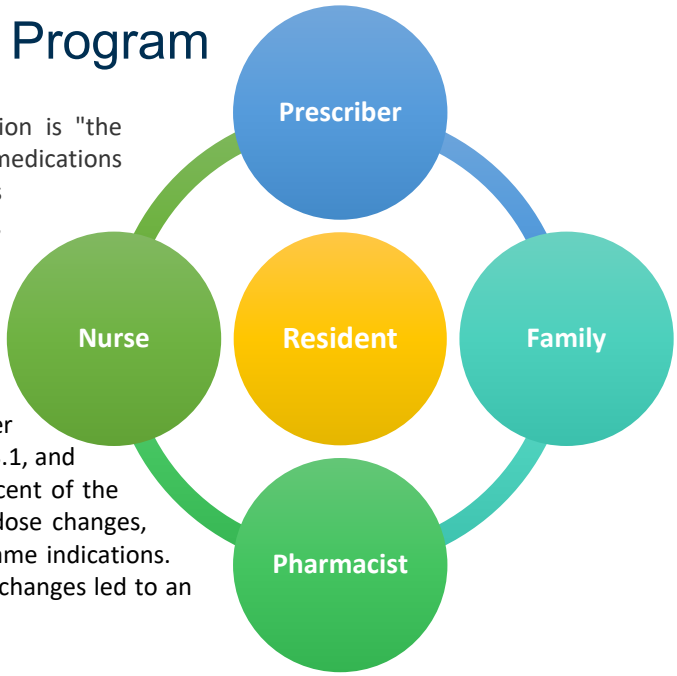
ICP Medication Reconciliation Program



As defined by The Joint Commission, medication reconciliation is "the process of comparing a patient's medication orders to all of the medications that the patient has been taking". This reconciliation is performed to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions.

A study of medication changes during transfer from nursing home to hospital and hospital to nursing home found inaccurate and incomplete reconciliation of medication regimens.[1] The mean number of medication orders altered per patient on admission to the hospital from a nursing home was 3.1, and from the hospital to the nursing home was 1.4. Sixty-five percent of the medication changes were discontinuations, 19 percent were dose changes, and 10 percent were substitutions for medications with the same indications. The investigators estimated that 20 percent of the medication changes led to an adverse drug event.

ICP offers our medication reconciliation program through our consultant pharmacist staff.
Upon admission, the facility notifies their consultant pharmacist, who will complete the review by comparing the hospital discharge medication list and home medication list with the orders entered into the electronic health record. Along with completing the medication reconciliation our consultant pharmacists address many other issues associated with new admissions. Below is a list of common areas of concern found during the reviews.

Clinical recommendations from medication reconciliation are categorized as follows:

Beers List
Drug Interactions
Duplicate Therapy
Diagnosis Correction
Match Pharmacy Order
Medication Administration
Order Clarification
PRN Psychotropic
Stop Date
Wrong Dose Entered
CHF Management
COPD Management
Diabetes Management
Home Med Omitted
Hospital Med Omitted
Miscellaneous
Pain Management
Renal Dosing
Wrong Directions Entered
Wrong Med Entered

[1] Boockvar K, Fishman E, Kyriacou CK, et al. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and long-term care facilities. Arch Intern Med. 2004;164:545–50.

Actual Data from January 1, 2020 to March 31, 2020

Recommendation Categories	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7	Facility 8	Totals
Adverse Reaction		2				2			4
Allergy						2			2
Beers List						5		1	6
CHF Management						2			2
COPD Management		1				1			2
Diabetes Management						2			2
Drug Interaction		2	2		1	3		1	9
Duplicate Therapy					4	6	1	1	12
Diagnosis Correction	4	15		7	34	31	17	15	123
Excessive or Inadequate Dose	2	15			3	8		2	30
Match Pharmacy Order	10	11		3	25	8	13	14	84
Medication Administration		2		1	3	16	2	3	27
Misc.	1				1	8	3		13
Missing Strength	1	2	1						4
Omission	1	7	1		7	12	7	1	36
Order Clarification	2	13			2	10	14	1	42
Pain Management		2				5	6		13
PRN Psychotropic	6		1		5	12	2	4	30
Renal Dosing		1			1	1			3
Stop Date	2	2			1	21	8	2	36
Wrong Directions Entered	7	10		1	4	15	5	2	44
Wrong Dose Entered			1	1	3	8	4	1	18
Wrong Med Entered	7	2			2	3	6		20
Total for the Quarter	43	87	6	13	96	181	88	48	562
Previous Quarter	27	81	19	37	135	173	76	15	563
Number of Reviews	21	76	4	4	32	105	49	17	308
Number of Reviews Previous QTR	19	64	13	12	52	116	58	7	341
Avg # Recs/Review	2.05	1.14	1.50	3.25	3.00	1.72	1.80	2.82	1.82
Avg # Recs/Review Previous QTR	1.42	1.27	1.46	3.08	2.60	1.49	1.31	2.14	1.65

Higher risk of causing harm.

Total number of high-risk recommendations	268
Average number of high-risk recommendations/review	0.87