Medication Safety Issue Brief

Medication Reconciliation

4 of 6 in a series

Series III

Accurately reconciling medications across the continuum of care is part four in a six-part series that highlights underlying causes of and solutions to medication errors. This series is a joint effort of the American Hospital Association, the American Society of Health-System Pharmacists and *Hospitals & Health Networks,* with generous support from McKesson. You may tear this card out for future reference. Additional copies are available in PDF format, along with those from two previous series, on the ASHP and *H&HN* Web sites (www.ashp.org and www.hhnmag.com).

• SUMMARY

Inaccuracies in a patient's medication history can lead to potentially harmful errors during a hospital stay. For medication use to be safe and effective, an accurate list of a patient's medications is needed and the information needs to be communicated across the continuum of care. At many organizations, the system is haphazard and disjointed, without a standard procedure outlining who should collect medication information from patients and how the information should be recorded. As a result, incomplete histories are not uncommon and the information that is collected does not always travel with the patient throughout their hospital stay.

• ISSUE BRIEF

Medication reconciliation is the process for obtaining and documenting a complete list of the patient's current medications upon admission to the hospital. That list is then compared with the medications that are prescribed during the stay. A complete list of the patient's medications is given to the next provider upon discharge or transfer to another health care setting.

The Joint Commission on Accreditation of Healthcare Organizations selected medication reconciliation as a 2005 National Patient Safety Goal. Hospitals will be required to have the process in place by January 2006. "Reconciliation is a huge problem," says Peter Angood, M.D., JCAHO's vice president and chief patient safety officer. "At the point of discharge, it's possible that a patient will be on an entirely different medication list than before they went to the hospital."

The process works. A study conducted at Johns Hopkins University on the medication reconciliation process in an adult intensive care unit found that medication orders were changed for 94 percent of the patients following reconciliation. Twenty-four weeks after the implementation of the process, nearly all errors were eliminated from discharge orders.

The Madison (Wis.) Patient Safety Collaborative, a provider and payer initiative, is targeting the discharge process. "We want to make sure the patient goes home better off or just as good as they were prior to admission," says Kendra Jacobsen, administrator. The collaborative is working with area pharmacies to develop a process that will provide pharmacists with an accurate list of the patient's medications. "This is not an easy process to do," Jacobsen says. "It's easier to tackle if you break it down." The collaborative plans to deal with medication reconciliation upon admission separately.

Primary responsibility for medication reconciliation should go to someone who is involved in the patient's care, such as a nurse or pharmacist with consultation from the physician. "Pharmacists can take a better medication history than physicians or nurses," Jacobsen says.

The Medication Safety Issue Briefs are a joint project of the American Hospital Association's Quality Agenda, the American Society of Health-System Pharmacists and *Hospitals & Health Networks*, and are made possible through the generous support of McKesson Corp.

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Communication is the key. "Everyone needs to know even the slightest change in the patient's treatment," Angood says.

• CASE STUDY

Legacy Health System, Portland, Ore.: Although medication reconciliation has been in place at the four-hospital Legacy Health System for about three years, "some of what we're doing needs more work," says Lynn Belcher, clinical specialist for quality and patient safety. The hospital received a grant from the Agency for Healthcare Research and Quality to strengthen its initiative. Legacy would like to invest in more training and make the process entirely electronic. Belcher says the system is doing well on the front end, obtaining information on patient medications and providing it to the physician, particularly for patients who come from one of the organization's physician practices, which are linked with a common electronic medical record. The biggest challenge is getting a list of reconciled medications after a patient is discharged to primary care physicians not affiliated with the hospital, mainly because it's not clear whose responsibility that should be. "It takes a lot of time and effort to determine who does what," says Belcher.

Creighton University Medical Center, Omaha, Neb.: The medication reconciliation process at Creighton is fully automated. The system, which has been in place since September 2004, has solved a perennial problem in health care: legibility. "The biggest benefit is the clarity of the report. It's easy to read," says Dianne Hayko, clinical information systems coordinator. The medication reconciliation form is part of the hospital's electronic medical record. Upon discharge, copies are printed out for the patient and the patient's primary care provider to improve continuity of care. The transition to medication reconciliation was not easy, says Hayko, because it required significant change in the discharge process. "It wasn't something that was done on a regular basis," she says. "We didn't have a consistent process at discharge." Once physicians and nurses understood the objective of the initiative—to improve patient care—they were supportive.

Northwestern Memorial Hospital, Chicago: A study of the medication process at NMH found discrepancies between the medication histories and documented medication orders in more than half of the patients. In addition, the study found that 22 percent of these discrepancies could have resulted in harm to the patient during hospitalization. A failure mode and effects analysis was conducted to identify problems and a medication reconciliation process was developed to prevent them from occurring again. "From a patient safety and financial perspective, this process helped paint a picture as to why this is important," says Kristen Gleason, research pharmacist coordinator. Nurse training has been key to the success of the process that began about three years ago. "Pharmacists receive lots of education and are taught how to ask questions," she says. "The nurses need to know the correct questions to ask the patient." Typically, Gleason says, nurses are now involved at the time of admission when they obtain the patient's medication history. •

ACTION *Agenda*

Here is a list of items that can help with the development and implementation of a medication reconciliation process:

- Educate patients about the importance of providing a complete list of the medications they are taking.
- Develop an electronic process, if possible, that will make the report easy to update and move with the patient.
- Engage the pharmacy department in the development and implementation of a medication reconciliation program.
- Place the list of the patient's medication history in a prominent place in the chart or the electronic health record.
- Thoroughly educate nurses and physicians to effectively collect patient information.
- Conduct a failure mode and effects analysis to find weaknesses in the medication reconciliation process.

ADDITIONAL RESOURCES:

Getting Started Kit: *Prevent Adverse Events (Medication Reconciliation): How-to-Guide*, Institute for Healthcare Improvement, www.ihi.org

Reconciling Medications, Massachusetts Coalition for the Prevention of Medical Errors, www.macoalition.org