Medication Reconciliation
From Admission to Discharge in Acute Care

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

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

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) C
plus
New medications started upon discharge
to identify and resolve discrepancies and prepare the Best Possible Medication Discharge Plan (BPMDP)

Developed by ISMP Canada for Safer Healthcare Now! Graphic adapted from St. Mary’s Hospital & Regional Medical Center, Grand Junction, Colorado, USA.