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Medication reconciliation: from admission to discharge using electronically generated medication forms from a clinical information system (P322D)

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Abstract:

Purpose: Medication Reconciliation is a process that has been cumbersome and complex in the past. Inaccurate medication list have caused numerous medication errors and is a significant source of dissatisfaction for patients. Incorrect dosages, illegibility, multiple prescribers, multiple medication lists and co morbidities have all contributed to medication reconciliation errors. The purpose of this project was to provide a concise, legible, user-friendly process to record medication information and communicate this information to key stakeholders in the medication delivery process.

Methods: In 2002, a medication reconciliation form was developed by an interdisciplinary committee to obtain more accurate home medication histories from patients and reconcile which of these medications to continue while in the hospital. This form evolved as the hospital's clinical information system evolved. Incorporation of home medication history into the electronic record allowed for an electronic form to be printed on a patient's admission, for a physician to then address each of the home medications on admission and at discharge. This form also allowed for a dose change by the admitting physician. Checkboxes easily allow the physician to quickly indicate whether to continue, discontinue or change a particular medication. A check-box form for post-surgery ordering of medications has also helped to reconcile medications postoperatively, helping to eliminate blanket orders such as "resume pre-op medications." For patients being transferred, a form was created to allow for easier communication of medication orders to the healthcare provider, whether it is to a nursing home or extended care facility. This form not only incorporates medications, but all other active patient orders, allowing the physician to fully address the patient's orders in an easy to use form. A separate form for discharge to home allows the inpatient medications to be compared to the home medication list for complete reconciliation on a single document. On this form there is even a section for a pharmacist (whose position is dedicated to medication reconciliation), to make any notes for patient discharge including therapeutic substitutions, reminders of vaccinations, and ensuring certain patients are discharged on needed medications based on a critical diagnosis (eg. aspirin for a new myocardial infarction patient, ACEI for CHF patients). The nurse then uses this form to create an easy to understand discharge document for each patient that highlights any medication changes they should be aware of on discharge.

Results: The use of technology through a clinical information system has allowed a much safer transfer process for patient's in our organization. Nursing, pharmacy, physician, and patient satisfaction with medication reconciliation has increased since implementation of the form. Nurses have the data stored in the system to bring up a previous home medication list on the patient's next admission. Pharmacy can easily read the orders and have more complete orders from the physicians, resulting in less time clarifying incorrect information. Physicians have accepted the change and are more apt to address each medication which in the past were not reviewed. Patients and Nursing Homes now have a typed information sheet to provide the data they need to continue medications after discharge. Medication error reports involving communication breakdowns have decreased in the hospital.