

## Medication Reconciliation Across the Continuum of Care

Supplier	Input (Start)	Admission Process	Output (Stop)	Customer
Patient, Family, Admitting nurse, Pre-surgery nurse, ER Nurse Comm. And Hosp. Pharmacies, MD, Friend, EMS, Home health agency, LTC Facility, Other Facilities	Med Bottles, Brown paper bag, Patient intake form, Family (caregivers), Patient's med card, Previous facility records (medication list and H&P), Outpatient pharmacy records, Transfer records	Obtain, Verify, and Document Patient Home Medication List  <i>Upon admission from home or ED, (or other facility) <b>obtain and document</b> a complete and accurate list of medications that the patient currently takes at home. The organization is expected to demonstrate effort to achieve completeness; ideally before the first dose of any administered drug but must be completed within first 24 hours. High risk medications such as Insulin, Coumadin, opiates, should be reconciled within the first four hours of admission. Your policy should clearly list these medications. Also, obtain the date/time medications were last taken and patient's general adherence to the regimen.</i>	An accurate, consistent list of all home medications including prescription drugs, herbals, supplements, and over-the-counter medications (OTCs). The list includes dosage, frequency, date and time last taken; and is accurate given the suppliers and inputs that are available.	Physicians, Pharmacists, Nurses, Laboratory personnel, Patient, Caregivers— essentially all members of the health care team.
Admitting provider (physician, PA, NP)	An accurate, consistent list of all home medications including prescription drugs, herbals, supplements, and over-the-counter medications (OTCs). May also consider: Laboratory reports, X-Ray, ER reports, Signs/Symptoms, H&P	The admitting physician reviews the Medication List and Writes Orders to: 1) continue, 2) discontinue, or 3) modify each of the medications on the list. Fluid process each time order is written.  <b>Compare the current list of home medications to the list of ordered medications. Ultimately, the prescriber must consider each home medication and appropriately and consciously decide: 1) continue as is, 2) discontinue, 3) modify. The goal is to avoid conflicts and unintentional omissions.</b>	Accurate Orders	Pharmacy, Nurse, Unit Clerks, Consulting physicians

Pharmacist, Admitting provider, Nurse	Admitting medication orders, Patient specific data (H&P, ht, wt, age, laboratory data) Pharmacist knowledge, Allergy information, Computer software, Internet, Printed resources, PDR, Formulary, Nurse double-check	<b>Orders reviewed for appropriateness</b> (ideally by pharmacist)	Accurate orders that are appropriate for patient's height, weight, age, and physiological status	Physicians, Pharmacists, Nurses, Laboratory personnel, Billing, Patient, Caregivers— essentially all members of the health care team.
Pharmacy personnel, Nurse, Unit Clerk,	Accurate, appropriate admitting medication orders	<b>Medications transcribed to medication administration record (MAR)</b>	Accurate MAR	Physicians, Pharmacists, Nurses, Laboratory personnel, Billing, Utilization Review, Dietician
<b>Supplier</b>	<b>Input (Start)</b>	<b>Intra-facility Transfer Process</b>	<b>Output (Stop)</b>	<b>Customer</b>
Discharging unit	1) Current MAR from the discharging unit, 2) Most recent list of ordered medications from the admitting unit	<b>Admitting provider compares</b> the medications on the MAR used in the discharging unit to the list of ordered medications for the admitting unit. Ultimately, the prescriber must consider each medication and appropriately and consciously decide: 1) continue as is, 2) discontinue, 3) modify. The goal is to avoid conflicts and unintentional omissions that occur as a result of transfers.	Complete, accurate orders and MAR appropriate for the admitting level of care	Physicians, Pharmacists, Nurses, Laboratory personnel, Billing, Patient, Caregivers— essentially all members of the health care team.

<b>Supplier</b>	<b>Input (Start)</b>	<b>Discharge Process</b>	<b>Output (Stop)</b>	<b>Customer</b>
Discharging provider, Nurse	1) Most recent list of ordered medications the patient received on last day in hospital, 2) Discharge orders, 3) Accurate, complete list of home medications generated upon admission	<b>Discharging provider compares</b> the three inputs to decide: 1) continue medication as is, 2) discontinue medication, and 3) modify medication. The goal is to avoid conflicts and unintentional omissions; especially not resuming a previous home medication.	1) An accurate and complete list of medications the patient will take at home. The list is in form of a patient medication card, it is understandable to the patient/caregiver and without duplications or omissions. 2) Accurate and complete prescriptions for patient to take to next provider	Patient/caregiver; All subsequent providers including Nursing Home, Home Health Agency, Community pharmacist, primary care physician, specialists
Discharging providers	Reconciled discharge orders, Patient medication card to complete, Discharge prescriptions, Dose/frequency/reason why taking, Time with patient to complete education, Interpreter for language barriers	<b>Discharging provider(s) educate</b> patient or caregiver regarding dose, frequency, reason for taking, side effects, and previous home medications that were discontinued and need to be disposed of.	Educated patient/caregiver who understand an accurate patient medication card that provides each home medication name dose, frequency, reason for taking, potential side effects, and how to dispose of discontinued previous home medications	Patient/caregiver; All subsequent providers including Nursing Home, Home Health Agency, Community pharmacist, primary care physician, specialists

Discharging providers	Reconciled discharge orders	<b><i>Discharging provider(s) communicate a complete list of the patient's home medications by phone, fax, or mail to the next provider of service.</i></b>	All subsequent providers knowledgeable of patient's current home medications incorporating changes made during hospitalization.	All subsequent providers including Nursing Home, Home Health Agency, Community pharmacist, primary care physician, specialists
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## Medication Reconciliation Across the Continuum of Care—Discharge

<b>Supplier</b>	<b>Input (Start)</b>	<b>Process</b>	<b>Output (Stop)</b>	<b>Customer</b>

