Clinician Medication Reconciliation Process

Ask patient to show you where **ALL** of their medications are located. Discuss which medications were taken prior to this hospitalization and which meds are currently ordered – include dosage and frequency, (include OTCs). Also simultaneously observe M1850 (transferring), M1860 (ambulation), and M1200 (vision).

↓

Cross-check medications included on discharge order with medications patient took previously, as well as what medications the patient believes he/she is supposed to take.

↓

Run computer “medication reconciliation” program to check for potential duplicate drug or drug-drug interactions.
(*REMEMBER THIS IS JUST ONE STEP IN RECONCILIATION)*

↓

If potential interactions or duplicate drugs are found, **contact physician** with this information and request a call back **same day** if at all possible. **Follow up until acknowledgement is received** that the physician is aware and is either changing the medication orders **or** decides to continue the medication. Document the physician contact, discussion, and outcome.

No potential interactions or duplicate drugs are found.

↓

Document the current medication list and fax medications to physician (e.g. print medication list, use “print screen” computer function, or make copy of neat handwritten list). On the fax message, request physician to review current medication list and call back within 24 hours with any discrepancies.

↓

Keep medication list current. Check after physician visits for changes or additions.

Developed by Lynda Laff, RN, BSN, COS-C, www.laffassociates.com