Medication Reconciliation: A New Role to Decrease Discrepancies

Amanda Fougere
Lehigh Valley Health Network, Amanda_A.Fougere@lvhn.org

Tracie Heckman MSN, RN, CMSRN
Lehigh Valley Health Network, Tracie.Heckman@lvhn.org

Published In/Presented At

Fourgere, A., Heckman, T. (2015, April). *Medication Reconciliation: A New Role to Decrease Discrepancies.* Poster presented at the NICHE Annual Conference, Orlando, FL.
Deturk, S. (2015, February). *Medication Reconciliation: A New Role to Decrease Discrepancies.*Poster presented at the American Nurses Association Seventh Annual Nursing Quality Conference, Orlando, FL.

Medication Reconciliation: A New Role to Decrease Discrepancy

Lehigh Valley Health Network, Allentown, PA

Abstract

Approximately 54% of inpatients have at least one discrepancy in the medications they report taking at home compared to those reported at time of admission.

Twenty-seven percent of prescribing errors in hospitals are caused by incomplete medication records at the time of admission. These statistics prompted key stakeholders evaluate current medication reconciliation processes.

Background/Current State

- 47.5% of inpatient medication reconciliations had at least one error.
- Multistep process with no identified "owner" or location to document.
- Practitioners working in silos resulting in duplicated work.
- Tremendous amount of time spent to reconcile medication lists.

Evidence-Based Process Redesign

Common thread in literature: Employ individuals who specialized in their function.

A rapid improvement event with key stakeholders including physicians, nurses and pharmacists determined a single health care resource as the best means to improve our process accuracy.

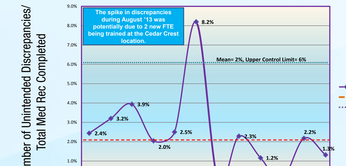
Medication Reconciliation Technician (MRT) - a certified pharmacy technician, with specialized training in patient interviewing and primary source medication list verification.

MRT Standard Work

1. Enter Best Possible Medication History (BPMH) into Home Medication Management system.
2. Print validated medication history for providers to use during admission process.
3. Document the reconciliation of the medication list.

Evaluation of Effectiveness

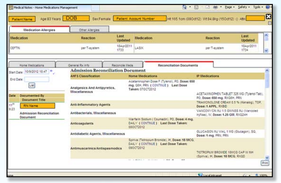
Med. Rec. Unintended Discrepancies by Month for LVH-CC
(Data From 3/01/13 to 2/28/14)



Date	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
Discrepancies (NUM)	6	6	6	6	6	14	6	6	4	4	4	4
Monthly Target (Mean)	3%	4%	4%	4%	4%	4%	3%	3%	2%	3%	3%	3%
Total Med Rec Completed (DEN)	164	135	137	147	80	81	141	175	88	133	138	132

Other Metrics Identified

- Medication reconciliation order usage
- MRT process completion (ordering physician to floor metric)
- Physician medical record time (how long a physician spent on medication reconciliation)
- Length of stay (med. rec. vs. non-med. rec. patient)
- Readmission rate (med. rec. vs. non-med. rec. patient)



Feedback

Physicians: *"I like the completeness."*
- Need MRT coverage at night
- Trigger the process even earlier

Nurses: *"This is how it should be done!"*
- Eliminates 2:00 am calls to doctors to verify medication orders

"The right discipline is doing the right job."

Case Manager: *"Best thing we could do for patients is get it right from the beginning."*
- Helps with insurance plans that restrict the number of medications covered

Next Steps

- Expand data analysis to second campus
- Re-validate process with stakeholders
- Build business case to expand program to include discharge process

References:

1. Van Den Bemt, P., Van Den Broek, S., Van Nunen, A.K., Harbers, J. & Lenderink, A.W. (2009). Medication reconciliation performed by pharmacy technicians at the time of preoperative screening, The Annals of Pharmacotherapy, (5)43, 868-74.