Burning the Medication Reconciliation Bridge

Karen Young RN, BSN
Lehigh Valley Health Network, karen.young@lvhn.org

Marguerite Petsuck RN, BSN
Lehigh Valley Health Network, marguerite.petsuck@lvhn.org

Daniel Patzek RN, BSN
Lehigh Valley Health Network, daniel.patzek@lvhn.org

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Karen Young, RN,BSN, Marguerite Petsuck, RN and Daniel Patzek, RN, BSN
Lehigh Valley Hospital–Hazleton, Pennsylvania

Organizational Facts

- Lehigh Valley Health Network's mission is to heal, comfort and care for the people of our community by providing advanced and compassionate health care of superior quality and value, supported by education and clinical research
- Lehigh Valley Hospital-Hazleton has more than 100 highly trained and well-respected physicians that serve over 100,000 people throughout the Greater Hazleton area

Medication Reconciliation Facts

- Medication reconciliation accuracy is an enormous problem across the healthcare continuum
- In hospitals it is estimated that 40% of medication errors are due to inaccurate collection and completion of medication reconciliation (AHRQ.gov, 2015)
- The Joint Commission also changed their ranking of medication reconciliation as a patient safety goal from 8 in 2006 to 3 in 2011 (AHRQ.gov, 2015)
- At Lehigh Valley Hospital-Hazleton we struggled with medication reconciliation accuracy, which was brought more to the forefront with the implementation of new hospitalists

What Contributes to the Medication Reconciliation Bridge Falling?

- Patients often do not know their medication lists and require pharmacies to be called for verification of medications
- Several different staff members can be updating medication reconciliation with no continuity
- Pharmacy involvement varies
- Most hospitals utilize the traditional nurse-based medication reconciliation programs
- Medication reconciliation has an increased risk of contributing to errors with increased transitions of care

Deciding to Burn the Medication Reconciliation Bridge

- Multidisciplinary meetings were held to discuss the issue with medication reconciliation
- After review and research it was decided to move towards a hybrid of both a pharmacy and nursing based medication reconciliation program
- 7 days a week during 9 am to 9 pm pharmacy technicians would be working in the emergency department and complete medication reconciliation for admissions. This would target the largest group of patients
- Pharmacy technicians would be more familiar with medications, dosages, and have a better rapport with local pharmacies when calling for clarification of medication lists
- This plan would also narrow down the amount of staff working on a patient's medication list
- Transitions of care would be done electronically within the EHR and utilize the patient's current medication list. However, the patient's home medication list would also be readily available within the routine
- The plan would be to monitor and expand the role of pharmacy and eventually redefine the whole process of medication reconciliation at all transitions

Pouring the Bridge Foundation

- The MARQUIS 2014 study provides a Return on Investment guide for adding staff that provides medication reconciliation at www.hospitalmedicine.org/MARQUIS. The ROI is based on readmission reduction due to medication counseling at discharge
- The study also offers plans and workflows to aid in the best patient safety practices for medication reconciliation
- This guide can be used to show administration how investing in staff to perform medication reconciliation can ultimately decrease costs

New Bridge, New Outcome?

- Since the induction of the hybrid pharmacy/nursing based medication reconciliation program medication accuracy has increased and stakeholder satisfaction has increased
- There has also been better identification of issues in regards to medication reconciliation. For example, issues with medications entered by provider practices have been identified and addressed
- The future move will be to have increased involvement and education by pharmacy staff to patients on medications and the medication list

Reference:

1. AHRQ.gov. (2015). Patient safety primer: Medication reconciliation. Retrieved March 11, 2016 from https://psnet.arhq.gov/primers/primer/1/medication-reconciliation.