



# MEDICATION RECONCILIATION FOR RURAL HOSPITALS

The Arizona Rural Hospital Flexibility  
Program

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# WHO IS JCAHO?

- ◆ Private, not for profit accrediting body since 1951.
- ◆ Board of Commissioners – American Hospital Association, American Medical Association, public members, American College of Physicians, American Society for Internal Medicine, American Dental Association, American College of Surgeons.



# The Joint Commission's Mission

To continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.



# UNOFFICIAL ROLE

- ◆ JCAHO is the only national entity that is out regularly looking at care delivery in the nations hospitals.
- ◆ JCAHO can influence the rate of innovation or technology transfer in the nations hospitals by publishing a new standard or national patient safety goal.
- ◆ Medication reconciliation wasn't invented in 2005.



## WHAT IS DRIVING HOSPITALS' PATIENT SAFETY EFFORTS?

- ◆ Health Affairs Volume 23, Number 2.
  - March/April 2004
- ◆ The most frequently mentioned initiatives either explicitly noted they were designed to meet JCAHO initiatives, or mapped back to JCAHO policies and requirements.
- ◆ The only frequently mentioned activity not directly linked to JCAHO was IT.



# SENTINEL EVENTS

- ◆ Voluntary reporting of fatal errors or permanent loss of functioning.
- ◆ Sentinel events that are voluntarily reported are the tip of the iceberg.
  - They are identified and known
  - Legal issues permit reporting
  - Each must be accompanied by a root cause analysis and action plan.



# Sentinel Event Experience to Date

*Of 2966 sentinel events reviewed by the Joint Commission,  
January 1995 through December 2004:*

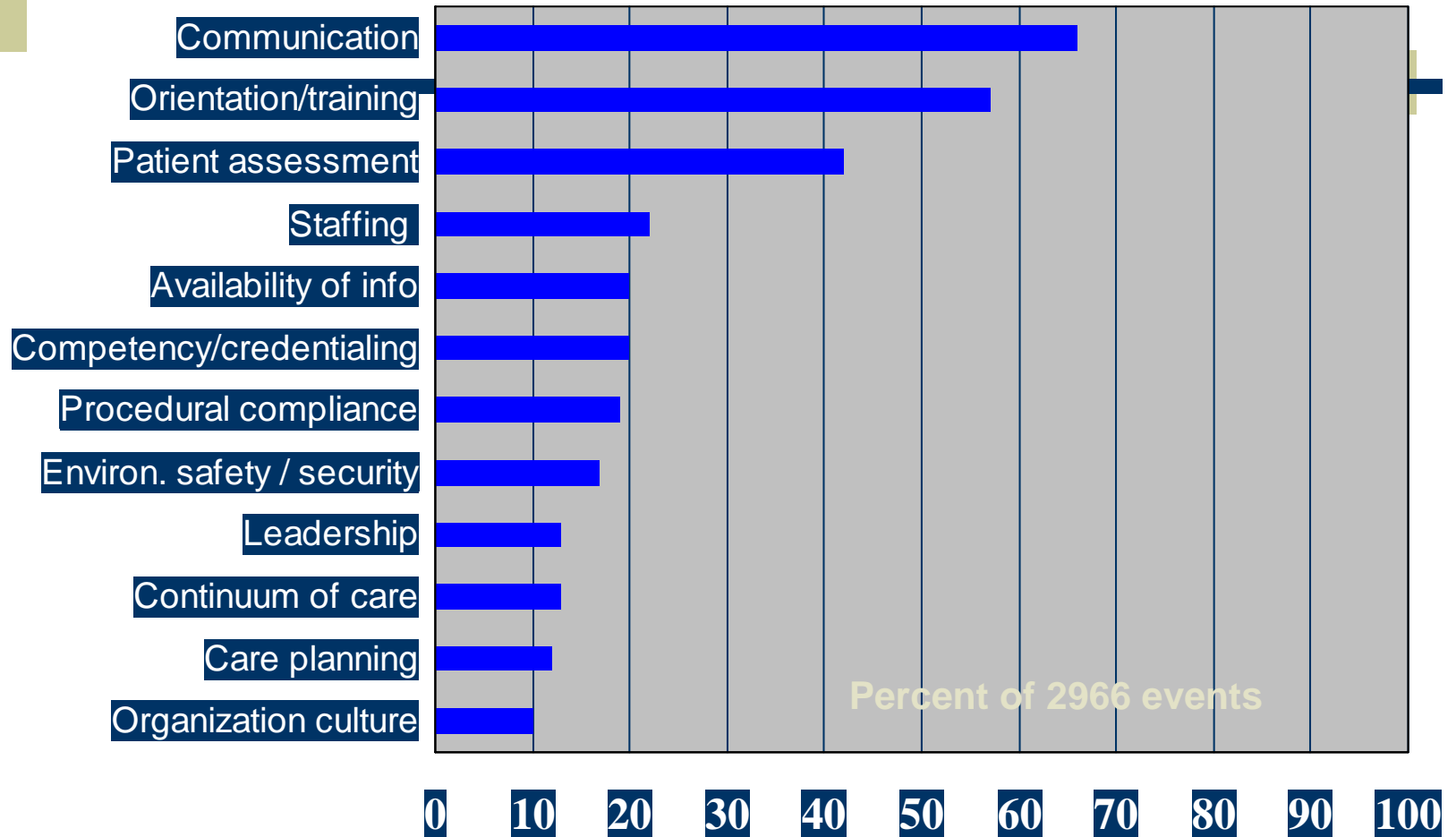
- 415 inpatient suicides
- 370 events of surgery at the wrong site
- 365 operative/post op complications
- 326 events relating to medication errors
- 221 deaths related to delay in treatment
- 144 patient falls
- 124 deaths of patients in restraints
- 107 assault/rape/homicide
- 85 transfusion-related events
- 84 perinatal death/injury
- 57 infection-related events
- 57 deaths following elopement
- 51 fires
- 49 anesthesia-related events
- 511 “other”

**= 2966 RCAs**

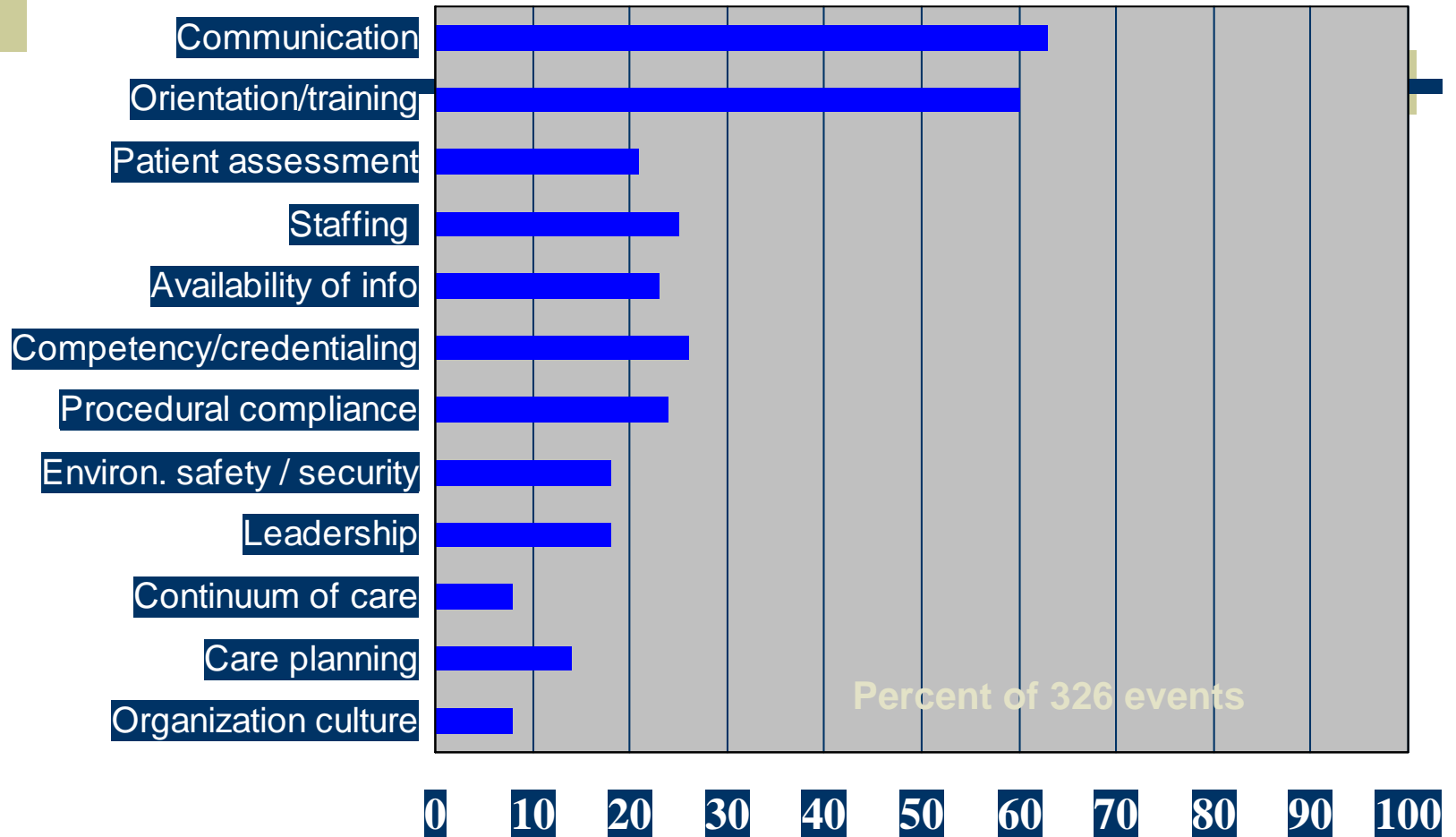


# Root Causes of Sentinel Events

(All categories; 1995-2004)



# Root Causes of Medication Errors (1995-2004)



# Communication as a Root Cause

- ◆ Mode of communication
  - Oral (55%)
  - Written (35%)
  - Electronic (10%)
- ◆ Participants
  - Among staff (60%)
  - With or among physicians (25%)
  - With patient or family (15%)
- ◆ Other communication issues
  - Transcription
  - Change-of-shift report
  - Paging systems






# Attributes of Effective Communication

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- ◆ Complete
  - ◆ Accurate
  - ◆ Timely
  - ◆ Unambiguous
  - ◆ Understood
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# MEDICATION RECONCILIATION

- ◆ NPSG Goal 8– Accurately and completely reconcile medications across the continuum of care.
  - A. During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of a patient’s current medications upon admission to the organization, and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list.



# MEDICATION RECONCILIATION

- ◆ B. A complete list of the patients medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner or level of care within or outside the organization.
- ◆ Applies to both hospitals and critical access hospitals, plus behavioral, home care, long term care and office based surgery programs.



# MEDICATION RECONCILIATION

- ◆ 2005 is the year to design, start and refine the process.
- ◆ 2006 is the year the process is expected to be completely implemented and will be qualitatively evaluated during surveys.
- ◆ Execution of the process will be evaluated on survey.



# MEDICATION RECONCILIATION- WHERE?

- ◆ Outpatient to inpatient admission.
- ◆ Transfer to a different level of care, ICU, OR.
- ◆ Discharge.
- ◆ While hospitalized MAR to MD orders to pharmacy profiles.



# WHAT KINDS OF ERRORS CAN WE HELP PREVENT?

- ◆ Errors of omission – someone forgets to write and order for a maintenance medication that the patient should be receiving.
- ◆ Errors of commission – someone starts a new medication, because they incorrectly think it is part of the regimen, or it is actually contraindicated by history or diagnosis.



# WHAT KINDS OF ERRORS CAN WE HELP PREVENT?

- ◆ Errors of confusion regarding brand vs generic terminology and payer or provider formulary therapeutic substitutes.
- ◆ Errors in dose, frequency or form.
- ◆ Errors upon discharge back to the home



# PETE'S MEDS



# PETE'S SOURCES OF MEDS

- ◆ VA Hospital pharmacy 45 minutes from home.
- ◆ VA mail order system.
- ◆ Near by community hospital pharmacy.
- ◆ Near by community pharmacy using prescriptions from community hospital.



**DISCHARGE INSTRUCTION SHEET**

DISCHARGE DATE:

DIAGNOSIS: *MI, AFib*

- MI, AFib, CVA*
- Fatigue, A3*

**MEDICATIONS:**

DRUG	DOSAGE	AMOUNT
1. <i>ASA</i>	<i>81 mg</i>	<i>PO Q24h</i>
2. <del><i>Aspirin</i></del>	<del><i>81 mg</i></del>	<del><i>PO Q24h</i></del>
3. <del><i>Aspirin</i></del>	<del><i>81 mg</i></del>	<del><i>PO Q24h</i></del>
4. <i>Aspirin</i>	<i>50 mg</i>	<i>PO Q24h</i>
5. <i>Dabigatran</i>	<i>150 mg</i>	<i>PO Q24h</i>
6. <i>Chondroitin</i>	<i>150 mg</i>	<i>PO Q24h</i>
7. <i>Levothyroxine</i>	<i>125 mcg</i>	<i>PO Q24h</i>

Pain Management Yes  No

Level 0 1 2 3 4 5 6 7 8 9 10

Location

Medication

Last Dose

Other Interventions

**FREQUENCY**

**PURPOSE(S) (Layman's Terms)**

*Aspirin 81 mg PO Q24h*  
*Levothyroxine 125 mcg PO Q24h*  
*Aspirin 50 mg PO Q24h*  
*Dabigatran 150 mg PO Q24h*  
*Chondroitin 150 mg PO Q24h*  
*Warfarin 5 mg PO Q24h*  
*Warfarin 75 mg PO (1x)*

**VACCINATIONS ADMINISTERED**

	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date
Pneumovax			
Flu			
Other			

DIET: *25 Na, heart healthy*

Copy Yes  No

ALLERGIES: *none*

ACTIVITIES/RESTRICTIONS: (address driving, walking, stairs, bathing, work)  
*50 mg*  
*As tolerated*

EQUIPMENT: /Durable Medical Equipment  
*none*

**CONTACT YOUR PHYSICIAN PROMPTLY IF YOU EXPERIENCE ANY PROBLEMS**

INSTRUCTIONS: (Include Wound Care)

- Chest pain palpitation one to ER*
- ~~*Call MD with concerning symptoms*~~
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**CONGESTIVE HEART FAILURE**

Yes  No

- Daily Weights: Call MD for weight gain 2-3 lbs in 24hrs. or 5lbs in 5 days
- Call MD: Increased shortness of breath, Increased tiredness or weakness, Increased swelling of feet or

**FOLLOW-UP APPOINTMENT/REFERRAL:**

- WHERE: *MAF Clinic* DATE: *1 week* TEL:
- WHERE: *Dr. Farag / Brooklyn VA* DATE: *1 week* TEL: *718-630*
- HOME CARE AGENCY: DATE:  TEL: *290*

RECEIVED AND UNDERSTAND THE ABOVE INFORMATION



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## IHI SAVING 100 K LIVES

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- ◆ Reconcile medications at all transition points.
- ◆ Reconcile upon transfer.
- ◆ Reconcile discharge orders with MAR.
- ◆ Reconcile admission orders with home medication list.
- ◆ Consistency with JCAHO expectations.



# WHY IS THIS IMPORTANT?

- ◆ Poor communication is responsible for up to 50% of medication errors and 20% of ADEs.
- ◆ Poor communication is the most frequently reported root cause submitted to JCAHO or medication related sentinel events.
- ◆ Business case for patient safety—benefit in not canceling procedures—start the reconciliation process in the home.





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# WHY IS THIS IMPORTANT?

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- ◆ ADR cost avoidance which contributes to length of stay.
- ◆ Avoid transfers back to ICU due to confusion about medications.



# STEPS IN THE PROCESS

- ◆ Verification – collect the list.
- ◆ Clarification – are the meds and doses appropriate? Identify the gains and losses.
- ◆ Documentation – ID the rationale for each new med and each med consciously not continued.
- ◆ Don't duplicate existing process, refine it.



# HOW DO WE START?

- ◆ Don't re-invent the wheel, borrow forms, processes and methods.
- ◆ Don't allow perfection to be the enemy of the good.
- ◆ Don't wait for CPOE or other technologic solutions.
- ◆ Don't wait for a big FTE increase to start.
- ◆ Nike motto – “Just do it.”



# HOW DO WE START?

- ◆ Think innovatively.
- ◆ Obtain forms off web, distribute forms to consumers.
- ◆ Use the phone interview, patient, family, community pharmacist or physician.
- ◆ Involve your admissions staff in the planning as most admissions are elective.
- ◆ Team responsibility not a single profession.
- ◆ Brown bag med analysis.



# JCAHO INTERVENTIONS AND TECHNIQUES

- ◆ Continual standards development and renewal.
- ◆ Sentinel event alerts.
- ◆ National Patient Safety Goals.
- ◆ New survey process (tracers) and surveyor education.
- ◆ Partner with others – universal protocol, ISMP.



# PARTNERING WITH PATIENTS

- ◆ Use Patients/Family as error partners
  - Instruct patients on clues to medication ‘changes’
  - Teach patients about medications
  - Teach patients actual names/doses
  - List medications & schedules at bedside for patient/family
  - Teach patients to aid ‘five rights’ rule



# BARRIERS TO SUCCESS

## Culture

- Bureaucracy
- Complexity of communication
- Issues of accountability
- Lack of teamwork
- Not wanting to accept responsibility
- Viewing this as a JCAHO task instead of a patient safety initiative



# CREATING A CULTURE OF SAFETY

- How is care provided?
- How are errors perceived?
- How are the reporters of errors perceived?
- Are they rewarded or punished?
- What are the barriers to reporting?
- Embrace the standards and goals for their value, not as a survey prep task.



# ◆ CHANGING CULTURE

- Make the safest thing to do, the easiest thing to do.
- Lessons from aviation
  - Dishonorable not to report
  - Neutral party reporting
  - Separate from performance review
- Leadership involvement and commitment.
- Put the patient first.



# DIRECT CONSUMER MEDICATION AWARENESS

- ◆ Public awareness campaign to help prevent medication errors cosponsored with employer groups.
- ◆ Speak Up!- Things you can do to prevent medication mistakes.
- ◆ My medication list for consumers.
- ◆ The web identifies many forms you and your patients can use.



# CAH'S AND PATIENT SAFETY

- ◆ Critical Access Hospital Patient Safety Priorities and Initiatives: Results of the 2004 National CAH Survey.
  - Flex Monitoring Team
    - University of Minnesota
    - University of North Carolina Chapel Hill
    - University of Southern Maine



# CAH'S AND PHARMACIST STAFFING

- ◆ Pharmacist hours per week
  - 4.2% report none.
  - 35.4% report 1-10 hours per week.
  - 14.8% report 11-20 hours per week.
  - 8.4% report 21-39 hours per week.
  - 20.9% report 40 hours per week.
  - 16.1% report more than 40 hours per week.
  - 68.6% of accredited CAH's report more than 40 hours per week.
  - 73.1% with admissions greater than 800 report more than 40 hours per week.

