

**Purpose:** To evaluate your facility's internal medication reconciliation processes:

- 1) the collection and accuracy of the home medication list
- 2) the accuracy and timeliness of the medication reconciliation of the home list to the admission orders
- 3) the documentation of rationale for intended medication discrepancies
- 4) the incidence of unintended medication discrepancies. Records of patients receiving high risk medications will be selected for review to identify root cause for unintended discrepancies.

## Instructions:

- Using the criteria below, audit 5-10 medical records of patients discharged from your facility on any anticoagulant, antihyperglycemic, or opioid.
- Answer Y or N to the following audit criteria questions using data elements found in the patient's medical record.
- Use the **Medication Discrepancy Tool** when needed, as stated below.

Medication Reconciliation Audit Criteria	Pt. 1 Y/N	Pt. 2 Y/N	Pt. 3 Y/N	Pt. 4 Y/N	Pt. 5 Y/N
Was an original home* medications list collected on admission?					
Did the list of original home medications collected at admission include the medication name, dose, route and frequency for each medication? (All elements for all drugs must be present for Yes)					
Was the original home medication list reconciled with admission orders in less than 24 hours?					
Did the reconciled medication list reside in a dedicated location in the medical record?					
Was there is a 1:1 match for every medication on the home medication list to the admitting orders? (All elements for all drugs must match for Yes)					
For medications without a 1:1 match, was a rationale for the discrepancy documented? If No, please complete the Medication Discrepancy Tool.					

\* "Original Home medications list" refer to medications the patient was taking where they lived prior to admission to your facility and includes lists provided by skilled nursing facilities, assisted living facilities, adult homes, home healthcare agencies, primary care, etc.





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