Medication Reconciliation: Opportunity to Improve Patient Safety

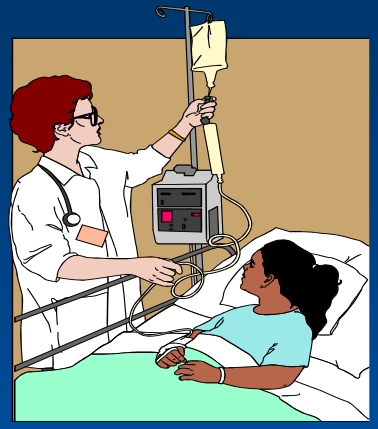
Sutoto

Overview

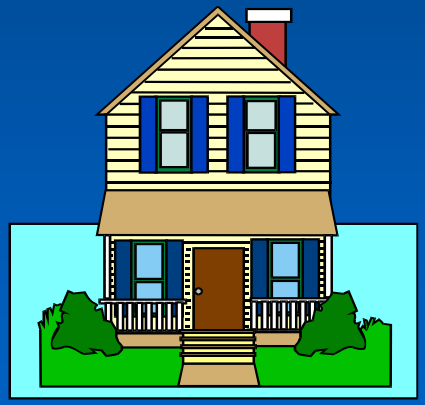
- Obtaining a Thorough Medication History
  - Impact
  - Challenges
- Medication Reconciliation
  - Impact on Patient Safety
  - Discussion

Obtaining a Thorough Medication History: Impact and Challenges to Patient Safety

Current Healthcare System

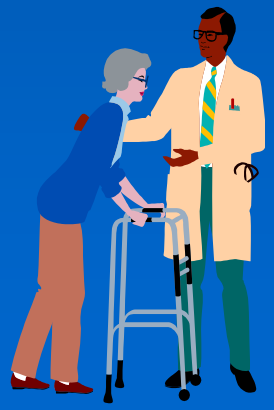


Acute care



Home care

Ambulatory care



Long term care

Challenges

- Patients and/or advocates ability to recall medications, doses and/or frequency of use
- Stress of transitioning through the healthcare system
- Health Literacy
- Language barriers; cultural beliefs
- Relationship with the healthcare clinician who is obtaining the history
- Interviewer's skill level
- Time constraints
- Accuracy and completeness of medication histories obtained from other resources
- Accessibility of patients' medication list during night/weekend hours

Impact

- Lack of knowledge of patients' medications at transition points (admission, transfer, discharge) is believed to be a key source of adverse events
  - Massachusetts Coalition for the Prevention of Medical Errors
- One study found over 70% of drug-related problems were recognized only through a patient interview
  - Jameson et al. *Ann Pharmacother*. 2001; 35:835-40
- Errors due to inaccurate or missing patient medication histories may not be preventable with most currently available CPOE systems
  - Bobb et al. *Arch Intern Med*. 2004; 164:785-92

The potential for medication errors and patient harm exists if medication histories are inaccurate and/or incomplete and are subsequently used to generate inpatient medication orders

Medication Reconciliation: Identifying and Resolving Discrepancies

What is Medication Reconciliation?

A comparison of the patient's current medication regimen against the physician's admission, transfer and/or discharge orders to identify discrepancies. Any discrepancies noted are discussed with the physician, and the order is modified, if necessary.

Why Perform Medication Reconciliation?

(insert medication reconciliation literature, examples below)

- Rate of medication errors in a 6 month period decreased by 70% after implementation of a medication reconciliation process at all phases of hospitalization
  - Rozich J.D. & Resar R. *JCOM*. 2001; 8: 27-34
- Pharmacist participation on medical rounds and reconciliation and verification of patient medication profiles at interfaces of care greatly reduced medication errors
  - Scarsi, K et al. *Am J Health-Syst Pharm*. 2002; 59: 2089-92
- One study found 94% of the patients had orders changed after an ICU stay. By reconciling all pre-hospital, ICU and discharge medication orders, nearly all medication errors in discharge prescribing were avoided
  - Provonost P, et al. *Journal of Critical Care*. 2003; 18:201-205.

The Joint Commission NPSG: Medication Reconciliation

Goal 8: To "accurately and completely reconcile medications across the continuum of care"

8.a. - Develop a process for obtaining and documenting a complete list of the patient's current medications upon admission to the organization, with the involvement of the patient, if possible. This process includes a comparison of the medications the organization provides to those on this list

8.b. - 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 and outside the organization. The complete list of medication is also provided to the patient on discharge from the facility.

*Source: TJC website http://www.jointcommission.org accessed 9/30/2006

Questions and Discussion