

# Medication Reconciliation – Getting Started

**Eric Nelson, M.S., R.Ph.**

Director of Pharmacy

Mayo Clinic Arizona

# Objectives

- Prevent adverse drug events in our patients!
- Help healthcare facilities begin to develop processes for medication reconciliation.
- Describe key leadership partners that will support this important work effort.
- Describe steps that can be done to get this issue on your organization's agenda.

# “Getting Started” Tasks

- Identify Team
- Engage Leadership
- Evaluate Existing Processes
- Obtain Baseline Measurement

# Identify Team

- Who are the players required for your team?
  - Nurses
  - Pharmacists
  - Physicians
  - Patients
- What other groups may be important?
  - Administration
  - Information systems
  - Case managers

# Engage Leadership

- Who are the key leaders for the group?
  - Medical Executive Committee
  - Pharmacy & Therapeutics Committee
  - Nursing Practice Committee
- What do they need to know?
  - National Patient Safety Goal
  - IHI 100,000 Lives Campaign
  - Resources required for compliance??

# Evaluate Existing Processes

- Who reviews and verifies medication orders when patients are:
  - Admitted
  - Transferred
  - Discharged
- What is the process in your facility?
- Who is involved in the process?
  - Patient
  - Nurse
  - Physician
  - Pharmacist

# Evaluate Existing Processes

Current admission process:

- Physicians and nurses both have admission drug lists for patients.
- Where are the lists documented?
- Do these lists match? If not, what then?
- Do they match the admission orders written for the patient?

“So many lists . . . so little time . . .”

# Evaluate Existing Processes

## Current transfer process:

- Are all medication orders re-written at the time of transfer within your facility?
  - Post ICU orders
  - Post Operative orders
- Who is responsible for reconciling the medication list upon transfer?
  - Sending team or receiving team

# Evaluate Existing Processes

Current discharge process:

- Physicians must write the drug list for patients at discharge—don't accept “continue home meds”
- Is the discharge medication list compared to the admission medication list?
- Do these lists match? If not, what then?
- Do patients get a document listing drugs and doses they are to take at home?

# Baseline Measurements

- Pilot a reconciliation form that works best for your institution.
- Develop a definition of “reconciliation” for your institution.
- Start with one patient and test your form for both the admission and discharge process.
- Examine patient medication list material that your patients receive upon discharge

# What Reconciliation Forms?

<b>PHYSICIAN ADMISSION &amp; DISCHARGE RECONCILIATION FORM</b>				<i>PLACE STICKER HERE</i>			
--	--	--	--	---------------------------	--	--	--

**KEEP THIS FORM WITH  
WITH PHYSICIAN ORDERS**

***P I L O T F O R M***

"Home" Prescription & Over the Counter Medications							Discharge Medications		
Order			Product Name <small>(List only those meds currently being taken)</small>	Dose <small>(mg, ml, gms number)</small>	How Often?	Route or Topical Site	Date & Time of Last Dose	Resume at same dose	Do Not Resume at Discharge to Home
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Already ordered						<input type="checkbox"/>	<input type="checkbox"/>

**Herbal Products NOT TO BE TAKEN IN HOSPITAL (Herbals will not be dispensed by Pharmacy.)**

Date/Time									
			Signature of RN Obtaining Medication History						



## UNIVERSAL MEDICATION FORM

**\*Fold this form and keep it in your wallet.**

<b>Name:</b>	<b>Address:</b>
<b>Phone Number:</b>	<b>Street:</b>
<b>Birth Date:</b>	<b>City/State/Zip:</b>

<b>Allergic To/Describe Reaction:</b>	<b>Allergic To/Describe Reaction:</b>

**List all prescription and over-the-counter (non-prescription) medications such as Vitamins, aspirin, Tylenol, and herbals (i.e.: Ginseng, Gingko Biloba, St. John's Wort). Include prescription meds taken as needed, (i.e.: Viagra, Nitroglycerin).**

<b>DATE</b>	<b>NAME OF MEDICATION/DOSE</b>	<b>DIRECTIONS: USE PATIENT FRIENDLY DIRECTION. DO NOT USE MEDICAL ABBREVIATIONS</b>	<b>DATE STOPPED</b>	<b>Reason for taking/ MD Name</b>

## **Patients:**

- 1. Always keep this form with you.**
- Take this form to **ALL** doctor visits and **ALL** medical testing (lab, x-ray, MRI, CT, etc.). Take this form to **ALL** pre-assessment visits for admission or surgery and **ALL** hospital visits (ER, in-patient admission, and out-patient visits).
- Update this form as changes are made to your medications. If a medication is stopped, draw a line through it and record the date it was stopped. If help is needed, ask Physician, Nurse or Pharmacist to help you fill out this form.
- In the COMMENTS column, record things like the name of doctor who told you to take this medication. You may also add the reason for taking the medication (high blood pressure, high blood sugar, and high cholesterol). Always keep this form with you.
- Tell your family, friends and neighbors about the benefits of using this form.
- When you are charged from the hospital, you will get an updated form. This will be reviewed with you and you will be given a copy. When you return to your doctor, take your updated form with you. Always keep this form with you. This will keep everyone up-to-date on your medications.

## **HOW DOES THIS FORM HELP YOU?**

### **By using this form, it**

- 1. Reduces confusion and saves time.** You do not have to remember all the medications you are taking, the form does this for you.
- 2. Improves communication.** Provides doctors, health care providers and institutions with a current list of ALL of your medications. Let's you or your family members know exactly what medications are to be taken and when.
- 3. Improves Medical Safety.** Medication interactions and suplications can be detected and corrected.

# Documentation Expectations

- Evidence in the record that the patient's home drug list was compared to the admission drug orders.
- Evidence in the record that the medication list was reviewed upon patient transfer.
- Evidence in the record that the discharge medication list was compared to the home drug list—changes detailed for patient.

# Next Steps?

- Modify your reconciliation form and definition as needed.
- Present findings to internal groups as appropriate.
- Expand process and scope (OTC & herbals).
- Measure resources required.
- Share lessons learned with others.

Questions?

# Contacts

**Suzanne Anders, RN, BSBA, CPHQ**

HSAG Clinical Quality Specialist

[sanders@azqio.sdps.org](mailto:sanders@azqio.sdps.org)

602.665.6171 or 520.661.9370

**Judith Richard, RN, MS, CPHQ**

HSAG Clinical Quality Specialist

[jrichard@azqio.sdps.org](mailto:jrichard@azqio.sdps.org)

602.665.6116

**Susan Sumwalt, RN, MA, CPHQ**

HSAG Clinical Quality Specialist

[ssumwalt@azqio.sdps.org](mailto:ssumwalt@azqio.sdps.org)

602.665.6176