

5 Diamond Patient Safety Program

Medication Reconciliation

2008

**This presentation was collaboratively developed by the Mid-Atlantic Renal Coalition (MARC) and the ESRD Network of New England for the 5-Diamond Patient Safety Program.*

The 5-Diamond Patient Safety Program is endorsed by the Renal Physicians Association (RPA) and American Nephrology Nurses' Association (ANNA).

What is Medication Reconciliation?

Simply.....

All medications are appropriately and consciously continued, discontinued or modified.

Medication Reconciliation

- Is a process for obtaining and documenting a complete list of the patient's current medications on a routine basis with the patient's involvement.
- The process includes a comparison of the patient's complete list of medications and is always communicated to the next provider of service when patients transfer to another setting, service, practitioner, or level of care.
- Reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.
- Reconciliations should be done by licensed personnel.

Is it important?

- Medication Reconciliation is one of the efforts to reduce the number of medication errors which occur world-wide every day.
- JCAHO reports that 63% of 350 sentinel* events related to medications were attributed to communication issues and half of the errors would have been avoided through an effective process of medication reconciliation.

*A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury.

Is it important?

- Maintaining an accurate medication list throughout the continuum of care can reduce the risk of adverse drug events.
- Medication reconciliation helps patients recognize they are responsible for their own health care and what happens to them.
- This is a way to help all of us be more health conscious.

What is the process?

- Designate one day for the patient to bring in all medications
- Develop and/or pull list from chart of medications
- Compare patients medications with the list
- Communicate the new list/changes to the patient and appropriate caregiver.

Process Recommendations

- Adopt a standardized form for reconciling
- Put the patient's medication reconciliation form in a highly visible portion of their chart
- Reconcile on a scheduled basis (i.e., last treatment of month, after return from hospitalization)
- Designate a team member to be responsible for implementing reconciliations and reporting variances to physician or physician extender
- Ensure that patients understand the importance of medication reconciliations and that they are expected to remind staff of appointments outside of the dialysis unit.

Other Information To Be Aware Of

- Medication side effects
- Special instructions for taking each medication (i.e., special foods or times or activities which might effect the benefits of the medication)
- Which medication might be discontinued when a new medication is added
- Medications with names that sound just alike or look alike

Keep a Personal Record

- Name, DOB, Address, Phone #
- Existing medical conditions
- Immunization record
- Allergies
- Medical provider names and phone #
- Pharmacy choice
- EKG (if available)
- Emergency contact

Keep a Personal Record

Continued

- List of current medications
 - Include all prescriptions, over-the-counter medications, and herbals
 - Dosage
 - Frequency
 - Medication purpose
 - Required monitoring

Official “Do Not Use” List

Do Not Use	Potential Problem	Use Instead
U (unit)	Mistaken for “0” (zero), the number “4” (four) or “cc”	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily) Q.O.D., QOD, q.o.d, qod (every other day)	Mistaken for each other Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO4 and MgSO4	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Additional Abbreviations, Acronyms and Symbols

(For possible future inclusion in the Official “Do Not Use” List)

Do Not Use	Potential Problem	Use Instead
> (greater than) < (less than)	Misinterpreted as the number “7” (seven) or the letter “L” Confused for one another	Write “greater than” Write “less than”
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number “2” (two)	Write “at”
cc	Mistaken for U (units) when poorly written	Write “ml” or “milliliters”
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write “mcg” or “micrograms”

Sources

- Massachusetts Coalition for the Prevention of Medical Errors
<http://www.macoalition.org/index.shtml>
- Institute of Healthcare Improvement
<http://www.ihl.org/IHI/Topics/PatientSafety/MedicationSystems/>
- The Joint Commission
http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_35.htm

Tools to Help

- For the patient
 - Poster – Know your Medications
 - Word Search
 - Sample Med List

Tools to Help

- For the Staff
 - Sample reconciliation forms
 - Case Study (PowerPoint)