

Medication Reconciliation

Preventing Medication Mis-Adventures

Linda K. McCoy, Pharm.D.
Director of Clinical Patient Safety
Banner Good Samaritan Medical Center
E-mail: linda.mccoy@bannerhealth.com
Phone: 602 239-2256

Background Information

- Concept developed by Institute for Healthcare Improvement (IHI) (www.ihi.org)
- Roger Resar, MD – Mayo developed concept
- Massachusetts Coalition for Prevention of Medical Errors (www.maocoalition.org)

Definition

- Reconciliation is a process of identifying the most accurate list of all medications a patient is taking –including name, dosage, frequency, and route – and using this list to provide correct medications for patients anywhere within the health care system.
- Reconciliation involves comparing the patient's current list of medications against the physician's admission, transfer and/or discharge orders

Medication Misadventures

- IOM Report (1999)
 - 7000 deaths per year due to medication errors
- ADEs
 - Estimated cost = \$2,595 for all ADEs
 - Estimated cost = \$4,685 for preventable ADE

Why do this?

- Chart review data:
 - Over 50% of medication errors occur at interfaces of care:
 - Patient admission to hospital
 - Patient transfer out of specialty units to other nursing units
 - Patient transfer to step-down care (SNF, LTC)
 - Patient discharge from hospital

IHI Initiative – 100,000 Lives

- Starting January 2005 – Implement key improvements – includes medication reconciliation
- Prevent “needless” deaths
- Report the results – June 14, 2006
[www. ih.org](http://www.ih.org)

JCAHO National Patient Safety Goal

- Accurately and completely reconcile medications across the continuum of care.
 - During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's 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.

JCAHO National Patient Safety Goal

- A complete list of the patient's 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.

Patient Safety

It's the right thing to do...

What is the problem?

- Interfaces of care lack a process for comparing the patient's most current list of medications against new physician orders for admission, transfer or discharge
 - Continue "home meds"
 - Discharge on "home meds"
 - Patient transfer orders listing critical care infusions on medication records

How are medications reconciled upon admission to hospital?

- Patient's home medications are compared to the physician's admission medication orders
- Medication history:
 - Obtain from patient and/or family
 - If patient or family not able:
 - Transfer form if from another facility
 - Checking with physician
 - Calling patient's pharmacy
 - Having patient's medication brought in
 - Searching through recent records

How are medications reconciled upon transfer within the hospital?

- Patient's most current medication administration record is compared to the physician's transfer orders
- Transfer with "same medications" not acceptable order

How are medications reconciled upon discharge?

- Patient's reconciled list of admission medications is compared against the physician's discharge orders.
 - Avoidance of potential duplicate therapy
 - Verification of dosing instructions
- "Discharge on same meds" – not an acceptable order

How are medications reconciled?

- Any medications, doses, routes and/or frequencies that do not match must be "reconciled"
- Discrepancies are brought to the attention of the physician
- Any resulting medication changes are documented, thus communicating the rationale for the change to the healthcare team

Keys to Successful Implementation

- Teamwork
- Commitment to the process by nurses, pharmacists and physicians is integral to achieving success
- Decentralization of pharmacy staff
- Structural support
 - Policies & procedures
 - Standardization
- Documentation tools
- Computerization and automation
- Staff training
- Patient education

Operational Pitfalls

- Staffing issues
 - RN shortage
 - Sick calls, vacations
- High number of admissions, discharges, transfers
- Accessibility to pharmacists
- Non-computerization of documents
- Availability of MD to do timely reconciliation
- Availability of inpatient & outpatient records
- Non-compliance with the process
- Uninformed patient populations

Operational Pitfalls

This is not going to be easy!

Can we do it together?

- Follow the Massachusetts example
- Form an Arizona Coalition
- Combine improvement efforts
- Share success stories
- Provide consistent patient education and encouragement to use a medication list