MEDICATION RECONCILIATION

WHAT'S IN IT FOR ME?

BENEFITS FOR PHARMACISTS

Medication Reconciliation (MedRec) is a structured process in which Healthcare Providers partner with patients and their family/caregivers to obtain a complete and accurate, up-to-date list of the patient's medications which is then reconciled with admission, transfer and discharge orders.

As patient advocates there are a few simple reasons why, as a pharmacist, you are an integral part of MedRec and the benefits gained by participating are:

- MedRec is a major and essential component of safe patient care in any environment[1]
  - A study found that more than 1 in 9 emergency department visits were due to drug related adverse events.[2]
  - Another study showed 23% of discharged patients experienced an adverse event, 72% were adverse drug events. Of all, 50% of were preventable and 17% resulted in readmission.[3]
  - 2012 AHS AHS MedRec pilot audit identified an average of 1.2 discrepancies per chart.
  - A 2010 study showed patients with order errors had 85% originate in medication histories, with almost half being omissions. 52% of the errors were identified as potentially requiring increased intervention to avoid harm, and 12% were potentially harmful.[4]
- MedRec is a shared professional responsibility
  - A recent US panel of stakeholders representing professional, clinical, healthcare quality, consumer and regulatory organizations, achieved consensus that hospital-based MedRec should employ *an inter-professional team approach* as the ideal.[5]
  - The Canadian Society of Hospital Pharmacists and the Institute for Safe Medication Practices Canada support the leadership role of pharmacists in ensuring comprehensive and timely MedRec. Pharmacists are uniquely qualified to lead the development, implementation, evaluation, and improvement of MedRec processes. MedRec is a shared responsibility of the patient, physicians, nurses, and pharmacy staff and is best accomplished through the collaborative efforts of the interdisciplinary team.[6]
- MedRec leads to better communication and better information
  - Canada's pharmacists practice in many patient-care settings: community pharmacies, hospitals and related health care institutions, family health clinics, home care, etc. Pharmacists collaborate with patients, their families and healthcare providers to benefit the health of Canadians.[7]
  - Pharmacists must work in an interdependent fashion with pharmacy colleagues, hospitals, primary care physicians, specialists, nurses, and other health care professionals in a wide variety of circumstances to facilitate communication among health care professionals.[8]
  - When MedRec is done at each transition of care the patients and health care professionals will have an accurate medication list for use across all sites and over time.[1]
- MedRec reduces workload and rework associated with medication management downstream
  - Pharmacists will spend less time tracking down and contacting prescribers to clarify and address discrepancies in medication orders.
  - After MedRec implementation, pharmacist time at admission was reduced by over 40 minutes per patient.[9]
  - Although MedRec systems take time to design and implement, such systems are necessary to ensure provision of safe care.[10]

REFERENCES

1) American Medical Association. (2007). *The Physician's Role in Medication Reconciliation: Issues, Strategies and Safety Principles.* American Medical Association.

2) Zed, P. J., Abu-Laban, R. B., Balen, R. M., Loewen, P. S., Hohl, C. M., Brubacher, J. R., et al. (2008). Incidence, severity and preventability of medication-related visits to the emergency department: a prospective study. *Canadian Medical Association Journal ,* 178 (12), 1563-1569.

3) Forster, A. J., Clark, H., Menard, A., Dupuis, N., Chernish, R., Chandok, N., et al. (2004). Adverse events among medical patients after discharge from hospital. *Canadian Medical Association Journal* , 170 (3), 345-349.

4) Gleason, K. M., McDaniel, M. R., Feinglass, J., Baker, D. W., Lindquist, L., Liss, D., et al. (2010). Results of the Medications at Transitions and Clinical Handoffs (MATCH) Study: An Analysis of Medication Reconciliation Errors and Risk Factors at Hospital Admission. *Journal of General Internal Medicine* , 441-447.

5) Greenwald, J.L., L. Halasyamani, J. Greene, C. LaCivita, E. Stucky, B. Benjamin et al. 2010. "Making Inpatient Medication Reconciliation Patient Centered, Clinically Relevant and Implementable: A Consensus Statement on Key Principles and Necessary First Steps." *Journal of Hospital Medicine* 5: 477–85.

6) Canadian Society of Hospital Pharmacists (CSHP). Medication reconciliation: statement on the role of the pharmacist. Ottawa (ON): Canadian Society of Hospital Pharmacists; 2009

7) Task Forse on a Blueprint for Pharmacy. Blueprint for pahrmacy: the vision for pharmacy. Ottawa (ON): Canadian Pharmacists Association (2008).

8) American Pharmacists Association and American Society of Health-System Pharmacists. Improving care transitions: Optimizing medication reconciliation. March 2012. Available at: http://www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx. Accessed February 11, 2013.

9) Karnon, J., Campbell, F., & Czoski-Murray, C. (2009). Model-based cost-effectiveness analysis of interventions aimed at preventing medication error at hospital admission (medicines reconciliation). *Journal of Evaluation in Clinical Practice* , 15 (2), 299-306.

10) Barnsteiner, J. H. (2008). Chapter 38: Medication Reconciliation. In R. G. Hughes, *Patient Safety and Quality: An Evidence-Based Handbook for Nurses.* Rockville: Agency for Healthcare Research and Quality (US).