Medication Reconciliation Discrepancies in Emr and Transitions of Care in Inpatient Pediatrics

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Medication Reconciliation Discrepancies in EMR and Transitions of Care in Inpatient Pediatrics

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BACKGROUND

• Transitions of care from the inpatient setting present a significant challenge to the delivery of accurate, safe, and coordinated medical care. One such challenge is the guarantee of consistent medication information across transition points. This raises the specter of medication discrepancies, which have been shown to occur in the care of 22 to 72.3% of pediatric patients. Though not all discrepancies cause direct harm, they can contribute to longer hospital stays, higher readmission rates, and increased utilization of the emergency room. Addressing this phenomenon, the Joint Commission (Wong et al.) has identified the need for standardized medication reconciliation processes.

OBJECTIVES

• Reduce pediatric resident dissatisfaction with the medication reconciliation process by 10%.
• Increase interdepartmental communication and cooperation during medication reconciliation by 50%.
• Create a "delete button" to delete duplicate orders on the discharge summaries.

ANALYSIS

• Subjective measure: Resident survey
  - Estimated confusion expressed by patients/caregivers: "Often" (50% of respondents); "Sometimes" (25% respondents)
  - Who is performing the majority of medication reconciliation?

RESULTS

• Data collected from all pediatric patients admitted to inpatient in November 2015
• Total medication duplications: 17
• Total instruction duplications: 5
• Total duplication errors: 22
• 100% of patients admitted with home medications
• 80% of instruction duplications occurred during admission
• 76.4% of medication duplications occurred on admission
• Longer length of stay did not correlate with increased errors

PROPOSED COUNTERMEASURES

• Medication Reconciliation Process
  - Standardize the medication reconciliation process
  - Identify the responsible parties and the correct procedure
  - Communicate to those involved and provide education
  - Increase interdepartmental communication
  - Improve EPIC functionality via IT liaison
  - Allow residents to record home medications that are not on formulary

• Enable function to link home medications to outpatient chart

FOLLOW-UP

• Accountability
  - Assign champion to assemble key players for communication with IT.
  - Administer survey and collect new data after changes have been implemented to evaluate goal achievements.

PLAN

• Drugs Formulary
  - Create list of common medications that are not included in the formulary and work with IT to bridge it into the system
  - Assemble a team to work with IT to improve EPIC functionality
  - Create a button that labels listed medication as a "home medication"

• Ordering Medications
  - Create a "link button" that will link the medication given while inpatient to the home medication list

• Discharge Duplicates
  - Create a "delete button" to delete duplicate orders on the discharge summaries

REFERENCES


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