Medication Reconciliation Protocol: Hahnemann University Hospital

1. *Protocol for medication reconciliation upon admission, any transition of care AND at discharge*
    1. We are in the process of implementing an electronic medication reconciliation process in all in-patient areas.
    2. Our current paper method: Upon admission an "adult database" is completed that includes current medications. The nurse completes one portion by independently asking the patient. The house staff also record admission medications on the history and physical at admission. At discharge the medications are written out once by the discharging physician (typically a member of the house staff) and again by the nurse. The nurse gives a final check that the lists are identical.
    3. New method- on admission, home medications are entered into system (verified by nurse), any new medications will automatically be populated into the med reconciliation system (no entry needed/interfaced). If the doctor d/c's it is removed from the medication reconciliation system. At discharge the physician reviews and reconciles the home meds and hospital administered medications.

2. *Identification of patient barriers (barrier assessments, questions asked upon admission to id barriers*)
    1. Patients are assessed for needs by case management. Patients are given a 5 day supply of meds and information about health district center if they have barriers. Patients without insurance are assisted in applying for coverage.

3. *Solutions/strategies to overcome patient barriers (i.e. transportation vouchers, providing discounted drug options)*
    1. See above

4. *Patient handouts to help patients/caregivers understand their prescriptions (dose, type, frequency)*
    1. The automated medication reconciliation process produces a "chart version" and a patient-friendly version that is broken down into sections such as "stop" meds and "change" meds. These are reconciled against the medications that were present at admission. A section "new" medication refers to medications that will be taken at home on discharge that are new scripts. The print-out has details about the prescription such as indication and dosing.

5. *Process for communicating to the patient/caregiver about their ongoing medication regimen*
    1. Medications, indications, side-effects are discussed at the POS (bedside) and reviewed again as a part of the discharge process.

6. *Materials/strategies used to improve medication management and engaging the patient/caregiver in their medication plan*
    1. The automated medication reconciliation was designed to focus on the patient comprehension of the medication plan. Currently there are no other materials or strategies in place.