Medication Reconciliation Worksheet for Post-Hospital Care

INTERACT®
Version 4.0 Tool

Part 1: Hospital Recommended Medications Needing Clarification

Medications Recommended by Hospital at Discharge for which Clarification is Needed	**Clarification Needed***	**Resolution for Final Medication Orders** *(Continue, Stop, Change)*

**Examples: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication*

Part 2: Medications Prior to Hospitalization Needing Clarification

Medications Taken Before Hospitalization Not Currently on Hospital-Recommended List	**Comments** *(e.g. reason for the medication before hospitalization, and reason it was stopped in the hospital, if known)*	**Resolution for Final Medication Orders** *(Continue, Stop, Change)*

Resident/Patient Name _____ **Date** _____/_____/_____

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Instructions for Completing the Medication Reconciliation Worksheet

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This Worksheet is intended to be a tool for nursing staff who are involved in reviewing medication orders for residents/patients admitted for post- acute care, with the goal of identifying clarifications and discrepancies that need to be resolved with the resident/patient's primary care clinician. Completing this worksheet will document that you have performed medication reconciliation at transition points of care as required by CMS.

CMS Defines Medication Reconciliation as follows: a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points of care.

NOTE: It is best to complete this Worksheet before calling the clinician for initial verification of orders. However, this may not always be possible. In these cases, verify the initial orders and discuss any major issues with the clinician. Then, use this Worksheet to identify clarifications and discrepancies, and resolve them with the responsible primary care clinician as soon as possible

Part 1

1. Complete the column on the left by carefully reviewing the medications recommended by the hospital at discharge, and listing medications that need clarification.
2. Complete the middle column by noting any issues that need clarification, for example: unclear diagnosis or indication, uncertain dose or route of administration, stop date, hold parameters, lab tests needed for monitoring, dose different than before hospitalization, medication duplication. This requires a discussion with resident and/or caregiver (if they were admitted to the hospital from home), or review of the most recent MAR (for residents/patients who were in the facility before the hospitalization).
3. Complete the section on 'Resolution for Final Medication Orders' by reviewing all clarifications needed with the resident/patient's primary care clinician and obtaining orders for those medications that should be continued, stopped, or changed.

Part 2

1. Complete the column on the left by carefully reviewing the medications recommended by the hospital at discharge with the resident/patient or resident representative (if they were admitted to the hospital from home), or reviewing the most recent MAR (for residents/patients who were in the facility before the hospitalization) and listing any medications that were taken before hospitalization that are not on the list recommended by the hospital.
2. Complete the middle column by noting the reason for the medication before hospitalization, if known, and the reason it was stopped in the hospital, if known.
3. Complete the section on 'Resolution for Final Medication Orders' by reviewing all clarifications needed with the resident/patient's primary care clinician and getting orders for those medications that should be continued (if any).

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