Medication Reconciliation

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KEYWORDS

• Medication reconciliation • Medication management • Clinical informatics
• Transitions of care • Patient safety

HOSPITAL MEDICINE CLINICS CHECKLIST

1. Medication reconciliation is the process of obtaining and maintaining a patient's medication list at every transition of care, and using this information when writing new medication orders or prescriptions for the patient.
2. Lack of reconciliation can lead to adverse drug events (ADEs), emergency department visits, and rehospitalizations. Up to 20% of medication errors during transitions of care lead to patient harm.
3. Reliable medication reconciliation processes can reduce ADEs and health care resource use. Using pharmacist resources to provide reconciliation for high-risk patient groups may be the most effective way to improve outcomes.
4. Medication reconciliation involves verification of a patient's medication information, clarifying any potential discrepancies, and documenting (reconciling) any changes to the medication information.
5. Medication reconciliation work flow requirements are more streamlined for ambulatory clinic and emergency department settings compared with the hospital setting.
6. Although many hospitals began with a paper-based medication reconciliation work flow, most electronic medical records (EMR) applications have medication reconciliation functionality, and EMR implementation in hospitals is becoming the norm.
7. Physicians, nurses, and pharmacists may participate in medication reconciliation; individual institutions have the responsibility for establishing their work flows.

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8. Overly complex processes and lack of clarity regarding lines of responsibility for performing reconciliation can hinder successful implementation.
9. There are multiple online resources for medication reconciliation best-practice standards and implementation tool kits.

KEY PRINCIPLES

1. What is medication reconciliation?

Definition of Medication Reconciliation

The concept of medication reconciliation was first introduced to the broader medical community in 2005, when the Joint Commission established it as a National Patient Safety Goal (NPSG) for hospitals. The definition outlined in the NPSG has evolved over time[1]:

- 2005 definition: "Completely and accurately reconcile medications throughout the continuum of care."
- 2011 definition: "Maintain and communicate accurate patient medication information."

One of the best operational definitions was established by an expert panel convened by the American Society of Health System Pharmacists (ASHP) and the American Pharmacy Association (APhA) in 2007[2]:

> *Medication reconciliation is the comprehensive evaluation of a patient's medication regimen any time there is a change in therapy in an effort to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions, as well as to observe compliance and adherence patterns. This process should include a comparison of the existing and previous medication regimens and should occur at every transition of care in which new medications are ordered, existing orders are rewritten or adjusted, or if the patient has added nonprescription medications to [his or her] self-care.*

A medication reconciliation process is therefore a more comprehensive version of a medication history. The process involves:

- Maintenance of accurate medication information for a patient
- Use of that information when new medication orders or prescriptions are written
- Communication of medication information changes to the patient when appropriate

From the perspective of a hospitalist, medication reconciliation is a process for comparing a patient's current medications with the medications ordered for the patient, whether at admission, transfer, or discharge.

Definition of Medications

Implicit in having a definition for medication reconciliation is the need for a definition of medication. According to the Joint Commission,[3] medications include:

- Prescription medications
- Over-the-counter medications