



Medication Reconciliation

Preventing Medication Misadventures

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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



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.



JCAHO National Patient Safety Goal

- Accurately and completely reconcile medications across the continuum of care.
 - 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. Process includes a comparison of the medications the organization provides to those on the list.
 - Develop and refine process in 2005.
 - Completely implemented by Jan 2006 for all patients.



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:
 - Transferring 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.



Operational Pitfalls

- Staffing issues
 - RN shortage
 - Sick calls, vacations
- High number of admissions, discharges, and 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
 - www.macoalition.org
- Form an Arizona Coalition
- Combine improvement efforts
 - Professional organizations—Medicine, Pharmacy, Nursing, Quality, Healthcare Improvement
- Share success stories – tools – forms – ideas
 - www.ihl.org
- Provide consistent patient education and encouragement to use a medication list



Can we make a difference?

“The names of the patients whose lives we save can never be known. Our contribution will be what did *not* happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.”

***Donald M. Berwick, MD, MPP
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