OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 6: Patient Care **POLICY: 6.035**

SUBJECT: **Medication Reconciliation**

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I. POLICY

Every patient at Oregon State Hospital (OSH) shall have all of his/her medications reconciled at admission, transfer, and discharge. Medication reconciliation is an interdisciplinary process designed to decrease Adverse Drug Events and Potential Adverse Drug Events. An outcome of medication reconciliation is to maintain the most accurate medication list available for each patient, at all times.

II. DEFINITIONS

A. "Medication Reconciliation" means the formal process of creating a complete and accurate list of each patient's current medication at admission - including drug name, dosage, frequency, and route – and comparing that list against the physician's admission, transfer and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.

The process involves three steps:

1. Verification-Collection of the patient's medication history.

2. Clarification-Ensuring the medications and doses are appropriate.

3. Reconciliation-Documentation of changes in the orders.

B. "Adverse Drug Event" means a medication incident causing an injury, large or small. Preventing Adverse Drug Events or Potential Adverse Drug Events is the impetus behind the concept of medication reconciliation. The reconciliation process has been shown to be a

powerful strategy in the reduction of medication errors as patients move from one level of care to another.

C. "Potential Adverse Drug Event" means a medication incident causing no observable injury, including those discovered and corrected before reaching the patient.

D. "High-Risk Medications" means medications that have a higher risk of causing adverse drug reactions. Those medications include but are not limited to Antibiotics, Insulins, Antihypertensives, Antiarrythmics, Anticoagulants, Inhalers, Seizure medications, Narcotic medications, and Oral hypoglycemics.

III. PROCEDURES

A. Medication Reconciliation on Admission: Pre-admission medication information shall be obtained by the registered nurse (RN). If, during the process of completing the Psychosocial History and obtaining collateral information, the social worker receives information about a patient's previous medications, that information shall be communicated to the unit physician by the social worker.

1. The patient's medication history shall be obtained from the patient, referring outside facility, jail/correctional facility, family, primary care physician, or other reliable sources. Patients being transferred from another facility should be transferred with a current medication list that includes allergies and last dose given for each medication. For those patients who do not have this list, a phone call shall be made by the receiving nurse to the previous facility to obtain the current list of medications.

2. The physician shall complete the Admission Medication Reconciliation form which, when combined with the regular physician's order form, serves as a part of the admission orders. The admission reconciliation process shall be completed by the physician within 24 hours of admission. High-risk medications shall be reconciled within four hours of admission.

3. Instructions for reconciling medications at admission:

   a. Enter the source of information (check all that apply). Attempts must be made to obtain information from the patient. Ask the patient or family/caregiver(s) about the use of "Over-the-Counter" medications and herbal supplements. A good faith effort shall be made to obtain accurate

information about all of the patient's current medications. It is the patient's responsibility to share information with his current provider to the best of his/her ability.

b. Enter any known allergies.

c. Check the appropriate box if the patient is not on any Pre-Admission Medications.

d. For each column, enter information known from above sources.

1) Medication Name: Enter generic name if available or brand name of "Over-the-Counter" medication or herbal supplement.

2) Dose: Enter strength or total dose taken (i.e., "mg" or "# tablets").

3) Frequency: Enter how often taken.

4) Route: Enter route of administration, i.e., PO, IM, rectally, injection, topical, etc.

5) Date/Time: Enter the approximate or actual date/time the medication was last taken by the patient PRIOR to arriving at OSH, if known.

6) Oregon State Hospital prohibits the use of patient's own medications and allows only a limited number of nutritional supplements while admitted as an inpatient. Any medications or nutritional supplements that accompany the patient to the facility should be (1) sent home with family or significant others if possible/appropriate or (2) sent to the Pharmacy Department for proper destruction.

7) Oregon State Hospital includes only a limited number of nutritional supplements as part of the medication formulary; specifically, only those for which there is medically credible evidence for patient safety and efficacy. Requests for nutritional supplements not included in the OSH formulary shall be treated as Non-Formulary requests with the exception that they shall not be procured and made available for patient administration immediately. Rather, availability of

these nonemergent items shall be delayed until the Pharmacy and Therapeutics Committee meets and considers each individual request.

4. All listed medications must have a checkmark in the appropriate box indicating to continue, discontinue, or write a new order. The physician shall write new medication orders at the bottom of the Admission Medication Reconciliation form. If the form does not allow enough space for all medications, additional copies shall be attached so all medications can be listed. At the bottom of the Admission Medication Reconciliation form the physician must sign and fill in the date and time of completing the form.

5. The RN shall ensure that all pre-admission medications have been checked by the physician and shall transcribe all prescribed medications to the Medication Administration Record (MAR). The RN shall check the appropriate box if the patient brought medications to the hospital. If yes, the RN shall check the appropriate boxes for either sending medications home or to the Pharmacy. The RN shall enter the date and time when sent. At the bottom of the Admission Medication Reconciliation form, the RN must sign and fill in the date and time of completing the form.

6. The original of the Admission Medication Reconciliation form shall be placed in the Physician Orders section of the Medical Record prior to admission orders, and is not thinned. A copy of the form shall be sent to the Pharmacy for profiling and filling, along with the physician's admitting orders.

7. The pharmacist shall ensure that all pre-admission medications have been checked on the Admission Medication Reconciliation form by the physician. The pharmacist shall check for medication appropriateness and interaction and notify the prescriber of any inconsistencies. The pharmacist shall check the appropriate box at the bottom of the Admission Medication Reconciliation form to confirm that any medications and/or "Over-the-Counter" medications/vitamins/supplements sent to the Pharmacy for the patient in question were destroyed. If yes, the pharmacist shall indicate when the items were disposed of. Under no circumstances shall the Pharmacy maintain or otherwise store medications brought in by a patient. At the bottom of the Admission Medication Reconciliation form, the pharmacist must sign and fill in the date and time of completing the form.

8. Once the initial Admission Medication Reconciliation form is sent to the Pharmacy and new information is received, changes/additions can be made in two ways:

   a. If the new information is received within 24 hours of admission, the physician shall complete a new Admission Medication Reconciliation form indicating that it is a revision to the previous form. The physician shall write "revised" on top of the form. The revised form shall be processed as above, with the original being placed in the Physician Orders section of the Medical Record and the copy being sent to the Pharmacy.

   b. If the new information is received after the initial 24 hours following admission, a revised Admission Medication Reconciliation form is not required. The physician shall indicate any changes/additions to medications on the standard Physician's Orders form and write a progress note to document these changes/additions.

B. Procedure for Handling Patient's Own Medications/Nutritional Supplements: Oregon State Hospital does not allow the administration of patient's own medications/nutritional supplements. Medications brought in with patients should either be sent home with family/significant others or conveyed to the Pharmacy Department for disposal.

C. Procedure for Handling Non-Formulary Medications:

1. Orders for investigational drugs must be limited to prescribers authorized to order the investigational medication and shall be considered on a case-by-case basis. The Director of Pharmacy or designee shall consult with the Chairman of the Pharmacy and Therapeutics Committee and the Institutional Review Board to consider each investigational drug request. Investigational drugs may not be used within the facility until and if approval is granted.

2. Unit or clinic physicians seeking formulary alternatives or with questions about medication or nutritional supplements are encouraged to consult one of the OSH pharmacists.

3. The pharmacy shall review the product for safety and potential interactions with patient's other medications.

4. The pharmacist has the sole discretion to determine the suitability of the product for use within OSH.

D. Medication Reconciliation after Outside Facility/Provider and Service: Upon return from an outside medical facility that results in a medication change, medication reconciliation must occur in the following manner: the attending physician must review the medications from the other provider and compare those medications to the patient's most recent medication review within four hours; this four-hour review must be done in person. After business hours the RN shall review any new medication orders from the outside medical facility and notify the on-call physician. If the on-call physician accepts the new medication orders, the physician must complete the medication reconciliation process within four hours as per policy. High-risk medications (as defined on page 2) shall be carefully reviewed and new orders be written if there are any changes required. The physician shall write a physician's progress note indicating that all medications have been reconciled.

E. After Business Hours Access to Medication Lists for Patients: When a patient returns from an outside medical service or is transferred after business hours, the attending physician shall call the Communications Center and request that a current medication list shall be sent to a designated printer in the Communications Center to ensure that a full medication review is being completed within four hours.

The same procedure applies to the Portland campus. The attending physician shall call the Communications Center and request that a current medication list shall be sent to a designated printer in Portland (across the hall from the P1A nursing supervisor's office).

F. Medication Reconciliation on Transfer: Upon transfer from one unit to another, the current MAR shall accompany the patient. The physician of the receiving unit, or psychiatric on-duty physician (POD), shall review high-risk medications within four hours. High-risk medications (as defined on page 2) shall be carefully reviewed and new orders shall be written if there are any changes required. Complete medication reconciliation must be done within 24 hours of transfer. The physician shall write a note in the physician's progress notes that the medications have been reconciled. Transfer orders with "continue previous meds" shall not be accepted. The physician of the receiving unit may use the medication review on transfer (reconciliation) as replacement of the required monthly medication review.

G. Medication Reconciliation on Discharge: The physician shall compare the discharge medication orders with the medications the patient is currently receiving, the medication review, or the Admission Medication Reconciliation form as appropriate, depending on the length of stay of the patient. The Discharge Plan Details form shall be filled out by the

physician and social worker. The physician shall indicate by checking the appropriate box on the form that all medications have been reconciled on discharge. The list of discharge medications shall be attached to this document and sent to the next provider of care. The patient shall receive a copy of the Discharge Plan Details form and the list of discharge medications. A copy of the Discharge Plan Details form and list of discharge medications shall be placed in front of the patient's Medical Record. Clear instructions on the discharge medications shall be given to the patient to avoid misunderstanding. The patient shall be informed that some medications may be discontinued that he/she had taken at home prior to admission, that some medications may continue that have been ordered during hospitalization, and that some new medications may be added as discharge orders. The patient may request to speak directly with a pharmacist to discuss questions they have regarding their medications. In addition, the patient shall be given written drug information leaflets by the Pharmacy that contains specific instructions about each individual discharge medication. Information is also given about precautions, i.e., what to do if doses are missed and who to notify if certain problems arise.

The RN shall check the physician's medication review orders against the prescription orders/and or discharge medication lists for accuracy. The RN shall report any differences to the physician. The Pharmacy shall notify the unit of the availability of discharge prescriptions. In general, discharge prescriptions shall only be made available two hours before discharge and should be returned to the pharmacy if the patient's discharge is delayed by more than two hours. If the discharge medications contain controlled substances, the RN receiving the medications shall be required to sign for receipt of same and is also responsible for returning medications to the Pharmacy in the event that discharge plans are delayed or cancelled. As soon as the discharge medications are sent from the Pharmacy, the RN shall verify the medications for accuracy, the correct amount being sent, dosages, frequency, and times. Any differences shall be reported to the Pharmacy.

H. Monitoring Medication Reconciliation: Compliance with The Joint Commission National Patient Safety Goal 8 shall be monitored by the Quality Improvement (QI) Department. The QI Department shall audit random medical records to check for completion of the Medication Reconciliation form within 24 hours of admission, a physician's note on the receiving unit indicating a review of medications and reconciliation of medications following any transfer, and completion of the Discharge Plan Details form documenting medication reconciliation at the time of discharge. A minimum of 70 cases shall be reviewed annually. Results of audits shall be reviewed in the Medical Department Continuous Quality

Improvement Committee (MDCQI) and shall be communicated to Administration and Program Directors.

IV. REFERENCES

The Joint Commission, Comprehensive Accreditation Manual for Hospitals, 2010, National Patient Safety Goal 8

Replaces Oregon State Hospital Policy and Procedure 6.035, *Medication Reconciliation*, dated 4/30/2007.