

**ST. JOHN'S**  
Hospital - Lebanon

Subject/Title: Medication Reconciliation

Effective: 2/08

Revision(s):

Reviewed:

Approved: \_\_\_\_\_

Distribution: Emergency Department

### **Medication Reconciliation**

#### **Policy:**

Medications will be reviewed for accuracy when a patient is admitted, transferred to a different level of care, and discharged. All patients in the Emergency Department meet these criteria. Blanket orders such as continue home medications, continue present medications, resume previous medications should not be used.

#### **Procedure:**

1. The ER nurse completes a Home Medication History form as part of the initial nursing assessment.
2. The patient's home medications, to include prescription, over the counter, and herbal supplements are listed.
3. The form is placed with the medical record for physician reference for comparison of prescribed medications to those taken prior to admission.
4. An order to "continue home medications" should not be written. If written, a nurse contacts the physician for accurate medication orders.
5. ER providers will review the listed medications and add any additional discharge medications when ready and sign at the bottom of the form. This signature indicates the physician has reviewed the medications listed.
6. The discharging nurse reviews these medications with the patient upon discharge providing appropriate education to the patient or their family. A copy of this form is sent home with the patient for reference.