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Medication Reconciliation

What is Medication Reconciliation?

Is a clinician's comparison of the prescribed medications a patient is using against the new medications ordered for the patient during an encounter, resolving any discrepancies, and updating the medical record to reflect them.

Why is Reconciliation Needed?

- Reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
- It should be done at every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner, or level of care.
- The intent is to avoid errors of omission, duplication, incorrect doses or timing, and adverse drug-drug or drug-disease interactions.
- A comprehensive list of medications should include all prescription medications, herbals, vitamins, nutritional supplements, over-the-counter drugs, vaccines, diagnostic and contrast agents, radioactive medications, parenteral nutrition, blood derivatives, oxygen, and intravenous solutions (hereafter referred to collectively as medications).
- Over-the-counter drugs and dietary supplements are not currently considered by many clinicians to be medications and thus are often not included in the medication record. As interactions can occur between prescribed medication, over-the-counter medications, or dietary supplements, all medications and supplements should be part of a patient's medication history and included in the reconciliation process.

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Medication Reconciliation is Intended to Identify and Resolve Discrepancies

‘There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies – it is a process of comparing the medications a patient is taking (or should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected in order to reconcile current and newly ordered medications and to safely prescribe medications in the future.’

Quote from the Joint Commission

‘Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Give the patient written information about the medicines they need to take. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.’

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Six Steps to Comply with Medication Reconciliation Requirements:

- Document medication regimen
- Strive to perform complete, accurate medication reconciliation
- Compare and reconcile all medications identified
- Update the patient's record with the reconciled, accurate medication list
- Provide information about new or changed medications
- Emphasize the importance of managing medication information

Whenever you make a change to a patient's regimen following an encounter, take the time to explain the reason(s) for the change, cover any new information about frequency and route, and provide a summary of this information in writing to the patient and any accompanying family members. Using teach-back methods can help ensure a patient and/or family member understands the new instructions.

Be sure patients understand that any new over-the-counter medications and supplements should be added to the list and communicated to the primary care physician during their next visit.

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Medication List Documentation:

- Name of Medication
- Dose
- How often to be taken (daily, once a week, etc.)
- Time of the day to be taken (if applicable – AM, PM, HS)
- Route (PO, Via NG tube, rectal, SQ, IM, etc.)

Reason for the medication is also helpful to list (HTN, CKD, etc.)

PRN Medications

PRN medications MUST list the reason for the medication and how often they can be given (on top of the regular required elements for medications)

Example: Hydrocodone-Acetaminophen 10/135 mg PO Q6 PRN for pain.

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What Should be on a Medication List?

- Over the counter medications
- Herbal supplements
- Prescribed medications
- Wound care ointments, creams, cleansers
- Oxygen

What should be done on each patient visit regarding medications?

- Ask the patient/caregiver if the patient has started taking any new medications, started using any new ointments or creams, or started on oxygen.
- Review all medications that are stored in the patient's home and ask questions regarding their use, provide education, and monitor if the patient is appropriately taking them.
- Compare medications in the home with the current medication list.
- Any discrepancies need to be reconciled at the visit.

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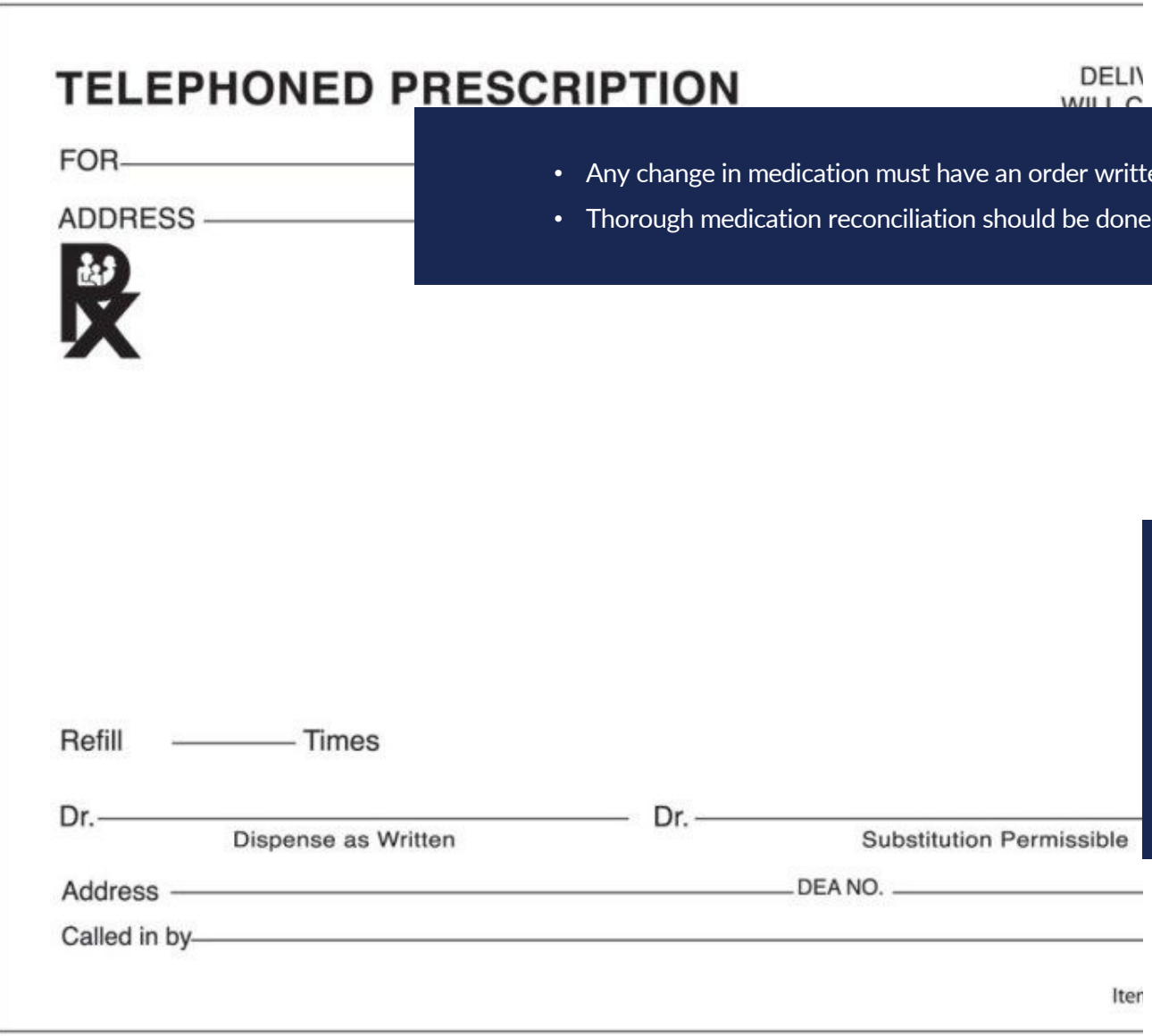
Medication Orders


TELEPHONED PRESCRIPTION

DELI

FOR

ADDRESS

Rx

Refill ——— Times

Dr. ——— Dr. ———

Dispense as Written

Substitution Permissible

Address ——— DEA NO. ———

Called in by ———

Iter

- Any change in medication must have an order written that is signed and dated by the provider.
- Thorough medication reconciliation should be done when patients transition from one type of care to another.

According to Medicare, a physician order must include the following elements in order to be considered valid:

- Reason for ordering the test or service (diagnosis description, ICD-9 code, sign(s), symptoms, medication)
- Test or service requested
- Provider's name
- Provider's signature
- Patient complete name
- Patient date of birth

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In addition, the following information may be included for medications:

- Date and time
- Medication name (generic or brand)
- Dosage strength
    - May depend on weight, BMI, lab results, comorbidities (e.g. liver or kidney disease)
    - E.g. 10 mg per kilogram
- Dosage form (e.g. syrup, solution, etc.)
- Route of administration (by mouth, intravenous, eye drops, per rectum, etc.)
- Frequency of administration (once a day, four times a day, every 6 hours)
    - Hospitals typically have set hours for meds
        - Four times a day might be 0800, 1200, 1600, 2000 or 0900, 1300, 1700, 2100. Meds are given at set times depending on pharmacy schedules. These times usually allow patients periods of uninterrupted rest without meds.
        - Every 6 hours: Meds may also be given with set intervals between doses such as 0600, 1200, 1800, 2400 depending on when the med was started. This method ensures the patient's blood level of medicines remains level throughout the 24-hour period. This may be crucial for some disorders such as Myasthenia Gravis.
- Time of administration (before meals, with meals, or on call to OR)
- Duration of therapy/order expiration

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Types of Orders

- Standing orders
- Stat – immediate administration
- As needed (PRN)
- One time
- Medication reconciliation when patients transition from one type of care unit to another.
    - E.g. when patients move from ICU to med-surg floor are discharged to another facility.

Parameters:

- Some medications are given with explicit parameters:
    - E.g. hold for SBP less than 110 mmHg or give for fever over 100F
    - A lack of written parameters does not necessarily mean there are none
        - E.g. digoxin is typically held if the HR is less than 60 beats per minute – this may or may not be written as part of the order
- Some medication administration such as insulin or heparin, may be dependent on lab results
    - E.g. heparin (aPTT)
    - Insulin (blood sugar – finger stick or lab)
    - Kidney function labs (e.g. creatinine)
    - Blood levels of medications (e.g. vancomycin peak and trough)
- As needed orders (PRN) should have parameters (e.g. as needed for nausea every three hours). Learners will need to determine the time of the previous dose to check that the patient can be safely given another dose.

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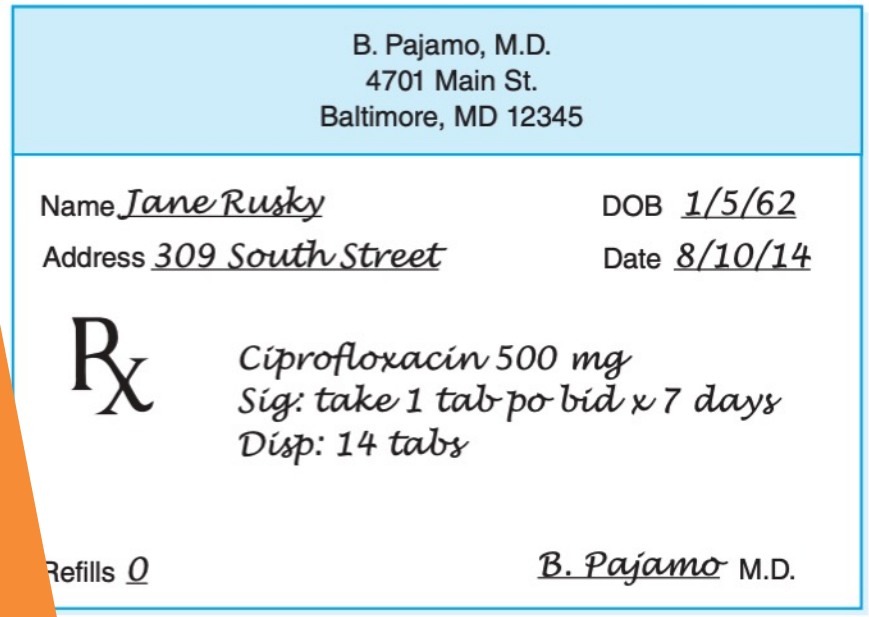
Abbreviations

To avoid medication errors, the spelling-out of words that are often abbreviated is also recommended, for example:

- Write ‘units’, not U or u
- Write ‘daily’, not od (once daily or qd / QD
- Write ’every other day’, not qod / QOD
- Write full drug names (e.g. Penicillin, not PCN)
- Use ‘greater than’ or ‘less than’ instead of > or <
- Do not sue @, write ‘at’
- Do note use ‘+’, use ‘and’ or ‘plus’ instead
- Do not use ‘&’, use ’and’
- Drug names should be written out in full
    - E.g. MS or MSO4 must be written out in full, morphine sulfate
- Apothecary measurements should not be used. Use metric instead.


B. Pajamo, M.D.
4701 Main St.
Baltimore, MD 12345

Name *Jane Rusky* DOB *1/5/62*

Address *309 South Street* Date *8/10/14*

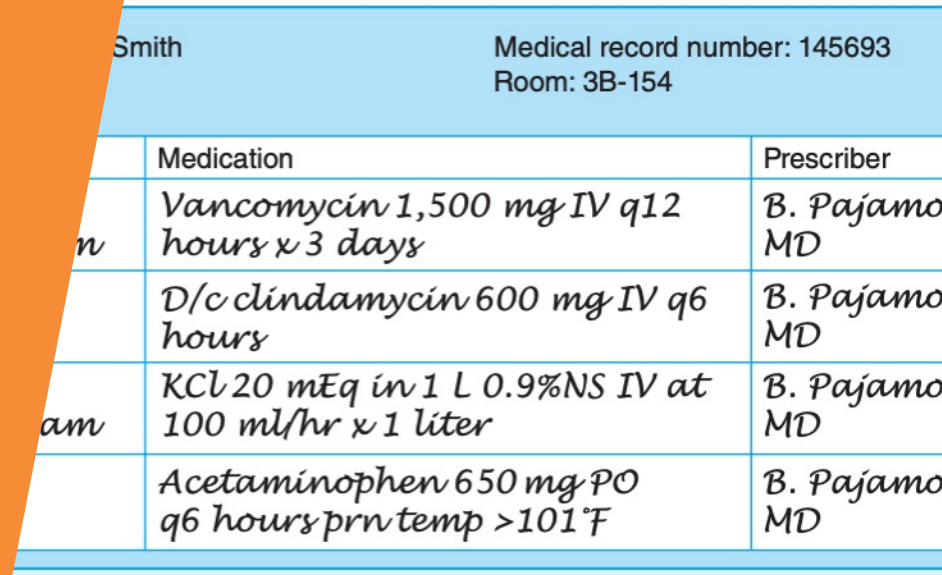
Rx

Ciprofloxacin 500 mg
Sig: take 1 tab po bid x 7 days
Disp: 14 tabs

Refills *0*

B. Pajamo M.D.

FIGURE 2.1 Sample prescription


Smith

Medical record number: 145693
Room: 3B-154

	Medication	Prescriber
n	*Vancomycin 1,500 mg IV q12 hours x 3 days*	*B. Pajamo MD*
	D/c clindamycin 600 mg IV q6 hours	*B. Pajamo MD*
am	*KCl 20 mEq in 1 L 0.9%NS IV at 100 ml/hr x 1 liter*	*B. Pajamo MD*
	Acetaminophen 650 mg PO q6 hours prn temp >101°F	*B. Pajamo MD*

FIGURE 2.2 Sample medication order

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Decimal Points

If decimal points are necessary, use a '**leading zero**' before a decimal point (e.g. write 0.5 mg, not .5 mg). Never use a '**trailing zero**' after a decimal point (e.g. write 5 mg, not 5.0 mg).

Medication Errors

Medical errors account for around 251,000 deaths every year.

82 percent of American adults take at least one medication and 29% take five or more medications.

Adverse Drug Events cause approximately 1.3 million emergency department visits and 350,000 hospitalizations each year.

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Incomplete or inaccurate medication lists may result in medication errors throughout the inpatient stay and upon discharge from the facility. According to a 2015 study by the Agency for Healthcare Research and Quality (AHRQ), more than half of admitted patients' medication lists contain at least one discrepancy and 40% of these identified discrepancies have the potential to cause harm (AHRQ, 2015).

Another study of medication reconciliation on admission found discrepancies between physician admission medication orders and the medication history obtained through interviews and that 39% of discrepancies had the potential to cause harm (Cornish, Knowles, Marchesano, et. al., 2005).

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Thank You

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