

Medication reconciliation in a community, nonteaching hospital

SUZANNE B. WORTMAN

The Joint Commission mandated that hospitals had to have a procedure implemented for the reconciliation of medications (ROMs) by January 1, 2006.^{1,2} This mandate is further explained in the Joint Commission's eighth National Patient Safety Goal, which describes the accurate and complete ROM across the continuum of care.

Poor communication at transition of care is reported to account for up to 50% of medication errors and 20% of adverse drug events.³ The reconciliation process may be compromised by gaps and barriers in the timely and effective exchange of information, in accountability by all entities, cohesiveness in the process, and in responsiveness to the changing needs of the patient.^{4,5} Effective communication tools are essential components of the medication reconciliation process. Several institutions have described reconciliation of medication programs in their institutions,^{2,6-12} yet many continue to struggle with this patient safety mandate. Cesta et al.¹³ described the development and evaluation of one medication information transfer tool. The letter included a final reconciled list of medications for the patient, as well as the patient's

Purpose. A medication reconciliation program involving physicians, pharmacists, nursing staff, and other personnel at a community hospital is examined.

Summary. The Joint Commission required hospitals to have a procedure in place for reconciling patient medication across the continuum of care by January 1, 2006. A multidisciplinary team was formed to address reconciliation of medications at DuBois Regional Medical Center. Baseline data on the number of medications unreconciled at admission, transfer, and discharge were collected. A reconciliation process and policy were developed and implemented. The pilot program took place on a nursing unit with a select group of physicians who were known leaders, who had a substantial patient volume, and who showed an interest in the program. Letters were sent to physicians to outline the opportunities of the program. The letters encouraged physicians to participate and cited advantages such as decreased legibility issues, less opportunity for transcription error, improvement in accuracy, convenience, and time saved by using electroni-

cally generated lists instead of lists written by hand. Continuous audits, feedback, and education provided an ongoing assessment of the benefit of the program in terms of reduction of unreconciled medications and highlighted opportunities for improvement. In June 2005, baseline statistics of unreconciled medications at admission and discharge were 15% and 18%, respectively. Following implementation of the program, numbers fluctuated but improved. During the second half of 2007, the percentages of unreconciled medications on admission and at discharge were less than 10% and continued the trend downward to less than 5%.

Conclusion. A community hospital has instituted a medication reconciliation program that involves physicians, pharmacists, nursing staff, and other personnel. Audits, feedback, and education are key components in the program's operation and improvement.

Index terms: Errors, medication; Health professions; Hospitals; Quality assurance
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medication history while in inpatient care. The letter was forwarded to the next pharmacist provider of care. Lubowski et al.¹⁴ described the successful execution of a medication reconciliation program by doctor of pharmacy degree students.

This article describes a program that has been developed and implemented at a 250-bed, community-based, nonteaching institution.

Initial development

A multidisciplinary team com-

SUZANNE B. WORTMAN, B.S., PHARM.D., BCPS, is Clinical Pharmacy Specialist, DuBois Regional Medical Center, 100 Hospital Avenue, DuBois, PA 15801 (sbwortman@drmc.org).

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prising representatives from nursing, pharmacy, performance improvement, management information systems (MIS), risk management and regulatory compliance, patient safety, and ad hoc physicians from the medical staff, health information management (HIM), and education and utilization review was created in October 2004. Staff nurses and managers from all hospital departments, including the emergency department (ED) and home health and hospice, were incorporated into a team, known as the ROM committee.

The team met on a monthly basis to discuss issues and concerns. The ROM committee obtained policies and procedures from other institutions and attended various presentations. Responsibilities were assigned based on hospital staffing capabilities and workflow. A draft policy was developed along with a flow chart outlining the process and defining responsibilities for reconciliation at each step. Preprinted order forms and prescriptions were formatted and added to the process. Numbers of unreconciled medication orders at admission, at transfer and postoperative, and at discharge were collected to provide baseline data. A timeline with specific goals was developed.

A pilot program of the discharge reconciliation process was then conducted to determine its feasibility and practicality. This pilot took place on a nursing unit with a select group of physicians who were known leaders, who had a substantial patient volume, and who showed an interest in the program. Letters were sent to physicians by the performance-improvement department and the vice president of medical affairs to outline the opportunities of this process. These letters encouraged physicians to participate and cited advantages such as decreased legibility issues, less opportunity for transcription error, improvement in accuracy, convenience, and time saved by using electronically generated lists instead

of lists written by hand. Practitioners received intense one-on-one education from the clinical pharmacist and two commissioned staff nurses. Daily input from the physicians aided in the development of an accurate, user-friendly format. Progress and impediments were noted, discussed, and analyzed.

Soon after initiation of the pilot, other physicians saw the preprinted orders and prescriptions and were eager to participate. Additional physicians and nursing units were included in the process. The ROM committee continued to work one-on-one with specific physicians to fine-tune the process. The program expanded to include the admission and transfer and postoperative processes. It was finally implemented hospitalwide to provide a cohesive, consistent process.

Procedures for hospital admissions

When a patient is admitted to the facility, the ED nurse obtains a list of home medications and allergies from the patient, the family, or both to be entered into the ED's computer system.^a This updated list of medications taken before admission is known as "meds PTA." It is printed and sent with the patient to a nursing unit.

The unit nurse reviews the ED list with the patient, updates it, and checks for any inconsistencies. If clarifications are necessary, the nurse checks with the patient's pharmacy, primary care physician, or other sources as appropriate. If the patient is part of DuBois Regional Medical Center's (DRMC's) home health and hospice system, the most current medication list is accessible via the computer system and can be used as an additional source of verification. The unit nurse reviews the information and composes a list of medications that the patient was taking before admission. The list is as accurate as possible and uses all

available information. This updated list is then entered into the "home medications" section of the inpatient nursing computer system.^b There is no interface between the ED and the inpatient computer system.

Generation of physician's order form. With the help of MIS specialists, this information has been reconfigured into a report template that is populated by data from the nurse charting. A hard copy of this report is generated by the nurse and placed in the "physician orders" section of the chart. This report, known as the "initial medication orders form" (Figure 1), serves as an official physician's order. It contains the patient's age, allergies, and home medications and provides additional space to allow new prescriptions to be written. The physician reviews the list of medications on the form and checks a box to indicate whether the medication is to be continued or discontinued. The form is then signed and dated. Ideally, this form is completed by the physician before admission orders are written.

The information in the nursing computer system is linked with the new medication orders for a patient who is entered in the pharmacy computer system^c by means of a locally developed database.^d There are no interfaces between the inpatient nursing and the pharmacy computer systems. Information in the database is updated on a continual basis. In an effort to observe the Health Insurance Portability and Accountability Act and maintain confidentiality, access to computerized patient information is limited to the unit where the patient was entered into the system. A hard copy is available on the chart for other areas.

Medication reconciliation form. The night-shift unit secretary accesses the database to print a "reconciliation of medications on admission" form (Figure 2) for all patients who were admitted in the previous 24 hours. The secretary then places it in

Figure 1. DuBois Regional Medical Center's initial medication orders form.

Active Reported Home Medications - Last Verified 11/19/2007 14:02							12/21/2007 12:53 Page 1 of 1
Drug Name	Dose	Route	Frequency	Comment	Continue	Discontinue	Start Date
Asacol (Mesalamine)	1 tablet	Oral	Daily		<input type="checkbox"/>	<input type="checkbox"/>	
Ativan (Lorazepam)	0.5 mg Tablet	Oral	HS		<input type="checkbox"/>	<input type="checkbox"/>	
Cardizem (Diltiazem HCl)	60 mg Tablet	Oral	Q12H		<input type="checkbox"/>	<input type="checkbox"/>	
Colace	100 mg Capsule	Oral	Daily		<input type="checkbox"/>	<input type="checkbox"/>	
Debrox (Carbamide Peroxide)					<input type="checkbox"/>	<input type="checkbox"/>	
Haldol (Haloperidol Lactate)	10 mg Solution	Intramuscular	PRN		<input type="checkbox"/>	<input type="checkbox"/>	
Inderal (Propranolol)	Tablet	Oral	BID	Unknown Dose	<input type="checkbox"/>	<input type="checkbox"/>	
Keflex (Cephalexin)	500-1000 mg Capsule	Oral	BID		<input type="checkbox"/>	<input type="checkbox"/>	
Lasix (Furosemide)	40 mg Tablet	Oral	Daily		<input type="checkbox"/>	<input type="checkbox"/>	
Lopressor (Metoprolol Tartrate)	50 mg Tablet	Oral	BID		<input type="checkbox"/>	<input type="checkbox"/>	
Nitroglycerin (Nitroglycerin)	0.4 mg Tablet, Sublingual	Sublingual	PRN		<input type="checkbox"/>	<input type="checkbox"/>	
Simvastatin (Simvastatin)		Oral	HS		<input type="checkbox"/>	<input type="checkbox"/>	
Vicodin (Hydrocodone-Acetaminophen)	5 mg	Oral	Q4H		<input type="checkbox"/>	<input type="checkbox"/>	
Zocor (Simvastatin)	20 mg Tablet	Oral	HS		<input type="checkbox"/>	<input type="checkbox"/>	

Allergy History

Allergen	Type	Onset Date	Primary Reaction	Other Reaction	Severity	Comment	Confirmed By and Date/Time
Percocet	DRUG	1/15/2000	Hallucinations		Severe		Training, Rn Three N., RN 07/19/2007 07:00
SULFA (SULFONAMIDES)	DRUG	1/15/2000	Rash		Mild		Training, Rn Three N., RN 07/19/2007 07:00
Animals	MISC		Exfoliative Dermatitis		Moderate		Training, Rn Two N., RN 11/19/2007 14:02
Bee/Wasp Stings	MISC		Anaphylaxis		Severe		Training, Rn Three N., RN 06/01/2007 14:23

New Medication Order

Drug Name	Dose	Route	Frequency

Physician: PHYSICIAN: Please review and sign, DATE and TIME

Physician Signature: _____ Date: _____ Time: _____

Name: DOE, JANE Age: 37 DOB: 5/24/1971 Acct: 5556667777
 Opt Out: No Gender: F Admit DT: 01/02/2008 14:21 MRN: 123456789
 Physician: Smith, Joe, MD Rm-Bed: 3050-01

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the physician orders section of the chart. This form groups, documents, and organizes the home medications and admission orders according to the *American Hospital Formulary System Drug Information* classification.¹⁵ If the initial orders form has not been addressed and completed by the physician at this point, it is discarded. The list of home medications remains available in the nursing documentation.

After reviewing the ROM on admission form, the nurse determines if further reconciliation is necessary and signs and dates the form. Any orders that need reconciliation are transcribed by the nurse onto the ROM clarification form. This is a blank template of the initial orders form that allows the nurse to list the medications that require reconciliation for physician review. If the form is not reviewed, signed, and dated as an order by the physician, the nurse contacts the physician for clarification. This process ensures reconciliation within 24 hours of admission. Orders that are regarded as critical are addressed immediately.

Pharmacy review of orders. Throughout the process, physician orders are faxed to the pharmacy department for review according to customary procedures. Clarifications of a critical nature are made directly between a pharmacist and a physician. Clarifications of a noncritical nature are addressed via a written notice that is sent to the unit nurse to be placed on the chart for physician review. Once orders are clarified and deemed safe and appropriate by the pharmacist, he or she enters the orders into the pharmacy computer system. A clinical pharmacist continues to attend interdisciplinary care rounds biweekly and reviews home medication lists.

Procedures for transfers

Before transferring a patient to another level of care, the unit secretary or nurse opens the database

and prints transfer and postoperative reorders and a current medication list from the pharmacy computer system. The nurse or secretary then places the forms in the physician orders section of the chart. Transfers between levels of care are addressed by the primary care physician or admitting physician. The physician reviews the medication list and checks “continue” or “discontinue” as appropriate. For patients coming from the operating room, the surgeon is responsible for completing the transfer and postoperative orders. As part of the preoperative checklist, the nurse confirms this form is present for the surgeon. The nurse also ensures that the surgeon completes the form in the recovery room before sending the patient back to the unit. In either case, this form serves as the reconciliation piece. This process is often completed by nursing staff via oral orders from the physician.

Procedures for hospital discharge

At discharge, the database is accessed again in order to print the following three things: (1) a “discharge prescriptions summary list,” which includes current medications as listed in the hospital pharmacy computer system, (2) a “home medications not reordered list,” which includes any medications the patient was taking at home before admission that were not reordered during the hospital stay or medications that were ordered but discontinued during the hospital stay, and (3) a “discharge prescriptions list,” which is the summary list in prescription format. The physician checks continue or discontinue as appropriate for medications listed on the discharge summary list and home medications not reordered list. These are considered a patient’s final reconciled lists of medications. Copies of these forms are distributed to the patient, the chart, and the next provider of care.

Any or all of the above can be handwritten. The discharge sum-

mary and home medications not reordered lists can be combined on an institution-specific discharge form, known as the “inpatient discharge reconciliation” form. This form may also be used when computer systems are not functioning. Intravenous medications do not print on the discharge prescriptions summary list or on the discharge prescriptions because many i.v. medications are given “as needed,” and the intent has been to avoid listing drugs that will be discontinued on discharge. The handwritten medication administration record (MAR) must be reviewed to view the list of i.v. medications. Schedule II medications *do* print on the discharge prescriptions summary list but do *not* print on the discharge prescriptions. Per physician request, they are to be handwritten to reduce the potential for forgery.

Forwarding to the next provider of care (primary care provider or referral) involves making sure the provider receives the most updated list of medications for the patient. If the next provider of care is in the DRMC network, the provider has access to the electronic medical record (EMR) or physician’s portal. The information is available within 24 hours of discharge. If the information is needed sooner, a call to HIM expedites the process. A list of DRMC providers can be found on the network’s intranet site and is available at the unit secretary’s desk. This list is updated and maintained by the credentialing office.

If the next provider of care is outside of the DRMC network, the chart is flagged by the utilization review department. If a physician instructs the patient to follow up with a provider outside of the network on the “discharge instructions sheet,” the chart is flagged by nursing. In both cases, extra copies of the discharge summary list, home medications not reordered list, and discharge prescriptions are placed on top of the chart. HIM then faxes or mails this

Figure 2. DuBois Regional Medical Center's form for reconciliation of medications on admission.

DOE, JANE
 Medical Record Number:
 123456789
 Admission Number:
 5556667777

DOE, JANE ROOM: 3050-01

Sex: F Weight (Kg): 88.9 Height (Inches): 66 IBWeight (Kg): 59.3 BSA: 1.98
 Allergies: PENICILLINS

ANTICONVULSANTS, MISCELLANEOUS

OXCARBAZEPINE

Home Med TRILEPTAL 300 MG BID ORAL
 Admit Med TRILEPTAL 300 MG TWICE A DAY ORAL

Reconciliation needed? Prescriber contacted? Reconciliation Completed?

BASIC OINTMENTS AND PROTECTANTS

LANOLIN

Admit Med LANOLIN OINTMENT 1 APPLIC AS NEEDED TOPL

Reconciliation needed? Prescriber contacted? Reconciliation Completed?

CATHARTICS AND LAXATIVES

BISACODYL

Admit Med DULCOLAX SUPPOSITORY 10 MG AS NEEDED RECT

Reconciliation needed? Prescriber contacted? Reconciliation Completed?

ETHANOLAMINE DERIVATIVES

DIPHENHYDRAMINE HCL

Admit Med BENADRYL 50 MG AS NEEDED IM

Reconciliation needed? Prescriber contacted? Reconciliation Completed?

IRON PREPARATIONS

IRON-DUCOSATE SODIUM

Admit Med FERRO-SEQUELS 1 TABLET TWICE A DAY ORAL

Reconciliation needed? Prescriber contacted? Reconciliation Completed?

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

IBUPROFEN

Home Med ADVIL 400 MG EVERY SIX (6) HOURS AS NEEDED ORAL
 Admit Med ADVIL 600 MG EVERY SIX (6) HOURS AS NEEDED ORAL

Reconciliation needed? Prescriber contacted? Reconciliation Completed?

Reviewed: _____
 (Nurse Signature)

Date: Wednesday, January 02, 2008 14:44

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information to the next provider of care during regular business hours. Nursing staff faxes the information for patients who are going to a skilled nursing facility or an acute care facility.

When the computers are down, an “inpatient admission reconciliation clarification form” and a “discharge reconciliation (discharge medication summary) form” are used for reconciliation on admission and at discharge. Reconciliation on transfer and postoperative is accomplished by rewriting the orders in the physician orders section of the chart, adding “medications reconciled” before the physician signs the chart.

All forms are bar coded for scanning into the appropriate section of the EMR. The discharge summary list and home medications not reordered list are assigned to a pharmacy medication reconciliation tab setup in the EMR to enable physicians and other health care workers access to the most recent, accurate list of patient medications. The discharge prescriptions, which are not always inclusive, are placed with the discharge instructions under a separate tab.

Education

The education of nursing staff, pharmacists, and physicians continues to be the responsibility of the clinical pharmacist, who serves as chair of the ROM committee. MIS and education departments have been involved in computer training. Staff nurses were identified and appointed by nursing supervisors of each respective unit as “super users.” The nursing supervisors attended inservices and continue to educate staff on their units. Mandatory inservices were held at the time of hospitalwide implementation. A self-learning packet was provided to each nursing unit and was placed on the hospital’s intranet site.

In addition to individual instruction, slide presentations and handouts were used to provide an over-

view of the National Patient Safety Goal requirements and the processes for compliance. A poster board that outlined the process was displayed on a rotating basis on the units and in the physicians’ lounge. Education took place at medication safety meetings, nursing inservice days, and physician staff meetings. On two occasions, physicians received a packet via interoffice mail that contained a summary of the National Patient Safety Goal requirements and specific physician roles in the process. As an added incentive to review the material, the continuing medical education department granted one hour of continuing-education credit for completion of an attached questionnaire.

The clinical pharmacist and two nurses address daily concerns. The MIS designees and the pharmacy-appointed MIS person address computer concerns as they arise.

The vice president of medical affairs is an ad hoc part of the ROM committee. Many physicians from the medical staff, including thought leaders, hospitalists, medical staff leaders, and those who show an interest because of success or concerns with the process, have been approached individually and recruited for the effort. Personal invitations and follow-up e-mails have been sent with ROM committee meeting reminders; however, attendance has been poor. Participation and compliance with the process by physicians were and continue to be two of the main challenges in the process.

Audit results

Nursing staff complete monthly audits of “admission and discharge reconciliation.” This effort began in December 2005. Transfer and postoperative reconciliation audits were added in 2006. For admission purposes, the list of home medications (i.e., those listed on the nursing assessment, ED assessment, and physician’s history and physical) is re-

viewed. The numbers of medications taken at home, including prescription, herbal, over-the-counter, and as-needed medications, are counted. This list is compared to the list of medications ordered within 24 hours of admission.

Aside from herbal medications, any medications omitted or ordered at a different strength or frequency without an explanation are deemed unreconciled. Herbal medications are not counted as unreconciled because it is against hospital policy for them to be continued during hospitalization. Blanket orders, such as orders written to “continue home medications,” are considered unreconciled. On transfer and postoperative, the medications ordered are compared to the handwritten MAR before transfer or surgery.

At discharge, the home medication and active medication lists are compared against the discharge summary transcribed for the patient. Herbal medications are included at discharge. Blanket orders, such as “continue same home meds,” are considered unreconciled.

Initially, charts were reviewed to identify whether the nurse, nurse practitioner, physician assistant, or physician was completing the reconciliation and to identify trends for particular medications or classes that might be difficult to reconcile. This effort became burdensome and was removed from the audit. The ability to collate the data electronically has been available since September 2007. The information is manually collected and entered into a locally developed database that can be manipulated to provide data that are unit specific or aggregate for all units combined.

Each month, all 10 nursing units randomly select 10 discharge charts (100 total) and determine the proportion of unreconciled medications. Aggregate data of all units combined in the first quarter of 2006 showed unreconciled medications at

admission to be at about 14% and about 15% at discharge. Less than 5% of medications were unreconciled at admission and at discharge as of the first quarter of 2008. Numbers have been fairly consistent for several months. The proportion of postoperative and transfer medication orders that were unreconciled overall is 9.74%, but some months are below that figure.

If discrepancies are noted with a pattern, the vice president of medical affairs notifies the attending physician (and discharging physician if different from attending) via letter. Feedback on unit-specific and aggregate data is provided to the unit manager and staff. These data are reviewed monthly by the ROM committee. A summary of this information is disseminated by the clinical pharmacist to the pharmacy and therapeutics committee. Nursing managers are updated about issues involving reconciliation on a monthly basis, and any changes deemed necessary are made and education is forwarded as appropriate. Aggregate results on discharge reconciliation were presented every quarter in 2006 to administration and department directors, the quality management team of the medical staff, the medical executive committee, and the hospital board. Reports have been submitted to the medication safety committee, patient safety committee, and senior management on a monthly basis by the performance-improvement manager. As a result of the audits, efforts are ongoing to improve consistency in the use of and adherence to the process of reconciliation by all disciplines.

Discussion

Strengths. The success of the ROM program can be attributed to the center's multidisciplinary approach from the beginning. All levels of professionals have been actively involved in the process. The MIS and pharmacy computer specialists have

worked diligently to update forms, while the clinical pharmacist and nurses continue to work tirelessly to educate and involve physicians in the process. Audits and timely feedback have made this a dynamic, adaptable process. Dialogue and communication have been open, and education continues to be an ongoing endeavor. Several physicians have championed the process. Local retail pharmacists were initially consulted to ensure legibility and consistent interpretation of the discharge prescriptions, as well as the scanning capabilities of their computerized systems.

In contrast to the previous haphazard and inconsistent processes of order writing, the reconciliation process allows a practical means to enhance safety. Overall, ROM has improved, which should translate into better quality care for patients.

Limitations. It is recognized that an ideal process would incorporate comprehensive pharmacist review of medications; however, given the availability of resources, this is not practical. Patient medications are reviewed for allergies, interactions, and duplication at the order-entry level. An overview and reconciliation of patient medications from preadmission to discharge are completed by one of two clinical pharmacists twice a week during inpatient interdisciplinary care rounds. Nursing staff carry out the majority of the medication review. The home medications are reviewed on admission and at discharge; however, they are not consistently reviewed in the transfer and postoperative processes. This presents an area of opportunity for improvement. Another area of weakness is the inability to enforce physician accountability and compliance. Although physicians are in agreement with the principle behind ROM, and they agree that it is best for patient care, it is a time-consuming process. The preprinted forms are used but not often completed as intended. Additional clarifications

are often necessary to ensure that complete reconciliation occurs. It is difficult to engage a majority of physicians in the process. Physicians continue to be invited to programming events, but attendance is poor. Requests have been made to present the program at physician meetings; however, the time allotted has only allowed a brief summary by physicians. There are many physician-owned practices, and a recommendation was made to include compliance on a physician report card. Requests were made for the heads of the medical and surgical staffs to support the effort. They agreed to present ROM concerns at their staff meetings. Education continues on a one-on-one basis and helps to ensure patients get the best care. Although the process is automated as best as possible, it is still a nurse-driven, time-consuming process.

Computer issues that pose limitations include i.v. medications not being printed on the discharge forms. The rationale is to avoid many as-needed i.v. medications used only in the hospital for symptom management from printing. Therefore, if the patient is discharged on an i.v. medication, such as an antibiotic, extra attention has to be paid. Another challenge is that MIS does not have the personnel to enable the discharge summary and home medications not reordered lists to print on a single form.

The process has increased awareness for the need for reconciliation and has provided a means for consistency. A reduction in the number of unreconciled medications has been shown by virtue of having the process in place. The actual benefit of the process in terms of patient and medication safety requires another study. This study has enabled a practical means to improve safety with limited resources. Evaluation of ED visits, readmission rates, or reduction in medication errors because of the implementation of the process has

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not been undertaken but might provide evidence of increased safety.

Future activities

Interfaces are being built to facilitate the transfer of information between computer systems. Additionally, computerized physician order entry and electronic prescribing in the future may help streamline the process by reducing the time required for clarification and the number of unreconciled orders.

Currently, efforts are being directed at the reconciliation process in the ancillary departments (e.g., radiology, presurgery, catheterization laboratory, short-stay procedure unit) and in the physician-owned practices. The clinics are to disseminate a single, standardized letter and blank medication profile for the patient to complete. An outpatient reconciliation form is to be used by practitioners in all areas. The printing of this form in the EMR at or before the visit is being investigated. The pharmacy medication reconciliation tab of the EMR contains inpatient and outpatient DRMC reconciliation forms in chronological order of visits, which provides a closed loop and continuity of care for patients using the health care system.

Efforts directed at educating the public about the importance of maintaining a complete and accurate list of current medications and knowing the indications are being pursued by pharmacy and home health and hospice with the support of hospital leaders.

Adequate personnel and resources remain a challenge. Resources are not necessarily dedicated to the project. The responsibilities are interwoven into the everyday workload; there-

fore, computer and form upgrades may take several weeks or months to occur.

Section 7002(b) of the Social Security Act mandated that all outpatient prescription orders be tamper-resistant.¹⁶ Because many physicians did not want to revert to handwriting discharge prescriptions, new printers dedicated to printing prescriptions only on specialized paper had to be purchased for every unit. This was a costly endeavor. To date, many physicians are not using the preprinted prescriptions. MIS is currently undertaking the process of enabling each part of the discharge portion of the reconciliation process to be printed independently (i.e., print the discharge summary list, home medications not reordered list, or discharge prescriptions).

Conclusion

A community hospital has instituted a medication reconciliation program that involves physicians, pharmacists, nursing staff, and other personnel. Audits, feedback, and education are key components in the program's operation and improvement.

^aMEDHOST, version 3.4, MedHost Corp., Dallas, TX.

^bHorizon Clinicals, version 7.6 SP2, McKesson Information Systems, Atlanta, GA.

^cHorizon, MedsManager, McKesson Horizon, Atlanta, GA.

^dMicrosoft Access, 2002 SP3, Redmond, WA.

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