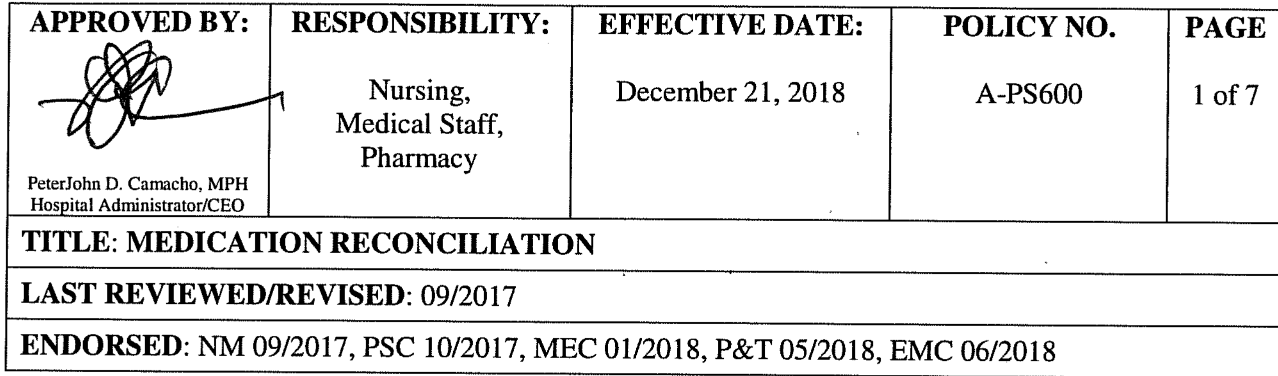
GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL



APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Nursing, Medical Staff, Pharmacy	December 21, 2018	A-PS600	1 of 7
TITLE: **MEDICATION RECONCILIATION**				
LAST REVIEWED/REVISED: 09/2017				
ENDORSED: NM 09/2017, PSC 10/2017, MEC 01/2018, P&T 05/2018, EMC 06/2018				

PURPOSE:

Medication reconciliation is an interdisciplinary process that compares the patient's most current list of home medications against the medical staff provider's orders, addressing discrepancies, thereby decreasing potential Adverse Drug Events (ADEs) and medication errors. The purpose of this policy is to provide guidance on the process for reconciling medications.

MEDICATION RECONCILIATION PROCESS:

1. Verification: Collection of current medication (home) listing.
2. Clarification: Making sure the medications and doses are appropriate
3. Reconciliation: Comparing new medications with the current medication listing and documenting the changes.
4. Transmit: Communicating the updated and verified list to appropriate caregiver, where applicable.

RESPONSIBILITY

MEDICAL STAFF PROVIDERS: It shall be the medical staff provider's responsibility to carefully review the patient's current medication listing prior to admitting the patient into the Hospital, or transferring the patient to another level of care. The medical staff provider shall communicate a resolution with the nurses or pharmacist when discrepancies in their medication order have been identified. At discharge, the attending medical staff provider shall review the patient's current medication listing, and communicate with the patient any changes in their pre-hospitalization medication listing.

NURSING & PROFESSIONAL SUPPORT STAFF: Licensed staff shall assess the patient's current medication listing and enter it into the iMED Home Medication section. Licensed staff shall review the patient's current listing against the ordered medications, communicate with the medical staff provider any discrepancies (omissions, duplicates, etc.), and document the resolved order in the Computerize Physician Order Entry section of the patient's electronic health record. Licensed staff shall update the patient's medication listing in the MAR. At discharge, licensed staff shall educate the patient on the discharge medication listing.

PHARMACIST: Upon the receipt of any medication order, the pharmacist shall review the order and identify any discrepancies (duplicates, contraindications, etc) with the patient's current medication listing, and communicate with the medical staff provider for a resolution (drug to drug intervention). Pharmacist must update patient's medication listing in eMAR via Computerized Physician Order Entry (CPOE). When there is CPOE system down time, Pharmacist must communicate to nursing any changes in the patient's medication order via the "Pharmacy to Nursing Communication Form" *(Attachment I)*.

POLICY:

1. Upon admission into the hospital via the Emergency Department or Urgent Care clinic, the patient's current medication listing shall be obtained and documented. The Medication Reconciliation process shall be initiated when medication(s) have been ordered for the patient during his/her admission or outpatient stay.

2. Upon making an appointment with other servicing departments (e.g., Special Services, Respiratory, Rehab Services, or Radiology), outpatients will be instructed to bring in a list of their current medications, over the counter as well as any vitamins, minerals, or herbal remedies to include dose, frequency, route, and indication.

3. An inpatient's current medication listing shall be obtained within 24 hours. If the patient cannot provide his/her current medication listing, the nurse shall obtain the information from reliable sources, such as the family member, caregiver, primary physician, and/or the outside pharmacy. If all attempts to obtain the patient's current medication listing have been unsuccessful within twenty-four (24) hours, documentation on all attempts shall be completed on the patient's notes.

4. An outpatient's current medication listing shall be obtained at the time of their visit. This list will be reviewed at each visit and updated as necessary.

5. In the event that the patient's condition is emergent and life-threatening, medication reconciliation will be completed when the patient's condition stabilizes—immediate care takes precedence.

6. The iMED Medication Reconciliation section will contain the patient's home, in-house and discharge medication listing for each stay.

7. During admission stay, the Medication Administration Record (MAR), or electronic MAR (eMAR) will serve as the patient's current medication listing.

8. At discharge, patients must be educated on the discharge medication listing and provided a copy of the listing.

PROCEDURE

I. INPATIENT ADMISSION

A. Upon admission, the admitting nurse is responsible to obtain the patient's current medication listing to include allergies and sensitivities, and enter it in the Optimum Medication Reconciliation tab, and Allergies section respectively. Information regarding the patient's current medications include: (a) Drug Name (b) Drug Dosage (c) Frequency of administration; (d) Route of Administration; and (e) the patient's last dose administration. The nurse is responsible for ensuring that medications are verified, and that there is a documented "yes" for verification under each medication.

B. The nurse compares the medication listing with the admitting medication orders. Any discrepancies (omissions, difference in dosage or frequency) shall be clarified and reconciled with the admitting medical staff provider.

C. The medical staff provider's order, through CPOE shall reflect any reconciled medications. The pharmacist is responsible to notify the medical staff provider of any other discrepancies (such as duplication, or drug incompatibilities) and reconcile the medications, or perform a drug intervention. When there is CPOE system down time, the pharmacist will complete the

"Pharmacy to Nursing Communication Form" *(see Attachment I)* and communicate with nursing the reconciled medications.

II. INPATIENT/INTERNAL TRANSFER

A. Upon initiating a transfer order, the medical staff provider reviews the patient's MAR/eMAR which serves as the patient's current medication listing. The medical staff provider shall reconcile which medications are to continue at transfer via Level of Care (LOC) application in CPOE Order Entry.

B. If the transfer order is to occur via telephone communication, the nurse shall communicate the current medication listing to the medical staff provider. The transfer orders shall include the listing of medications the medical staff provider indicates to continue at transfer via Level of Care (LOC) application in CPOE Order Entry.

C. The receiving nurse is to review the MAR, with the medication orders, and clarify any discrepancies and reconcile.

D. The charge nurse is responsible to continuously update the MAR to reflect the medication orders, and any other reconciled medications performed by the pharmacy that are documented via CPOE or "Pharmacy to Nursing Communication Form" (Attachment I).

E. For all discontinued medications in the MAR, the nurse must indicate discontinued, date/time, and nurse initials.

III. DISCHARGE HOME FROM INPATIENT UNIT

A. When the patient is discharged, medical staff provider reviews the patient's medication listing prior to admission (home medication listing), and the current medication listing (MAR/eMAR) and determines which medication is safe to continue at discharge.

B. The nurse will review the patient's medication listing and the MAR/ eMAR, with the discharge medication orders. Any identified discrepancies shall be clarified with the medical staff provider and reconciled.

C. During discharge instructions, the nurse shall review the discharged medication listing with the patient and/or the family member. A copy of the discharge medication listing shall be provided to the patient.

D. The nurse shall instruct the patient and/or the family member to bring the copy of the discharge medication listing to the follow up primary care visit, or a consulting visit. A copy of the discharge medication listing should also be provided to the Home Health Care Agency, if applicable. Discharge instructions should also include to update the medication listing when changes occur, and to always have with them a copy of the medication list in case of an emergency.

IV. TRANSFER TO ANOTHER FACILITY

A. If the patient is to be directly transferred to another treatment facility (SNU, Guam Behavioral Health and Wellness Center, Naval Hospital, Guam Regional Medical City, off-island transfer), a copy of the current medication listing (Medication Reconciliation or the MAR/eMAR) is to be included in the patient's record, which will follow the patient to the accepting facility. The nurse/medical staff provider shall endorse this current medication listing to the accepting facility.

V. OUTPATIENT

A. The list of patient's medications shall be documented in the Optimum Medication Reconciliation tab. *Exception regarding Emergency Room*: For patient seen initially through the Emergency Room, medication reconciliation can be found in the emergency department record. Medications given during the ER visit can be found in the emergency department record nursing notes.

B. In the event that the electronic health record system is down, medication reconciliation will be documented on the Medication Reconciliation Form for a single visit (see Attachment II) or the Multiple Visits Medication Reconciliation Form for multiple visits (see Attachment III).

C. If medication is to be administered to the patient during the outpatient visit, the medication reconciliation process shall continue and the registered nurse/technologist/therapist shall assess the date and time of the last dose that the patient administered his/her medication(s). Any medications that have a potential for a drug-to-drug interaction must be clarified and reconciled. This process and any changes made as a result must be documented.

D. At discharge, if there are any changes to the patient's current (home) medication listing, then the registered nurse/technologist/therapist shall review the discharged medication listing with the patient. A copy of the patient's medication listing shall be provided to the patient. The patient shall be instructed to bring the medication listing to his/her follow up primary care provider visit.

RESCISSIONS:

A-PS600, Emergency Department & Inpatient Admission, of the GMHA Administrative Manual made effective July 11, 2011.

A-PS610, Outpatient Medication Reconciliation, of the GMHA Administrative Manual made effective July 11, 2011.

ATTACHMENTS:

I. PHARMACY TO NURSING COMMUNICATION FORM
II. MEDICATION RECONCILIATION FORM
III. MEDICATION RECONCILIATION FORM—MULTIPLE VISIT

ATTACHMENT I

PHARMACY TO NURSING COMMUNICATION FORM

GUAM MEMORIAL HOSITAL AUTHORITY
PHARMACY DEPARTMENT
TEL.: 647-2255 FAX: 649-5507

PHARMACY TO NURSING COMMUNICATION FORM
(The form shall serve as a drug order intervention log sheet)

DATE: ____________ TIME: __________ PRESCRIBING PROVIDER: _______________________

PATIENT NAME: ____________________________ HOSPITAL #: ________ ROOM #: __________

The provider's order for ____

has been CHANGED/CLARIFIED by/with the provider to read as ________________________________

____

Reason for paging the provider:
☐ Non-formulary ☐ Not in-stock ☐ Dose too high ☐ Dose too low ☐ Wrong route
☐ Deviated Frequency ☐ Incompatibility ☐ Duplicate order ☐ Others (specify) ___________________

Pharmacist: _____________________________ _____________________________
Name (print) Signature/Date & Time

Nurse: _____________________________ _____________________________
Name (print) Signature/Date & Time

PHARMACY TO NURSING COMMUNICATION FORM
(The form shall serve as a drug order intervention log sheet)

DATE: ____________ TIME: __________ PRESCRIBING PROVIDER: _______________________

PATIENT NAME: ____________________________ HOSPITAL #: ________ ROOM #: __________

The provider's order for ____

has been CHANGED/CLARIFIED by/with the provider to read as ________________________________

____

Reason for paging the provider:
☐ Non-formulary ☐ Not in-stock ☐ Dose too high ☐ Dose too low ☐ Wrong route
☐ Deviated Frequency ☐ Incompatibility ☐ Duplicate order ☐ Others (specify) ___________________

Pharmacist: _____________________________ _____________________________
Name (print) Signature/Date & Time

Nurse: _____________________________ _____________________________
Name (print) Signature/Date & Time

ATTACHMENT II

MEDICATION RECONCILIATION FORM

☐ **NO KNOWN DRUG ALLERGIES**

Allergies	Reactions	Allergies	Reactions
1		3	
2		4	

Place a "x" if yes
○ Smoking
○ Breastfeeding
○ Pregnant
____ wks gestation

MEDICATIONS PRIOR TO VISIT ☐ **Patient does NOT have any home medication**

List all medications including nutritionals (vitamins), herbal supplement, pumps & patches

Medication Description (Name, Dose, Route, Freq)	Indication (Reason)	Last dose (Date/Time)	RESUME MEDICATION: ADMISSION		DISCHARGE		COMMENTS
			yes	no	yes	no	
		Licensed staff's initials (per attending physician's order)					

Not Original

Source: ☐ Patient ☐ Family ☐ Provided List ☐ Others: ____________________

☐ After 24 hours, unsuccessful attempts to obtain Home Medication Listing due to unreliable sources.

Medication Listing Retrieved and Transcribed by (Name & Title): ____________________ Date: __________ Time: __________

Signature: ____________________

☐ Medication Reconciliation is not applicable, there are no changes to patient's medication at discharge.
☐ Medication Reconciliation is not applicable, patient only prescribed short term medication, see Discharge prescription medication below
☐ Patient Admitted, see Home Medication section in iMED

DISCHARGE PRESCRIPTION MEDICATION (Name, Dose, Route, Frequency)	INDICATION	COMMENT

Discharge Instructions: You may continue the above medications, which is indicated "yes" under resume medications. Other medication may be prescribed to you at discharge, which your healthcare professional has discussed above. If you have any questions please contact your primary physician.
PLEASE BRING THIS FORM TO YOUR FOLLOW UP APPOINTMENT WITH YOUR PRIMARY CARE PROVIDER.

Acknowledged by:
Patient/Parent Signature: ____________________

Discharged by (Name & Title): ____________________
Signature: ____________________
Discharge Date: __________ Time: __________

Patient ID Label

Medication Reconciliation Form
GMHA FORM # 0581 STOCK # 990581
FORM REVISED: 08/2010
APPROVED DATE: NM 01/2011, PSC 02/2011, P&T 06/2011, HIMC 08/2010

ATTACHMENT III

MEDICATION RECONCILIATION FORM—MULTIPLE VISITS

ALLERGIES	REACTIONS	ALLERGIES	REACTIONS
1		3	
2		4	

Primary Diagnosis: ______________________

Operative/Procedural History: ______________________

____

PATIENT ID LABEL

MEDICATION LIST: List all medications including nutritionals (vitamins), herbal supplement(s), pumps, and patches.

Medication	Directions (Dose, Route, Freq.)	Indication							
		DATE							
		TIME							
		STAFF INITIAL							
		PATIENT INITIAL							

KEY CODE

A. Takes medications routinely as ordered
B. Not taking medications as ordered
C. Taking medications not ordered by physician
D. Medication discontinued (must document reason)

Directions: Review patient current medication listing per unit's protocol. Enter key code D, indicate reason for discontinuance of medication. The reconciled medication is to be reviewed with the patient based on the conditions indicated in the policy. **Have the patient sign their initials at the end of each visit to acknowledge that he/she understands what was reviewed**. The patient should inform the registered staff when any of the current medication listing was changed.

INITIAL	PRINT NAME & TITLE	INITIAL	PRINT NAME & TITLE	INITIAL	PRINT NAME & TITLE

Medication Reconciliation Form – Multiple Visits

GMHA FORM # 990583 STOCK # 990583
FORM REVISED: 07/2010
APPROVED DATE: PSC 02/2011, P&T 06/2011, MEC 07/2011, HIMC 07/2010

Not Original