Medication Reconciliation

Definition: Medication reconciliation is a process that involves several clinical steps:

1. Upon admission, obtain the complete list of medications the patient is taking (or should be taking) prior to admission (e.g., the patient's medication history). This list should be obtained from the patient, whenever possible, although other resources (e.g., family, caregivers, community pharmacies, past medical records, primary care physician) may need to be contacted as needed. This list should be documented in a single location within the medical record that is utilized and is accessible to all healthcare providers.

2. After documentation, this list is confirmed with the patient, or additional resources if needed, to help ensure accuracy and completeness.

3. Once admission orders are written, they are compared (reconciled) against this medication history list to ensure there are no unintended differences (i.e., confirming that any changes, omissions, or additions are purposeful based on the patient's current clinical status and/or out formulary). Any unintended discrepancies should be discussed with he physician and any resulting changes should be documented.

4. If the patient is transferred from one unit to another during hospitalization, medications patients are receiving in the sending unit are reviewed and updated accordingly to reflect the patient's treatment plan for the new care setting. A review of the medications the patient was taking prior to admission should also be done to assess if they are still applicable or not for the receiving unit or new care setting (i.e., to assess if a home medication held upon admission is now appropriate and could be restarted in the new care setting.) As stated above, any unintended discrepancies should be discussed with the physician and any resulting changes should be documented.

5. To prepare for discharge, the current medication orders are reviewed and compared to the list of medications the patient was on prior to admission. This comparison (reconciliation) and assessment helps form the patient's discharge medication list. The patient should be counseled on any changes, additions or deletions that were made to the medications they were taking prior to admission. The patient's discharge medication list should also be communicated to the next provider of service (oftentimes, this will be the primary care physician).

6. Although health care professionals are already doing many of these clinical steps, we have internal and external data to support that medication errors, and in many cases patient harm, are occurring. We have developed a standardized process for doctors, nurses, and pharmacists to obtain, document and confirm a patient's home medication list. The process ensures that the most accurate, complete medication history is documented for each patient and that all inpatient and home medications reconcile.

Source: Medications at Transition and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation (AHRQ, A-25, p. 95).