

MEDICATION RECONCILIATION



WHAT IS IT? *Medication reconciliation is a process designed to prevent medication errors at patient transition points. It includes:*

- Creating the most complete and accurate list or Best Possible Medication History (BPMH) of all home medications for each patient.
- Using that list when writing medication orders.
- Comparing the list against the physician's admission, transfer, and/or discharge orders; identifying and bringing any discrepancies to the attention of the physician; and, if appropriate, making changes to the orders ensuring the changes are documented.

WHY DO IT? *Adverse Drug Events (ADEs) are frequent occurrences in Canadian hospitals. Communication problems between healthcare professionals in different care settings are a significant factor.*

- A 2004 Canadian study found drug and fluid related events were the second most common type of procedure or event related to adverse events.¹
- In a Canadian investigation, Forster et al. found that 23% of hospitalized patients discharged from an internal medicine service experienced an adverse event; of the 23%, 72% were ADEs.²
- Chart reviews reveal over half of all hospital medication errors occur at the interfaces of care.³
- A Canadian study by Cornish and colleagues found that 53.6% of the study population had at least one unintended discrepancy, of which 38.6% were judged to have the potential to cause moderate to severe discomfort or clinical deterioration. Most discrepancies (46.4%) included the omission of a regularly used medication.⁴
- Accreditation Canada includes medication reconciliation as part of its required organizational practices⁵

HOW TO DO IT *Medication Reconciliation starts with completing a BPMH*

- Review the prescription drug database information (PIP)
- Interview the patient &/or family
- Review medication vials &/or patient's personal medication list
- Review MAR if transferred from another facility/service
- Compile information from these sources to develop an up to date list of what the patient/client is actually taking at the time
- **Remember** to include all over-the-counter medications, herbals, supplements, vitamins, and physician samples!

¹ Baker GR, Norton PG. The Canadian Adverse Events Study: the incidence of adverse events among hospitalized patients in Canada. Can Med Assoc J. 2004; 170 (11):1678-1686.

² Forster AJ, Clark HD, Menard A, Dupuis N, Chernish R. et. al., Adverse events among medical patients after discharge from hospital. Can Med Assoc J. 2004; 170(3):345-349

³ Rozich JD, Resar RK. Medication Safety: One organization's approach to the challenge. J Clin Outcomes Manage. 2001;8(10):27-34. 4

⁴ Cornish PL, Knowles SR, Marchesano R, Tam V, Shadowitz 5, Juurlink DN, EtcHELLS EE. Unintended medication discrepancies at the time of hospital admission. Arch Intern Med. 2005;165:424-429.

⁵ Accreditation Canada. Required Organizational Practices. Accessed July 2008. Available at: www.accreditationcanada.ca/default.aspx?page=355&cat=30

MEDICATION RECONCILIATION PROCESS MAP

- Review PIP
- Interview patient/family
- Check medication vials
- Review patient personal medication list
- Review MAR if transferred
- Include OTCs, herbals, vitamins, supplements, and physician samples

