DEPARTMENT OF VETERANS AFFAIRS (VA)
SALT LAKE CITY HEALTH CARE SYSTEM
Salt Lake City, Utah

MEMORANDUM 11.55 December 27, 2018

MEDICATION RECONCILIATION

1. PURPOSE:

This policy will establish a process for accurately and completely reconciling patient's medications across the continuum of care. The purpose of reconciliation is to ensure maintenance of accurate, safe, effective and patient centered medication information.

2. POLICY:

Medication Reconciliation will be initiated at every episode or transition in level of care, where medications will be administered, prescribed, modified, or may influence the care given. Updated medication information at the end of the episode of care is:

i. Represented in the VA electronic medical record (including changes relevant to the episode of care), and

ii. Communicated to the patient, caregiver or family member, and appropriate members of the health care team.

A good faith effort to reconcile medication information between the patient, caregiver or family member will be considered as meeting the requirement of medication reconciliation. These circumstances will be documented in CPRS.

3. RESPONSIBILITIES:

a. Facility Director responsible for assigning a Medication Reconciliation Point of Contact and ensures local policies conform to critical quality and safety elements.

b. Chief of Staff is responsible for ensuring adequate training and education is completed for VA providers to complete medication reconciliation.

c. Medication reconciliation point of contact ensures National and VISN information is disseminated among all health providers.

d. A VA provider who orders or administers medications is responsible for adherence to policy and the procedures associated with it.

e. Patient is responsible for informing any non-VA provider of their changes in medications.

f. Ancillary Health Care personnel will inform all VA providers of medication discrepancies when discovered.

g. Patient Safety will monitor adherence to policy.

4. DEFINITION OF TERMS:

a. Essential Medication List: Items considered medications include all local active medications, remote active medications, and Non-VA Medications. It will include name of drug, strength/dosage of drug and instruction for use. Additionally, the list of local medications will include recently discontinued medications, recently expired medications and medications that are in the pending status, in order to accurately determine what medications a patient may be taking. It will not include supply items such as glucometers, testing strips, Foley catheter supplies, etc.

b. Local Active Medications: The active medications ordered and/or administered by the treating VA facility in the Computerized Patient Record System (CPRS).

c. Medication Reconciliation: Medication reconciliation is a review of medications that will help identify problems to avoid potential harm to the patient. It is the process of obtaining medication information, comparing the information, assembling, documenting, and communicating with patient/family member/caregiver. The gathered relevant medication information is then communicated to the appropriate members of the health care team and documented in the electronic medical record.

d. Non-VA Medication: Non-VA medications include, non-VA prescription medications filled at non-VA pharmacies, VA provider prescribed medications filled at non-VA pharmacies, other medications, such as sample prescription medications provided from a non-VA provider's office, and any herbal remedy, vitamins, nutraceuticals, over the counter drugs and any product designated by the Food and Drug Administration (FDA) as a drug.

e. Prescribers: This will include any licensed medical professional with prescriptive authority.

f. Remote Active Medications: Medication information from other VA facility and/or Department of Defense and/or other retail Pharmacies.

g. $\leq$ 24-Hour Length of Hospital Stay: Patients who are discharged within 24 hours after being admitted to the hospital.

5. PROCEDURES:

a. Hospital Admission:

i. Upon admission to the hospital, the patient's medication list will be reviewed with the patient and/or family if appropriate.

ii. The medication list should be reviewed with the patient by the admitting prescriber.

iii. Pharmacy personnel including pharmacists, pharmacy technicians, students, residents or externs will review the medication list with the patient and/or family member(s) and note any discrepancies. Pharmacy personnel will then update the patient's CPRS medication profile, including NON-VA meds, to accurately reflect the patient's current medication regimen. Pharmacy personnel will then compare this completed list with the medications ordered for the patient on admission. Discrepancies will be noted and communicated to the physician. Pharmacy personnel will then enter an admission Medication Reconciliation Note in CPRS to document that medications have been reconciled and discrepancies noted and communicated to the prescriber.

iv. $\leq$ 24-Hour Length of Hospital Stay: Pharmacy personnel will not perform an admission medication reconciliation as above for patients discharging within 24 hours of admission, but will complete a Discharge Medication Reconciliation as discussed below.

v. Transfer from Outside Facility: Admitting office will obtain most recent Medication Administration Record (MAR) from outside facility prior to accepting the patient. This MAR should either be faxed to our admitting office or arrive with the patient on transfer. If this documentation is not available on admission, the physician and pharmacist will attempt to obtain it as soon as possible. A copy of this MAR will be filed in the patient's soft chart. Pharmacy personnel will then enter an admission Medication Reconciliation Note in CPRS to document that medications have been reconciled and discrepancies noted and communicated to the prescriber.

vi. Transfer from Extended Care Facility (ECF): Most recent MAR will be obtained from the ECF by the admitting prescriber. If prescriber is not able to obtain recent MAR from ECF during off hours, this will be done as soon as possible the morning following admission by either the prescriber or pharmacy personnel. A copy of the ECF MAR will be filed in the patient's soft chart. Pharmacy personnel will then enter an admission Medication Reconciliation Note in CPRS to document that medications have been reconciled and discrepancies noted and communicated to the prescriber.

b. Transfer Between Treating Specialties:

i. Medication orders will not auto-discontinue when patients transfer level of care or treating specialties. The accepting prescriber will review all medication orders post transfer for appropriateness and document medication reconciliation in the electronic chart. If medications unexpectedly discontinue during transfer, the accepting prescriber will enter new orders and document medication reconciliation in the electronic chart.

c. Discharge:

i. Prescribers will review admission medication list and reconcile with current inpatient medication list in CPRS. Prior to writing discharge instructions, prescribers will update the outpatient medication profile to reflect medication changes made during admission.

ii. Prescriber will write Discharge Instructions in CPRS, complete Discharge Medication Reconciliation consult to Clinical Pharmacy Specialist, and consult Discharge Pharmacy to process pending prescription orders. Exceptions to this include, no Discharge Medication Reconciliation consult will be placed on patients leaving AMA, interfacility transfers, same day surgery patients, and ophthalmology patients.

iii. Clinical Pharmacy Specialist will perform discharge medication reconciliation, containing updated medication information, highlighting what is changed, added, or discontinued in response to consults placed. The Clinical Pharmacy Specialist will ensure completion of discharge medication reconciliation prior to or within 24 hours of discharge and resolve any discrepancies identified. If the discharging service performs and documents discharge medication reconciliation, the Clinical Pharmacy Specialist may discontinue the Discharge Medication Reconciliation consults, so as not to duplicate work.

iv. Care provider will then provide counseling to patient and/or family member(s) about patients' current medication regimen, including any changes made in the medication regimen during admission. The Discharge Instruction Note will include documentation that the patient was provided this counseling and the patient will sign the note as a statement that counseling was indeed provided. A signed copy of this note will be placed permanently in the patients' soft chart.

v. Patient will bring his/her copy of the discharge instructions to the discharge pharmacist for medication counseling.

vi. Discharge pharmacist will complete pending medication orders, clarify problems identified with medication orders, counsel patient, and dispense medications as outline in Memorandum 119.22.

vii. Discharge to ECF: Medication reconciliation will occur as above.

d. $\leq$ 24-Hour Length of Hospital Stay: Pharmacy personnel will not perform an admission medication reconciliation for patients discharging within 24 hours of admission. Clinical Pharmacy Specialists will perform a Discharge Medication Reconciliation as above prior to or within 24 hours of discharge.

e. Outpatient Visits:

i. Primary Care: The Primary Care Provider reviews the medication list with the patient and/or caregiver and documents in the Primary Care note. They document the following:

1. Medications reviewed with the patient, including:

a. Local Active VA Prescription(s)

b. Remote Active VA Prescription(s)

c. Non-VA medication(s)

d. Recently Expired VA Prescription(s) as appropriate

e. Recently Discontinued VA Prescription(s) as appropriate

f. Pending Medication Order(s) where relevant (e.g. where patient is being seen by multiple providers in the same day)

2. Verified patient's understanding of indications.

3. Documents discrepancies

4. Provides an updated medication list to patient/caregiver after the visit.

5. Documents patient was provided a medication list.

ii. Emergency Department: Emergency care personnel will retrieve a list of active medications from the patient, the caregiver or the electronic chart if possible. A reconciliation of medication and condition of patient will be conducted at the beginning of the visit and discrepancies noted in the electronic record. If significant changes are made to the medication profile, Emergency Care personnel will provide to the patient/caregiver changes on the patient instructions paper work given at the end of the visit.

iii. Specialty Care Clinics: Medications will be reconciled within their specialty practice any time a new medication is ordered and/or administered. Information about new specialty medications written at this appointment will be provided by the Health Care Provider at the end of the visit.

6. <u>REFERENCES:</u>

VHA Directive 1164: Essential Medication Information Standards – June 2015

VHA Directive 1164: Essential Medication Information Standards – Appendix A

The Joint Commission National Patient Safety Goals 2015 – NPSG 03.06.01

VHA Directive Medication Reconciliation

VHA Handbook 1907.01 Health Information Management and Health Records July 22, 2014

7. RECISSION: Center Policy Memorandum 11.55, "Medication Reconciliation for Inpatients", dated January 10, 2017.

8. RECERTIFICATION DATE: This policy is scheduled for recertification on or before the last work day of December 2021.

9. FOLLOW-UP RESPONSIBILITY: Chief of Staff

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SHELLA STOVALL, MNA, RN
Director