Name of Policy: Medication Reconciliation **Policy Number**: 3364-100-70-15 **Approving Officer**: Chief Executive Officer, Chief of staff **Responsible Agent**: Chief Executive Officer, Director of Pharmacy **Scope**: University of Toledo Medical Center Hospital Administration	UTOLEDO HEALTH **Effective date: 02/24/2025** **Original effective date**: 03/26/2008
Key words: Medication, Reconciliation, Medication List, Duplication, Errors	

☐	New policy proposal	X	Minor/technical revision of existing policy
☐	Major revision of existing policy	☐	Reaffirmation of existing policy

(A) Policy statement

The University of Toledo Medical Center (UTMC) will reconcile medication information to maintain and communicate accurate patient medication information.

(B) Purpose of policy

Medication reconciliation is an interdisciplinary process involving the medical, pharmacy, and nursing staff. The process is designed to decrease medication drug related problems, as well as generate the most accurate medication list available, especially at the transitions of care.

Medication reconciliation will be performed to clarify any discrepancies between the patient's actual medication regimen and those ordered. This will allow the medical provider to review the information and order the appropriate medications and dosages for patients while under their care.

(C) Definitions

(1) Medication Reconciliation: a process for reviewing the patient's current medications for duplications, omissions, and interactions while also comparing the patient's current medications with those medications ordered for the patient while under the care of the organization to identify and resolve any discrepancies.

(2) Medication: any prescription medication, sample medication, herbal remedy, vitamin, nutraceutical, vaccine, or over the counter drug; diagnostic and/or contrast agent used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications, respiratory therapy treatments including oxygen, parenteral nutrition, blood derivatives, and intravenous solutions (plain, with electrolytes and/or drugs); and any product

designated by the Food and Drug Administration (FDA) as a drug. This definition does not include enteral nutrition solutions (which are considered food products), and other medical gases.

(3) Reverse Reconciliation: a modification of the medication reconciliation process in which information is only obtained for specific medications/classes of medication deemed relevant to the current service being provided

(D) Procedure

Upon the patient's admission or presentation and with the involvement of the patient or designee, a list of the patient's current medications is obtained and documented in the patient's health record. Medications ordered for the patient while under the care of the organization are compared to those on the list. The complete list of active medications is provided to the patient/parents/caregiver on departure at the end of the encounter.

1. Inpatient

(a) A list of the patient's current medications is obtained. The list contains the name, dose, frequency, route, and last known dose, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information may include:

(i) Patient/parent/caregiver interview
(ii) Review of self-completed or patient-provided medication list
(iii) UTMC Health Medical Record
(iv) Outside medical or pharmacy records
(v) Surescripts database resource

(b) Patient height, weight, allergies and pregnancy and lactation status is also recorded.

(c) The medications are documented by a qualified individual and reviewed for duplications, omissions, and interactions. This becomes the pre-admission medication list. Examples of qualified individuals include physicians, physician assistants, nurse practitioners, nurses, pharmacists, or designees under their supervision.

(d) The provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter

(e) Upon transfer of care from one acute level of care to another, the receiving provider reviews the current inpatient medications and the home medications ordering the appropriate medications for the new level of care.

(f) At the time of discharge, the provider compares the home medication list to the hospital medication list and decides which medications are to be stopped, continued, or modified, as reflected in discharge medication list, discharge summary, and patient prescriptions.

2. Ambulatory

(a) A list of the patient's current medications is obtained. The list contains the name, dose, frequency, and route, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information may include:

(i) Patient/parent/caregiver interview
(ii) Review of self-completed or patient provided medication list
(iii) UTMC Health Medical Record
(iv) Outside medical or pharmacy records
(v) Surescripts database resource

(b) Patient height, weight, allergies and pregnancy and lactation status is also recorded.

(c) The medications are documented by a qualified individual and reviewed for duplications, omissions, and interactions. Examples of qualified individuals include physicians, physician assistants, nurse practitioners, nurses, pharmacists, or designees under their supervision.

(d) The provider updates the medication list to ensure that any changes, including additions and deletions, to the medication list are reflected in the list prior to the conclusion of the patient encounter.

(e) If new medications are prescribed or changes are made to the existing regimen, the patient/family/caregiver is provided with the medication list.

3. Procedural Areas

(a) A list of the patient's current medications is obtained. The list contains the name, dose, frequency, route, and last known dose, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information may include:

(i) Patient/parent/caregiver interview
(ii) Review of self-completed or patient provided medication list
(iii) UTMC Health Medical Record
(iv) Outside medical or pharmacy records
(v) Surescripts database resource

(b) Patient height, weight, allergies and pregnancy and lactation status is also recorded.

(c) The medications are documented by a qualified individual and reviewed for duplications, omissions, and interactions. Examples of qualified individuals include physicians, physician assistants, nurse practitioners, nurses, pharmacists, or designees under their supervision.

(d) The provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter

(e) If the patient is an outpatient and new medications are prescribed, the patient/family/caregiver is provided with the mediation list and the importance of managing the medication list is explained.

(f) If the patient is an inpatient, medication reconciliation procedures for inpatients are followed.

4. Modified Medication Reconciliation Areas

(a) The default medication roster in all settings is the "Comprehensive" medication list. It includes the name, dose, frequency, route, and last known dose for all the patient's medications.

(b) UTMC may identify specific Modified Medication Reconciliation (MMR) areas in which collection of a 'comprehensive' medication list is not required.

(c) The MMR areas include those Ambulatory and Procedural areas in which
(i) Medications are not routinely prescribed or administered and/or
(ii) Patient safety is not compromised by use of a "Selective" medication list.

(d) The "Selective" medication list allows for the collection of less information than that required by the "Comprehensive" medication list method and is medically appropriate in these settings or situations.

(e)The "Selective" medication reconciliation method may include:
(i) Collection of drug name only or a combination of 1 or 2 additional elements from the "Comprehensive" medication list
(ii)use of reverse reconciliation, or
(iii) collection of no medication list.

Approved by: _____ Daniel Barbee Chief Executive Officer _____ Date _____ Puneet Sindhwani MD Chief of Staff _____ Date *Review/Revision Completed by:* *Lindsey Eitniear, Acute Care Pharmacy Director*	**Policies Superseded by This Policy:** • *3364-101-06-09* Initial effective date: 03/26/2008 All Review/Revision Dates: 9/24/2008 10/15/2008 10/1/2010 9/1/2011 1/1/2012 4/1/2014 5/1/2017 3/1/2020 8/13/2023 Next review date: