

Reconciling Medications Reference Articles

Primary Articles

Gordon, AB. *Success Story: Luther Midelfort Achieves Dramatic Error Reductions*. Institute for Healthcare Improvement Continuous Improvement Newsletter #3 (May, 2001). www.ihl.org/resources/patientsafety/Results/ci0501lmsuccess.asp

Institute for Safe Medication Practices. *Use your pre-admission process to enhance safety*. ISMP Medication Safety Alert! October 30, 2002; p. 2.

Michels RD, Meisel S. *Program using pharmacy technicians to obtain medication histories*. *Am J Health-Sys Pharm*. October 1, 2003;60:1982-6. Early version appeared under title "Use of Pharmacy Technicians to Reconcile Patients' Home Medications" as *Am J Health-Sys Pharm* Best Practice Awards. 2002. www.ashpadvantage.com/bestpractices/2002_papers/michels.htm

Pronovost P, et. al. *Medication reconciliation: a practical tool to reduce the risk of medication errors*. *Journal of Critical Care*. 2003 Dec;18(4):201-205.

Pronovost P. *Prescription for Safety in the Surgical Intensive Care Unit*. www.saludhopkins.com/English/Institutions/Pronovost%20Patient%20Safety.asp

Rozich JD, Resar RK, et. al. *Standardization as a Mechanism to Improve Safety in Health Care: Impact of Sliding Scale Insulin Protocol and Reconciliation of Medications Initiatives*. *Joint Commission Journal on Quality and Safety*;30(1):January, 2004:5-14.

Rozich JD, Resar RK. *Medication Safety: One Organization's Approach to the Challenge*. *JCOM* 2001; 8(10):27-34.

Whittington J, Cohen H. *OSF Healthcare's Journey in Patient Safety*. *Quality Management in Health Care*. 2004 Jan-Mar;13(1):53-9. Modified version available on-line as: Haig, K. *One Hospital's Journey Toward Patient Safety – a Cultural Evolution*. *Medscape Money & Medicine* 4(2), 2003. www.medscape.com/viewarticle/460721.

Young D. *Massachusetts Moves Ahead with Patient Safety Initiatives*. *American Journal of Health-System Pharmacy*. March 1, 2004 (Vol. 61, No. 5), *AJHP News*. Provided on American Society of Health-System Pharmacists WEB site: www.ashp.org/news/ShowArticle.cfm?id=4233

Supporting Literature on Adverse Drug Events and Medication Errors

- AHRQ. Reducing and Preventing Adverse Drug Events to Decrease Hospital Costs. Research in Action, Issue 1. AHRQ Publication Number 01-0020, March 2001. www.ahrq.gov/qual/aderia/aderia.htm
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- Billman G. Medication coordination for children with cancer (Children's Hospital – San Diego). Presentation at AAP Patient Safety Summit. May 21, 2002.
- Branowicki P, Billett AL, Patterson A, Bartel S (Children's Hospital/Dana-Farber Cancer Institute). Sentinel Events: Opportunities for Change. Presentation at MA Coalition Conference on Practical Strategies for Improving Medication Safety. November 18, 2002.
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- Scott BE, et. al. Pharmacy-nursing shared vision for safe medication use in hospitals: Executive session summary. *Am J Health-Sys Pharm.* 2003; 60 (May 15):1046-52. www.ashp.org/public/pubs/ajhpopen/5b-sf-Thompson.pdf
- U.S. Pharmacopeia. Miscommunication Leads to Confusion and Errors: Cause of Errors, Case Illustration, and Suggestions to Minimize Errors in Communication. *USP Patient Safety CAPSLink Newsletter*, December 2003. See also other issues analyzing errors submitted to their medication error database.

Key WEB-based resources

Agency for Healthcare Research and Quality (AHRQ)	www.ahrq.gov/qual/errorsix.htm
American Society of Health-System Pharmacists	www.ashp.org
Institute for Healthcare Improvement (IHI)	www.ihl.org
Institute for Safe Medication Practices	www.ismp.org
National Patient Safety Foundation	www.npsf.org
Pathways for Medication Safety	www.medpathways.info
QualityHealthCare.org	www.QualityHealthCare.org
US Pharmacopeia (CAPS, MedMarx)	www.usp.org
VA National Center for Patient Safety	www.patientsafety.org

The following topic-specific reference lists are also available on request:

- Improving the Accuracy of the Medication Intake History
- Role for Pharmacy
- Practical Approaches to Implementing System Changes
- Developing a Culture Safety
- Projecting Implementation Costs and Benefits
- Medication Cards for Patients
- Risk Assessment, Root Cause Analysis
- Failure Mode and Effects Analysis