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ORIGINAL ARTICLE

Whose responsibility is medication reconciliation: Physicians, pharmacists or nurses? A survey in an academic tertiary care hospital

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Abstract *Background:* Medication errors occur frequently at transitions in care and can result in morbidity and mortality. Medication reconciliation is a recognized hospital accreditation requirement and designed to limit errors in transitions in care. *Objectives:* To identify beliefs, perceived roles and responsibilities of physicians, pharmacists and nurses prior to the implementation of a standardized medication reconciliation process. *Methods:* A survey was distributed to the three professions: pharmacists in the pharmacy and physicians and nurses in hospital in-patient units. It contained questions about the current level of medication reconciliation practices, as well as perceived roles and responsibilities of each profession when a standardized process is implemented. Value, barriers to implementing medication reconciliation and the role of information technology were also assessed. Analyses were performed using univariate statistics. *Results:* There was a lack of clarity of current medication reconciliation practices as well as lack of agreement between the three professions. Physicians and pharmacists considered their professions as the main providers while nurses considered physicians followed by themselves as the main providers with limited roles for

Abbreviations: SQUH, Sultan Qaboos University Hospital; ACI, Accreditation Canada International; JCI, Joint Commission International

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pharmacists. The three professions recognize the values and benefits of medication reconciliation yet pharmacists, more than others, stated limited time to implement reconciliation is a major barrier. Obstacles such as unreliable sources of medication history, patient knowledge and lack of coordination and communication between the three professions were expressed. *Conclusions:* The three health care professions recognize the value of medication reconciliation and want to see it implemented in the hospital, yet there is a lack of agreement with regard to roles and responsibilities of each profession within the process. This needs to be addressed by the hospital administration to design clear procedures and defined roles for each profession within a standardized medication reconciliation process.

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1. Introduction

Medication errors are an important cause of morbidity and mortality (Aspden et al., 2006). They are common e.g. at transitions in care as a result of gaps in communication and information transfer among health care providers and between them and their patients. Several studies have reported on medication errors when patients are discharged from, admitted to, or transferred within the health care (i.e. "interfaces of care"). There are reports that 60% of all medication errors occur in such interfaces (Rozich and Resar, 2001). Medication reconciliation is a process designed to limit medication errors and discrepancies at transitions in care (Gleason et al., 2004). In a recent systematic review it was concluded that "The evidence demonstrates that this process has the potential to identify many medication discrepancies and reduce potential harm" (Lehnbom et al., 2014). It is a required organizational practice by Accreditation Canada International (ACI) and is a Joint Commission (JCI) mandate since 2006 (JCI, 2006).

Medication reconciliation is defined by the Institute for Health Improvements (IHI) as "the process of creating and maintaining the most accurate list possible of all medications a patient is taking (including drug name, dosage, frequency, and route) and using that list to guide therapy. The goal is to provide correct medications to the patient at all transition points within the hospital. Medication reconciliation can be considered complete when each drug the patient is taking has been actively continued, discontinued, held, or modified at each transition point". Transitions in care include changes in setting, service, practitioner or level of care (IHI, 2015). A structured medication reconciliation process comprises five steps: (1) develop a list of current medications; (2) develop a list of medications to be prescribed; (3) compare the medications on the two lists; (4) make clinical decisions based on the comparison; and (5) communicate the new list to appropriate caregivers and to the patient (JCI, 2006).

Medication reconciliation is a process that is both complex and time consuming. Physicians, nurses and pharmacists are usually involved with different roles at different levels. However, it can be difficult to see the true value of medication reconciliation and to commit to it as a profession in an already busy and challenging work environment. Lee et al., have looked into the views of healthcare providers and their perception of their roles and responsibilities in completing in-patient medication reconciliation and found lack of agreement among clinicians about their different roles (Lee et al., 2014). This has also been seen in other similar studies (Clay et al., 2008; Vogelsmeier et al., 2013). To our knowledge, no prior studies in the Arabian Gulf region have addressed the issue of perceptions and roles of health care providers prior to the actual implementation of a standardized medication reconciliation process.

In this study, our aim was to identify beliefs and perceived roles, responsibilities and barriers to implementing medication reconciliation in an academic tertiary care hospital seeking an international accreditation by ACI.

2. Methods

The survey was conducted at Sultan Qaboos University Hospital (SQUH), a 450 bed-academic, tertiary care hospital with a number of specialties including medicine, surgery, pediatrics and obstetrics and gynecology (OB/Gyne). The hospital was undergoing accreditation by ACI and one of the accreditation requirements was to implement medication reconciliation. At the time of the survey, the hospital was still in the process of developing policies and procedures for the implementation of a structured medication reconciliation process. The survey was designed based on questions from two prior surveys, ((ISMP), 2006) and (Schnepf, 2006) with adjustments to suit the local SQUH setting. The survey covered areas such as current profession and seniority level, the number of years in this hospital, whether any form of medication reconciliation was practiced at the time of the survey, roles on identified medication reconciliation steps from admission through discharge, value of medication reconciliation, available time to implement, barriers to implementation, priority areas to start medication reconciliation and finally the role of information technology.

Survey questions varied in type and included questions with yes/no answers, Likert scale, multiple choices as well as those with open-ended questions. At the time of the survey, there were about 250 physicians working at in-patient units and 60 pharmacists/assistant pharmacists in the pharmacy. Clinical pharmacy is practiced in SQUH and all clinical inpatient areas were covered by clinical pharmacists. From the nursing side, there were about 800 nurses working in in-patient areas in the hospital. The survey was distributed as hard copies during a 2-month period from September to October 2013. In the case of physicians and nurses, this was done during clinical and management meetings to cover staff that was caring for the admitted patients only and not out-patients. Targeted pharmacists were all staff (including assistant pharmacists) working in the pharmacy. On perceived roles in medication reconciliation

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