

## **Pharmacist Self Learning Module**

The compelling argument for medication reconciliation, according to the Institute for Healthcare Improvement, is:

- Medication errors are one of the leading causes of injury to hospital patients.
   Chart reviews reveal that more than half of all hospital medication errors occur at the interfaces of care. —Rozich JD, Resar RK. Medication Safety: One organization's approach to the challenge. JCOM. 2001;8 (10): 27-34.
- Experience from hundreds of organizations has shown that poor communication
  of medical information at transition points is responsible for as many as 50
  percent of all medication errors in the hospital and up to 20 percent of all adverse
  drug events. Institute for Healthcare Improvement 100,000 Lives Campaign.
  (Available at: ww.ihi.org/IHI/Programs/Campaign/.)
- Drug-related morbidity and mortality are often preventable and pharmaceutical services can reduce the number of adverse drug events, the length of hospital stays and the cost of care. —Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. Am J Hosp Pharm. 1990; 47:533-43.
- An up-to-date and accurate medication list is essential to ensure safe prescribing in any setting.

**Definition:** Medication reconciliation is a formal, interdisciplinary process of obtaining a complete and accurate list of each patient's home medications and comparing the hospital admission, transfer and discharge orders to that list. Discrepancies are communicated to the prescriber and changes are made to the patient's orders, if appropriate.

There are three steps to the medical reconciliation process:

- 1. **Collection**—Compiling the home medication list
- 2. Clarification—Ensuring that medications and doses are accurate
- 3. **Reconciliation**—Resolving discrepancies between the home medication list and the medication orders from the hospital

**Objective:** This self-learning module is designed to instruct the pharmacist in the process of medication reconciliation and its implementation at Legacy Health System and to define the role of the pharmacist in this interdisciplinary process.

Medication reconciliation is an interdisciplinary process that involves nursing, pharmacy, and the licensed independent practitioner (LIP). The medical reconciliation process takes place whenever a patient is enters into any part of Legacy Health System,

including the emergency department, procedural areas, surgery, inpatient areas, etc. If the patient receives medications (or his/her response to treatment or service is affected by medications) then medication reconciliation must occur.

## Steps to medical reconciliation at Legacy Health System

- 1. When the patient enters Legacy, a home medication list is collected as part of the nursing admission assessment.
- 2. The home medication list is entered into RxPad in E-Chart (Legacy Health System's electronic medical record) by the nursing staff.
- 3. **For admitted patients**, the home medication list is printed out and placed in the " Physician Orders" section of the patient's chart.
- 4. The LIP reviews the list and either continues or discontinues each home medication. It is the LIP's responsibility to reconcile any discrepancies between home medications and the medications ordered as a result of inpatient treatment.
- 5. Once completed and signed, the reconciled list becomes an order and is copied and sent to the pharmacy.
- 6. The RPh inputs the medications ordered into E-Chart and selects "Med Reconciliation @ Admit Complete" from the compendium H-O button in E-Chart. This will show up on the nightly MAR and will be used to audit compliance with medication reconciliation.
- 7. In treatment/procedural areas in which the patient is not admitted, the home medication list is added to RxPad and is used as a reference when medications are administered, however, the pharmacist does not receive a printed report for home medications.

## For transfers:

- 1. The receiving unit prints out the home medication list from RxPad.
- 2. The receiving LIP reconciles the home medication list and hospital-ordered medications, as above.
- 3. The transfer orders and reconciled RxPad orders are sent to pharmacy.
- 4. The RPh inputs the transfer orders into E-Chart and selects "Med Reconciliation @ ransfer Complete" from the compendium H-O button in E-Chart. This will show up on the nightly MAR.

## At discharge, for both admitted and non-admitted patients:

 The LIP generates prescriptions using RxPad. He/she is immediately notified of any duplication, allergy conflict or drug interaction with the home medication list. The LIP reconciles any conflict between the home medication list and hospitalordered prescriptions.

- 2. The LIP either prints out the prescriptions or electronically faxes the prescriptions to the retail pharmacy identified by the patient.
- 3. The reconciled RxPad list is printed out and given to the patient at discharge. This list includes all medications the patient needs to take at home—both old and new prescriptions.
- 4. A second list of the medications the patient should no longer take at home is also printed and given to the patient.
- 5. Both lists are faxed to the patient's primary care physician.

See the <u>RxPad Cheat Sheet</u> for instructions on how to use RxPad and how to print out the various reports and handouts.