# Centers Health Care

| | | | | |
|---|---|---|---|---|
| **POLICY:** | MEDICATION – RECONCILIATION | | **POLICY NO:** | **C-MED-14** |
| **Dept: Nsg** | CLINICAL OPERATIONS | ☐ **New** ☒ **Revised** | **Last Date Revised:** | 1/2020 |
| | | | **Prev. Date Revised:** | 4/16, 8/2019 |
| | | | **Creation Date:** | 4/2013 |
| **RELATED FORMS:** | | | | |

**POLICY:**

The Center will accurately reconcile medications of newly admitted residents to contribute to the creation of an accurate master medication list.

Medication reconciliation is a formal process of obtaining a complete and accurate list of each patient's current medications (including name, dosage, frequency, and route) and comparing the incoming admission, transfer and/or discharge medication orders to that list. Discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders. Any resulting changes in orders are documented. Use the designated form to list all prescription, non-prescription (OTC), herbal supplements, vitamins, patches, and inhalers either taken routinely or on an as needed basis.

**PROCEDURE:**

1. Medication reconciliation is completed any time an individual is admitted to the Skilled Nursing Facility (SNF). **This includes: New admissions, readmissions from home or hospital, respite stays, etc.**
2. When a patient or resident is admitted to the SNF, the list of all medications ordered upon admission to the SNF should be compared and reconciled with all other medications the individual was taking including:
    - Medications taken at home
    - Medications taken during the previous admission to the center (if readmitted)
    - Medications noted on the discharge summary
    - Medications identified by the individual or family member
    - Medications that were taken routinely or PRN
3. Substances to be included as "medications" include prescription, non- prescription or over the counter substances, herbal supplements, vitamins, patches, and inhalers that may potentially interact with prescribed medications.
4. Complete the medication reconciliation as follows

    - Designate whether reconciliation is a quality assurance exercise or part of the admission or readmission process
    - Review the medications needing to be reconciled by comparing the resident's hospital discharge orders, discharge prescriptions, hospital admitting orders, previous MAR and any medications reported by family, patient, medication bottles, and include dose, frequency, route, and PRN medications
    - It is not necessary to list all the medication orders with the reconciliation; list / compare only medications identified as having discrepancies.
    - Obtain the date and time of last dose if information is available
    - Indicate source of data using codes provided
    - For medications that do not match, indicate the element(s) that require review
    - Document the outcome of the review of each identified discrepancy in EHR, identify if the order is

continued, modified, or discontinued
- Designate whether there is an indication in the discharge summary to support the use of the medication ordered
- If there is no indication to support medication ordered, seek information from providers in hospital, community, physician, family, or patient, and document diagnosis or rationale on order sheet

5. Document the medication discrepancies in Resident's medical record. Document what actions were taken by the nurse to resolve the discrepancy
    - If the discrepancy was unresolved, document how the discrepancy was communicated to the charge nurse, physician, pharmacy, and/or next shift

6. Medication reconciliation will begin upon admission and re-admission
    - The medication reconciliation form will then be re- reviewed within 24 hours

7. Upon discharge from the Center, a final medication list will be provided to the patient or the patient's agent.
    - Provide education to the patient or resident and family member on medications, administration, and the importance of keeping an updated accurate medication list