

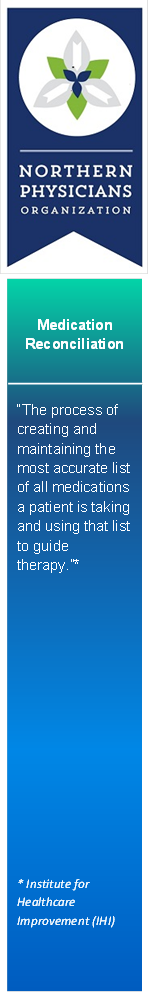
**Medication Reconciliation**

“The process of creating and maintaining the most accurate list of all medications a patient is taking and using that list to guide therapy.”\*

*— Institute for Healthcare Improvement (IHI)*

**Medication Reconciliation**

A Process Toolkit for Physician Offices



Define

Standardize

Modify

Update

**Compiled by:**

Kathleen Brown, RPh

Clinical Pharmacist

(231)935-9194 / [kbrown2@mhc.net](mailto:kbrown2@mhc.net)

**Developing Your Medication Reconciliation Process**

*“Medication Reconciliation is the process of comparing a patient’s medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.” -* Joint Commission on Accreditation of Healthcare Organizations.

**Questions to Ask To Develop Your Practice’s Process with Tips Detailed**

***Medication History***

1. Who obtains a medication history?

* To help assist with creating a medication list, some practices are asking all and/or new patients to bring in all their medications (much like they are asking them to bring in their advanced directives).
* See the Tips Page (attached) for information that should be inquired about and questions to help with obtaining the history.

1. What is captured during a medication history interview?

* Should obtain past and current medication: prescription, over-the-counter, herbals, and immunizations.
* How is the patient taking the medication? Verify against the prescription bottle, pharmacy list, hospital records, or other providers.
* The Mr. Ross diagram (attached) assists the patient in remembering all their medications and what they are for.

1. When is a medication history obtained?

* Initial visit/New Patient

1. Where is the medication history documented within the patient’s medical record?

* This is EHR specific.

1. How is a medication history documented (i.e., structured paper form; electronic entry; etc.)?

* If using an EHR, it is best to make it structured data to help with the review process.

1. How do you monitor and measure that medication histories are obtained and documented appropriately?

* If using structured data, you could pull a report for review.

***Comparison (Reconciliation)***

1. Who compares (reconciles) medication orders to medication histories?

* Many practices utilize a clinical team member to complete this process with the patient prior to seeing the provider.

1. What is the process for reconciliation?
   * Best done by using actual medication bottles from home and asking the patient what medications they are taking and how they are taking them.

* Some practices have found it beneficial to print the medication list prior to the patient’s appointment and have the patient review it when they check in.
* Go through the current medication list with the patient and document any discrepancies.

1. When does reconciliation occur?

* At every visit prior to seeing the provider.
* ACO 12: States that those patients 65 and older that have been discharged from any inpatient facility need to be seen within 30 days and have a medication reconciliation of the discharged medications with the current medication list. Questions that should be asked during the process are
  + 1. Based on what occurred in the visit, should any medications that the patient was taking or receiving prior to the visit be discontinued or altered?
    2. Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?
    3. Have any new prescriptions been added today?

These questions should be reviewed by the provider who completed the procedure, or the provider who evaluated and treated the patient.

1. If the answer to all three questions is “no,” the process is complete.
2. If the answer to any question is “yes,” the patient needs to receive clear instructions about what to do — all changes, holds, and discontinuations of medications should be specifically noted. Include any follow-up required, such as calling or making appointments with other practitioners and a timeframe for doing so. Institute for Healthcare Improvement (IHI)
3. Where is the documentation found in the medical record that the reconciliation took place?

* This is EHR specific.

1. How do you identify which discrepancies require clarification?

* See the Critical Thinking Process to Identify and Clarify Discrepancies table (attached).

1. How do you monitor and measure that reconciliation is occurring?
2. Utilize the structured data fields to pull reports for review.

***Order***

1. Who places the medication order?
2. What is the process for ordering medications?

* Some practices have changed the policy to medications only being renewed at the patient’s annual exam.

1. When are medications usually ordered in relation to obtaining a medication history?

* Medication history should be obtained prior to ordering to help reduce the risk of discrepancies.

1. Where are the ordering decisions for each of the patient’s current medications documented (i.e., documenting plan to continue blood pressure medication the patient takes)?
   * This will be specified by the provider, but the use of structured data fields is recommended.
2. How are discrepancies resolved?
   * See the Critical Thinking Process to Identify and Clarify Discrepancies table (attached).

***Resolution***

1. Who follows up on unintended medication discrepancies?

* A Provider should follow-up. See the Critical Thinking Process to Identify and Clarify Discrepancies table (attached).

1. What is the mechanism to resolve unintended discrepancies?

* Based on practice specific policies.

1. When does the follow-up occur?

* The Provider will indicate when this should occur.

1. Where is the documentation located within the patient’s medical record indicating that discrepancies were resolved?

* EHR and Provider Specific.

1. How do you document resolution or outcome of the intervention?

* This will be specified by the provider, but the use of structured data fields is recommended.

1. How do you monitor and measure that unintended discrepancies were actually resolved?

* Utilize the structured data fields to pull reports for review.

**Tips for Conducting a Patient Medication Interview**

**Medication Information**

To obtain or verify a list of the patient’s current medications, you should inquire about:

* Prescription medications
* Over-the-counter (OTC) drugs
* Vitamins
* Herbals
* Nutraceuticals/Health supplements
* Respiratory therapy-related medications (e.g., inhalers)

Full dosing information should be captured, if possible, for each medication. This includes:

* Name of the medication
* Strength
* Formulations (e.g., extended release, controlled delivery, etc.)
* Dose
* Route
* Frequency
* Last dose taken

**Medication History Prompts**

Incorporating various types of “probing questions” into the patient interview may help trigger the patient’s memory on what medications they are currently taking. Here are some suggestions:

* Use both open-ended questions (e.g., “What do you take for your high cholesterol?”) and closed-ended questions (e.g., “Do you take medication for your high cholesterol?”) during the interview.
* Ask patients about routes of administration other than oral medicines (e.g., “Do you put any medications on your skin?”). Patients often forget to mention creams, ointments, lotions, patches, eye drops, ear drops, nebulizers, and inhalers.
* Ask patients about what medications they take for their medical conditions (e.g., “What do you take for your diabetes?”).
* Ask patients about the types of physicians that prescribe medications for them (e.g., “Does your ‘arthritis doctor’ prescribe any medications for you?”).
* Ask patients about when they take their medications (e.g., time of day, week, month, as needed, etc.). Patients often forget to mention infrequent dosing regimens, such as monthly.
* Ask patients if their doctor recently started them on any new medicines, stopped medications they were taking, or made any changes to their medications.
* Asking patients to describe their medication by color, size, shape, etc., may help to determine the dosage strength and formulation. Calling the patient’s caregiver or their community pharmacist may be helpful to determine exact medication, dosage, and/or directions. For inquiring about OTC drugs, additional prompts may include: What do you take for a headache, for allergies or for a cold?

*1. Adapted from the Joint Commission Resources and the American Society of Health-System Pharmacists Medication Reconciliation Handbook. Chapter 5: Educating your staff. Oakbrook Torrance, IL: Joint Commission Resources, 2006.*

*2. For a full range of medications as defined by The Joint Commission, refer to its accreditation material.*

**Critical Thinking Process to Identify and Clarify Discrepancies**

|  |  |
| --- | --- |
| **Category** | **Example** |
| **“One-to-One” Match:**  Medication ordered for the patient during an episode-of-care, or upon a discharge, matches what the patient was taking previously. Physician follow-up not required. | Patient takes furosemide 40mg by mouth twice daily at home, which was continued at hospital discharge. |
| **Intended Discrepancy** (i.e., purposeful)**:**  Discrepancies exist but are appropriate based on the patient’s plan of care (e.g., based on information gathered based on a review of the physician’s history and physical and progress notes, based on communication/handoffs. Physician follow-up not required. | -Antibiotics started for infection.  -“As needed” medications ordered for pain/fever.  -Warfarin and Aspirin held for a procedure. |
| **Unintended Discrepancy:**  Discrepancies exist and require clarification of intent because there is no supporting documentation of explanation based on the patient’s current clinical condition or care plan. Physician should be consulted for resolution and resulting changes and/or clarifications documented.  NOTE: Examples given have no supporting clinical explanation. | **Omission:** Patient reports taking a medication before. It was not ordered on admission or it was not listed on the discharge instructions.  **Commission:** Medication is ordered at admission that the patient did not take before hospitalization. Medication is listed on the patient’s discharge instructions, but it was not ordered during the hospital stay and the patient did not take before hospitalization.  **Different dose, route, or frequency:** Different doses, routes, or frequency of medication listed on the patient’s discharge instructions than what was ordered during the hospital stay or that the patient reports taking before hospitalization.  **Different Medication Ordered:** Medication in the same therapeutic class is ordered on admission or is listed on the patient’s discharge instructions and differs from what the patient reports. No clinical explanation or formulary substitution supports difference. |

*\*Information on pages 1, 2 and 4 is compiled and reprinted from AHRQ’s MATCH Toolkit for Medication Reconciliation*- *August 2012*

**MR. ROSS**

(Medication Reconciliation Review of Systems Subject)

Brain-sleep/mood/memory/headache/fever (OTC)

Hair-medicated shampoo

Eyes-drops (OTC or prescription)

Ears-drops (OTC or prescription)

Mouth-lozenges, inhalers, sublingual/vitamins/supplements/aspirin

Nose-sprays/oral allergy meds or decongestants

Elbows-creams (rash/dry skin)

Stomach-dyspepsia medications (OTC)

Pancreas-insulin/other injectable

Bowels-constipation/diarrhea meds/suppositories (OTC) Urinary products, ED

Knees-psoriasis/dry skin

Feet-dry skin/fungal infections

*\*J Am Pharm Association 2013*

*“Use of a medication reconciliation tool in an outpatient geriatric clinic”*