

D.27 MEDICATION RECONCILIATION

Department of Veterans Affairs
VA Healthcare Network
Upstate New York at Albany

Standard Operation Procedure D&T-119-09
February 1, 2016

MEDICATION RECONCILIATION

1. **PURPOSE:** To document our processes for accurately and completely reconciling medications across the continuum of care, following the Joint Commission National Patient Safety Goal 03.06.01.
2. **RESPONSIBILITY:**
 - a. The Medical Center Director has overall responsibility for ensuring that processes are implemented for medication accuracy and reconciliation.
 - b. The Chief of Staff, Associate Director of Patient/Nursing Services and Managers/Supervisors are responsible for providing guidance and for ensuring compliance with the provisions of this policy.
 - c. All Clinical Service Chiefs will ensure the medical staff and other providers with prescriptive privileges are educated, trained, and comply with this policy.
 - d. All Professional Staff must be educated, trained, and comply with this policy.
3. **PROCEDURES:**
 - a. Medication Reconciliation consists of the following key components:
 - (1) Obtain information about the current use of medications and document in the medical record.
 - (a) A good faith effort must be made to determine how patient is actually using medications, including drug names, dose, frequency, and indication.
 - (2) At the end of the episode of care, the updated medication list is documented in the medical record, including changes relevant to the current episode of care, as well as a documented plan to address discrepancies identified during the episode of care.
 - (a) Note: Addressing a medication discrepancy does not always require adjusting a medication order of managing a medication. Referral to appropriate service is acceptable.
 - (3) Prescription orders are updated as necessary to maintain an accurate medication profile, including adjusting prescriptions to reflect updated dosing information, ordering new or changed medications, discontinuing medications which are no longer being used, and maintaining the Non-VA section of the medical record with agents obtained outside the VA.
 - (4) The updated medication list is provided to the patient at the end of the episode of care.

Note: When the only medications prescribed are intended for a short duration, the medication information provided at the end of the episode of care may include only these medications.
 - (5) Patient is educated on all changes to medications, including new, changed or discontinued agents, with documentation of education provided and patients understanding of education in the medical record.

- (6) The Veteran will be counseled to keep a copy of his medication list with him at all times, show this list to other non-VA providers of healthcare, and to update the list whenever changes in the medication regimen occur.
- b. Products to be documented: Prescription medications, vitamins, nutraceuticals, over-the-counter (OTC) medications, vaccines, radioactive medications, respiratory therapy-related medications, parenteral nutrition, blood derivatives, intravenous solutions, (plain or with additives), and any product designated by the Food and Drug Administration (FDA) as a drug.
- c. Medication sources to consider: Local VA pharmacy, medications from other VA facilities (via remote data view), community pharmacies (prescription or over-the-counter medications), sample medications, or from any other sources.
- d. For patients being admitted to the hospital or community living center (CLC):
 - (1) A qualified individual, typically the provider or a Transitional Care pharmacist, will obtain information on the patient's medication use prior to hospital admission. If unable to obtain patient/caregiver interview about use of medications, despite a good faith effort, all efforts will be documented in the medication reconciliation progress note.
 - (a) To request a pharmacist to complete admission medication reconciliation, place admission medication reconciliation consult via the hospital admission order set or the pharmacy consult menu.
 - (2) For patients residing in a long term care facility or those transferring from another care facility with supervised medication administration, a good faith effort to obtain the medication list from the patient's previous facility will be made.
 - (3) Compare the obtained information to the medication information available in the medical record.
 - (4) Document identified discrepancies in the medication reconciliation note along with a recommendation for any actions that need to take place to adjust the inpatient medication regimen based on the current clinical situation.
 - (a) Discrepancies include omissions, duplications, contraindications, unclear information, and changes.
 - (5) For pharmacist-completed admission medication reconciliation notes, the pharmacist will view alert the responsible provider to the completed note for evaluation of noted discrepancies and recommendations. The responsible provider will review pharmacist-completed admission medication reconciliation notes for all patients.
 - (6) The responsible provider will evaluate discrepancies and document a plan for reconciliation.
- e. For patients transferring between inpatient services:
 - (1) The provider ordering medications upon transfer will document the reasons for omissions, changes, and initiation of new medications.
 - (2) A Transitional Care pharmacist will review the medication regimen that was in place from the sending location, and compare it to the medication regimen ordered by the current inpatient location. Discrepancies will be noted and recommendations for corrections will be included in the CPRS transfer medication reconciliation note.

- (3) The pharmacist will view alert the responsible provider to the completed progress note.
- (4) The responsible provider will evaluate discrepancies and document a plan for reconciliation.
- f. For patients being discharged from the hospital or CLC:
 - (1) The provider will place a discharge medication reconciliation consult via pharmacy menu for Transitional Care pharmacist involvement, or will perform and document discharge medication reconciliation according to current policy.
 - (a) For pharmacist involvement in the discharge medication reconciliation process:
 1. Provider places pharmacy consult for discharge medication reconciliation.
 2. The responsible pharmacist will review medication list and discrepancies identified at the time of admission, and will compare to the current inpatient list of medications.
 3. The pharmacist will confirm the intended discharge medication regimen with the prescribing provider based on review of inpatient and outpatient medication use, as well as identified discrepancies.
 4. For medication discrepancies not able to be reconciled at the time of discharge (i.e. Medications managed by a specialty service or those outside of the providers' scope of practice), at a minimum a plan must be documented for reconciling the discrepancy. This can include recommending the patient follow up with the prescriber for clarification and/or alerting the prescriber to the discrepancy.
 5. The discharging provider will order new and changed outpatient medications, and will discontinue medications which are no longer indicated.
 6. The pharmacist will process new and changed medications for discharge.
 7. The pharmacist will include an updated outpatient medication list in the discharge medication reconciliation note. VA providers will have access to this list in CPRS.
 8. The providers discharge instructions will include the same complete and accurate updated outpatient medication list.

For patients being discharged to a setting which requires them or their family/caregiver to manage their medications, the medication list included in the discharge instructions should be written in patient-friendly language (void of SIG codes and medical abbreviations).
 9. The discharge instructions, with the updated medication list, are printed and provided to the patient prior to discharge by a staff member.
 10. The pharmacist will counsel the patient/caregiver on the updated list. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.
 11. For patients being discharged to a facility with supervised medication administration, the complete medication list is included in the discharge instructions and is sent to the patients receiving facility, either with the patient or via fax by assigned Social Worker.
 12. The patient will pick up discharge medications at the outpatient pharmacy.

- (b) For discharge medication reconciliation without Transitional Care pharmacist involvement (i.e. Outside of Transitional Care pharmacy service hours) the following modifications will be made to the discharge process described in the previous section:
1. Provider will review admission medication reconciliation note for list of medications and discrepancies identified at the time of admission, and will compare to the current inpatient list of medications.
 - (a) If an admission medication reconciliation note has not yet been completed, the provider will obtain information on the patient's medication list and actual use prior to hospitalization in accordance with section 3.d. above ("For patients being admitted to the hospital or community living center (CLC).")
 - (b) The responsible provider will evaluate discrepancies and document a plan for reconciliation.
 2. The provider will determine the intended discharge medication regimen based on review of inpatient and outpatient medication use, as well as identified discrepancies.
 3. The provider will order new and changed outpatient medications, and will discontinue medications which are no longer indicated.
 4. The providers discharge instructions will include a complete and accurate updated outpatient medication list. The list will highlight new, changed, or discontinued therapies, as well as the documented plan for resolution of discrepancies. VA providers will have access to this list in CPRS.
 - (a) For patients being discharged to a setting which requires them or their family/caregiver to manage their medications:
 - (1) The medication list included in the discharge instructions should be written in patient-friendly language (void of SIG codes and medical abbreviations).
 - (2) The provider, or a qualified designee, will counsel the patient/caregiver on the updated list. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.
 - (b) For patients being discharged to a facility with supervised medication administration, the complete medication list is included in the discharge instructions and is sent to the patients receiving facility, either with the patient or via fax by Social Work/Discharge Planner.
 5. The discharge instructions, with the updated medication list, are printed and provided to the patient prior to discharge by nursing staff.
 6. Patient will report to outpatient pharmacy for prescription processing and pickup.
- (c) For patients being discharged with no changes to their maintenance medication regimen, or for those whose changes only involve short term medications, the medication information provided to the patient in the discharge instructions may include only these medications.
1. For patients with no medication changes, the provider will document that patient should continue home medications as prior to admission in the discharge instructions.

2. For patients with only short term medication adjustments, the provider will order the new or changed outpatient medications.
 - (a) The discharge instructions, with the new medications included, are printed and provided to the patient prior to discharge by nursing staff.
 - (b) The provider, or a qualified designee, will counsel the patient/caregiver on the new short term medications. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.
 - (c) Patient will report to outpatient pharmacy for prescription processing and pickup.

Note: Medication reconciliation as described above should be completed regardless of discharge status (i.e. Regular release, Irregular Discharge, Against Medical Advice). Every attempt should be made to provide complete reconciliation services to all patients. In the event that a patient refuses to stay in the hospital for the complete discharge process, appropriate actions will take place to ensure the patient is provided with any necessary medications and an updated medication list. This may include alerting the PCP or PACT RN, as well as mailing medications and the medication list.

In all of the above described scenarios, the medication list included in the discharge summary must match that which was included in the discharge instructions.

g. Primary Care Clinics:

- (1) A complete and accurate medication history will be obtained and documented in CPRS for each patient. The provider, or another qualified designee (i.e. RN, Clinic/PACT Pharmacist, etc.), as assigned within each clinic setting, will be responsible for obtaining the medication history. A good faith effort must be made to interview the patient/caregiver whenever possible to determine actual medication use.
- (2) The provider will evaluate discrepancies and document a plan for reconciliation. Note: Addressing a medication discrepancy does not always require adjusting a medication order of managing a medication. Referral to appropriate service is acceptable.
- (3) At the end of the episode of care, the updated medication list is documented in the medical record, including changes relevant to the current episode of care and a documented plan to address the identified discrepancies.
- (4) Prescription orders are updated as necessary to maintain an accurate medication profile. This may include adjusting prescription orders based on identified discrepancies, ordering new or changed medications, discontinuing medications which are no longer being used, or maintaining the Non-VA section of the medical record with agents obtained outside the VA.
- (5) The updated medication list is provided to the patient.
 - (a) For patients with medication changes, the provider, or another qualified designee (i.e. LIP (Licensed Independent Practitioner), Pharmacist, etc.), will counsel the patient/caregiver on the updated list. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.

(b) For patients with only short term medication adjustments, the provider will order the new or changed outpatient medications. Written information on the short-term medications will be provided to the patient, and documented in the medical record.

1. The provider, or another qualified designee (i.e. LIP, Pharmacist, etc.), will counsel the patient/caregiver on the new short term medications. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.

(c) When no medication changes are made, and the next provider will have access to the medication list (in CPRS) there is no need to print a new medication list.

h. Specialty Clinics

(1) For clinic settings where minimal medications are used or prescribed, and carry little risk of duplication, omission, or drug interaction (e.g. topical fluoride in dentistry, infiltration work for dental work or wound suturing, contrast medium or enteric barium for imaging studies), reconciliation in this context simply means checking the patient's current medications and history of sensitivities and allergies to make an informed decision about the use of these minimal medications.

(2) Identified discrepancies will be documented in CPRS, along with a plan for reconciliation. Note: Addressing a medication discrepancy does not always require adjusting a medication order of managing a medication. Referral to appropriate service is acceptable.

(3) Prescription orders related to the reason for the visit are updated as necessary to maintain an accurate medication profile. This may include adjusting prescription orders based on identified discrepancies, ordering new or changed medications, discontinuing medications which are no longer being used, or maintaining the Non-VA section of the medical record with agents obtained outside the VA.

(4) At the end of the episode of care, the updated medication list is documented in the medical record, including changes relevant to the current episode of care and a documented plan to address other identified discrepancies.

(5) The updated medication list is provided to the patient, and the patient/caregiver is counseled on the updated medication list. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.

(a) For patients with only short term medication adjustments, the provider will order the new or changed outpatient medications. Written information on the short-term medications will be provided to the patient. (For example, name, dose, route, frequency, purpose).

1. The provider, or a qualified designee, will counsel the patient/caregiver on the new short term medications. The episode of counseling will be documented in the medical record, along with the patient/caregivers understanding of the education.

(b) When no medication changes are made, and the next provider will have access to the medication list (in CPRS) there is no need to print a new medication list.

i. Emergency Department

- (1) 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 inhibit the ability to gather this information upon the initial contact.
- (2) A good faith effort must be made to determine how patient is actually using medications, by assigned clinic staff. This should include drug names, dose, route, frequency, and indication.
- (3) The provider will evaluate discrepancies and document a plan for reconciliation. Note: Addressing a medication discrepancy does not always require adjusting a medication order of managing a medication. Referral to appropriate service is acceptable.
- (4) At the end of the episode of care, the updated medication list is documented in the medical record, including changes relevant to the current episode of care and a documented plan to address any identified discrepancies. This can include recommending the patient follow up with the prescriber for clarification and/or alerting the prescriber to the discrepancy.
- (5) Prescription orders are updated as necessary to maintain an accurate medication profile. This may include adjusting prescription orders based on identified discrepancies, ordering new or changed medications, discontinuing medications which are no longer being used, or maintaining the Non-VA section of the medical record with agents obtained outside the VA.
- (6) The patient is educated on all changes to medications, including new, changed or discontinued agents, with documentation of the education provided, and patients understanding of education in the medical record.
- (7) The updated medication list is provided to the patient.
 - (a) When no medication changes are made, and the next provider will have access to the medication list (in CPRS) there is no need to print another medication list.
 - (b) For patients with only short term medication adjustments, the provider will order the new or changed outpatient medications.
 1. The provider, or a qualified designee, will provide written information on the new short term medications. The information, along with the episode of counseling, will be documented in the medical record. The patient/caregivers understanding of the education will be documented as well.
 2. Patient will report to outpatient pharmacy for prescription processing, additional counseling, and prescription pickup.
- (8) If the patient is admitted to an inpatient unit through the emergency department, the full medication history and reconciliation procedure will commence as described above, in "For patients being admitted to the hospital or CLC".

j. Home Based Primary Care (HBPC)

- (1) Clinicians query patients about medication changes, use, new orders, errors, and/or compliance issues on admission (to HBPC) and each home visit thereafter. This includes looking at labels on ordered medication bottles and discussing dosages and frequency. Clinicians will also review patients' use of over-the-counter medications.

- (2) The provider will identify discrepancies and document a plan for reconciliation. Note: Addressing a medication discrepancy does not always require adjusting a medication order of managing a medication.
- (3) At the end of the episode of care, the updated medication list is documented in the medical record, including changes relevant to the current episode of care and a documented plan to address the identified discrepancies.
- (4) Prescription orders are updated as necessary to maintain an accurate medication profile. This may include adjusting prescription orders based on identified discrepancies, ordering new or changed medications, discontinuing medications which are no longer being used, or maintaining the Non-VA section of the medical record with agents obtained outside the VA.
- (5) The patient's medication list is updated at the home.
 - (a) When no medication changes are made, and the next provider will have access to the medication list (in CPRS) there is no need to print a new medication list.
- (6) The patient/caregiver is educated on all changes to medications, including new, changed or discontinued agents, with documentation of the education provided, and patients/caregivers level of understanding.
- k. Medication changes not associated with a clinic visit or hospitalization (i.e. Tele health, Phone consultations, etc.)
 - (1) Comply with procedures described above for medication reconciliation in outpatient settings.
 - (a) Prescription orders should be updated to reflect the new/changed/discontinued therapies, with typical procedure for mail out or prescription pickup (if needed urgently).
 - (b) An updated medication list is mailed to the patient.
 - (c) Medication counseling should be provided, with documentation of the education provided, and patients/caregivers level of understanding.

4. **REFERENCES:**

Joint Commission National Patient Safety Goals 03.06.01

VHA Directive 2011-012

VISN 2 Network Memorandum 10N2-232-14 VISN 2 Medication Reconciliation Policy

5. **RESCISSIONS:** None.

6. **FOLLOW UP RESPONSIBILITY:** Chief of Pharmacy ext. 65718

7. **REVIEW:** This SOP is scheduled to be reviewed on February 1, 2019.

8. **CONCURRENCE:** ECNS
ECMS
ADPNS
Chief of Staff