

## Medication Reconciliation – The Basics

Medication reconciliation  
Posted 11/8/2006

Is anyone having success implementing Medication reconciliation? How are you doing it? How does Pharmacist play a role in your hospital?

Thanks,  
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Certainly a work in progress. We've used a paper form for initial presentation, whether inpatient or outpatient, and we re-tooled a report from our pharmacy system to make it a reconciliation form for transfers and discharges.. For the most part, this has worked well. Forms are typically filled out by a nurse and pharmacy enters them since we've made the reconciliation forms order forms as well. The greatest obstacle has been when a physician will not say whether to continue or discontinue a med that he/she did not order. Surgeons and radiologists have expressed the greatest resistance, but other disciplines have expressed similar concerns. In a community hospital, without residents and without many hospitalists, there is no one to consistently make that decision, to continue that med or not. We're thinking that we need to have the attending make that choice, but success has been mixed.

Matt Levanda  
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Medication Reconciliation  
Posted 8/4/2006

Hi all

I would like to hear from anyone who thinks they have solved this issue (medication reconciliation). Let me know the basic structure of your solution and whether it has withstood a JCAHO review. Best to reply via email.

Thank you!

Greg Prouty, Pharm.D.  
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For accuracy sake, we have “taken” medication reconciliation away from Nursing and we are having the Rounding Pharmacists do all the medication reconciliation at our hospital. We are also able to bill those hours to Nursing Services.

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Hi,  
How do you have enough Pharmacist to do that?? How large is your hospital--- are Pharmacists doing everything--Admission- Transfers and Discharges?  
Thanks  
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JCAHO was in here last month and our reconciliation process passed muster. They want to see that you’re doing it (we do it everywhere – admissions, discharges, transfers to a different level of care, inpatients, & outpatients), that you’re monitoring it, and, in particular, that you documented you’re passing the list onto the next level of care. We have a written form that is completed at initial presentation, whether outpatient or inpatient, including the ED. Upon admission this has become part of the initial nursing assessment and so has to be completed within 8 hours. At transfer and discharge we print a report from our pharmacy system that we doctored to make it a transfer and discharge reconciliation form. Previously, this form was a list of first all active meds, followed by all inactive meds. We added two columns to check if the meds are to be continued at transfer and a row at the bottom to list the name of the next provider of care to give or fax the form to and sign and date it. Most of this work is done by nursing. Obstacles – radiology and surgery. Stills works in progress. Lessons learned – make it an order form so that you cut out duplication of effort.

Matt Levanda  
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We have a similar process. Nursing records current medication regimen on the admission assessment then print the info which is placed on the chart for md review and indication to continue, discontinue or modify. Nurses are completeing this in for ED patients, surgical patients and inpatients. At transfer, discharge or change in level of care, ie post-op, nursing generates a form which basically mirrors the current MAR and indicate continue, modify or discontinue. If the patient is discharged to another facility or to a resthome or nursing home this form is forwarded to the facility. If they are discharged home the info is transferred to a discharge form by nursing staff and given to the patient.  
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Although this sounds terrific, I just can't imagine the time commitment.  
Do you have an idea yet of how much time per patient you spend on this?

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We have one Pharmacist dedicated to doing nothing but Med Reconciliation. With 15 to 20 new admits per day, this equals roughly 20 minutes per patient --- if that much. The one person dedicated to this project really adds consistency.

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Ken,

Are weekends covered?

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What do you do on evenings and weekends (and days off) when this person is not "in-house"?

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What occurs at night as we get many admits after midnight and whatever nurse admits the patient also does the reconciliation immediately. It sounds like the recon. Is done during day shift at your institution and if so are you doing all the admissions for the 24 hour period?

Bill Stein  
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We take care of the Med Reconciliation first thing in the morning, continuing all day / all evening. This includes the weekends and holidays. Usual turn around/completion time is about 12 hours for overnights and 6 to 12 hours during the day/evening.

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Medication Reconciliation  
Posted 3/10/2006

Greetings all.

Now that we've entered the brave new world of medication reconciliation, we've encountered two major obstacles; surgeons and radiologists. While some surgeons have embraced the practice, some are resisting saying that reconciliation is a task that should be performed by the patient's medical doctor. We have explained the benefits (Don't you want to know if you're patient is on Coumadin, Plavix, ibuprofen, even aspirin?) but they counter with the fact that they didn't prescribe nor order most of the meds and so it's not their job to continue them. Our radiologists say that they don't even know medications since their practice is removed from direct patient care. I can understand their concern, however, they still are physicians and medication ordering is within their scope of practice. The contrast media they order are medications and so they have to know how contrast affects and is affected by other meds. They do ask about some things, such as metformin, but that's as far as they'll go. Any guidance, experience, or wisdom with these issues would be greatly appreciated.

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Matt-

Our organization is a large health system, 11 hospitals and 40+clinics. We have just addressed the issue that you describe regarding surgeons and medication reconciliation. The senior leadership team for the health system approved a physician accountability policy for each step in the med rec process: admission, discharge and transfer reconciliation. Surgeons may delegate the responsibility to the appropriate physician- in most cases the hospitalist. The delegation has two caveats:

1. Must occur early enough postoperatively. This avoids the situation where the hospitalist is called in with the patient is ready to go and the physician is taking a look at the meds for the first time..difficult position to be in!
2. The medication list must be of sufficient enough complexity that the delegation of responsibility is appropriate. Hospitalists were being called in for med rec on every surgical patient- even when the patient was on one or two medications. This is a grey area but is really saying "call us when you really think we can add value to the med review".

The policy has helped clarify expectations- in particular for orthopedic surgeons. Hope this helps.

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Medication Reconciliation  
Posted 1/27/2006

A few questions for the group;

1. Are you taking a medication history for current home meds?
2. What criteria are you using to medications added to reconciliation document as it flow through your system?
  - a. Pre- Op meds?
  - b. Post Op meds?
3. Are you or do you plan to give the completed document to the patient at discharge?
4. Have you developed an internal tool?
  - a. Paper – computer- web or intranet based?

Thanks

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Our solution is a two part form, one is a handwritten form to be completed by a nurse at initial presentation to the facility, whether outpatient or inpatient. The next is a form generated by our pharmacy system for physicians to complete for inpatients transferred to a different level of care or service, and at discharge. Our discharge list is supposed to be faxed to the next provider of care and can be copied and given to the patient.

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1. Are you taking a medication history for current home meds?  
Yes, the nurse takes the medication history straight to the med rec form
2. What criteria are you using to medications added to reconciliation document as it flow through your system?  
Transfers are handled by comparing the MAR with the original list.

3. Are you or do you plan to give the completed document to the patient at discharge?  
The original Med rec form has a section for discharge and is THREE part and one given to the patient

4. Have you developed an internal tool?

Paper 3 part form completed on admission and reconciled at transfer and discharge

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We use Meditech and have developed:

1. Home Medication List – the nurses enter meds into queries and a form is created listing these meds. A prescriber reviews this form and edits as necessary and then signs the form. This form is sent to pharmacy for order entry.
2. Postop and inhouse transfers – we have a custom report that looks at the current active orders and creates an order form for the prescriber to add/change/delete. Once signed, it's sent to pharmacy.
3. At discharge, we have a custom report that pull all active med orders for all meds except IV's and IVPB's and prints as a discharge prescription. The prescriber can add/change/delete on the form and once signed, it's a valid prescription.

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We are in the process of implementing a software program to assist with med reconciliation. When a patient is registered in our organization, the computer will query third-party payers and pharmacy-benefit managers to retrieve any fill/refill data that is available (less than 60-second process). This document will be available during the patient interview and history-taking process and there is an area to indicate continue or discontinue those meds on admission. This will be communicated along with current inpatient meds as the patient transitions through different levels of care.

If there is no data retrieved, we have an identical form that was developed for use to obtain the medication history and indicate to continue/discontinue on admission.

We are able to print a list of meds at discharge.

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Sandra-

Is the software you are implementing home grown or is there a vendor for it? Is it integrated into your hospital-wide system or stand-alone?

Thanks

Joe Haynes, R.Ph.,C.Ph.,MBA  
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Joe,

HRMC is a Critical Access Hospital (25 beds) that recently converted from an acute care facility that was licensed for 66 beds. We are a tax-supported, stand-alone facility. The software is from HealthCare Systems, Inc of Montgomery, Alabama ([www.hcsinc.net](http://www.hcsinc.net)). We happen to have their pharmacy information system (Medics), but this program can function independently. Because we do have their Medics system, we will be easily integrating this with the total medication reconciliation package available from them. We are in the process of implementation and this just seems like such a simple and affordable answer to such a plaguing problem. We will see what retrieval percentages we get on our particular patient population. Their program is set up so that a hospital does not have to pay for a query if no data is retrieved, so there is no money lost there.

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Med Reconciliation (again!)

Posted 3/14/2006

Two questions for the group regarding everyone's favorite National Patient Safety Goal, medication reconciliation...

1. Is anyone experiencing problems getting accurate and complete information from the patient on admission? If so, has anyone developed a plan for dealing with this?
2. Has anyone tried using a pharmacy technician to contact patients' pharmacies for accurate medication histories?

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Our P&T Committee developed a medication admission reconciliation form that lists all the current medications the patient are on when admitted to the hospital and a block the physician checks if he wants the nurse to contact the patient's pharmacy or nursing home. Each medication is listed on the form and a block of yes or no is checked by the physician whether to continue the medication on admission. It has taken some time to develop the form, but it's been a hit with everyone. It has prevented leaving off drugs the patient was on prior to admission.

J. Benjamin, Jr.  
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1. Is anyone experiencing problems getting accurate and complete information from the patient on admission? If so, has anyone developed a plan for dealing with this?

We do share the same situation at our institution. What our pharmacists are doing is documenting in our online record that the patient either was unable to provide a complete medication history and the reason for that. In other circumstances we have been speaking with the caregivers or calling the patient's pharmacy for more detailed information.

2. Has anyone tried using a pharmacy technician to contact patients' pharmacies for accurate medication histories?

We have not

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We've had a medication history form from which the physician can check a box to "continue" a medication during hospitalization. We've been using this form for 7 or 8 years. The patient's nurse fills out the form. It is helpful in capturing this information and resuming home medications. But I do have a few words of caution.

We are not a teaching hospitals for medical residents, so our physician population is made up of community-based physicians who typically are running between 2-3 hospitals and their clinic, doing surgery, etc. - and they look for any time short cut that they can find.

Of course there is a problem getting accurate information. Even when the patient thinks they know how they take their medications, there is frequently errors. And over time, physicians assume that whoever is filling out the form is assuring the accuracy and they stop doing an adequate review of the list. For some reasons, they begin to see that as someone elses responsibility, even though they do sign their name to it. So now you have an order to continue medications for which there is inaccurate or missing information. So we are partially solving one problem but creating several others. Now you have an easy method of continuing all the stuff they take at home, but many of the medications should be held while they are in the hospital. Others are simply polypharmacy, and may include a lot of OTC, herbals, alternative therapies, etc.

1) You're going to need to decide how much time you have to call hometown pharmacies, primary care offices, etc. vs. just trying to get the prescriber to pick a reasonable dose. And of course decide who will do the calling, since it can be problematic during certain hours of the day. And of course the info you get won't always be up-to-date.

2) Our nurses do about as good a job as you could expect, but this is really a job that a pharmacist ought to be doing. I spent 40 minutes talking with a patient and his wife two days ago about his complicated seizure regimen, and finally figured out that the patient was getting confused about how many tablets of Tegretol XR and Depakote ER he took at bedtime. The nurse had written down what the patient had stated, and the physician checked "yes" to continue, but it wasn't resolve until I could talk to someone at his house who read me the labels off his prescription bottles. So if non-pharmacists collect and fill out the info - your pharmacists are going to need to approach every "order" with a level of suspicion, and question anything that looks odd.

3) Another word of warning - nurses frequently write a dose, but then will write 2 tabs, or 1/2 tab, and so its never clear if the dose is the total dose, or if you take it times the number of tabs written elsewhere.

I am aware of at least one group who reported having pharmacy technicians take the med history. An experienced tech does have more knowledge about dosage forms then nursing staff. However, collection of this data and transcribing it is a big responsibility, because it is akin to prescribing when you have physicians who aren't giving the list adequate oversight and review. Job security for pharmacists I guess. Just wish we could have the resources for pharmacy to do the job up front, and again at discharge.

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Medication Reconciliation  
1/10/2006

Could others share their process for the JCAHO-required medication reconciliation at transfer between level of care. Our definition of level of care is into or out of the Intensive Care Unit. Our system generates a form of all current medications with yes/no boxes for the physician to continue or discontinue the medication and a general reminder at the top of the form to review and resume home medications as appropriate. We have not had much success with getting our practitioners to address these forms within the 24 hour time limit we established.

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Jennie Edmundson Hospital Pharmacy  
Council Bluffs, Iowa

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The critical care units (includes step down units) print a medication list similar to what you have described when the patient is going to transfer. The problem is that the physician transferring the patient may write the order to transfer in the chart and then leave the unit. If this occurs, the receiving unit is typically responsible for calling the physician to reconcile the medications. We have had success where in the units where nursing staff is persistent but we still have room to improve. As usual, physician compliance is the major issue.

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We are about to start as well. We would like to believe that compliance will be high- since they are now having to manually write out the reorders. Use of these forms is expected to streamline the process.

Our stop order policy includes having to rewrite orders when a patient undergoes general anesthesia. This will be included in the process.

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Continuing Home Medications  
Posted 5/9/2007

We are having an issue with how home medications are continued upon admission. Currently this task is carried out by the pharmacist. This has become a big issue here due

to JCAHOs policy about blanket reinstatement of orders. If anyone could share how they handle this it would be greatly appreciated.

Thanks,  
Dereck Young, PharmD  
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It is my understanding that JCAHO requires each medication to be addressed individually, with an order to "continue" or "discontinue".  
Our hospital requires the above, but also requires that each medication be ordered individually on a physician's order form.

Larry M. Ford, R.Ph.  
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There are many way to tackle the ordering ... but the toughest challenge is getting an 'accurate' list of home medication to review. The most 'patient centric' approach that I have seen was developed by a few physicians from NY. Check out [www.mymedilist.net](http://www.mymedilist.net) this is the free portion where patients can keep a HIPAA compliant list of their prescription and non-prescription items as well as allergies, prescribing MDs, DX for the medication and other important medical info ... they can print out a wallet cart and an 8.5 x 11 report for MD or hospital. That same group have two other web portal ... MediRecon ... the hospital portal ... and another portal for physicians. The hospital portal has work queues for nursing, physicians and pharmacist that assure compliance with JCAHO requirements. If your physicians are not computer savvy ... they will work with you to develop paper reports with check boxes to continue or discontinue. Then on discharge ... update the list after the hospital adjustments ... print a patient friendly med summary .... and can auto update the next care provider via secure fax or e-mail. There are other vendors offering software solutions ... but all the other require the patient to be a hospital patient before a home list can be compiled. We hope to setup kiosks to pro-actively get local residents enrolled 'before' they are patients.

Christ Kokinos, Director of Pharmacy Informatics  
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This is the one of the functions of medication reconciliation. Gather the list of home meds upon presentation, verify the accuracy, & decide to continue, discontinue or alter each med when admitted or treated. Most of the list gathering is done by nurses in our facility.

The verification is done by pharmacy and, of course, the physician ultimately decides what to (or not to) order.

Matthew Levanda  
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Compiled through med reconciliation, a list generated for the physician to reconcile during the admission order process.

Thank-you,  
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There are software packages that also query data sources to provide an initial list for the clinician to use during the interview process. I work for a company that provides such a solution.

Bob Vinti  
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Hello All:

We have attempted to solve this problem through medication reconciliation: one of IHI's 6 interventions as well as jcaho standard. we actually revised the h&p to include a column under medication history that asks, if the md intends to continue the home rx, yes/no/change. f you want i can email you a copy of our revised h&p.

Regards,

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