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Multidisciplinary approach to inpatient medication reconciliation in an academic setting.

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A limited number of guidelines promote best practices for medication reconciliation. This study describes the implementation of a standardized reconciliation process on an academic family medicine inpatient service. Using a newly designed form, investigators developed a system of shared ownership among nurses, pharmacists, and physicians that led to reductions in medication discrepancies. Data from more than 100 patients also demonstrated a reduction in the severity of discrepancies, although actual adverse events were not measured following discharge. Similar to published case studies, these findings provide a model for implementing a reconciliation process beyond the use of an electronic system or pharmacist-only intervention.