

NPS Goal 3.06.01 FAQ's: Medication Reconciliation

1. What is medication reconciliation?

Medication reconciliation is the process of:

Developing a list of medication that the patient is currently taking and comparing the medications on this list with those being ordered, prescribed or changed to ensure that there are no errors of transcription omissions, duplication of therapy, drug-drug and drug-disease interactions. A new medication list must be provided to the patient at discharge or when their chronic medications are changed during an outpatient encounter and the patient should be advised to carry their list at all times and to share it with their healthcare providers.

2. Why is this goal important?

This goal is important because it helps to prevent medication errors and potential or actual harm to patients.

3. Does this goal only include inpatients?

No. This goal applies to patients who are admitted and to patient's seen in the outpatient, ambulatory or procedural settings.

Inpatient Settings and Emergency Department Observation:

4. What is the MGH process when the patient is admitted?

- Within 24 hours of admission, the admitting clinician uses many sources to generate the Preadmission Medication List (PAML). These resources may include: the patient, caregiver, electronic records, etc.
- The nurse reviews and verifies the list with the patient, edits the PAML and communicates any discrepancies to the admitting clinician
- The pharmacist reconciles all ordered medications with the PAML medications to ensure accuracy of drug, dose, frequency and route and to ensure that there are no omissions, duplications and other errors.

5. Is it necessary to reconcile medications upon admission for a patient in labor who is NPO except for sips of water until she delivers? Can the medications just be reconciled after delivery?

A list of the patients pre-admission medications should be built at the time of admission and no later than 24 hours after admission. If the patient in labor has received prenatal care at MGH, the list should already have been obtained and included in the prenatal record. If not, it should be obtained as soon as possible. After-the-fact reconciliation is not acceptable unless the urgency to treat the patient precludes prospective reconciliation.

6. What is the process when a patient is transferred within the hospital?

The clinicians transferring and receiving the patient should review the PAML when writing transfer orders and the pharmacist reconciles the new orders with the PAML to ensure there are no omissions, duplications or other errors.

7. What is the process at discharge?

- The discharging physician compares the PAML with current active medications and builds a discharge medication list by indicating for each PAML medication and each

current medication whether it should be continued, discontinued or changed when the patient is discharged from the hospital. This process automatically generates a Patient Discharge Medication List (PDML) which will instruct the patient on what to take when they leave the hospital. The PDML includes notes for patients highlighting which medications are “new”, changed in dose or frequency or which preadmission medications should be “Stopped.”

- The nurse reviews the PAML and discharge medication list and communicates any discrepancies to the physician. The nurse then reviews the PDML with the patient and instructs them on how to take their discharge medications. The nurse reminds the patient to share the PDML with their PCP and other caregivers and to carry it at all times in case of an emergency.
- The list is included in the Post-hospital Care Plan and is given to the patient.

8. What if the patient is discharged to another health care facility?

The PDML (Patient Discharge Medication List) is given to each patient even those discharged to other health care facilities and is included in the Patient Care Referral Forms.

9. How can I find out how the nurses on my unit are doing with reconciliation?

On the inpatient units you can find out in two ways

1. Your Nursing Director gets a quarterly report
2. At any given time, you can find out in CAS which patients on your unit have a completed PAML. To do this: click CAS→Orders→Tools →Reports→PAML activity. In the left hand column, click on your unit, then click Display PAML Activity.

10. Where can I find the MGH policy that addresses Medication Reconciliation?

See *Medication Reconciliation*, in the Clinical Policy and Procedure Manual which is on-line.

Outpatient, Ambulatory and Procedural Settings:

11. What is the process for patients who are having an outpatient procedure and their new prescription is to be taken for only a short duration e.g. antibiotics?

In this situation, a modified reconciliation process may be followed. The patient’s current list is compared with those to be administered. If there are no changes and only short term medications are prescribed, the clinician only needs to provide information about the new medication.

12. What is the MGH process for establishing an accurate Medication List for outpatients?

For patients who are seeing a provider with whom they will likely be establishing a longer term relationship, staff in practice will initiate the medication list in the EMAR medications module (Shared medication list) at the earliest possible time, preferably at the first visit and no later than the third. (This applies to both PCPs and Specialists) This responsibility includes making a good faith effort to resolve uncertainties or disputes regarding the appropriateness, dose, or other discrepancies.

13. Who uses and maintains the outpatient medication list?

The information in the list is shared by all providers. Each provider who prescribes and manages the patient’s medications is responsible for adding the medications they prescribe to the medication list within EMR. Each provider is also responsible for assuring the accuracy and upkeep of the medication list within EMR. Specialists are responsible for reconciling medications within the scope of their practice.

14. How frequently is the outpatient medication list reviewed with the patient?

At the time a patient arrives for every return visit, practices shall make the best efforts to identify, review and document in the EMR medication module any medication changes since the last visit. Since the type of staff differs in each practice, MGH policy defines the roles of the Nurse practitioners, RNs, LPN's, pharmacists, medical assistants and secretaries in the review of medication lists.

15. Where can I find the MGH policy that addresses medication list documentation in ambulatory?

See *Medication List Documentation and Management of Ambulatory Patients*, in the Clinical Policy and Procedure Manual which is on-line in Trove.

16. How will Joint Commission surveyors evaluate compliance with this goal? Here are examples of how surveyors evaluate compliance:

- **Ask nurses** to describe the medication reconciliation procedure
- **Ask physicians** to describe the medication reconciliation procedure
- **Ask pharmacists** to describe the medication reconciliation procedure
- **Ask the patient** who is about to be discharged to see if he or she has received a list of medications to update and review at the time of their outpatient encounter or at discharge from the hospital.