New York State Partnership for Patients

Nursing Centered Initiatives
Adverse Drug Events

NYSPFP ADVERSE DRUG EVENT REDUCTION INITIATIVE
TEAM ACTION PLANNING WORKSHEET FOR MEDICATION RECONCILIATION

The following practice recommendations checklist, developed by NYSPFP in partnership with the Institute for Safe Medication Practices (ISMP), provides medication reconciliation process improvement strategies for consideration as hospitals work to reduce adverse drug events and optimize care.

PRACTICE RECOMMENDATIONS	CHECKLIST OF HOSPITAL'S IMPLEMENTATION STATUS			ACTION PLAN/NEXT STEPS
	FULLY	PARTIALLY	NONE	List specific activities your team will try to accomplish to fully implement each practice recommendation. Include a detailed plan (what, who, how, and starting when) in your notes.
Medication reconciliation is an online process in the electronic health record (EHR).				
A validation step is performed by a physician or pharmacist after the collection of a medication list.				
Dedicated practitioners are used to collect the medication history (Pharmacy technicians, pharmacists, or nurses).				
Admission medication reconciliation is completed by the physician within 24 hours of admission.				

TEAM ACTION PLANNING WORKSHEET FOR MEDICATION RECONCILIATION (continued)

PRACTICE RECOMMENDATIONS	CHECKLIST OF HOSPITAL'S IMPLEMENTATION STATUS			ACTION PLAN/NEXT STEPS
	FULLY	PARTIALLY	NONE	List specific activities your team will try to accomplish to fully implement each practice recommendation. Include a detailed plan (what, who, how, and starting when) in your notes.
The discharge medication reconciliation process is completed by the physician.				
Patients with polypharmacy (receiving 8 or more medications) or patients who are first-time users of insulin or an anticoagulant have a pharmacist consultation prior to discharge.				
High-risk patients (heart failure, diabetics receiving new insulin, noncompliant diabetics, patients with new anticoagulant orders) have a scheduled follow up visit and an appointment for appropriate laboratory monitoring prior to discharge.				
The organization routinely engages the use of disease management practitioners (through Home care, case management, etc.) specifically for high-risk patients e.g., Heart Failure Patients.				
A pharmacist is an active part of the home care team reviewing drug histories and managing high-risk patients.				
The hospital has a formalized process with area long-term care facilities/rehab facilities to share a current medication list upon admission, transfer, as well as an updated list on discharge.				