

# 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.<sup>1</sup>
- 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.<sup>2</sup>
- Chart reviews reveal over half of all hospital medication errors occur at the interfaces of care.<sup>3</sup>
- 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.<sup>4</sup>
- Accreditation Canada includes medication reconciliation as part of its required organizational practices<sup>5</sup>

## **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!

<sup>1</sup> 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.

<sup>2</sup> 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

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

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

<sup>5</sup> Accreditation Canada. Required Organizational Practices. Accessed July 2008. Available at: [www.accreditationcanada.ca/default.aspx?page=355&cat=30](http://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

