Medication Reconciliation at All Transitions
Prevent adverse drug events (ADEs) by implementing medication reconciliation at all transitions in care—at admission, transfer, and discharge.

Domain

Processes to Support Care:
Processes that are essential to support and maintain the delivery of care to all types of patients, across all units and settings in the hospital

Aims

Patient Centered:
Care throughout a patient’s experience that is coordinated, informed, and grounded in respectful interactions with care providers that are consistent with the patient’s values, expectations, and care decisions

Safe:
Delivery of care in a manner that minimizes any risk of harm to a patient

Process Attributes

Cost to Implement
The monetary resources required to implement this process

Moderate: In addition to the improvement effort, relies on additional personnel and/or technology

Time to Implement
The amount of time, from months to years, it will take on average to establish this process

More than 2 years

Difficulty to Implement
The challenges of implementing this process

Most Challenging: Involves multiple units or disciplines AND requires a substantial shift in culture and/or operations

Level of Evidence
The degree to which the actions in this process are supported by research and experience; based on the Cochrane scale

Some Evidence: Level III — Studies published with some control included

Details

Elements

A reliable medication reconciliation process for each patient has three steps:

- Verification: Obtain a complete and accurate list of the patient’s current medications, including name, dosage, frequency and route.
- Validation: Review current medications and indicate which are to be continued, doses altered, temporarily held or discontinued. Although not required, rationale for changes can be included.
- Clarification: Compare the medication list with medication orders at admission and each transition in care.
Reliable medication reconciliation programs establish standard forms and procedures to ensure the process is initiated at admission, during transitions within the hospital, and to home or other care facility.

Outcomes
- **Harm**: Decreased harm to patient (e.g., Harms per 100 patient days, as measured by the IHI Global Trigger Tool)
- **Patient Satisfaction**: Increased patient satisfaction (e.g., HCAHPS Willingness to Recommend, HCAHPS Hospital Rating)
- **Readmissions within 30 Days**: Decreased readmissions within 30 days
- **Reliability**: Increased delivery of evidence-based care 100% of the time

Service Lines and Critical Functions
- Applies in All Patient Settings
- Hospital Medicine, Adult
- Medication Management

Key Measures
- Percent unreconciled medications at admission, at transfer, or at discharge
- Unreconciled Medications on Charts
  - Numerator: Number of medications on the chart not reconciled
  - Denominator: Total number of medications on the chart

Reasons and Implications

Importance for Patients and Families
Reviewing the patient’s list of medications taken before their hospitalization or before they are transferred to a new unit of the hospital, and matching the list to their new medication prescriptions list, prevents errors that can cause serious harm.

Requirement, Standards, Policies, and Guidelines
- **Agency for Healthcare Research and Quality (AHRQ)**
- **Centers for Medicare & Medicaid Services (CMS)**
- **National Priorities Partnership (NPP)**
  - Safety
  - Care Coordination
- **National Quality Forum (NQF)**
  Safe Practice for Better Healthcare—2009 Update
  Safe Practice 17: Medication Reconciliation
- **The Joint Commission (TJC)**
  National Patient Safety Goal 8 will be evaluated during surveys, but will not be factored into the accreditation decision
- **The Joint Commission (TJC)**
  Sentinel Event Alert Issue 35: Using medication reconciliation to prevent errors

Financial Implications
- Expense reduction can occur due to reduction in adverse drug events.

Prerequisites
- Adoption of a clear definition of medication reconciliation
- Agreement that medication reconciliation is a multidisciplinary process
Resources

Additional Resources

- **Institute for Safe Medication Practices (ISMP)**
  Teleconference: Medication Reconciliation Parts I and II

- **North Carolina Hospital Association**

- **National Transitions of Care Coalition (NTOCC)**
  The National Transitions of Care Coalition (NTOCC) is a group of concerned organizations and individuals who have joined together to address problems associated with transitions of care of patients from one practice setting to another. NTOCC was founded in 2006 by the Case Management Society of America (CMSA) and sanofi-aventis, U.S. to define solutions addressing those gaps that impact safety and quality of care for transitioning patients, particularly seniors. The NTOCC website provides links to participating organizations.

- **Institute for Safe Medication Practices (ISMP)**
  Medication Safety Alert: Building a case for medication reconciliation

- **American Hospital Association (AHA)**
  Hospitals in Pursuit of Excellence – Individual Case Studies
  Improving Medication Reconciliation
  Contra Costa Regional Medical Center

- **Agency for Healthcare Research and Quality (AHRQ)**
  Patient Multidisciplinary Training for Medication Reconciliation

- **American Medical Association (AMA)**
  The Physician’s Role in Medication Reconciliation

- **Massachusetts Coalition for the Prevention of Medical Errors**

- **US Department of Health and Human Services**
  Partnership for Patients

- **Agency for Healthcare Research and Quality (AHRQ)**
  Patient Safety Tools: Improving Hospital Discharge through Medication Reconciliation and Education

- **Massachusetts Coalition for the Prevention of Medical Errors**
  Medication Reconciliation- Measurement Tools

Information Compiled By

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