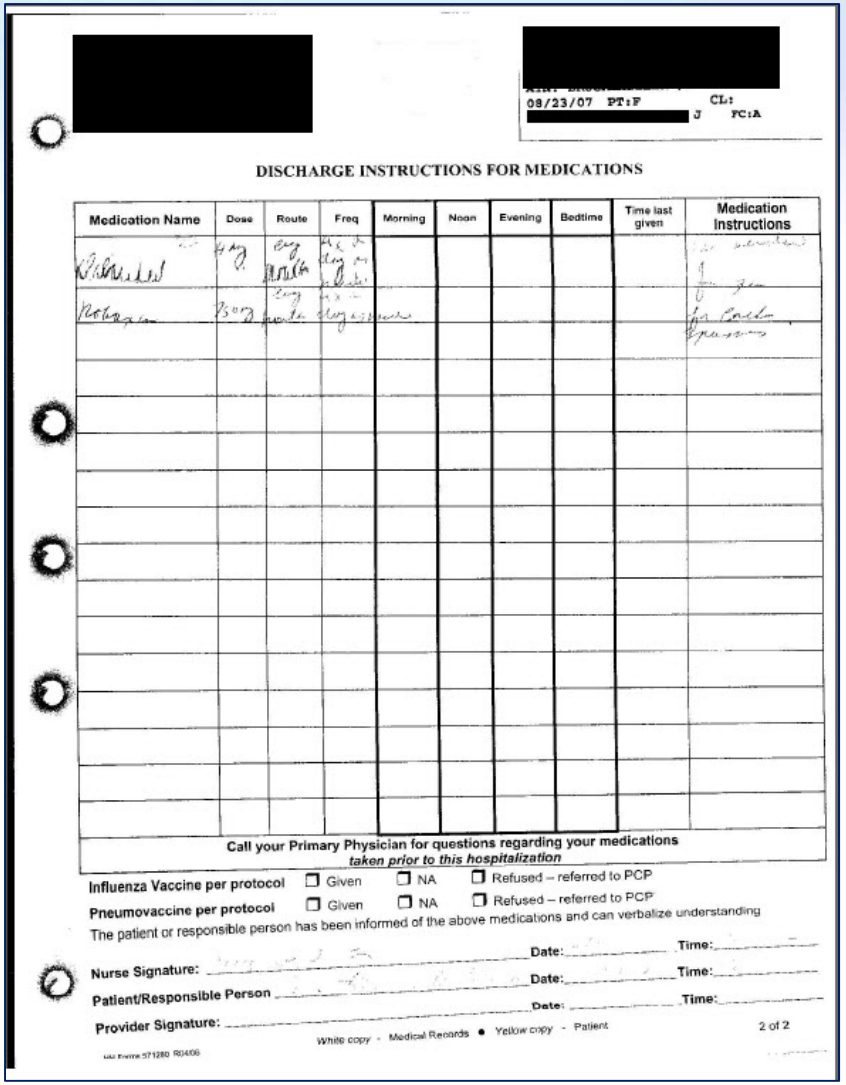
Sometimes It Feels Like WRECKonciliation

A New Idea!

Let's Face It - It's Not Really *That* New

- ✓ 8 home medications
- ✓ Taken daily at night
- ✓ Given in the a.m. while inpatient
- ✓ One stopped on admission
- ✓ DC to home with 2 PRN medications
- ✓ No instruction for stopped medication
- ✓ No last dose info
- ✓ Please don't let me continue



[redacted]

[redacted]

08/23/07 PT:F [redacted] J CL: FC:A

DISCHARGE INSTRUCTIONS FOR MEDICATIONS

Medication Name	Dose	Route	Freq	Morning	Noon	Evening	Bedtime	Time last given	Medication Instructions
[illegible]	40mg	[illegible]	[illegible]						
[illegible]	80mg	[illegible]	[illegible]						

Call your Primary Physician for questions regarding your medications *taken prior to this hospitalization*

Influenza Vaccine per protocol ☐ Given ☐ NA ☐ Refused – referred to PCP

Pneumovaccine per protocol ☐ Given ☐ NA ☐ Refused – referred to PCP

The patient or responsible person has been informed of the above medications and can verbalize understanding

Nurse Signature: _____ Date: _____ Time: _____

Patient/Responsible Person _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____

White copy - Medical Records • Yellow copy - Patient

2 of 2

A Little History

2005: Joint Commission announced the 2006 NPSG requirements for Medication Reconciliation

Reconcile Medications at All Transition Points:

Reconcile Admission Orders with Home Medication Lists
When a patient [illegible] lications ordered upon admission [illegible] onciled — with the list of medic [illegible] the hospital. If any pre-admissi [illegible] citly declared to be inappropriat [illegible] e patient's physician. The physician should then either order the medication or formally confirm that the omission was deliberate. Early in the process of implementing medication reconciliation, someone should talk to all the physicians, asking them to routinely document the reason for excluding any medication on admission — and reminding them of the goal of improving patient safety. A brief note on the order form for each deliberate medication omission will save everyone time and save the physician the effort answering extra questions.

Just Kidding!

Let's Break It Down

A Little History

- 2005: Joint Commission announced the 2006 NPSG requirements for Medication Reconciliation
- Reconcile Admission Orders with Home Medication Lists
  1. Admission
     - Ordered meds compared (reconciled) with Home
  2. Omitted home medications
     - Nurse or Pharmacist – contact physician
     - Physician
       - Formally confirm deliberate omission
       - Order the medication

A Little History

- 2005: Joint Commission announced the 2006 NPSG requirements for Medication Reconciliation
- Reconcile Admission Orders with Home Medication Lists
- Early in the process “someone” should talk to all the physicians:
  - Ask for routine documentation of reason for omission
  - Remind them of the goal to improve pt safety
  - A brief note on the order form for each deliberate medication omission will save everyone time and save the physician the effort of answering extra questions.

A Candid Opinion

- Failure was Certain
- Wishy-Washy
- No Clear Direction
- Seemingly Optional

What it Looks Like Now

Goal 8: Accurately and completely reconcile medications across the continuum of care.

All Elements of Performance indicate: *"This element of performance is not in effect at this time."*

Breaking News!

It's Broken Alright

"Since the Goal on medication reconciliation was instituted in 2005, many organizations have struggled to develop and implement effective and efficient processes to meet the intent of the Goal."

Provided from www.jointcommision.org

Breaking News!

It's Broken Alright

Effective January 9, 2009

- Goal 8 will continue to be evaluated
- Expectations will be refined
- Findings will not be factored into the accreditation decision
- Findings will not generate Requirements for Improvement (RFIs)
- Findings will not appear on the accreditation report

Breaking News!

It's Broken Alright

As of March 5, 2010, TJC will:

- Consult with health care organizations, physicians, pharmacists, nurses, surveyors and other stakeholders
- Craft an improved NPSG 8
- Craft an NPSG that can be readily implemented by January 2011

Phew!

We get a little reprieve…

- Concentrate on other projects
- See what TJC comes out with
- Take a wait-and-see approach

While You Were Sleeping….

Meaningful Use came along

Easy Concept – Challenging Practice

"The reconciliation process is challenging to document using health IT instead of using a pen and paper that says 'meds reviewed'. It's easy if you're thinking about it. It's another thing to make that happen inside the computer system."
"The technology by itself cannot do it. You must build a process in your practice to make that happen, and that's the challenge."

- C. Martin Harris, Cleveland Clinic

Provided from http://govhealthit.com/Article.aspx?id=73271

Meaningful Use: Objective #2

Implement drug-drug, drug-allergy, drug-formulary checks

- Measure: The eligible hospital has enabled this functionality

Meaningful Use: Objective #4

Maintain active medication list

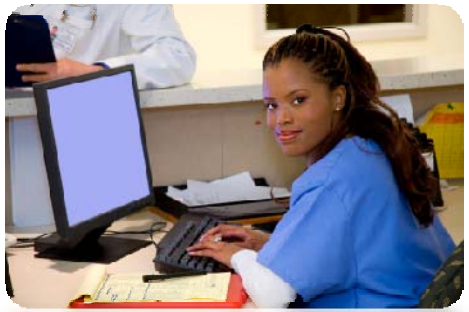
- Measure: At least 80 percent of all unique patients admitted by the eligible hospital have at least one entry (or an indication of “none” if the patient is not currently prescribed any medication) recorded as structured data

Meaningful Use: Objective #5

Maintain active medication allergy list

- Measure: At least 80 percent of all unique patients admitted to the eligible hospital have at least one entry (or an indication of “none” if the patient has no medication allergies) recorded as structured data

Meaningful Use: Objective #16



Provide patients with an electronic copy of their discharge instructions and procedures at time of discharge, upon request

- Measure: At least 80 percent of all patients who are discharged from an eligible hospital and who request an electronic copy of their discharge instructions and procedures are provided it

Meaningful Use: Objective #18

Perform medication reconciliation at relevant encounters and each transition of care

- Measure: Perform medication reconciliation for at least 80 percent of relevant encounters and transitions of care

The Federal Register

"Electronically complete medication reconciliation of two or more medication lists (compare and merge) into a single medication list that can be electronically displayed in real time."

Provided from Federal Register / Vol. 75, No. 8 / Wednesday, January 13, 2010 / Rules and Regulations / Page 2028

Meanwhile, Back at The Joint Commission

Awaiting Approval

A separate medication list

The requirement for maintaining a separate medication list has been relaxed and is no longer mandatory. Medication information still needs to be updated and documented in the record but does not have to be tied to a single list

Provided from http://blogs.hcpro.com/accreditationcenter/2010/04/draft-medication-reconciliation-standards-bring-simplification/

Meanwhile, Back at The Joint Commission

Awaiting Approval

The hospital defines criteria

The extent of medication information collected for various types of patient encounters and care settings is not the responsibility of the hospital to define as opposed to a complete list being required.

Provided from http://blogs.hcpro.com/accreditationcenter/2010/04/draft-medication-reconciliation-standards-bring-simplification/

Meanwhile, Back at The Joint Commission

Awaiting Approval

Written discharge medication information if indicated

The need to provide the patient with written medication information upon discharge is only required when there are changes to the home list of when a short duration medication is added such as antibiotics. This eliminates the need to produce a written list at the end of every patient encounter.

Provided from http://blogs.hcpro.com/accreditationcenter/2010/04/draft-medication-reconciliation-standards-bring-simplification/

A Candid Opinion

- Failure Seems Certain Again
- Wishy-Washy
- No Clear Direction
- Seemingly Optional

A Candid Opinion

- TJC waited for the government to place more stringent guidelines before creating theirs
- They say med recon is “only required when there are changes to the home list” but how can you decide if there are new home meds unless you reconcile?
- Facilities will still have no concrete guidelines and will spend valuable time debating and reading between the lines

Roadblocks to Success

Inadequate Support

- Administration was not part of initial project plan
- Nurse Managers trying to protect staff
- Project initiated by Nursing without Pharmacy involvement
- Physicians feel process is optional

Work It Out!

Inadequate Support

Taking Action:

Provide Administration with data to support initiatives:

- Regulatory requirements
- Patient safety
- Revenue increase
  - Decreased readmissions
  - Government incentive

Work It Out!

Inadequate Support

Taking Action:

Provide Administration with data to support initiatives:

- In other words: Clearly establish the current costs and the expected solution/benefits

Work It Out!

Inadequate Support

Taking Action:

Provide Administration with data to support initiatives:

- Keep in mind the 4 quadrants:

  Financial Customer

  Learning Growth

Work It Out!

Inadequate Support

Taking Action:

Provide Administration with data to support initiatives:

Must appeal to all quadrants but **financial** will be the most compelling

Costs:

- Team creation
- Data gathering
- Staff education (continuous)
- Procedure and policy update

Work It Out!

Inadequate Support

Taking Action:

Provide Administration with data to support initiatives:

Must appeal to all quadrants but **financial** will be the most compelling

Benefits:

- Decrease ADEs
- Fewer readmissions
- Patient safety. May post-DC medication reconciliation errors are handled by PCP and never reported

Work It Out!

Inadequate Support

Taking Action:

Provide Administration with data to support initiatives:

- Regulatory requirements
- Patient safety
- Revenue increase
  - Decreased readmissions
  - Government incentive

Work It Out!

Inadequate Support

Taking Action:

Enlist Physician Leaders/ Thought Leaders:

- Patient safety #1 goal
- No question of intent or skill
- Can't do it without their support
- Goals
  - Decreased readmissions
  - Government incentive

Work It Out!

Inadequate Support

Taking Action:

Enlist Physician Leaders/ Thought Leaders.
Prepare for common questions and concerns:

- Will it add time I don't have?
- Will it increase phone calls?
- I may not want to order/continue every home med.

Must have support plan in place and share outcome data.

Work It Out!

Inadequate Support

Taking Action:

Enlist Advocates. Prepare to be a great sales person:

- Making the Case for Leadership PowerPoint
- Making the Case for Staff PowerPoint

Provided from the MATCH toolkit at http://www.nmh.org/nm/making+the+case

Roadblocks to Success

- Inadequate Support
- Poor Processes

"The most important factor for successful medication reconciliation is to have very strong processes in place."

Eliot Heller, M.D., CMIO - The Bronx-Lebanon Hospital Center in New York

Roadblocks to Success

Poor Processes

- Poor understanding of role
- “Why do nurses always get dumped on?”
- “I don’t want to call Dr. Jekyll about this omission. She’ll holler at me.”
- Paper in outpatient, CDS on Units
- PHA Tech in ED, Nurse on Unit
- What if patient can’t tell me?
- Dr. Hyde left without signing off on the MR form

Work It Out!

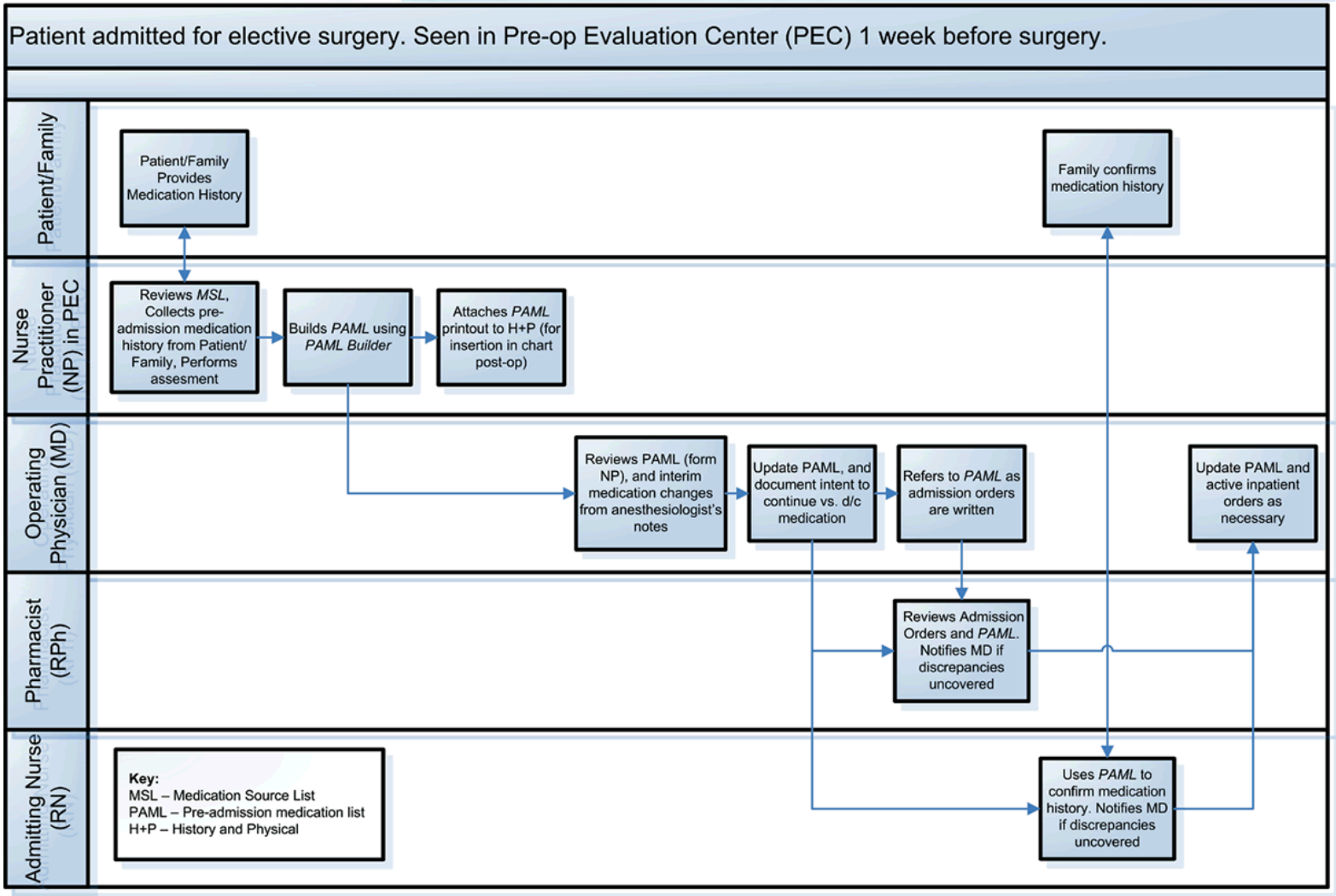
Poor Processes

Taking Action:

- Clear role assignment for every workflow:
  - Diagrams
  - Resources on units
- Education of responsibilities
- Enlist champions to establish buy-in
- Tell, don't ask

Work It Out!

Responsibility Chart



Provided from: http://webmm.ahrq.gov/case.aspx?caseID=158#figure

Work It Out!

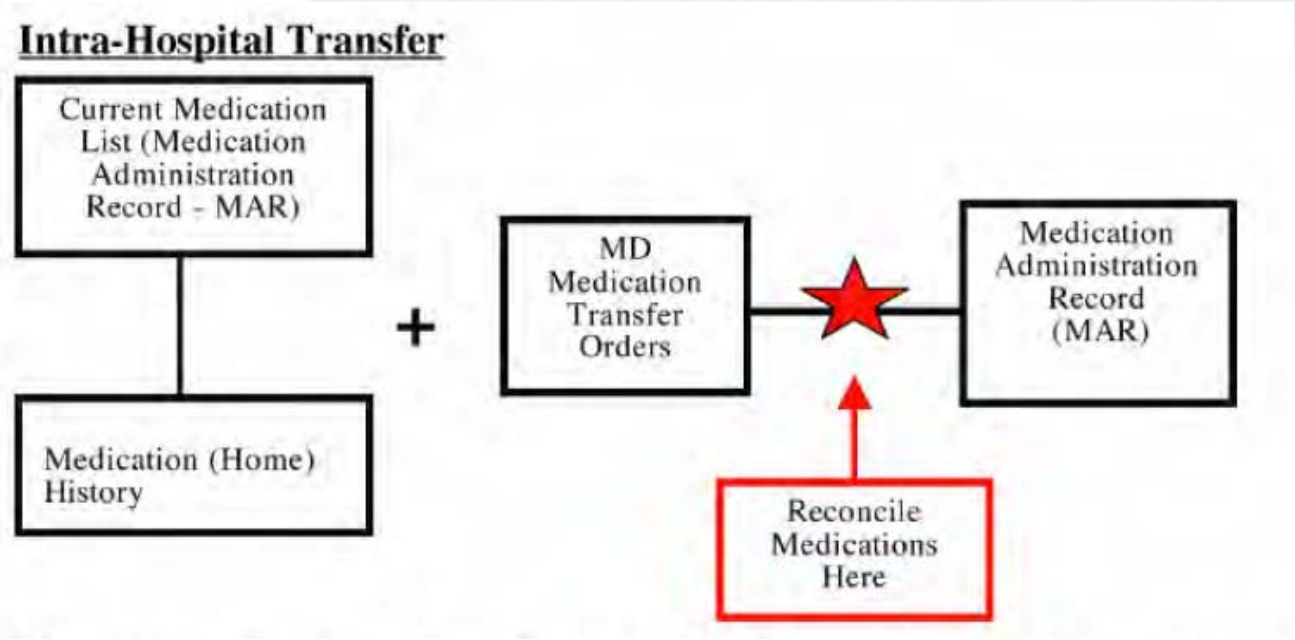
Reconciliation Chart

Admission

Provided from: http://www.ncqualitycenter.org/downloads/MRToolkit.pdf

Work It Out!

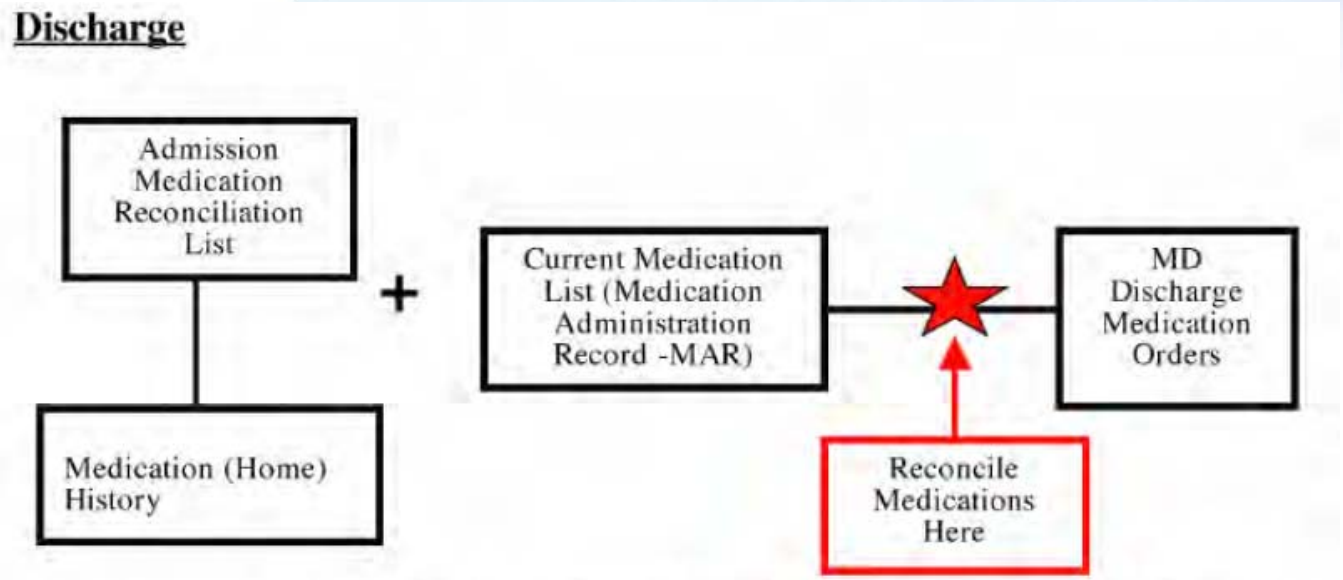
Reconciliation Chart



Provided from: http://www.ncqualitycenter.org/downloads/MRToolkit.pdf

Work It Out!

Reconciliation Chart



Provided from: http://www.ncqualitycenter.org/downloads/MRToolkit.pdf

Work It Out!

Poor Processes

Maintaining Accountability:

- Scheduled assessment/peer review
- Not punitive
- Gather data
  - Re-educate as needed
  - Adjust procedures
- Celebrate successes
  - Incentives
  - Small prizes

Roadblocks to Success

- Inadequate Support
- Poor Processes
- Inaccurate History

Patients have not been educated on the importance of providing an accurate list

  - Multiple Physicians
  - Multiple Pharmacies
  - Sound-alike drugs
  - Old rx's/bottles hanging around

Work It Out!

Inaccurate History

Taking Action:

- Retail pharmacy history
- Insurance history
- Primary care physician history
  - Physician office integration
  - HIE
- Collaborate with area healthcare facilities
- Establish statewide standard
- EDUCATE OUR PATIENTS!

Work It Out!

The Med Form

For additional Med Forms, go to: www.themedform.com

THE MED FORM

Name:_____Date Completed:_____
Preferred Pharmacy/Phone:_____
Address:_____
Phone Number:_____Birth Date:_____
Emergency Contact/Phone:_____

Allergies and Drugs to Avoid/Adverse Reactions:

_____
_____
_____

Current Medications:
List all medications you are taking, include over-the-counter (e.g., aspirin, antacids, vitamins and herbals).

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

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Reason for Taking:_____Directions:_____
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Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Always keep this form with you. *(over)*

Work It Out!

Education Example

Run Date: 05/05/10 PATIENT DISCHARGE INSTRUCTIONS PAGE 1
Run Time: 1014
Run User: FJF Discharge Information - Patient Sheet

Patient:	IATRIC,DEMO 10 WILDWOOD LANE BOXFORD, MA 01921 Age: 40 DOB: 03/25/67	Physician:	BERMAN,JOEL 27 GREAT POND ROAD BOXFORD, MA 01921 978-805-4100

Discharge Date: May 5, 2010

Following are prescriptions you have received from Dr. Joel Berman

FUROSEMIDE TABLET (LASIX)	40 MG	Daily	By Mouth
DIGOXIN TABLET (LANOXIN)	0.25 MG	Daily	By Mouth
	Special Instructions: Take with water		
RANITIDINE TABLET (ZANTAC)	150 MG	Twice a day	By Mouth
CLARITIN	10 MG	Daily	By Mouth
LEVOTHYROXINE (SYNTHROID)	0.1 MG	Daily	By Mouth
	Special Instructions: Take on an empty stomach at least 30 minutes before breakfast		

Following is a list of medications you should continue taking.
No prescriptions have been provided

CARVEDILOL TABLET (COREG)	12.5 MG	Daily	By Mouth
	Special Instructions: Take with food or a snack		
ALBUTEROL INHALER (PROVENTIL)	2 PUFFS	As needed	Inhale
PERCOCET TABLET	1 TABLET	Every 4 Hours as needed	By Mouth
	Special Instructions: As needed for surgical pain		

***** YOU SHOULD STOP TAKING THE FOLLOWING MEDICATIONS *****
Discard all leftover doses

DIGOXIN TABLET (LANOXIN)	0.125 MG	Daily	By Mouth
	Special Instructions: See new dose. Discard all leftover tablets		

Work It Out!

Education Example

UNIVERSAL MEDICATION FORM
Tuomey Healthcare System
803-778-9000
GIVE THIS COPY TO THE PATIENT
Patients: Fold this form and keep it in your wallet for easy access.

Patient's Name: **IATRIC,PDI**
Date of Birth: 07/26/1978

Date Started: 10/26/06

Emergency Contact/Phone Numbers:

IMMUNIZATION RECORD (Record the date/year of last dose taken, if known)		
TETANUS	FLU VACCINE(S)	
PNEUMONIA VACCINE	HEPATITIS VACCINE	OTHER

Allergic To/Describe Reaction:	**Allergic To/Describe Reaction:**

Medications: Include all prescription and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, ginko). Include medications taken as needed (example nitroglycerin).

NAME OF MEDICATION/DOSE	DIRECTIONS/NOTES Use patient friendly directions (Do not use medical abbreviations.)	DATE STOPPED	* RX	* PEI
ALENDRONATE TABLET 10 MG	Once Daily 30min Before Meal			
AMOXICILLIN CAPSULE 500 MG	Three Times Daily			
CAPTOPRIL TABLET 12.5 MG	Three Times Daily			
CARVEDILOL 25 MG	Once Daily			
DIGOXIN TABLET 0.25 MG	Once Daily			
FUROSEMIDE TABLET 40 MG	Once Daily			
LevoTHYROXINE TABLET 125 MCG	Once Daily			
SIMVASTATIN TABLET 1 TAB	Once Daily			
METHOCARBAMOL TABLET 750 MG	Every 4 Hours as needed			

*Rx (prescriptions) and *PEI (patient education information) given at time of discharge from hospital.

Reminders to patients:

1. Please fold this form and keep it in your wallet for easy access.
2. If you start to take any new over-the-counter medications or herbals, add these to your list so you will have a complete list.
3. Show this form each time you are asked which medications you take (doctor visits, diagnosic tests, emergency room, hospital, etc.) This will save you time. Continue to update the form.
4. Extra forms are available at many doctors' offices, pharmacies, and www.scha.org.

Work It Out!

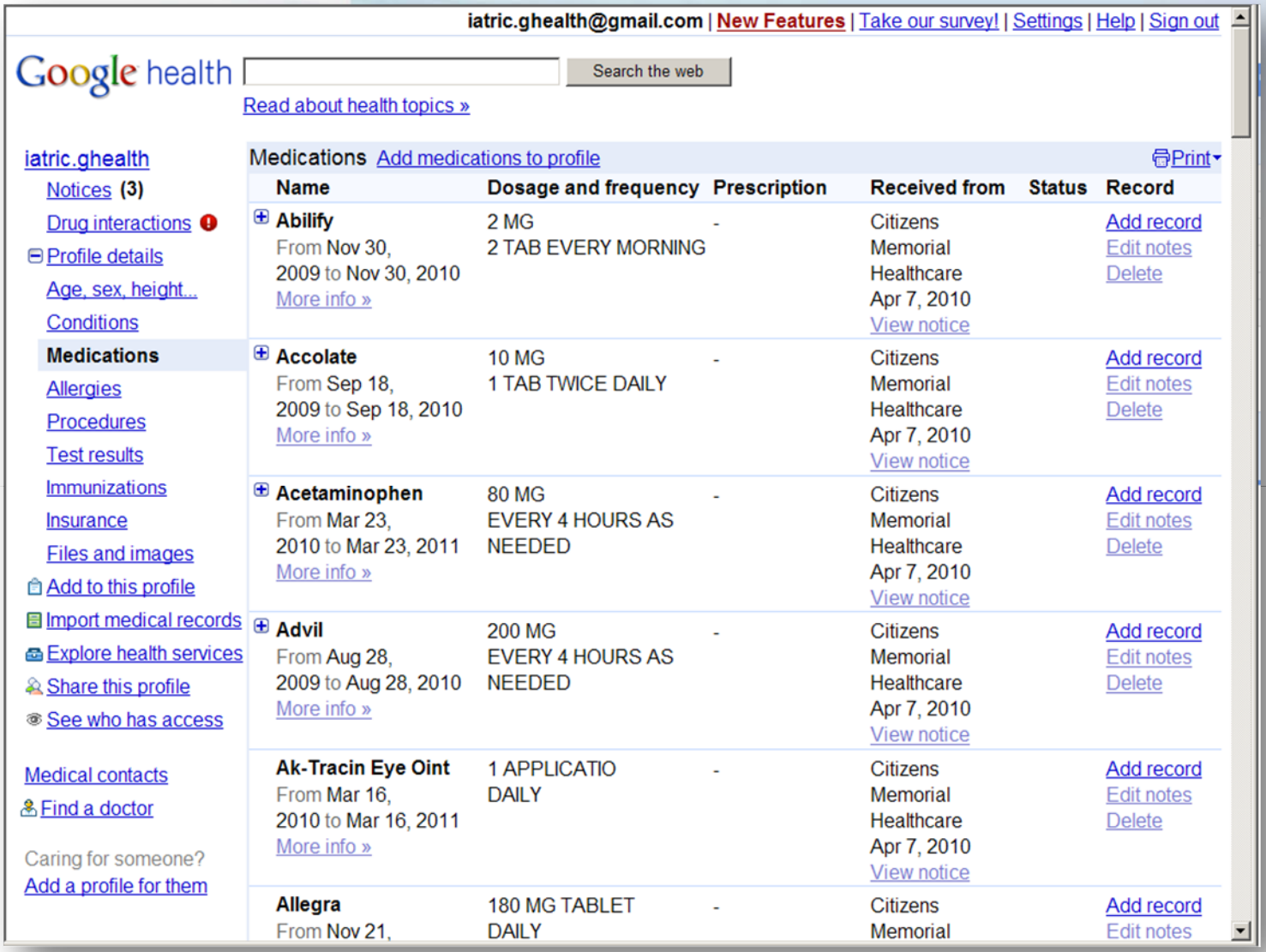
Inaccurate History

Taking Action:

- Retail pharmacy history
- Insurance history
- Primary care physician history
  - Physician office integration
  - HIE
- EDUCATE OUR PATIENTS!
- Personal Health Record
  - Google Health
  - Microsoft HealthVault

Work It Out!

Inaccurate History



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- Notices (3)
- Drug interactions
- Profile details
  - Age, sex, height...
  - Conditions
  - **Medications**
  - Allergies
  - Procedures
  - Test results
  - Immunizations
  - Insurance
  - Files and images
- Add to this profile
- Import medical records
- Explore health services
- Share this profile
- See who has access

Medical contacts

Find a doctor

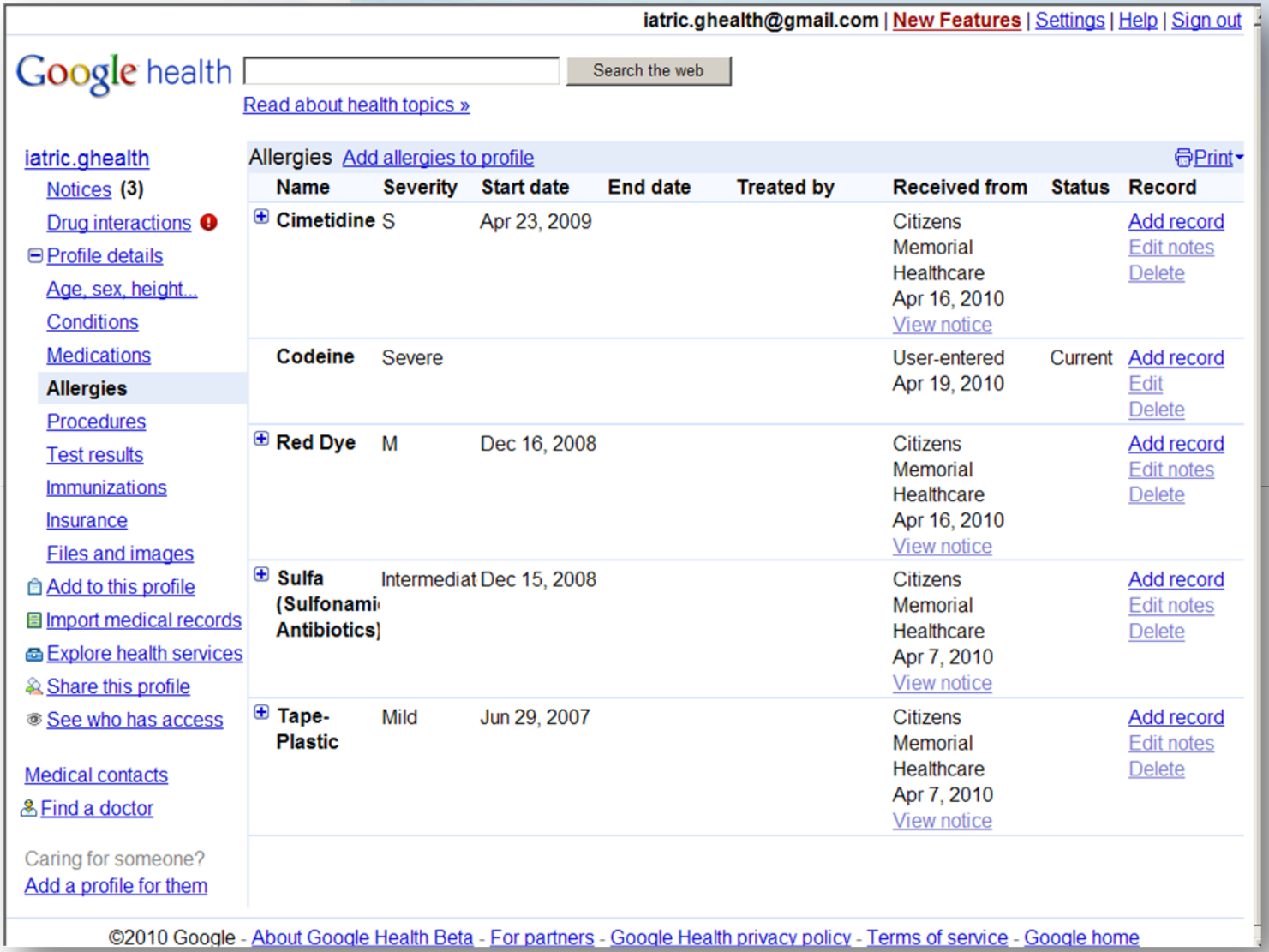
Caring for someone?
Add a profile for them

Medications — Add medications to profile — Print

Name	Dosage and frequency	Prescription	Received from	Status	Record
Abilify From Nov 30, 2009 to Nov 30, 2010 More info »	2 MG 2 TAB EVERY MORNING	-	Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete
Accolate From Sep 18, 2009 to Sep 18, 2010 More info »	10 MG 1 TAB TWICE DAILY	-	Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete
Acetaminophen From Mar 23, 2010 to Mar 23, 2011 More info »	80 MG EVERY 4 HOURS AS NEEDED	-	Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete
Advil From Aug 28, 2009 to Aug 28, 2010 More info »	200 MG EVERY 4 HOURS AS NEEDED	-	Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete
Ak-Tracin Eye Oint From Mar 16, 2010 to Mar 16, 2011 More info »	1 APPLICATIO DAILY	-	Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete
Allegra From Nov 21,	180 MG TABLET DAILY	-	Citizens Memorial		Add record Edit notes

Work It Out!

Inaccurate History



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Medical contacts

Find a doctor

Caring for someone?
Add a profile for them

Allergies — Add allergies to profile — Print

Name	Severity	Start date	End date	Treated by	Received from	Status	Record
Cimetidine	S	Apr 23, 2009			Citizens Memorial Healthcare Apr 16, 2010 View notice		Add record Edit notes Delete
Codeine	Severe				User-entered Apr 19, 2010	Current	Add record Edit Delete
Red Dye	M	Dec 16, 2008			Citizens Memorial Healthcare Apr 16, 2010 View notice		Add record Edit notes Delete
Sulfa (Sulfonamide Antibiotics)	Intermediat	Dec 15, 2008			Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete
Tape-Plastic	Mild	Jun 29, 2007			Citizens Memorial Healthcare Apr 7, 2010 View notice		Add record Edit notes Delete

Work It Out!

Inaccurate History

Taking Action:

Get the word out!

- Press Release
- News articles
- Wallet Cards
- Community bulletins
- Adult Education

Roadblocks to Success

- Inadequate support
- Poor Processes
- Inaccurate History
- Excluded Stakeholders
  - Administration/Senior Leadership
  - Physicians
  - Pharmacists
  - Nurses
  - Patients

Work It Out!

Excluded Stakeholders

Taking Action:

- Form a Medication Reconciliation Leadership Team
- Include members from each of the aforementioned groups including a patient representative
- Solicit the project endorsements needed for success!
- Remove organizational barriers

Roadblocks to Success

- Inadequate Support
- Poor Processes
- Inaccurate History
- Excluded Stakeholders
- Goals are not Measureable

Work It Out!

Immeasurable Goals – Create a Workflow Diagram

BUILDING A FLOWCHART DIAGRAM

Questions to Help you Flowchart your Current Process, New Process or Process Redesign at Admission, Transfer and Discharge

ADMISSION

Medication History
1. Who obtains a medication history?
2. What is captured during a medication history interview?
3. When is a medication history obtained?
4. Where is the medication history documented within the patient's medical record?
5. How is a medication history documented (i.e., structured paper form; electronic entry; etc.)?
6. How do you monitor and measure that medication histories are obtained and documented appropriately?

Orders
1. Who places medication orders?
2. What is the process for ordering medications?
3. When are medications usually ordered in relation to obtaining a medication history?
4. Where are the ordering decisions for each of the patient's current medications documented (i.e., documenting plan to continue blood pressure medication patient takes at home)?
5. How are discrepancies resolved?

Comparison (Reconciliation)
1. Who compares (reconciles) medication orders to medication histories?
2. What is the process for reconciliation?
3. When does reconciliation occur?
4. Where is documentation found in the medical record that reconciliation took place?
5. How do you identify which discrepancies require clarification?
6. How do you monitor and measure that reconciliation is occurring?

Resolution
1. Who follows up on unintended medication discrepancies?
2. What is the mechanism to resolve unintended discrepancies?
3. When does the follow-up occur?
4. Where is the documentation located within the patient's medical record indicating that discrepancies were resolved?
5. How do you document resolution or outcome of the intervention?
6. How do you monitor and measure that unintended discrepancies were actually resolved?

Provided from:
http://www.nmh.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251241810261&ssbinary=true

Work It Out!

Immeasurable Goals – Create a Workflow Diagram

BUILDING YOUR FLOWCHART DIAGRAM *CONT.*

INTRA-FACILITY TRANSFER

Orders
1. Who reviews current medication orders and updates orders in preparation for new level of care?
2. What is your process for review and updating medication orders in preparation for transfer?
3. When does the review and update occur?
4. Where is the intent/plan for each medication documented in relation to the medication orders in preparation for transfer?
5. How are medication orders handled in preparation for transfer (i.e., rewritten)?

Comparison (Reconciliation)
1. Who compares (reconciles) medications upon transfer?
2. What is the process for reconciling orders a patient is currently receiving in the sending unit compared to orders the patient will be receiving at the new level of care?
3. What is the process of comparing these orders to the patient's pre-admission medication list?
4. When does reconciliation occur in preparation for transfer?
5. Where is the documentation that reconciliation took place?
6. How do you identify discrepancies requiring clarification during reconciliation?
7. How do you monitor and measure that reconciliation is occurring?

Resolution
1. Who follows up on unintended medication discrepancies?
2. What is the mechanism to resolve unintended discrepancies?
3. When does the follow-up occur?
4. Where is the documentation located within the patient's medical record indicating that discrepancies were resolved?
5. How do you document resolution or outcome of the intervention?
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Work It Out!

Immeasurable Goals – Create a Workflow Diagram

BUILDING YOUR FLOWCHART DIAGRAM *CONT.*

DISCHARGE

Medication Discharge List and Reconciliation

1. Who reviews, reconciles and updates the patient's medication list in relation to current orders in preparation for discharge?
2. What is the discharge reconciliation process?
3. When does this occur?
4. Where is the updated, complete medication history documented within the patient's medical record?
5. How is the patient's medication list documented in preparation for discharge?
6. How do you monitor and measure that the patient's medication list was updated and a complete list was given to the patient highlighting any changes?
7. How do you communicate the patient's updated, complete medication list to the next provider of service and who provides this communication?

Resolution:

1. Who follows up on unintended medication discrepancies at discharge?
2. What is the mechanism to resolve unintended discrepancies at discharge?
3. When does the follow-up occur?
4. Where is documentation located within the patient's medical record indicating that discrepancies were resolved?
5. How do you identify discrepancies requiring clarification during reconciliation?
6. How do you document resolution or outcome of the intervention?
7. How do you monitor and measure that unintended discrepancies were actually resolved?

Provided from:
http://www.nmh.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251241810261&ssbinary=true

Work It Out!

Immeasurable Goals

Taking Action:

- Gather data before project starts and then monthly
  - Share statistics with leaders:
  - Administrations
  - Physicians
  - Nursing
  - Pharmacy
  - Community
- "Medication Reconciliation works!"

Tips for Success

This is not the Ronco Roaster: In other words, you can't "Set it and forget it."

- Ongoing peer review
- Re-education/Validation
- Follow-up with leadership – data
- Provide patients with feedback

Tips for Success

Data Collection:

- Compare pre-project data to current
  - All visits
  - All discharges
  - Reconciliation complete
    - Admission/Registration
    - Discharge/Depart

  i.e. #Home Med lists/ # Admits
  # Charts with all reconciled/# Admits

Tips for Success

Medication Reconciliation Surveillance Tool

Reviewer Initials:			Date of Review:							Age:						
										Gender:						
Admission Orders					**Admission Medication History**					**Medication History - Patient Interview**						
Medications Ordered					**Medications Listed**					**Medications**						
Drug	**Dose**	**Rt**	**Freq**	**Code**	**Drug**	**Dose**	**Rt**	**Freq**	**Code**	**Drug**	**Dose**	**Rt**	**Freq**	**Last Dose**	**Code**	**Source**

Codes: 1. No discrepancy; 2. Discrep but no clarification: 2a) New medication; **2b)** MD decision not to order or dose/rt/freq change based on clinical status; **2c)** Similar or alternative drug prescribed based on formulary or clinical condition; **2d)** Judged not clinically significant for hospital stay **3. Discrep requires clarification: 3a) Omission; 3b) Commission; 3c)** Different Dose; **3d)** Different Route; **3e)** Different Frequency; **3f)** Different Medication ordered.

Resource Information: 1. Pt interview; 2. Med list; 3. Family/Surrogate; 4. Old medical records; 5. Prescription vials; 6. Call to pharmacy or physician office; 7. Other (specify)

Provided from: http://www.nmh.org/nm/assessment

Tips for Success

MEDICATION RECONCILIATION Audit Form

Unit:_____Manager:_____Date:_____
Data Collector's Name:_____

Introduction:

- The data is to be collected and reported on a _____ basis
- During each _____, a total of _____ charts should be selected for record review
- Findings are to be tracked through your own quality process.
- Provide copies of the completed audit form to _____
-

Instructions:

Medication Reconciliation is the process of comparing medications the patient has been taking prior to admission/entry to the hospital to the medications the organization is about to provide to identify any unintended discrepancies. If a patient will be provided/given *any* medications while under our care or prescribed any new drugs to take after their stay, Medication Reconciliation is required.

1. Confirm a medication list was collected from the patient upon arrival to (list must include medication name, dose, route, and frequency).
2. The list must then be available in the patient's chart for the caregiver to review prior to initiating care.
3. Identify that the complete and updated list of medications was then provided to the patient at discharge and discussed within the context of discharge instructions ("resume home meds" is not acceptable)

Medication Reconciliation	Pt. 1 Y/N	Pt. 2 Y/N	Pt. 3 Y/N	Pt. 4 Y/N	Pt. 5 Y/N
• List of home medications was collected from the patient at the time of arrival and medication name, dose, route, frequency were documented in the appropriate location of the medical record					
• List of home medications collected was available for the care givers to review prior initiating care					
• Updated Medication list was provided to the patient at discharge from NMH and discussed in the context of discharge instructions					

If you observe someone **NOT** doing the right thing, ask the following questions:
1. Is this a supply/logistic issue (can't find forms, pens, etc.)?

_____

2. Is this a performance/knowledge/skill issue?

_____

3. Is this a human factors (distraction, noise, fatigue) issue?

_____

4. Other barriers to compliance?_____

_____

Goal: 100% Compliance
Numerator:

- Number of medication lists collected and completed on NMH outpatients requiring medication rec
- Number of medication lists that were provided back to outpatients in the context of discharge instructions.

Denominator: Number of outpatients requiring medication reconciliation.

Provided from: http://www.nmh.org/nm/assessment

Tips for Success

- Be prepared to engage supporters
- There are often locations/groups that do not follow the process
  - Not optional!
  - Hold team members accountable
- Engage your community
- Share your success with the community
- Patients are vital to the success

Resources

- Health Data Management: http://www.healthdatamanagement.com/issues/18_1/medication_reconciliation-39495-1.html
- AHRQ: http://webmm.ahrq.gov/media/cases/images/case158_fig1.gif
- On the Wards: http://onthewards.com/2010/02/the-challenges-of-medication-reconciliation-and-patient-safety/
- Northwestern Memorial Hospital: http://www.nmh.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fvnd.ms-powerpoint&blobkey=id&blobtable=MungoBlobs&blobwhere=1251241811138&ssbinary=true
- Northwestern Memorial Hospital: http://www.nmh.org/cs/Satellite?blobcol=urldata&blobheader=application%2Fvnd.ms-powerpoint&blobkey=id&blobtable=MungoBlobs&blobwhere=1251241811890&ssbinary=true

I Can Help!

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Sometimes It Feels Like WRECKonciliation