

# Medication Reconciliation

## From Admission to Discharge in Acute Care

### ADMISSION

#### AT ADMISSION:

The goal of admission medication reconciliation is to ensure there is a conscious decision on the part of the patient's prescriber to continue, discontinue or modify the medication regimen that a patient has been taking at home.

#### Compare:

**Best Possible Medication History (BPMH)**

vs.

**Admission Medication Orders (AMO)**

to identify and resolve discrepancies

### TRANSFER

#### AT TRANSFER:

The goal of transfer medication reconciliation is to consider not only what the patient was receiving on the transferring unit but also any medications they were taking at home that may be appropriate to continue, restart, discontinue or modify.

#### Compare:

**Best Possible Medication History (BPMH)**

and the

**Transferring Unit Medication Administration Record (MAR)**

vs.

**Transfer Orders**

to identify and resolve discrepancies

### DISCHARGE

#### AT DISCHARGE:

The goal of discharge medication reconciliation is to reconcile the medications the patient is taking prior to admission and those initiated in hospital, with the medications they should be taking post-discharge to ensure all changes are intentional and that discrepancies are resolved prior to discharge.

#### Compare:

**Best Possible Medication History (BPMH)**

and the

**Last 24 hour Medication Administration Record (MAR)**

+

plus

**New medications started upon discharge**

to identify and resolve discrepancies and prepare the Best Possible Medication Discharge Plan (BPMDDP)