**Best Practices Checklist**

Medication Reconciliation

Hospital Discharge to Nursing Home

**Information Transfer/Communication**

Standardized information sharing and communication processes for:

* Communicating medication information from hospital to nursing home upon discharge
* Conducting “warm” handoffs with nursing home
* Identifying the care provider at receiving nursing home facility

Comprehension of medication information:

* Discharging hospital provides ongoing training to the nursing home staff to understand the content of the discharge summary, particularly the medication-related information
* Hospital educates patients, families, and caregivers on medications upon discharge

**Medication Discharge List and Reconciliation**

Standardized process and policy for completing medication reconciliation upon hospital discharge:

* Compile complete and accurate list of medications the patient will take upon discharge
* Use an interdisciplinary approach to completing medication reconciliation involving physicians, nurses, pharmacy, patients, and families
* Use anticipated date of discharge
* Hospital and nursing home staff conduct case reviews for medication-related readmissions and identify areas for improvement

Complete and accurate medication lists are developed and documented on discharge summaries:

* Medication name
* Dose
* Route of administration
* Frequency
* Date when the next dose is due
* Time the next dose is due
* Duration of therapy
* Indication for use
* Medication allergies and sensitivities

Addressing medication-related issues:

* Hospital and nursing home communicate and clarify formulary medication discrepancies

**Best Practices Checklist**

Medication Reconciliation

Nursing Home Admission from Hospital

**Information Transfer and Communication**

Standardized information sharing and communication processes for:

* Communicating medication information from hospital discharge to nursing home admission
* Conducting “warm” handoffs between clinical staff
* Identifying a clinical contact at acute care facility

Comprehension of medication information

* Discharging hospital provides ongoing training to the nursing home staff to understand the content of the discharge summary, particularly the medication-related information
* Nursing home educates patients, families, and caregivers on medications

**Medication Reconciliation and Comparison**

Standardized process and policy for completing medication reconciliation upon nursing home admission:

* Compile complete and accurate list of medications the patient will take upon admission to the nursing home
* Use an interdisciplinary approach to completing medication reconciliation involving physicians, nurses, pharmacy (consultant, vendor or in-house pharmacy services), patients and families
* Hospital and nursing home staff conduct case reviews for medication-related readmissions and identify areas for improvement

Addressing medication-related issues:

* Hospital and nursing home communicate and clarify formulary medication discrepancies

**Medication Orders**

Ordering medications:

* Process to document changes from the hospital discharge list when order is placed

Complete and accurate medication lists are developed, and admission orders are written:

* Medication name
* Dose
* Route of administration
* Frequency
* Date when the next dose is due
* Time the next dose is due
* Duration of therapy
* Indication for use
* Medication allergies