STANDARDIZING MEDICATION RECONCILIATION

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MEDICATION RECONCILIATION

**Purpose:** to create the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the admission, transfer, and/or discharge orders.

**Goal:** to ensure that all correct medications are given to the patient and to prevent unintended changes or omissions of medications at all transition points.
INTRODUCTION

• Medication Reconciliation (MR) is thought of as an effective strategy for reducing discrepancies during transitions of care.

• It is reported that an average hospitalized patient is subject to at least one medication error per day.¹

Project Focus

• Identify the number of healthcare facilities that utilize an in-house standardized approach for MR

• Determine if survey respondents believe that their current institution’s MR method needs improvement.
METHODS

Your Input on Medication Reconciliation Requested

A group of P3 student pharmacists from The University of Iowa are seeking your input on medication reconciliation for a research project. The goal of the project is to identify variables in the process of medication history and medication reconciliation collection between institutions. That data will be used to create a standardized method for these processes.

Click here to complete the brief 10 question survey by August 31, 2017. Feel free to contact Jessica-Ngo@uiowa.edu if there are any questions.
PARTICIPANTS

PHARMACISTS (12)
PHARMACY DIRECTOR (3)
PHARMACY RESIDENT (1)
CERTIFIED PHARMACY TECHNICIAN (1)
MANAGER OF PHARMACEUTICAL SERVICES (1)

RESPONDENTS WERE FROM THE STATE OF IOWA, HOSPITAL & COMMUNITY PHARMACIES, WHO RECEIVE IPA EMAILS
MATERIALS
PROCEDURE

• Participants completed a 10 question survey
• Responses were collected and analyzed on a SurveyMonkey platform
RESULTS

Do you believe the process of medication reconciliation at your institution could be improved?

Yes: 100.00%

No: 0%
DOES THE HOSPITAL HAVE A STANDARDIZED PROCESS AND/OR TRAINING FOR PREPARING STAFF TO COMPLETE A MEDICATION HISTORY OR MEDICATION RECONCILIATION?

- Yes: 30.00%
- No: 70.00%
WHERE IS THE MEDICATION HISTORY AND MEDICATION RECONCILIATION DOCUMENTED?
WHEN IS MEDICATION RECONCILIATION (THE PROCESS OF CREATING THE MOST ACCURATE LIST POSSIBLE OF ALL MEDICATIONS A PATIENT IS TAKING) DONE AT YOUR INSTITUTION? (SELECT ALL THAT APPLY)
WHO COLLECTS MEDICATION HISTORIES (DETAILED, ACCURATE AND COMPLETE ACCOUNT OF ALL PRESCRIBED AND NON-PRESCRIBED MEDICATIONS THAT A PATIENT HAD TAKEN OR IS CURRENTLY TAKING PRIOR TO A NEWLY INITIATED INSTITUTIONALIZED OR AMBULATORY CARE) AT YOUR INSTITUTION? (SELECT ALL THAT APPLY)
WHICH HEALTH CARE PROFESSIONAL PERFORMS MEDICATION RECONCILIATION AT YOUR INSTITUTION? (SELECT ALL THAT APPLY)
SURVEY FINDINGS

• Most institutions surveyed had no standardized process or training protocol for the processes of collecting medication histories and performing medication reconciliation.

• Many healthcare providers of different backgrounds were involved in the process.

• All survey respondents unanimously agreed that there is a need for improvement in these processes.

• There is a need for standardization of training.
SURVEY FINDINGS

• Gaps in communication at transitions of care

• Lack of consistency

• Lack of accuracy in medication lists
DISCHARGE STUDY

• Prospective Cohort Study
• Examined the rates of medication reconciliation errors and patient misunderstanding of medications at discharge
• Assessed accuracy of medication reconciliation by comparing medication lists from admission to those at discharge
• Patient understanding of medication changes was assessed through post-interview follow-up
• Findings: A quarter of all hospital discharge medication changes were unintended and patients had a misunderstanding of two-thirds of new medications or medication changes
• Medication errors occurred more frequently in those unrelated to the primary diagnosis
• Patients were more likely to misunderstand medication changes unrelated to the primary diagnosis

FUTURE DIRECTIONS

• Creation and Implementation of a Collaborative Education Institution (CEI) course
• Other standardized processes: Immunization certification, CPR certification
• Objective: Standardizing the processes of medication history collection and medication reconciliation
• Focus areas: Bridging gaps in communication at transitions of care, accuracy of medication lists and their importance, impact of medication reconciliation on patient care
• Hiring a staff pharmacist specifically for medication reconciliation
• Medication Background
• Consistency to reduce medication errors and bridge gaps in communication
LIMITATIONS

• Intended Survey Respondents: Those that are involved in collecting medication histories and performing medication reconciliation

• Responses Received: Hospital, Clinic, and Community Pharmacy Settings

• Limited external validity: Only Institutions in Iowa were surveyed
CONCLUSION

• Medication Reconciliation serves a purpose
  • To prevent drug therapy problems

• DISCHARGE study findings
  • Medication changes at discharge were unintended in many cases
  • On average, patients misunderstood two-thirds of new medications or medication changes

• Standardized medication reconciliation
  • Implement CEI course
  • Hire a pharmacist for medication reconciliation
REFERENCES


