRS including the documentation of inpatient orders that will be continued upon discharge and new medications and/or dosage/schedule changes that will be added to the patient's medication regimen.
			4. Communicate the medication regimen to the patient or surrogate. A discharge instructions sheet containing the medication regimen information will be provided to the patient or surrogate.
			5. Upon discharge document the discharge medication list in the discharge note.
			6. If a patient is discharged to a non-VA facility, a copy of the current medication list will accompany the patient or surrogate.
Long Term Care / Community Living Center (CLC) and Blind Rehab Center (BRC)	Pharmacist	At the time of discharge	1. Compare the discharge prescriptions with the active inpatient medication regimen (including nutritional supplements and supplies) and active outpatient medication list and communicate discrepancies to the provider(s) for clarification.
			2. Review provider Discharge Instructions note and compare against new discharge prescriptions as well as existing outpatient prescriptions: a. Communicate with the prescriber any discrepancies detected including need for discontinuation of any undesired medications; b. Document any medication reconciliation discharge discrepancies in the Pharmacy Discharge Medication note with the prescriber as an additional signer. c. Adjusts medication discharge orders per provider.
			3. Provide discharge medication counseling to the patient or surrogate at the bedside or at the Pharmacy. Give the revised medication printout list to the patient or surrogate during the counseling session.
Long Term Care / Community Living Center (CLC) and Blind Rehab Center (BRC)	Nurses (LVN or RN)	At the time of discharge	Instruct/remind the patient or surrogate of his/her responsibility to wait for discharge prescriptions, pharmacist counseling and updated medication list prior to leaving the facility. Provide supplemental medication education and or training to patients or surrogate as requested.