Risk Points for Medication Reconciliation in Home Care



Admission



Home Care



Circle of Care



Physician/Clinic appointments



Self Care



Long Term/Acute Care

Goal: To establish a complete, accurate medication list including prescribed and non-prescribed medications upon admission to home care.

Once all discrepancies have been identified and resolved using medication reconciliation, the result is the active and reconciled medication list.

communicate up-to-date, complete and accurate medication list when visiting or consulting with a health care practitioner within the clients' circle of care.

Risk points requiring medication reconciliation may include: health care or clinic appointments, change in client health status, standards set by organization, care transferred to an alternate level of care within the organization.

The home care clinician updates the medication list after each clinician consultation or client visit to a health care practitioner within the clients' circle of care.

communicate up-to-date, complete and accurate medication list to the next provider of care after discharge from home care.

Discharge

If the client is being discharged to acute or long -term care, the clinician updates and communicates the client's current reconciled medication list to the next provider of care.

If the client is being discharged into self care, the clinician verifies that the client/family understands any changes to their medication regimen.

At all interfaces of care, the home care clinician should verify that the client/family understands all changes to their medication regimen.