OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 242
VERSION: 4

SUBJECT/TITLE: **MEDICATION RECONCILIATION**

POLICY: Providers (physicians and nurse practitioners) shall adhere to medication reconciliation procedures to maximize safe medication practices at points of care and care transitions. Clinicians shall make a good faith effort to obtain accurate medication information from the patient and/or other sources and document this information in a useful way to those who manage medications.

PURPOSE: To enhance medication safety and minimize adverse drug events.

DEPARTMENTS: All

DEFINITIONS:

PROCEDURE:

1. INPATIENT:
    a. Admission: Responsible healthcare providers will record the current list of medications the patient is taking on admission. The list contains name, dose, frequency, and route, whenever possible based on the information available. The primary means for obtaining the list is the patient/parent/caregiver interview, the Electronic Medical Record (EMR), and any available outside records. The medication list will be reviewed and compared to admission orders written for duplications, omissions, and interactions.
    b. Transfers within the Hospital: for transfers within the hospital (e.g., transfers from one inpatient unit to another) medication reconciliation will be performed by the provider initiating the transfer **and/or** the provider receiving the transfer, as appropriate.
    c. Discharge: At the time of discharge, the practitioner compares the home medication list to the hospital medication list and decides which medications are to be stopped, continued, or modified, as reflected in the discharge medication list, discharge summary, and patient prescriptions. A copy of the list will be given to the patient/parent/caregiver, with instructions to bring it to all medical appointments and the importance of managing medication information is explained.

2. OUTPATIENT:
    a. Medication reconciliation will be performed at all face-to-face visits between a provider (physician or nurse practitioner) and a patient.
    b. A list of the patient's current medications will be obtained. The list

contains the name, dose, frequency, and route, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information is patient/parent/-caregiver interview, the EMR) and any available outside records.

c. The medications are documented and reviewed for duplications, omissions, and interactions. The healthcare provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter.
d. The provider updates the medication list to ensure any changes, including additions and deletions, to the medication list, are reflected in the list prior to the conclusion of the patient encounter.
e. If new medications are prescribed or changes made to the existing regime, the patient/family/caregiver is provided with the medication list and the importance of managing the medication list is explained.

3. PROCEDURAL AREAS:
   a. A list of the patient's current medications is obtained. The list contains the name, dose, frequency, and route, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information is patient/-parent/caregiver interview, the EMR, and any available outside records.
   b. The medications are documented and reviewed for duplications, omissions, and interactions. The healthcare provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter.
   c. The provider updates the medication list to ensure any changes, including additions and deletions, to the medication list are reflected in the list prior to the conclusion of the patient encounter.
   d. If the patient is an outpatient and new medications are prescribed, the patient/family/caregiver is provided with a medication list and the importance of managing the medication list is explained.
   e. If the patient is an inpatient, medication reconciliation procedures for inpatients are followed.

4. MEDICATION RECONCILIATION (OUTPATIENT) INVOLVES THE FOLLOWING STEPS:
   a. RN/LVN will review with the patient current medications and make updates in ORCHID as necessary.
   b. The provider (MD or NP) who evaluates the patient will complete medication reconciliation following the ORCHID workflow instructions (Attachment 1 & 2). Per these instructions the provider:
      i. Makes a determination to continue, stop, or refill medications for which such a determination is a component

of the specific visit. The ORCHID icon to "continue", "stop", or "refill" each medication appear as part of the medication reconciliation workflow in ORCHID (see Attachments 1 & 2).

ii. For medications for which there is no decision made by the provider to "continue", "stop", or "refill" as per the ORCHID workflow, the provider must still click on the buttons to "Acknowledge Remaining Home Medications" and "Sign", as per the ORCHID workflow.

iii. By selecting "Acknowledge Remaining Home Medications", the provider is not indicating the appropriateness of the medication(s) or dosage(s), as that would have been determined by, and remains the responsibility of, the initial prescriber. The provider is only responsible for determining whether a medication should be changed or held as a result of the visit or procedure.

References:
Joint Commission National Patient Safety Goal03.06.01, 2018
Institute for Healthcare Improvement: *Reconciling Medications in the Outpatient Setting.* November 16, 2017

References: National Patient Safety Goal 03.06.01	
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