Medication reconciliation

Barton Pharmacy — Standard Operating Procedure (SOP)

Definitions:

Medication reconciliation = creating the most accurate list possible of all medications a patient is taking to provide correct medications to the patient at all transition points

- including drug name, dosage, frequency, and route and comparing that list against the physician's admission, transfer, and/or discharge medication orders
- reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions

Multi-disciplinary reconciliation of patient medications across the continuum of care.

Procedure:

Morning

1. Open medication reconciliation tracking spreadsheet under "documents" to see what patients have been visited.
2. Go through the current list of admitted patients and print medication reconciliations from the night before and early morning that are not on the spreadsheet.
   a. To print go to the Patient List
   b. Single click on the patient you want
   c. Click the down arrow next to "Single Patient Report"
   d. Click "Medication reconciliation Admission" to print the medication reconciliation and select your printer

3. Take a look at each medication reconciliation page and write the date of their admit somewhere on the top for your reference.
4. Run a MedHx report (outside medication reconciliation database) and reconcile both reports
5. Review the "reconcile medications" section to identify additional medications that EPIC has documented at other facilities

Performing the medication reconciliation

6. Before and after entering a patient room:
   a. Use the sanitizer available outside each room and follow protection protocols that will be posted outside the patient's door if applicable.

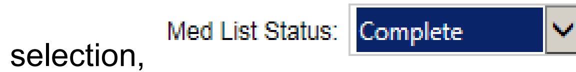
7. Identify yourself “Good morning! I am Cathy from the Pharmacy and I just want to go over your med list and make sure we have everything correct. Is this a good time for us to visit?”
8. Use the two patient identifiers, patient name and date of birth for every patient even if you know them.
9. Verify the patient’s allergies and obtain the specific reaction to the allergy, (e.g. hives, rash) because many are blank in EPIC.
10. Ask if there are any other allergies to food or medications and the reactions they give the patient.
11. Ask what the patient’s home pharmacy is so we can add it to EPIC. I say “which pharmacy do you use to get your medications?”
12. Verify meds, directions, etc.
13. Get the last date and time the patient took their meds. If they ask why, I let them know we try to time the doses as close to their home routine as we can.
14. Once completed - ask this series of questions to make sure everything is covered, many times the patient may forget when they are feeling so sick and need a little memory jog:
    a. Are there any vitamins, minerals or Aspirin you take that are not on this list we just went through
    b. Any inhalers, nasal sprays, eye drops or creams
    c. Any patches for pain, nausea or smoking, etc.
    d. Do you have an insulin or pain pump inside your body
    e. Do you use Oxygen or CPAP machine at night or a nebulizer at home
    f. If the patient takes nothing I often ask if they have any BP or Cholesterol meds just to double check that there really isn’t anything they have forgotten.
15. In closing, I usually say something like “Ok great, thank you for your time! And take care.” This may change with each conversation.

Documenting the medication reconciliation and following up with the clinical pharmacist

16. Find a workstation and access the patient chart to update medication reconciliation accordingly.
    a. At this time you will be verifying medications, calling pharmacies or clinics as needed.
        i. If info is faxed, please ensure the record is uploaded into the patient’s chart for others to see if needed. The unit clerk is trained to properly do this, so please ask them to help with this.
    b. If the patient has their medication bottles and/or a detailed list that is current it can be helpful in verification of the meds. Remember the medication reconciliation is **how the patient is taking the meds not how they are prescribed by the physician.**

c. If there is a discrepancy and the medication has been ordered, immediately call the clinical pharmacist to let them know and they will reach out to the MD.

d. First go to allergies and update as needed. Mark as reviewed.

e. Update the medication reconciliation accordingly with correct meds, dates and times. Make sure on the bottom of the medication reconciliation to make the appropriate selection, 

f. If it is not finished and you need to come back to it, mark it as “Partial”.

g. Once updates to allergies and medications are complete, enter a progress note that a medication reconciliation has been performed, using the dot phrase “.medrec”

h. Finally, check in with the clinical pharmacist and provide them with your findings. They will reconcile the patient’s medications against the new home meds record and follow up with the patient’s MD if needed.

i. Update the excel tracking form with all the required fields

    i. This is nested in the Pharmacy shared drive under:

        1. Pharmacy □ Medication reconciliation tracking □ “20__ current year” medication reconciliation data