Example Staff Education Materials

Reconciling Medications
A New Patient Safety Initiative

Purpose:
To assure that patients receive appropriate medications while hospitalized.

Why reconcile?
Reconciling is designed to improve communication at patient transfer points. Chart reviews have revealed that over half of all medication errors occur at the interfaces of care (at admission, when patients are transferred out of specialty units, and at discharge). Some examples of interface errors with serious adverse consequences include:

- No orders for vital home meds:
  Epileptic patient, no meds prescribed for that condition
  High blood pressure meds not taken, patient stroke
- Failure to restart meds on transfer:
  Patients on psychotropic drugs not restarted after transfer out of ICU
  Not restarting Coumadin at discharge; fatalities, very serious consequences (thrombo-embolic events); includes case where Coumadin discontinued in anticipation of day surgery, surgery cancelled, Coumadin never restarted
- Doubling up:
  Patient discharged on digoxin, takes that and prior prescription for Lanoxin, resulting cardiac arrest fatal
- Unresolved variances drug/dosage/frequency/route:
  Serious adverse results for erroneous patient-report of insulin type/dosage; potentially fatal dosage form errors especially failure to specify controlled release form

The Process:
"Reconciling Medications" is a formal process for developing a complete and accurate home medication list, comparing that list against medication orders at each stage of the patient's hospitalization, and resolving any discrepancies.

There are several steps to this process, all of which are designed to greatly improve the care we give our patients. Some of these steps will take added time in the early part of the patient's stay, but should actually save time later.

The basic steps in the process are summarized in the attached box. Note, however, that we will be initiating a series of small tests to identify how to integrate the reconciling process into our current practices. Everyone's input on how the process is working will be used to make adjustments.

Source: **Massachusetts Coalition for the Prevention of Medical Errors** ***Reconciling Medications Collaborative***

Collaborative Project:
Our activities are part of a statewide collaborative effort supported by the Massachusetts Coalition for the Prevention of Medical Errors and the Massachusetts Hospital Association designed to reduce medication errors statewide. The work is part of a patient safety grant awarded by the Agency for Healthcare Research and Quality (AHRQ).

Request for Input:
Please help us implement the reconciling project by providing input on any of the process components such as the following:

- How does the reconciling form itself work? Do you have enough room to enter information? Are there other important items that should be added?
- How long does it take to fill out the form? Any ideas on how to reduce that time?
- Does completing the form duplicate information you need elsewhere and are there ways we can reduce the duplication of effort?
- Did you have trouble reaching the MD to verify discrepancies?
- What should we do to ensure all unreconciled medications are resolved in a timely fashion -- strategies for handing off unreconciled medications at shift changes, back-up plans for when the ordering MD is unavailable, etc?

Instructions for Reconciling Medications at Admission

(Illustrative example, key components depend on reconciling form used and hospital policies)

1. Nursing has primary responsibility for completing the reconciling form, although note that the admitting physician and pharmacy can also complete the form (e.g. if RN hasn't completed at time orders are to be written or for patients with complex medication issues)

2. List all home medications on the reconciling form, noting **drug name, dosage, frequency, route, and time last dose taken.**

   - If the reconciling form does not allow space for all home medications, attach a second copy so all meds can be listed.
   - If the patient is not currently taking medications, explicitly note "currently not taking medications" [some forms have a check box for this]
   - Verify home medications, as necessary, with patient, patient's family, pharmacy, transferring facility, PCP/specialist, clinic records, or other resources.
   - Include OTC and herbals.
   - Attempt to get as specific a time as possible for time last taken, such as 8 a.m.

3. Compare physician admission orders to the home medication list and identify whether the medication was ordered and whether the dosage, frequency, or route was changed. Please ensure that all medications ordered by consultants are also reconciled.

4. For every variance identified between the home medication list and the physician orders, contact the physician to resolve the discrepancy.

   - Exclude those where MD has made explicit notation to discontinue or the obvious contraindications (e.g. "Patient admitted for bleed due to warfarin"; warfarin would not be continued)
   - All variances should be reconciled before the next therapeutically prescribed dose or within 4 hours for high-risk medications and always within 12 hours
   - Be sure to communicate any unreconciled medications at shift changes

5. Signatures: The nurse/caregiver taking the medication history must sign on the "Home Medication Information" line. The physician verifying orders must sign on the "Physician" line.

6. Place the form as the first page in the physician's progress notes.

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