Let's talk about Medication Reconciliation:

What is Medication Reconciliation? The Institute for Health Care Improvement (IHI) defines the process as, the process of creating 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 physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient - sounds simple. However, in real practice it is quite complex. Patient's, in today's health care environment see multiple providers, go to multiple pharmacies, if hospitalized, have many of their medications automatically substituted during their stay, and go home with confusing instructions.

Getting to the truth about which medications a patient is on, which is the essence of medication reconciliation, turns out to be one of the more frustrating endeavors for all health care providers. Again, according to the IHI, "…studies show that inconsistent knowledge and record keeping about medications directly threaten patient safety, causing up to 50 percent of all medication errors in the hospital and up to 20 percent of adverse drug events (ADEs)!"

What are we doing at Heywood Healthcare to address this complex issue? Well a number of things actually. One, in October 2018 we started a Pharmacy Technician driven process to obtain an accurate home medication list – this is the first step to getting at the truth! Our Pharmacy Technicians work from 10:30am – 7pm Monday – Friday (and we will be attempting to add weekends later in 2019), they are seeing an average of 35 patients a month, who are on average on 10 medications each, and they are spending on average 25 minutes per patient! That is staggering, and without this kind of resource, no other health care professional has that amount of time to spend. The program has been successful, and we are seeking to expand it. One challenge that both our Pharmacy Technicians have, and any other staff attempting to get an accurate home medication list, is that the providers are attempting to order inpatient medication prior to this process being complete. For this reason we have added this statement to our newly approved Medication Reconciliation Policy: **Upon completion of the home medication list, and NOT before**, the LIP will use the list of home medications to facilitate inpatient medication orders as soon as possible but within 24 hours of admission, shorter time frames for high risk drugs, potentially serious dosage variances, and/or upcoming administration times.

The Joint Commission's National Patient Safety Goals for 2019 state, "Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, *and the need to continue current medications."* This is the other major challenge of medication reconciliation; once we have an accurate list, should the patient **STILL** be taking these medications. Because of the complexity of the process, and it's time consuming nature, the tendency is to continue all the medications from home, the reality is that the patient MAY be here because of an issue with one or more of these medications. This is the reason for this key statement in our Medication Reconciliation Policy, "The LIP must evaluate each medication on the home medication list to ensure that it is appropriate to be continued on an inpatient basis."

Thus the three pillars of medication reconciliation for a patient being admitted to the hospital are:

1. Attempt to the best of our abilities to obtain the most accurate medication list that the patient has upon entering the ED (that is, finding the truth)!

2. Waiting for the process to be as complete as possible prior to ordering any inpatient medications and

3. Evaluating each medication on the home medication list to ensure that it is appropriate to be continued on an inpatient basis

If we can accomplish all three, then we are on our way to improving our medication reconciliation process!

This is but one step of the process, the other key step is at discharge from the hospital. Again, The Joint Commission's National Patient Safety Goals for 2019 gives guidance, "Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter." It further states, "*Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter. Note: Examples include instructing the patient to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations.*

A striking point about the above is that is puts responsibility for this on the patient! Educating our patients that it's in their best interest to have their most up to date medication list with them at all times, ultimately, makes the process easier for all of us!

The other major thing we are doing at Heywood Healthcare is embarking on a program called, "Meds to Beds." This program engages our local pharmacies, Chair City Pharmacy and Athol Pharmacy to provide discharge medications, ideally, at the time of discharge, to those patients that indicate they want this service. Both Chair City Pharmacy and Athol Pharmacy have pharmacists that are available to answer patient's questions regarding their medications and/or providing in home consultations. Additionally, they can package a patient's medication in a unique manner, so that all of their medications for a given day are in the appropriate bubble pack.

Combining an accurate medication list up front, with a pharmacy partner that can manage a patient's medication at home is a powerful 1-2 punch in addressing the challenges of medication reconciliation and in improving outcomes for our patients.

References: http://www.ihi.org/Pages accessed 3-27-2019
https://www.jointcommission.org/hap_2017_npsgs/ accessed 3-27-2019