

CONNECTICUT VALLEY HOSPITAL OPERATIONAL PROCEDURE MANUAL

SECTION I:	PATIENT FOCUSED FUNCTIONS
CHAPTER 2:	Provision of Care, Treatment and Services
PROCEDURE 2.25:	Medication Reconciliation
REVISED:	07/25/07; 04/13; 7/17; 02/18
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PURPOSE: To maintain continuity of care and maximize patient safety related to medication management, Connecticut Valley Hospital (CVH) will provide a mechanism for the reconciliation of a patient's medications across the continuum of care.

SCOPE: All Physicians, APRNs, RNs, LPNs and Pharmacists

POLICY:

To ensure that CVH has medication management mechanisms in place to improve patient safety and provide efficacious treatment by avoiding medication errors related to transcription, omission, duplication of therapy, drug-drug and drug-disease interactions.

PROCEDURE:

I. At Time of Admission

A. Verification:

1. The Nurse or Prescriber at the time of admission will, to the best of his/her ability, substantiate the patient's current medications through verification with the patient. If the patient cannot provide the information, at least one reliable source will be utilized. Reliable sources may include the most recent prescriber(s), the referring agency, Inter-Agency Patient Referral Report ([W-10](#)), family members, the dispensing pharmacy(ies) of record, and/or review of provided prescription bottles. The Nurse or Prescriber will complete the Admission Medication List and Verification Form ([CVH-581a](#)) and Medication List and Verification Continuation Form ([CVH-581b](#)), if needed.
 - a. The patient's name, MPI Number, division location, admission date, and time will be documented.
 - b. Under "Data Source," the Nurse or Prescriber will check the data source(s) utilized in order to verify the patient's medication regimen.
2. In the main body of the form, the Nurse or Prescriber will list all medications that the patient is taking at the time of admission, including the name of the medication, the dose, the frequency and route of administration, topical site when indicated, and date and time last taken by the patient.
3. In addition, the Nurse or Prescriber will list all over-the-counter medications and herbal preparations, including vitamins and dietary supplements used by the patient at

the time of admission, noting dose, route of administration, frequency, and date and time last taken by the patient.

4. At a minimum, the Nurse or Prescriber will confer with the patient in order to verify his/her medication regimen.

B. Reconciliation:

1. In order to reconcile the verified medication list, the prescriber (the Psychiatrist, the Ambulatory Care Services (ACS) clinician, or the On-Call Physician) will compare each verified medication to the admission medication orders.
2. If the verified medication has been ordered by the prescriber, the prescriber will place an "x" in the "As Prescribed" column, and will place his/her initials in the last column.
3. If the verified medication has been omitted from or revised on the admission medication orders, the prescriber will place an "x" in the "Discrepancy" column, and will place his/her initials in the last column. Any identified discrepancies will be clarified by the prescriber that is, the clinical rationale for the omission or revision will be explained. The prescriber's signature (with date and time) will confirm that he/she has reviewed the verified medication list and has provided the necessary clarification.
4. The reconciliation procedures must be completed by the Prescriber within 8 hours of the patient's admission.

II. At Time of Transfer within CVH

A. Reconciliation:

1. In anticipation of transfer, the Nurse on the unit transferring the patient will print-out the "Pyxis Patient Profile" and forward the Pyxis Patient Profile to the receiving unit with the Medical Record.
2. Upon receipt of the "Pyxis Patient Profile," the Prescriber (the Psychiatrist, the Ambulatory Care Services clinician, or the On-Call Physician) will review the "Pyxis Patient Profile" before ordering medications for the patient.
3. The above-referenced Prescribers will attest to his/her review by providing his/her signature, printed name, date, and time on the Pre-Transfer Pyxis Patient Profile.
4. The "Pyxis Patient Profile" will be filed in the Physician orders section of the Medical Record preceding the corresponding orders written upon transfer.

III. At the Time of Admission from Medical Discharge Acute Care (MD/AC) or Return From Extended Visit Hospital (EVH)

The Nurse or Prescriber will follow the verification and reconciliation procedures as described in Section I. A. (Admission) above.

IV. At the Time of Planned Outside Consultation/Planned Procedure or Direct Admission (MD/AC-EVH) to Another Facility

- A. Patients having a consultation appointment as an outpatient will have a Consultation Form completed by the referring physician. A “Pyxis Patient Profile,” printed out by ACS, listing all the current medications, is attached to the Consultation Form. Both of these are faxed to the Consultant’s office by the Employee Health Clinic Nurse.
- B. Patients having surgical or other medical/psychiatric assessments or procedures at facilities outside CVH will have an Inter-Agency Patient Referral Report (W-10) completed by the appropriate clinician (ACS Clinician or Psychiatrist). The referring physician will ensure that this W-10 is completed prior to the day of the procedure and unit nursing staff will ensure that it is sent with the patient on the day of the procedure (a Pyxis Profile print-out may be attached).

V. At the Time of Referral to an Emergency Department

- A. A W-10 form must be provided to the Emergency Department at the time of referral.
- B. It is the responsibility of the Attendings of record (Psychiatrist and ACS Clinician) to ensure that an Inter-Agency Transfer Form (W-10) has been completed and that an accurate list of all prescribed medications at the time of referral (including name, dose, frequency and route of administration, time and date of last dose) has been included (Pyxis Profile may be attached).

VI. Upon return from Planned Outside Consultation/Planned Procedure or Return from an Emergency Department

The receiving Psychiatrist, ACS Clinician or on-call Physician will review the consultant’s findings/recommendations and note in the Progress Notes his/her plan of action in response to the recommendations.

VII. Discharge/Temporary Leave or Visit to an Outside Facility Exceeding 24 Hours Duration

- A. It is the responsibility of the Attendings of record (Psychiatrist and Ambulatory Care Services Clinician) to ensure that either a “Discharge/Aftercare Plan” form ([CVH-2](#) for GPD or [CVH-2a](#) for ASD/BH) or an Inter-Agency Patient Referral Report (W-10) has been completed and that an accurate list of all medications to be continued (including name, dose, frequency and route of administration, time and date of last dose) has been documented at the time of discharge or at the time of a temporary leave/visit to an outside facility that will exceed 24 hours in duration.
- B. The “Discharge/Aftercare Plan” form ([CVH-2](#) for GPD or [CVH-2a](#) for ASD/BH) or Inter-Agency Patient Referral Report (W-10) will be provided to the recipient healthcare agency or healthcare service provider at the time of discharge or initiation of the visit.
- C. The patient will receive a list of his/her medications upon discharge as documented on the Discharge/Aftercare Plan Form ([CVH-2](#) for GPD or [CVH-2a](#) for ASD/BH).