

## Medication Reconciliation Programs

Suzanne Anders, RN, BSBA, CPHQ  
Clinical Quality Specialist  
Health Services Advisory Group

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## Quality, Risk, and Error

Consider . . .

- Culture
- Discipline when actions are malicious or illegal
- Notifying patients/family of an error
- Sharing reports (clinicians, trustees, public)
- Counseling (psychological) for clinicians who cause harm
- Incentives and feedback

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## Barriers

- No one is interested in the data
- Staff resistance to data process
- Reluctance to accept change
- Bedside clinicians are overworked
- Inter/intra departmental resistance
- Project is not visible within the organization

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## Staff Resistance

- Assure that the reconciliation goal is understood
- Share results—daily if possible
- Reassure staff that the process is for improvement and patient safety, not punitive or judgmental
- Streamline data collection
- Integrate data collection into daily routine
- Seek champions

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## We Tried Changing . . .

And it did not work!

- Why did the previous efforts fail?
- Failing tests can provide necessary information.
- Limit change to small cycles.
- Respond to processes that do not work.

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## Lack of Interest

- Assess commitment to reconciliation
  - Is there visible administrative support?
- Present data as simply as possible
  - Consider graphs rather than tables.
- Limit data collection
  - Are you collecting too much data?
- Evaluate the use of data within the PDSA cycle
  - If you are not collecting too much data, is it the data you need to help the PDSA process?

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## Reconciliation Can . . .

- Prevent omission of an at-home medication
- Match in-house dose, frequency, and route with at-home dose
- Assure medications follow the patient from one care site to another

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## Automation?

Automation of bad processes will not solve problems.

- Reliance in automation results in a false sense of security
- Belief that automation will ensure safety
- Circumvent the automated process
- Major change

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## Standard Forms

- Patient identification
- For each medication
  - Dosage
  - Frequency
  - Date/time of last dose
  - Compliance with dose and frequency
- Allergies
- Physician signature
- Verifier name and title

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## Optional Items

- Medication purpose
- Pharmacy contact
- Patient weight
- Presence of kidney or liver failure
- Name/relationship of person providing information
- OTC medications and herbal remedies
- Information about pregnancy/breast-feeding

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## Process

### Policies

- Define responsibility/accountability for reconciliation
- Define time frames (24 hours after admission, shorter time for high-risk medications, upcoming medications)
- Describe process of reconciliation
- Provide back-up procedures for special situations
- Include a process for nonreconciled medications
- Identify high-risk situations
- Prohibit blanket orders (e.g., “Resume at-home meds”)

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## Process

- Policies
  - Define responsibility/accountability for reconciliation
  - Define time frames (24 hours after admission, shorter time for high-risk medications, upcoming medications)
- Forms
  - Place form in consistent, highly visible location
  - Improve access to drug information and pharmacy advice
- Monitoring
  - Orientation and ongoing education
  - Provide feedback

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## Reconciliation Programs

- Institute for Healthcare Improvement (IHI) [www.ihl.org](http://www.ihl.org)
- American Hospital Association (AHA) [www.aha.org](http://www.aha.org)
- Agency for Healthcare Research and Quality (AHRQ) [www.ahrq.gov](http://www.ahrq.gov)
- Massachusetts Coalition for the Prevention of Medical Errors [www.macoalition.org](http://www.macoalition.org)

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## Institute for Healthcare Improvement

- Has been done as a collaborative
- More than reconciliation
- Available to the public
- “Improving medication systems should result in a reduction in harm to patients. Achieving breakthrough levels of improvement in reducing harm from medications requires that an organization make changes to improve four fundamental areas in parallel.”

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## Four IHI Medication Improvements

- Culture
- High-Hazard Medications
- Core Medication Processes
- Reconciliation

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## IHI How to Improve

- Measures
- Changes
- Stories
- Tools
- Resources
- Literature
- FAQs

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## American Hospital Association

- Not only reconciliation of medications
- 3-part program
  - Leading a Strategic Planning Effort
  - Looking Collectively at Risk
  - Assessing Bedside Bar-Coding Readiness

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## Strategic Planning

- Culture of safety
- Improve medication safety
- Evaluate technology
- Reduce risk of errors for high-alert meds
- Blame-free environment
- Involve the community
- Controlled formulary

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## Risk

- Building blocks
- Failure mode and analysis
- Assess risk
- Medication flow process

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## AHRQ

- Included as patient safety
- Not how to, rather what to accomplish . . .  
action steps
- Few tools, limited information

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## AHRQ Action Steps

- Analyze the formulary.
- Maximize pre-typed orders.
- Implement dosing protocols.
- Review policies, procedures, and practices for independent double-checking.
- Conduct a failure mode analysis of floor stock for dangerous drugs and look-alike packages.
- Complete the unit dose system for medications likely to cause harm.

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## More AHRQ Steps

- Ensure reconciliation of patients' home medications.
- Ensure communication and use of allergy information.
- Simplify a process by reducing the number of steps.
- Improve access to information.
- Automate wisely.

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## Massachusetts Coalition

- Began in 1987 with the goal of disseminating knowledge and information about the causes of, and to develop strategies to prevent, sentinel events.
- Related issue was the need for a non-punitive and confidential reporting system to learn about errors.

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## Reconciling Medications

A formal process of obtaining a complete and accurate list of each patient's current home medications and then comparing the physician's admission, transfer, and/or discharge orders to that list.

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## Coalition Project Includes:

- Overview
- Safe Collaborative News and Reporting Topics
- Process Information
- References
- Forums
- Toolkit

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## Coalition Impact

- Decrease in medication errors by 70 percent and reduced adverse drug events by 15 percent

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## Contact Information

Suzanne R. Anders, RN, BSBA, CPHQ  
sanders@azqio.sdps.org  
602.665.6171

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