Name of Policy:	**Medication Reconciliation**
Policy Number:	3364-100-70-15
Department:	Hospital Administration
Approving Officer:	Chief Executive Officer Chief of Staff
Responsible Agent:	Chief Executive Officer
Scope:	The University of Toledo Medical Center and its Medical Staff

THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Effective Date: 3/1/2020
Initial Effective Date: 3/26/2008

_____ New policy proposal	_____ Minor/technical revision of existing policy
_____ Major revision of existing policy	__x__ Reaffirmation of existing policy

(A) Policy Statement

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 staff, pharmacy staff, 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) Procedure Inpatient

1. UTMC will obtain information on the medications the patient is currently taking when the patient is admitted to the hospital.

   a) The medication history may be obtained from the patient and/or family members who are present at the time of initial contact. If the patient or family is able to provide accurate data no additional source of information is required. If it is determined the patient and/or family members are not reliable or available, then an effort must be made to verify that the list is as accurate as possible. In those cases when patient and family are not considered to be a reliable source of information, alternative sources must be utilized.

   b) The medication history will be collected to the best extent possible including: height, weight, allergies, pregnancy and lactation status, current list of all medications, dosage, frequency, and date/time of last dose prior to admission or event taking place. The home medication list will be confirmed in the clinical portal or recorded manually in areas without an electronic medical record.

2. A qualified individual will compare the medication information provided above with the medications ordered for the patient while in the hospital in order to identify and resolve discrepancies. All Medications listed in the history are reviewed by the medical provider and ordered as indicated: pharmacy and nursing should question all unclear discrepancies. Examples of qualified individuals include physicians, physician assistants, nurses, pharmacists, or designees under their supervision.
3. Upon transfer of care from one acute level of care to another, the medical provider reviews the current inpatient medications and the home medications ordering the appropriate medications for the new level of care.
4. Upon discharge, medications will be individually reviewed by the discharging provider electronically or on paper.

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(D) For non-admitted patients:

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1. Emergency Department:
   A list of home medications needs to be obtained so the provider will know what the patient is currently taking at home. This includes prescription medications, over-the-counter medications, herbals and supplements.

(Minimally obtain name of medication, dose and frequency – within the patient's ability to recall. Encourage patients to bring medication bottles to all appointments. The patient's home pharmacy can be called if the provider must know medication information unknown to the patient in order to provide treatment or order prescriptions.)

2. Invasive Outpatient procedures/Sedation procedures
   A home medication list needs to be collected so the health care providers are aware of the medications the patient is currently taking.

3. *General procedures*
   Standard x-ray procedures, e.g. chest x-rays, x-rays of extremities ordered by outpatient physicians, etc. do not require a home medication list.
4. General Lab procedures, PT/OT/Speech Therapy,Pulmonary Function Testing:
   Do not require a home medication list.

E: Out-patient Process:

1. When a list of the patient medications is to be obtained: at minimum, the name of the medications should be listed.
2. When only short-term medications are prescribed at discharge, the patient / family will be given a list of only the short-term medications. Examples of short-term medications are antibiotics, analgesics and muscle relaxers for acute injuries, etc.
3. If there are any concerns that the patient/family does not understand the full list of medications the patient should be taking, a full medication list should be provided for patient education purposes.
4. If changes are made in a patient's long-term medications, e.g. anti-hypertensives, anti-depressants, etc., including change in dosages, additions or deletions, a full medication list must be given to the patient.
5. In the outpatient setting, a complete, documented medication reconciliation process is used when:
   a) Any new long-term medication is being prescribed.
   b) There is a prescription change for any of the patient's current, known long term medications.

References: NPGS.03.06.01

Approved by:		**Review/Revision Date:**
		9/24/2008
		10/15/2008
/s/	02/24/2020	10/1/2010
Daniel Barbee MBA, RN, BSN, FACHE	Date	9/1/2011
Chief Executive Officer		1/1/2012
		4/1/2014
		5/1/2017
/s/	02/27/2020	3/1/2020
Samer Khouri MD	Date	
Chief of Staff		
Review/Revision Completed By:		
HAS		
Nursing Pharmacy Committee		
Chief of Staff		**Next Review Date:** 3/1/2023

Policies Superseded by This Policy: 3364-101-06-09

It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.