# Advanced Medication Reconciliation in Transitions of Care Training Course

21 – 25 December 2026
Seoul

AGILE LEADERS
Training Center

AGILE LEADERS
Training Center

# Advanced Medication Reconciliation in Transitions of Care Training Course

**Ref:** 1511_211617 **Date:** 21 – 25 December 2026 **Location:** Seoul **Fees:** 10000 Euro

## Overview

Advanced Medication Reconciliation in Transitions of Care Training Course is a one-week course for healthcare professionals responsible for medication histories and care transitions, who leave with a Medication Reconciliation Control File. The course develops best possible medication history practice, discrepancy resolution, clinical handoffs, patient communication, documentation, escalation, and quality measurement across admission, transfer, and discharge. Agile Leaders Training Center presents medication reconciliation as an accountable multidisciplinary patient-safety process.

## Who Should Attend

- Functions responsible for medication history collection and verification
- Teams responsible for prescribing, dispensing, and administration controls
- Personnel responsible for admission, transfer, and discharge coordination
- Units responsible for clinical governance and medication safety
- Functions responsible for patient and caregiver medication communication

The course assumes participants already contribute to medication-use processes and leaves out prescribing authorization and patient-specific treatment decisions.

## Departments and Industries

The course supports departments coordinating medication information across health and care settings.

- Hospital pharmacy and clinical services
- Primary and ambulatory care organizations
- Residential and long-term care services
- Nursing, discharge, and care coordination teams
- Quality, safety, and clinical governance units

## Learning Objectives

By the end of this course, participants will be able to:

- Apply a best possible medication history method
- Analyze intentional and unintended medication discrepancies
- Build accountable admission, transfer, and discharge workflows
- Prioritize high-risk reconciliation cases and escalation
- Use patient-centered medication communication methods

AGILE LEADERS
Training Center

- Evaluate reconciliation quality through process measures

## Course Agenda

### Day 1: Reconciliation Governance and Risk

- Transitions-of-Care Medication Risk Map
- Medication Reconciliation Responsibility Matrix
- Admission, Transfer, and Discharge Control Model
- High-Risk Patient Prioritization Checklist
- Medication Information Source Reliability Grid

### Day 2: Best Possible Medication History

- Structured Patient and Caregiver Interview Method
- Prescription and Nonprescription Medicine Capture Form
- Multi-Source Medication Verification Protocol
- Dose, Route, Frequency, and Indication Record
- Best Possible Medication History Quality Check

### Day 3: Comparison and Discrepancy Resolution

- Medication List Comparison Worksheet
- Intentional and Unintended Discrepancy Classification
- Omission, Commission, and Documentation Error Taxonomy
- Prescriber Clarification and Escalation Pathway
- Discrepancy Resolution and Closure Log

### Day 4: Handoffs, Communication, and Improvement

- Clinical Handoff Medication Communication Standard
- Patient-Friendly Updated Medication List
- Medication Change Rationale Communication Template
- Reconciliation Process Measurement Dashboard
- Workflow Failure Review and Corrective Action Cycle

### Day 5: Medication Reconciliation Practice

- Suggested Exercise: Best Possible Medication History Interview
- Suggested Exercise: Admission Discrepancy Classification
- Suggested Exercise: Transfer Escalation and Closure
- Suggested Exercise: Discharge Medication Handoff
- Capstone Exercise: Medication Reconciliation Control File

AGILE LEADERS
Training Center

## Practical Exercises

The course uses suggested activities based on fictional hospital, ambulatory, residential care, and discharge scenarios.

- Suggested activity: obtain and verify a medication history using patient, caregiver, pharmacy, and clinical-record evidence.
- Suggested activity: classify discrepancies, identify required clarification, and document accountable resolution.
- Suggested activity: prepare an updated medication list and communicate changes at discharge.
- Suggested activity: review reconciliation data and propose workflow corrective actions.

## FAQs

### Who suits advanced medication reconciliation training, and what does it assume?

Healthcare professionals involved in medication histories, clinical handoffs, prescribing support, dispensing, administration, discharge, and quality suit the training; it assumes workplace responsibility for medication-use processes.

### How does medication reconciliation training differ from general medication management training?

Medication reconciliation training concentrates on accurate information transfer, list comparison, discrepancy resolution, and communication at care transitions rather than the broader management of medication use.

### What is a best possible medication history?

A best possible medication history is a structured account of actual medication use, built through patient or caregiver interview and verification against one or more reliable information sources.

### How are medication discrepancies resolved during transitions of care?

Medication discrepancies are classified, checked for documented clinical intent, clarified with the responsible prescriber when necessary, corrected, recorded, communicated, and closed with accountable ownership.

### How can medication reconciliation quality be measured?

Medication reconciliation quality can be measured through completion, timeliness, source verification, discrepancy type, resolution, communication, escalation, and recurring workflow-failure indicators.

## Conclusion

Participants leave with a Medication Reconciliation Control File containing history, comparison, discrepancy, escalation, communication, and measurement tools. The file creates traceability from source information to resolved medication decisions. It helps teams strengthen clinical handoffs and reduce avoidable information failures across care transitions.