

JCAHO
National Patient Safety Goal # 8

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.

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.

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, President and CEO, Institute for Healthcare Improvement.

Provide consistent patient education and encouragement to use a medication list.

What Else Should I Know?

One danger area is with generic prescription medications that a patient may duplicate with a brand-name drug. Gina Rogers, Director of the Medication Reconciliation Program at the Massachusetts Coalition for the Prevention of Medical Errors, noted an example of a heart patient sent home with a prescription for the generic drug digoxin. The patient may inadvertently double the dose by resuming the brand name prescription, Lanoxin, he was previously taking. For this reason, the Medication Reconciliation Process is particularly important at discharge.

Collaboration and TEAMWORK are essential in the success of the Medication Reconciliation Process!

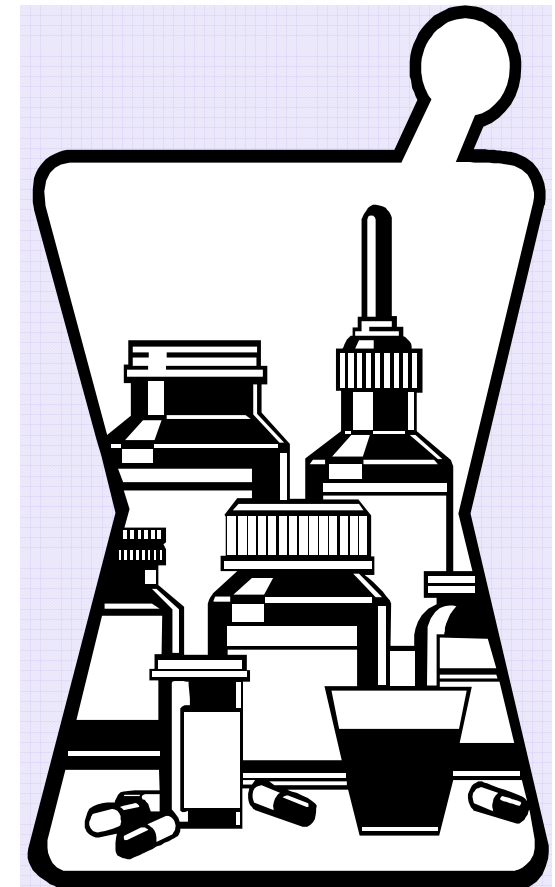
The Lewistown Hospital
Medication Reconciliation Committee
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Medication Reconciliation
at
Lewistown Hospital

A Guide for Healthcare Providers

National Patient Safety Goal #8



Transferring Medication Information Across Settings: Keeping The Process Free from Error

From experience, we know that our patients and residents are at highest risk for medication errors during transitions in care. Poor communication at transition points is responsible for as many as 50% of all medication errors in the hospital setting and up to 20% of adverse drug events (ADEs). Whenever a patient moves from one setting to another, clinicians should compare previous medication orders with new orders and plans of care plus **reconcile any differences**.

Patients admitted to a hospital commonly receive new meds or have changes made to their current meds. As a result, the new medical regimen prescribed during a transition to another level of care, including discharge, may inadvertently omit meds the patient has been taking for some time and still has indications to take.

Medication Reconciliation is the process for obtaining and documenting the most accurate list possible of the patient's current medications upon admission to the hospital. That list is then compared with the medications prescribed during the stay.

The Medication Reconciliation process for Lewistown Hospital has been developed to ensure that patients have the most up-to-date medication list possible.

This education pamphlet is planned to provide you with information on how that process is designed to work and what your role is in keeping patients safe. We are hopeful that you will gain insight and cooperation in moving this initiative forward allowing us to provide greater levels of safety for our patients.

Some Examples of When to Reconcile Medications

1 . Admission Reconciliation: the process of matching the medication orders with the home medication list. This must be completed within 24 hours. High-Alert medications must be reconciled within 4 hours or prior to the next scheduled dose.

2 . Discharge Reconciliation: the process of writing a matching discharge order for each medication listed on the MAR *and* home medication list. Special attention should be devoted to prevent duplication.

3 . Reconciliation upon transfer in level of care (ICCU) and Post-operatively: the process of reviewing and matching the MAR *and* home medication list. This process is currently identified in our policies and will not be reflected on a paper form at present.

THE PROCESS

Medication Reconciliation is an interdisciplinary process between Physicians, Pharmacy, and Nursing.

A home medication list (current medication history) will be obtained at time of admission. Available resources may include the patient/family, the patient's pharmacy, previous medical records, and the primary care provider's office.

The list will include over-the-counter medications taken routinely or currently and should include ALL medication dosages, frequency, route, and last dose date/time.

The ordered/prescribed medications will be compared to the home medication list (current medication history). Any variance will be reconciled. Variances may include a change in the medication, route, dose, or frequency.

Communicate the most recent complete list of meds and times of the patient's most recent dose.

ADDITIONAL MEDS

Example: A patient is admitted through the ED. The nursing staff starts the Medication Reconciliation Form and it is completed on the nursing unit. The physician reviews the form and orders the appropriate medications. Later in the day, the family visits and an additional medication is added to the patient's med history. *How should this be handled?* When additional home medications are discovered after the physician has reviewed the form, a new form will be printed and ADDENDUM will be written on the form, along with the additional medication. The reconciliation process is the same as the original.

*While this process will take you time, it is the right thing to do! **Keeping our patients safe!***

OPERATIONAL PITFALLS

"Medication Reconciliation is something that at first glance seems like it should be an easy thing to do...it turns out its not that easy" according to JCAHO's Richard Croteau, MD, executive director for Patient Safety Initiatives.

Barriers may include: Staffing issues, high number of admissions/discharges, accessibility to pharmacists, availability of physician, availability of inpatient/outpatient records, non-computerized documentation, non-compliance with the process, and uninformed patient populations.

The perception that the med list must be perfect is not accurate. Remember that as the process is first introduced, information may not be perfect. **Medication history taking is a skill, not a technical responsibility.** *The underlying goal is worth your efforts.*