PURPOSE:

1. To ensure timely, accurate and complete medication information is captured and documented to compare and compile a comprehensive list of the patient's medications against the physician's orders to communicate this information across the continuum of care, i.e., admission, transfer, referral, and discharge and address discrepancies, thereby:
   1.1. Reducing medication-related errors and potential adverse drug event (ADE) and adverse drug reaction (ADR), unintended changes or omission of medication therapy at all transition points, and;
   1.2. Improving patient safety and outcomes.

LEVEL:

All Nurses, Pharmacist, Physicians, Radiology Technician, Respiratory Technicians, Anesthesia Technicians and other Authorized Healthcare Providers of Riverside Medical Center, Inc. (RMCI)

DEFINITION OF TERMS:

Authorized Health Care Provider- for the purpose of this Policy, it includes Registered Nurses, Physicians, Registered Pharmacists, Radiology Technicians, Respiratory Technicians, Anesthesia Technician, and other designated clinicians by RMCI.

Discharge Medication List- the list of all medications the patient is to continue taking upon discharge. This is not an order, rather a complete list of continuing medications. This list should include all routine medications for the patient, including clinic-administered medications.

Medication- any prescription medications, including, inhalers, drops, sprays, ointments, patches, contraceptives; sample medications, herbal remedies, dietary

supplements, vitamins, nutraceuticals, over-the-counter (OTC) drugs, vaccines, diagnostic and contrast agents used on or administered to persons to diagnose, treat or prevent disease or other abnormal conditions; radioactive medications; respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. The definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

Medication Reconciliation (Med Recon)- the process of identifying and creating the most complete and accurate list of medications a patient is taking including medication name, dose, dosage, frequency, and route-and comparing that list against the admission, transfer, and/or discharge orders. The goal is to ensure that all correct medications are received by the patient and to prevent unintended changes or making changes to the orders including omissions, duplications, interactions and name/dose/route confusion. Other steps include updating the medication list, orders change during the episode of care and communicating the updated list to the patient and next known provider of care. It is also verifying, clarifying and reconciling the patient's most current list of medications against the physician order within 24 hours of admission.

Relevant patient care areas- For the purpose of this Policy, these are all areas where the patient's response to the care, treatment or service could be affected by the medications the patient has been taking, particularly those areas where medications are prescribed or administered, including Emergency Department (ED), Outpatient Department (OPD) Clinics, Retrieve Center, Dental Department, Endoscopy Unit, Diagnostic & Medical Imaging Department, Inpatient Units (IPU), Operating Room (OR)/Post Anesthesia Care Unit (PACU)/Recovery Room(RR), Procedure Rooms/Areas and Home Care Services (HHCS).

Timely Manner- As accurately and completely accomplished to the extent that information is available in the Medication Form within this timeframe:

- **Admission** – within 24 hours of admission; high risk medications must be reconciled within 12 hours of admission or prior to the next prescription or scheduled dose.
- **Non-emergent transfer** – within 4 hours of internal transition of care.
- **Emergent transfer** – within 2 hours of patient stabilization for nonessential medications required for continued care.
- **Discharge** – 24 hours prior to the actual discharge.

POLICY:

1. It is the policy of RMCI that all patient care areas prescribing and administering medications shall comply with the Med Recon process to maximize safe medication practices at continuum of care, e.i., admission, transfer, referral, discharge or end of care.

2. All heath care providers or prescribers shall reconcile patient medications within 24 hours at continuum of care utilizing the Med Recon Form. Under no circumstances shall orders be honored which apply a blanket reinstatement of prehospitalization medications (i.e., "resume home medications"). Telephone or verbal orders may be used to complete this process following approved RMCI Policy.
   2.1. A complete list of current medications, allergies, and medication sensitivities, including dose, route, frequency and any other key information shall be obtained and documented for each patient on admission at relevant patient care areas. A comparison of the current list with the medications ordered in RMCI is completed. Discrepancies are reconciled within specified time frames *(see Definition of Terms)*. This list shall be updated at all admissions and clinic visits whenever medications are prescribed, administered, or the response to the care or service provided to the patient could be affected by medications.

2.2. All new medications prescribed or administered shall be reconciled against this list during the patient's care and treatment. Inpatients transfer between services or levels of care have all medications reconciled. If a new medication is prescribed (or changes are made to the current regimen), the patient electronic medication list is then updated and a copy of the updated list is provided to the patient.

2.3. A complete list of medications shall be given to the patient upon discharge, and communicated to the next known health care provider or service when the patient is referred or transferred to another health care provider, service or level of care within or outside RMCI.

2.4. The only situations where a list of current medications does not need to be documented are those visits when a patient does not receive any prescriptions for medications, medications are not applied or administered, or when the care provided to the patient does not depend on the medications they are taking.

2.5. If a list of the patient's medications cannot be obtained from the patient because of the patient factors limiting their ability to provide this information at the time of the encounter, documentation of why this list could not be obtained must occur in the patient Med Recon Form.

2.6. In the outpatient setting, a list of current medications shall be obtained on patient intake and reviewed whenever a procedure is being performed where there may be a risk of a medication interaction.

2.7. A complete list of the patient's medication shall be communicated to the next health care provider when a patient is referred or transferred to another setting, service, health care provider or level of care within or outside RMCI. Reconciliation shall occur any time when orders are rewritten and any time the patient changes service, setting, health care provider or level of care and new medication orders are written.

2.8. During discharge, in addition to communicating an updated list to the next health care provider, the patient shall be provided a complete list of medications that he/she will be taking after discharge, as well as instructions on how long to continue taking any newly prescribed

medications. The patient is encouraged to carry the Discharge Summary Form and RN Discharge Notes to share this information with any health care providers.

2.9. In all settings, the patient's list of medications shall be updated and provided to the patient whenever a new medication is prescribed or recommended for the patient. The list shall also be provided directly either through documentation or other communication to the next known health care providers to the patient.

3. Patients and their families/caregivers, responsible physicians, nurses, pharmacists and other health care providers shall be involved in the Med Recon process.

4. The Inpatient Pharmacy Department shall audit the compliance of relevant patient care areas to the Med Recon process utilizing the best possible Medication Reconciliation Audit Tool.

APPROVAL:

	Name/Title	Signature	Date
Prepared by:	**MA. MADELYN N. LACSON, RPh., RN** Inpatient Pharmacy Supervisor		1/11/22
Verified:	**STEPHANIE CAMILLE O. SAMONTE, RPh.** Inpatient Clinical Pharmacist		1/11/22
	MIRIAM HOPE D. BRAVO, RPh. Inpatient Pharmacy Manager		1/11/22
Reviewed by:	**DENNIS C. ESCALONA, MN, FPCHA, FPSQua** Quality Assurance Supervisor		01/11/2022
Recommending Approval:	**PRINCESS M. ABELLON, MBA** Pharmacy Division Officer		1/11/2022
	HENRY F. ALAVAREN, MD, FPSMID, FPSQua Total Quality Division Officer		1/12/2022
Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		2/12/22

DOCUMENTATION:

New Policy

DISSEMINATION:

1. RMCI Hospital Communicator
2. Conducting hospital wide continuing education to all healthcare professionals.

REFERENCE:

1. Accreditation Canada Qmentum International Standards 2015.
2. Agency for Health Research and Quality (AHRQ): Medications at Transitions and Clinical Handoffs (MATCH) Toolkit (www.ahrq.gov/qual/match).
3. American Medical Association (2014). The Physicians Role in Medication Reconciliation. Retrieved from: www.ama-assn.org/resources/doc/cqi/medrec-monogragh.pdf
4. American Society of Health-System Pharmacists, Medication Reconciliation Basics
5. Central Board for Accreditation of Healthcare Institutions (2011.)
6. Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Alert, Issue 35, January 23, 2006; updated February 9, 2006.
7. Joint Commission Perspectives on Patient Safety, Volume 6, Issue 8, August 2006, performing medication Reconciliation in short-stay areas, Meeting National patient Safety Goal 8
8. Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Events (Medication Reconciliation). Retrieved from: www.ihi.org/knowledge/Pages/Tools/How to GuidePreventAdverseDrugEvents.aspx
9. Institute for Healthcare Improvement website includes section on medication Reconciliation Review, http://www.ihi.org/.
10. Institute for healthcare Improvement (2008). Reconcile medications at all transition points. Retrieved from,

http://www.ihi.org/knowledge/PagesChanges/ReconcileMedicationsatAllTransitionPoints.aspx

11. Institute for Safe medication Safety Alert, April 21, 2016, http://www.ismp.org/MSArticles/20050421.htm.
12. Safer Health Now! (2012). Medication Reconciliation: Getting Started Kits. Retireved from: www.saferhealthcarenow.ca/EN/interventions/medrec/Pages/default.aspx
13. USP Patient Safety CAPSlink, October 2005, United States Pharmacopeia http://www/usp.org/patientSafety/newsletters/capsLink/.

PURPOSE:

To discuss the steps in implementing the Medication Reconciliation (Med Recon) policy.

SCOPE:

All Pharmacy Division personnel of Dr. Pablo O. Torre Memorial Hospital

PERSON RESPONSIBLE:

Nurses, Pharmacists, Physicians and other Authorized Healthcare Providers

PROCEDURE:

1. Verification of the past and current medication is conducted by either the Responsible Attending Physician/Physician Resident-on-duty, Nurse-on-duty, or Clinical Pharmacist whoever is available on duty for all patients admitted to the In-patient unit of the Emergency Department and document on the Med Recon Form no later than 24 hours after admission.
2. A complete list of current medications, allergies, and medication related data and any other key information such as the patient's medication history and social history related to medication is obtained and documented for each patient on admission at the ER and at relevant patient care areas including the nursing stations using the Med Recon form.
3. Med Recon is performed by the healthcare provider available on duty, preferably by a clinical pharmacist. A comparison of the current list with the medications ordered in the hospital is completed.
4. The healthcare provider who performed the Med Recon for a patient must contact the attending physician or resident on duty for clarifications regarding discrepancies identified during the reconciliation.
5. The attending physician then decides whether to continue or discontinue medications upon the patient's admission or when a patient is transferred to another level of care.
6. The Med Recon list is updated at all admissions and patient care areas whenever medications are prescribed, administered, or the response to the care or service provided to the patient could be affected by medications.
7. All new medications prescribed or administered must reconcile against this list during the patient's care and treatment.
8. A complete list of medications is given to the patient upon discharge, and communicated to the next known health care provider or service when the patient is referred or transferred to another health care provider, service or level of care within or outside the hospital.

REFERENCE:

1. Accreditation Canada Qmentum International Standards 2015.
2. Agency for Health Research and Quality (AHRQ): Medications at Transitions and Clinical Handoffs (MATCH) Toolkit (www.ahrq.gov/qual/match).
3. American Medical Association (2014). The Physicians Role in Medication Reconciliation. Retrieved from: www.ama-assn.org/resources/doc/cqi/medrec-monogragh.pdf
4. Joint Commission on Accreditation of Healthcare Organizations, Sentinel Event Alert, Issue 35, January 23, 2006; updated February 9, 2006.
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6. Institute for Healthcare Improvement (2012). How-to Guide: Prevent Adverse Events (Medication Reconciliation). Retrieved from: www.ihi.org/knowledge/Pages/Tools/How to GuidePreventAdverseDrugEvents.aspx
7. Institute for Healthcare Improvement website includes section on medication Reconciliation Review, http://www.ihi.org/.
8. Institute for healthcare Improvement (2008). Reconcile medications at all transition points. Retrieved from, http://www.ihi.org/knowledge/PagesChanges/ReconcileMedicationsatAllTransitionPoints.aspx
9. Institute for Safe medication Safety Alert, April 21, 2016, http://www.ismp.org/MSArticles/20050421.htm.
10. Safer Health Now! (2012). Medication Reconciliation: Getting Started Kits. Retireved from: www.saferhealthcarenow.ca/EN/interventions/medrec/Pages/default.aspx
11. USP Patient Safety CAPSlink, October 2005, United States Pharmacopeia http://www/usp.org/patientSafety/newsletters/capsLink/.

APPROVAL:

	Name/Title	Signature	Date
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	MIRIAM HOPE D. BRAVO, RPh. Inpatient Pharmacy Manager		1/11/22
Reviewed by:	**DENNIS C. ESCALONA, MN, FPCHA, FPSQua** Quality Assurance Supervisor		1/11/2022
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Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		

DR. PABLO O. TORRE MEMORIAL HOSPITAL

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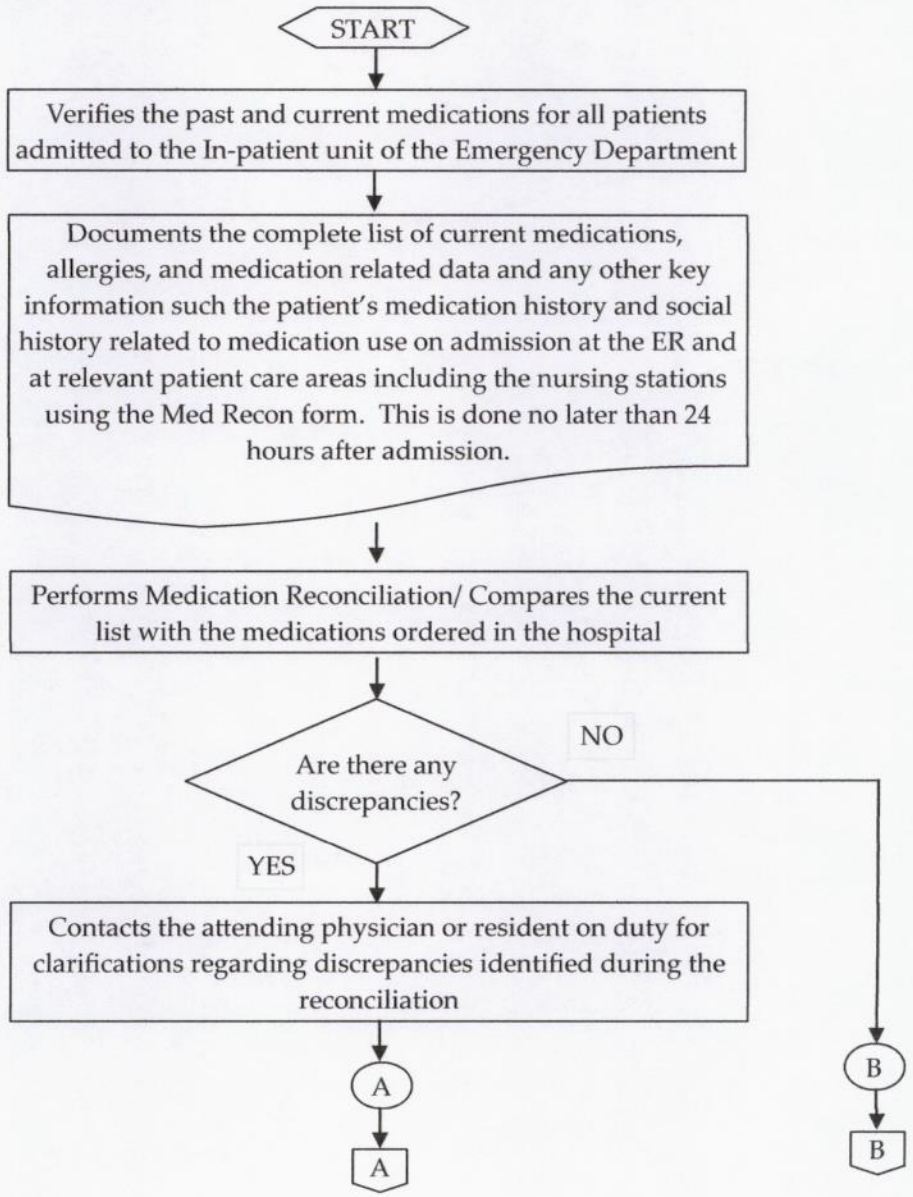
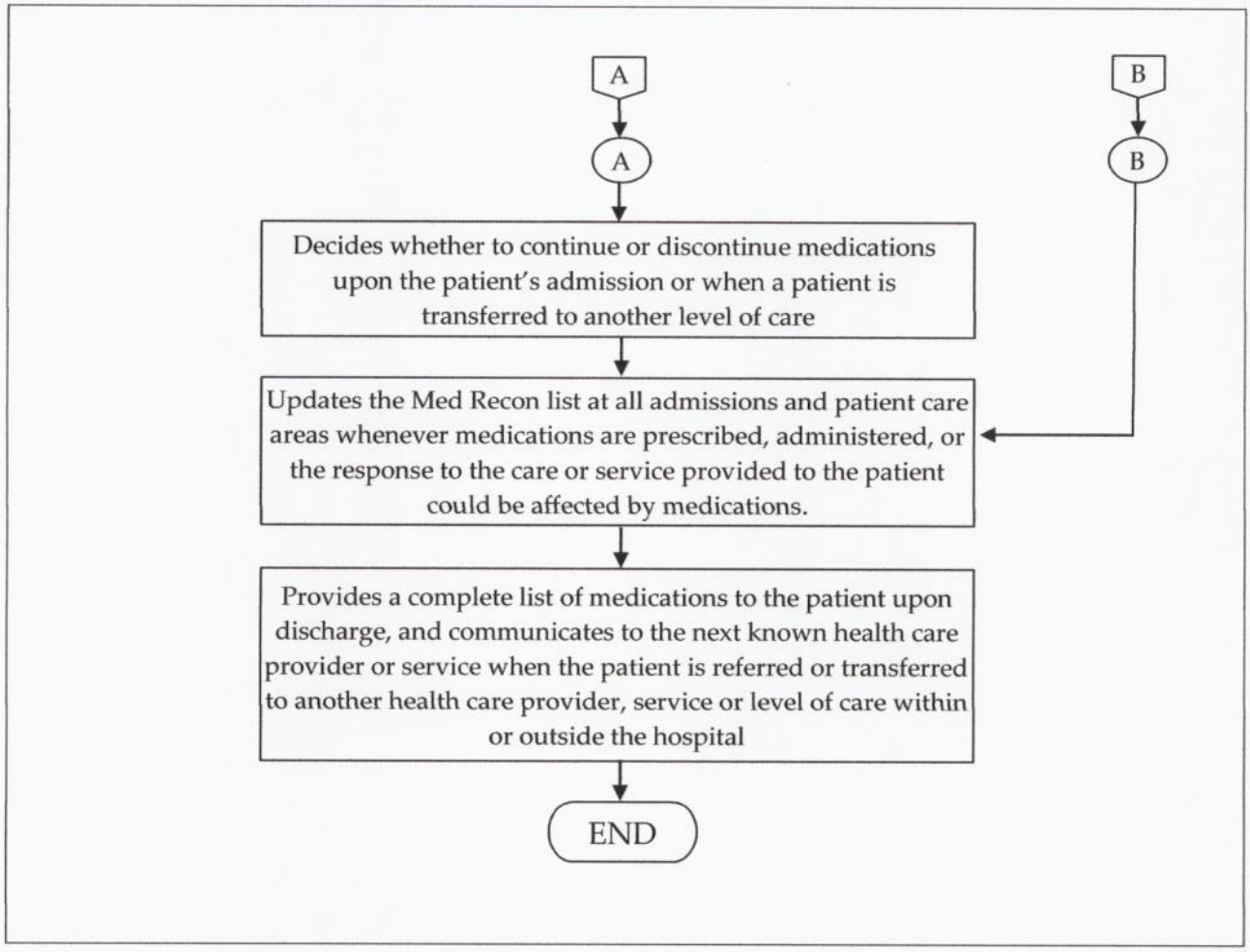
FLOWCHART





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Approved:	**GENESIS GOLDI D. GOLINGAN** President and CEO		2/12/22

KEY TASKS	PERSON RESPONSIBLE
1. Conducts verification of the past and Current medication	Can be the any of the following: Responsible Attending Physician, Physician Resident-on-duty, Nurse-on-duty, or Clinical Pharmacist whoever is available on duty
2. Obtains a complete list of current medications, allergies, and medication related data and any other key information such as the patient's medication history and social history related to medication using the Med Recon form.	Healthcare provider, preferably a Clinical Pharmacist
3. Performs Medication Reconciliation/ Compares the current list with the medications ordered in the hospital	Healthcare provider, preferably a Clinical Pharmacist
4. Contacts the attending physician or resident on duty for clarifications regarding discrepancies identified during the reconciliation	Healthcare provider who performed the Med Recon
5. Decides whether to continue or discontinue medications upon the patient's admission or when a patient is transferred to another level of care.	Attending Physician
6. Updates the Med Recon list at all admissions and patient care areas whenever medications are prescribed, administered, or the response to the care or service provided to the patient could be affected by medications	Nurse-on-duty or Clinical Pharmacist

7. Provides a complete list of medications to the patient upon discharge, and communicated to the next known health care provider or service when the patient is referred or transferred to another health care provider, service or level of care within or outside the hospital.	Nurse-on-duty or Clinical Pharmacist

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	Department/Section:	Pharmacy Division
	Document Title:	**MEDICATION RECONCILIATION**

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