UCONN
HEALTH

CLINICAL POLICY
Medication Reconciliation

A. EFFECTIVE DATE :
August 12, 2020

B. PURPOSE :
To provide a safe and effective process for obtaining, documenting, and communicating medications across a patient's continuum of care.

C. POLICY :
All clinical areas must develop and adhere to medication reconciliation procedures to maximize safe medication practices at care transitions. Clinical area leaders ensure that good faith efforts are made to obtain accurate medication information from the patient and/or other sources and document this information in a useful way to those who manage medications.

D. SCOPE :
All clinical areas.

E. DEFINITIONS :
Medication Reconciliation: a process for reviewing the patient's current medications for duplications, omissions, and interactions while also comparing the patient's current medications with those medications ordered for the patient while under the care of the organization in order to identify and resolve any discrepancies.

Medication: any prescription medication, sample medication, herbal remedy, vitamin, nutraceutical, vaccine, or over-the-counter drug; diagnostic and/or contrast agent used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, and intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

Reverse Reconciliation: a modification of the medication reconciliation process in which information is only obtained for specific medications/classes of medication deemed relevant to the current service being provided

F. MATERIAL(S) NEEDED :
None

G. PROCEDURE :
Upon the patient's admission or presentation and with the involvement of the patient or designee, a list of the patient's current medications is obtained and documented in the patient's health record. Medications ordered for

the patient while under the care of the organization are compared to those on the list. The complete list of active medications is provided to the patient/parents/caregiver on departure at the end of the encounter.

A. Inpatient
1. A list of the patient's current medications is obtained. The list contains the name, dose, frequency, and route, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information may include:
   a. Patient/parent/caregiver interview
   b. Review of self-completed or patient provided medication list
   c. UConn Health Medical Record
   d. Outside medical records
   e. Surescript database resource
2. The medications are documented and reviewed for duplications, omissions, and interactions. This becomes the pre-admission medication list.
3. The provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter.
4. The provider compares the preadmission medication list with the medications ordered for the patient in order to identify and resolve discrepancies.
5. At the time of a change in service or when there is a change in level of care, the receiving practitioner decides which medications are to be stopped, continued, or modified, as reflected in the transfer medication orders. When transferring from the Intensive Care Unit, both the sending and receiving providers will complete the medication reconciliation.
6. At the time of discharge, the practitioner compares the home medication list to the hospital medication list and decides which medications are to be stopped, continued, or modified, as reflected in discharge medication list, discharge summary, and patient prescriptions.
   a. A paper or electronic copy is given to the patient/parent/caregiver, with instructions to bring it to all medical appointments and the importance of managing medication information is explained.
   b. A copy of the discharge medication list remains in the patient's medical record.

B. Ambulatory Practices
1. A list of the patient's current medications is obtained. The list contains the name, dose, frequency, and route, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information may include:
   a. Patient/parent/caregiver interview
   b. Review of self-completed or patient provided medication list
   c. UConn Health Medical Record
   d. Outside medical records
   e. Surescript database resource
2. The medications are documented and reviewed for duplications, omissions, and interactions. The provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter.
3. The provider updates the medication list to ensure that any changes, including additions and deletions, to the medication list are reflected in the list prior to the conclusion of the patient encounter.
4. If new medications are prescribed or changes are made to the existing regimen, the patient/family/caregiver is provided with the medication list and the importance of managing the medication list is explained.

C. Procedural Areas

1. A list of the patient's current medications is obtained. The list contains the name, dose, frequency, and route, whenever possible, based on the information available. The primary means of obtaining the patient's current medication information may include:
   a. Patient/parent/caregiver interview
   b. Review of self-completed or patient provided medication list
   c. UConn Health Medical Record
   d. Outside medical records
   e. Surescript database resource
2. The medications are documented and reviewed for duplications, omissions, and interactions.
3. The provider reviews the medication list prior to ordering medications during the encounter and/or prescribing medications at the end of the encounter.
4. The provider updates the medication list to ensure that any changes, including additions and deletions, to the medication list are reflected in the list prior to the conclusion of the patient encounter.
5. If the patient is an outpatient and new medications are prescribed, the patient/family/caregiver is provided with a medication list and the importance of managing the medication list is explained
6. If the patient is an inpatient, medication reconciliation procedures for inpatients are followed.

D. Modified Medication Reconciliation Areas

1. The default medication roster in all settings is the "Comprehensive" medication list. It includes the drug name, dose, route, and frequency for all of the patient's medications.
2. The organization may identify specific Modified Medication Reconciliation (MMR) Areas in which collection of the "Comprehensive" medication list is not required.
3. The MMR areas include those Ambulatory and Procedural areas in which
   1) Medications are not routinely prescribed or administered and/or
   2) Patient safety is not compromised by use of a "Selective" medication list.
4. The "Selective" medication list allows for the collection of less information than that required by the "Comprehensive" medication list method and is medically appropriate in these settings or situations.
5. The "Selective" medication reconciliation method may include:
   1) collection of drug name only or a combination of 1 or 2 additional elements from the "Comprehensive" medication list
   2) use of reverse reconciliation, or
   3) collection of no medication list.

H. ATTACHMENTS :
None

I. REFERENCES :
None

J. SEARCH WORDS :
Medication, reconciliation, med rec

K. ENFORCEMENT:
Violations of this policy or associated procedures may result in appropriate disciplinary measures in accordance with University By-Laws, General Rules of Conduct for All University Employees, applicable collective bargaining agreements, the University of Connecticut Student Code, other applicable University Policies, or as outlined in any procedures document related to this policy.

L. STAKEHOLDER APPROVALS :
On file

M. COMMITTEE APPROVALS :
None

N. FINAL APPROVAL :

1. Andrew Agwunobi, MD, MBA (Signed)   08/26/2020
Andrew Agwunobi, MD, MBA   Date
UConn Health Chief Executive Officer

2. Anne D. Horbatuck, RN, BSN, MBA (Signed)   08/25/2020
Anne D. Horbatuck, RN, BSN, MBA   Date
Clinical Policy Committee Co-Chair

3. Scott Allen, MD (Signed)   08/25/2020
Scott Allen, MD   Date
Clinical Policy Committee Co-Chair

4. Caryl Ryan, MS, RN (Signed)   08/17/2020
Caryl Ryan, MS, RN   Date
VP Quality and Patient Service & Chief Nursing Officer

O. REVISION HISTORY :
Policy Approved: 3/2006
Revisions: 1/2009, 3/2011, 8/2014, 4/2015, 12/2017, 9/2018
Reviewed Without Changes: 8/2020