



Institute for  
Healthcare  
Improvement



مؤسسة حمد الطبية  
Hamad Medical Corporation  
HEALTH • EDUCATION • RESEARCH  
صحة • تعليم • بحوث

Middle East Forum

2016

# Medicine Reconciliation



# Faculty

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- Shady Botros (IHI)



- Anas Hamad (HMC)



# Description

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"Patients often receive new medications or have changes made to their existing medications at times of transitions in care. Although most of these changes are intentional, there is a significant risk of miscommunication and unintended changes when patients get in or out of hospital or move between different care providers. On admission to a hospital, or during a visit to a clinic or physician office, it is vital to accurately know what medications a patient is taking in order to develop a safe and appropriate treatment plan. Medicines reconciliation can reduce incidents of avoidable medicines-related harm by generating an accurate and up to date medication list to help avoid prescribing errors, missed doses and miscommunication hence ultimately improving patient safety.

During this session the faculty will describe the process of medication reconciliation, its benefits and offer suggestions on how to implement a successful program"

# Objectives

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- Describe the steps involved in medication reconciliation
- List the measures needed to determine the effectiveness of a medication reconciliation process
- Discuss the role of healthcare providers and patients in medication reconciliation
- Discuss ideas on how to develop and enhance a Med Rec process

# What does Medicine Reconciliation mean to you?



# Medicine Reconciliation is....

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A formal process for identifying and correcting **unintentional** medication discrepancies across any **transitions of care**

# WHY?

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- When people move from one care setting to another, between 30% and 70% of patients have an error or unintentional change to their medicines<sup>(1)</sup>
  - 40% potential for moderate to severe harm<sup>(2)(3)</sup>

1.NICE guidelines (NG5). National Institute for Healthcare & Excellence. UK. March 2015

2.Cornish et al. Unintended medication discrepancies at the time of hospital admission. Arch inter Med. 2005.;165:424-429

3. Kwan J et al. Medicines reconciliation during transition of care as a patient safety strategy. A systemic review. Ann Intern Med. 2013; 158:397-403

# Elaine's Story

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- 29 years old
- Admitted to the acute surgical receiving unit on Friday at 18:40
- 2 day history of pain, redness & no pulsations in her left areteriovenous fistula
- Some intermittent pins & needles in her fingers
- Fisulta feels firmer than previously with the firmness now extending up her arm



# Elaine's Story

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- Hypertension
- Chronic renal failure requiring haemodialysis
- Fistula created in 2010
- Renal transplant in 2012

# Elaine's Story - Day 1 (Fri)

Admitted by the ward doctor & her Medication history is obtained from a GP referral letter

## Medication

Current Date Commenced	Drug Details	Date Last Issue
17/04/2014	<b>Doxazosin Mesilate Tablets 4 mg</b> ONE TO BE TAKEN EACH DAY 56 TABLET	14/10/2014P
17/04/2014	<b>Tramadol Hydrochloride Capsules 50 mg</b> 1 CAP 3 TIMES DAILY 84 CAPSULE	14/10/2014P
07/08/2013	<b>Prednisolone Tablets 5 mg</b> 1 TAB MANE 56 TABLET	11/09/2014P
15/11/2012	<b>Atenolol Tablets 25 mg</b> ONE TO BE TAKEN EACH DAY 56 TABLET	14/10/2014P
26/07/2012	<b>Folic Acid Tablets 5 mg</b> 1 TAB DAILY 56 tablet	04/08/2014P
26/07/2012	<b>Hydroxocobalamin Solution for injection 1 mg/ml, 1 ml ampoule</b> TO BE INJECTED THREE MONTHLY 1*5 ampoule	10/04/2014P
23/07/2012	<b>Ranitidine Tablets 150 mg</b> 1 TABLET TWICE DAILY 112 TABLET	11/09/2014P
23/07/2012	<b>Adcal-D3 Chewable tablets Tutti Frutti</b> ONE TO BE TAKEN TWICE A DAY 112 TABLET	29/05/2014P

# Elaine's Story - Day 2 (Sat)

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- Reviewed by vascular surgery team
- Diagnosed with fistula thrombus
- High dose LMWH
- Radiological investigation to explore extent of clot

# Elaine's Story - Day 4 (Mon)

Evening,

21.14	E	Clo pain when passing urine.
15.0		Pain obvious midline

27.10.14	(N)	seen at emergency Nil dietary
20.50		intake this shift
	(AUP)	treatment plan a insitu relieving
		independently.
	(M)	mobilising independently.
	(C)	SEWS @ remain 8°
	(E)	some discomfort whilst passing
		urine. urinalysis taken and
		sample sent.

# Elaine's Story - Day 5 (Tues)

28.10.14 14<sup>50</sup> FY2 [REDACTED]  
↓ Renal function today.  
Na<sup>+</sup> 130  
K<sup>+</sup> 5.1  
U<sub>r</sub> 10.4 (6.5 on admission 24.10.14)  
Cr 247 (138 - 24.10.14)  
eGFR 20 (40 - 24.10.14)

28.10.14 12<sup>00</sup> FY2 [REDACTED]  
Informed by pharmacist - has not been prescribed mycophenolate  
since admission.  
No mention of mycophenolate on GCS or GP letter on  
admission.  
Pharmacy have clarified with GP - normally on 500mg mycophenolate  
mofetil QDS.  
(P) Prescribe now!  
Renal to review urgently.

# Elaine's Story - Day 5 (Tues)

1600hrs r/d by [REDACTED] (Had Casualty)  
Needs renal biopsy tomorrow. We will organise.  
Miss Lurwt tonight.  
bam bloods i cng in the morning.

# Elaine's Story - Day 6 (Wed)

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29/10/14	Provisional biopsy report.
	no evidence of acute rejection
	no evidence of acute interstitial
	nephritis.

Elaine is discharged 2 days later with no complications

# Elaine's Story

How did the pharmacist know???

## Medication

Current Date Commenced	Drug Details	Date Last Issue
17/04/2014	<b>Doxazosin Mesilate Tablets 4 mg</b> ONE TO BE TAKEN EACH DAY 56 TABLET	14/10/2014P
17/04/2014	<b>Tramadol Hydrochloride Capsules 50 mg</b> 1 CAP 3 TIMES DAILY 84 CAPSULE	14/10/2014P
07/08/2013	<b>Prednisolone Tablets 5 mg</b> 1 TAB MANE 56 TABLET	11/09/2014P
15/11/2012	<b>Atenolol Tablets 25 mg</b> ONE TO BE TAKEN EACH DAY 56 TABLET	14/10/2014P
26/07/2012	<b>Folic Acid Tablets 5 mg</b> 1 TAB DAILY 56 tablet	04/08/2014P
26/07/2012	<b>Hydroxocobalamin Solution for injection 1 mg/ml, 1 ml ampoule</b> TO BE INJECTED THREE MONTHLY 1*5 ampoule	10/04/2014P
23/07/2012	<b>Ranitidine Tablets 150 mg</b> 1 TABLET TWICE DAILY 112 TABLET	11/09/2014P
23/07/2012	<b>Adcal-D3 Chewable tablets Tutti Frutti</b> ONE TO BE TAKEN TWICE A DAY 112 TABLET	29/05/2014P



# HOW?

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- Formal process that involves **THREE** Key components:
  - **COLLECT**
    - Patient (where possible)
    - Prescription & Non-prescription
  - **CONFIRM**
    - Multiple sources
  - **COMMUNICATE**
    - Medical Record (standard & visible)

# Tip 1. Standardisation

Medicines Reconciliation		Please indicate the source(s) of Medication history: At least 2 sources, one being the patient if appropriate, are required			
<input type="checkbox"/> Patient	<input type="checkbox"/> ECS (check date of last issue)	<input type="checkbox"/> EDD (within last month)	<input type="checkbox"/> GP referral letter		
<input type="checkbox"/> Patient's own medications	<input type="checkbox"/> Drug chart from another hospital	<input type="checkbox"/> Nursing home prescription	<input type="checkbox"/> GP prescriptions		
<input type="checkbox"/> Relative / carer	<input type="checkbox"/> GP practice (verbal)	<input type="checkbox"/> Other (please specify)			

ADMISSION MEDICATION			ACTION		
Name (Generic)	Dose	Frequency	Hold	Stop	Comments (if medication held or stopped)

Note: Unless indicated to stop / hold, medication should be continued on TPAR / discharge.

Adverse reactions / Allergies					
<b>No Known Drug Allergies</b> <input type="checkbox"/> OR	Drug / Substance:	Reaction:	Drug / Substance:	Reaction:	

**Are you satisfied this medication history is complete and accurate? Yes • No •**  
If "no", what further action is necessary (contact GP, etc)?

Medicines Reconciliation on Admission verified by? Name:	Signature:
--	------------

# Tip 1. Standardisation

## Medicines Reconciliation

Please Indicate the source(s) of Medication history:

At least 2 sources, one being the patient if appropriate, are required

- Patient
- Patient's own medications
- Relative / carer
- ECS (check date of last issue)
- Drug chart from another hospital
- GP practice (verbal)
- EDD (within last month)
- Nursing home prescription
- Other (please specify)
- GP referral letter
- GP prescriptions

If the patient is taking  
**Aspirin, Clopidogrel (Plavix®), Dipyridamole (Persantin®), Warfarin, Rivaroxaban, Apixaban or Dabigatran**  
then contact senior medical staff for advice regarding continuation of therapy.  
If unavailable then **WITHOLD** therapy until senior review within 24 hours

ADMISSION MEDICATION			ACTION		
Name (Generic)	Dose	Frequency	Hold	Stop	Comments (if medication held or stopped)

Are you satisfied this medication history is complete and accurate? Yes • No •

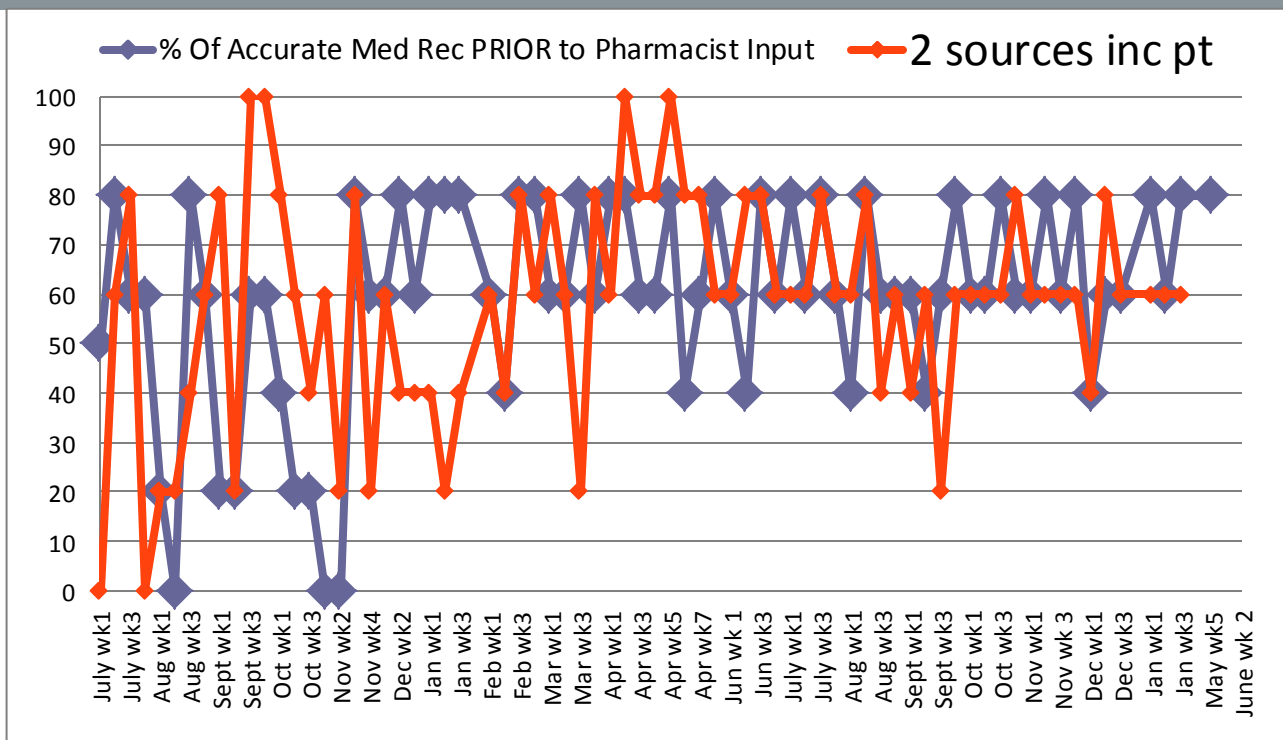
If "no", what further action is necessary (contact GP, etc)?

Medicines Reconciliation on Admission verified by? Name:

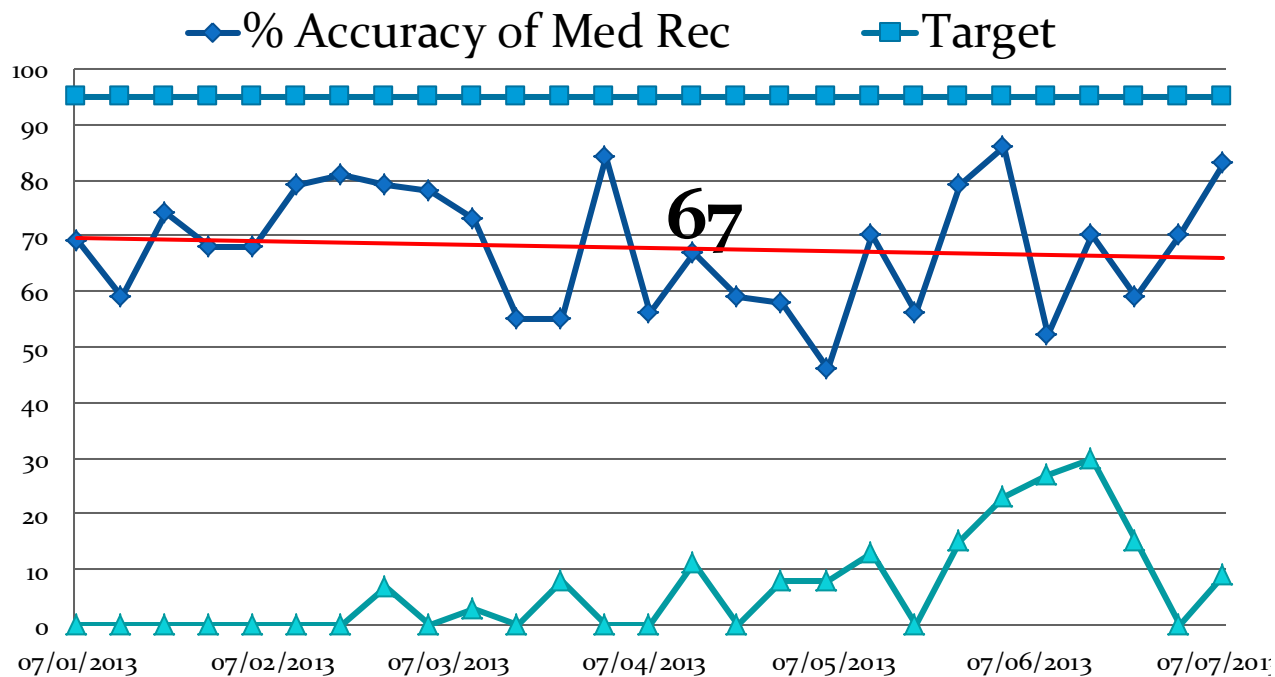
Signature:

Social Care: Home Help \*District Nurse \*Meals on wheels \*

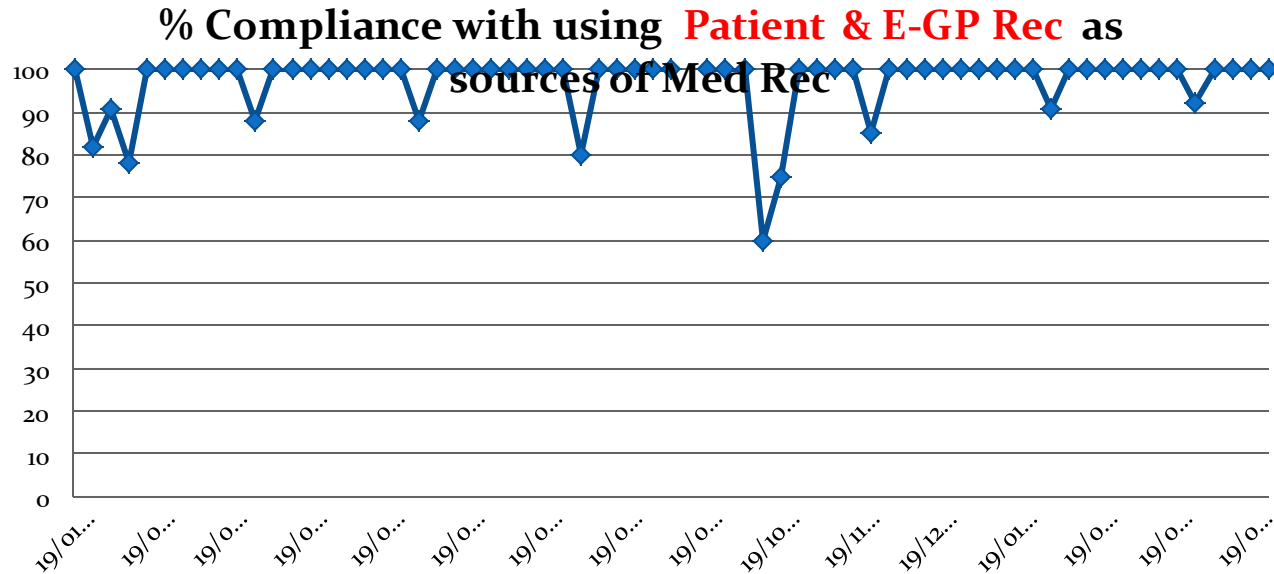
# Using 2 sources incl Patient



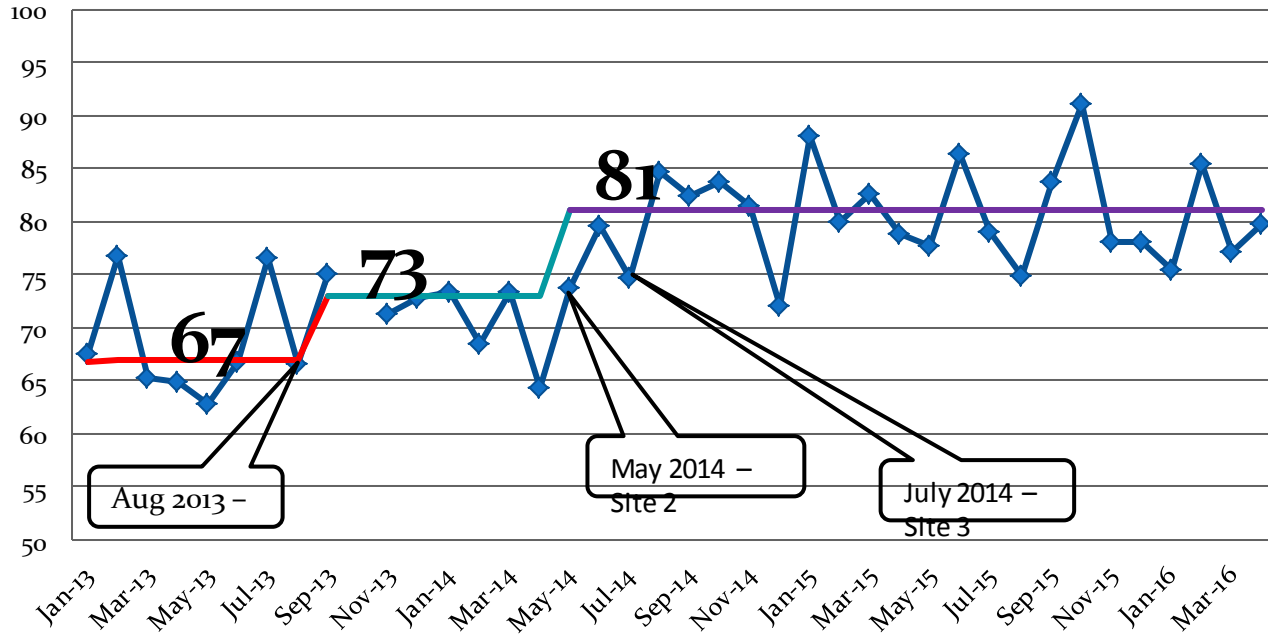
# Using Patient & Electronic GP record



# Using Patient & Electronic GP record



# Using Patient & Electronic GP record



## Tip 2. Verification

Medicines Reconciliation			Please Indicate the source(s) of Medication history: At least 2 sources, one being the patient if appropriate, are required		
<input type="checkbox"/> Patient	<input type="checkbox"/> ECS (check date of last issue)	<input type="checkbox"/> EDD (within last month)	<input type="checkbox"/> GP referral letter		
<input type="checkbox"/> Patient's own medications	<input type="checkbox"/> Drug chart from another hospital	<input type="checkbox"/> Nursing home prescription	<input type="checkbox"/> GP prescriptions		
<input type="checkbox"/> Relative / carer	<input type="checkbox"/> GP practice (verbal)	<input type="checkbox"/> Other (please specify)			
ADMISSION MEDICATION			ACTION <small>Note: Unless indicated to stop / hold, medication should be continued on TPAR / discharge.</small>		
Name (Generic)	Dose	Frequency	Hold	Stop	Comments (if medication held or stopped)
Adverse reactions / Allergies					
No Known Drug Allergies <input type="checkbox"/> OR	Drug / Substance:	Reaction:	Drug / Substance:	Reaction:	
<b>Are you satisfied this medication history is complete and accurate? Yes • No •</b>					
If "no", what further action is necessary (contact GP, etc)?					
Medicines Reconciliation on Admission verified by? Name:			Signature:		

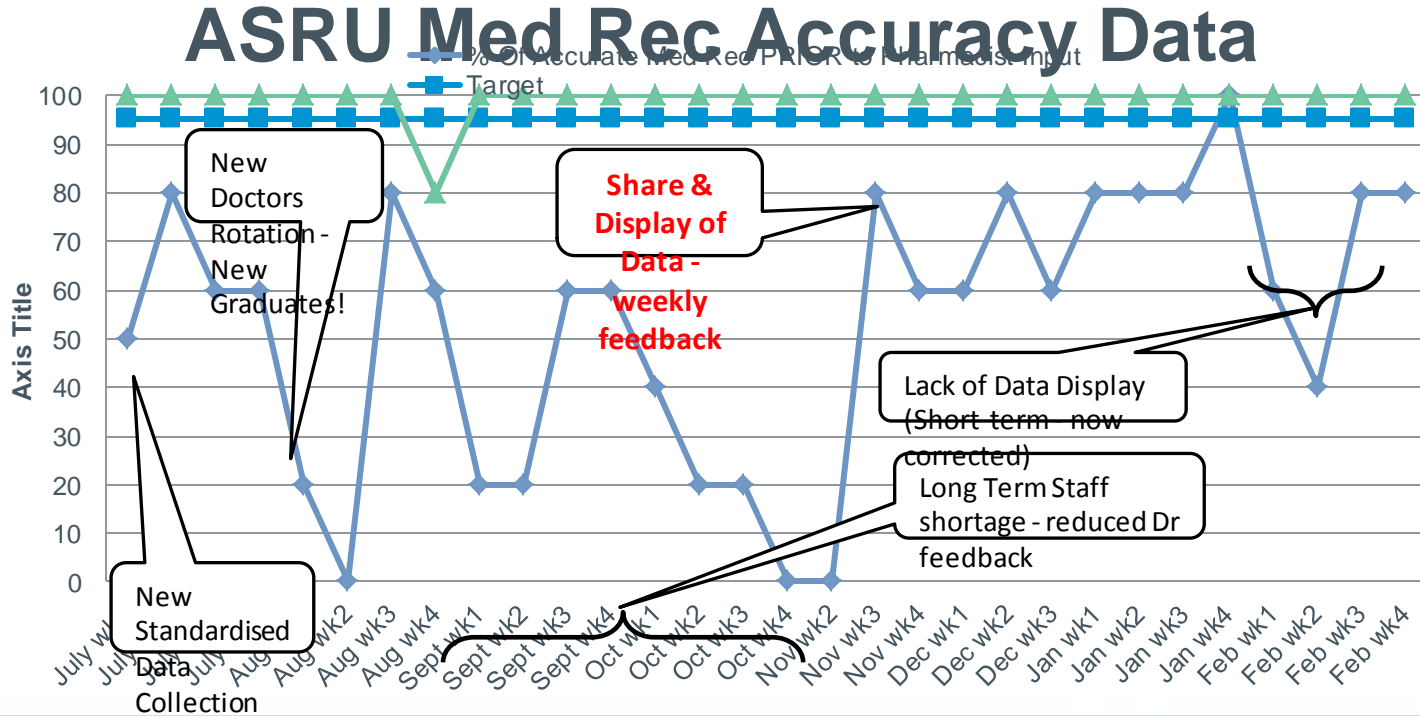


## Tip 3. Data Collection

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- Monitoring
  - Improvement (not judgment)
  - Sharing

# Share & Display of Data



# WHO? WHAT? WHEN?

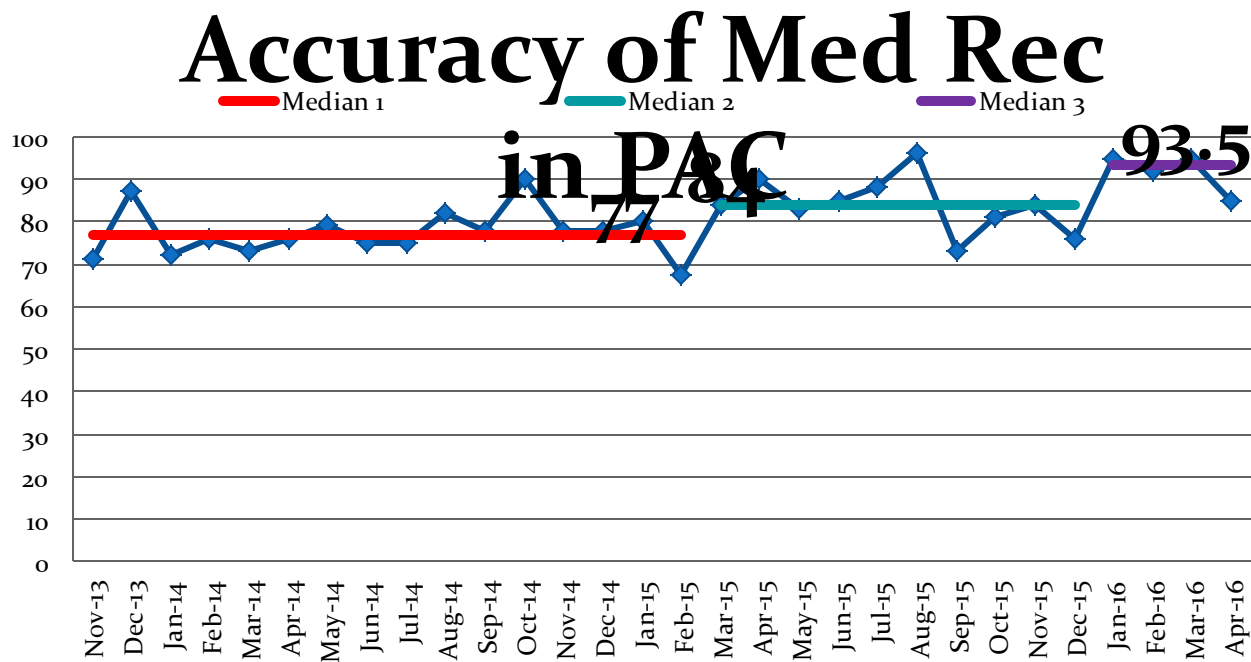


# HOW to start?

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- Segmentation
  - Med Rec on admission
  - Test in pilot site(s)
- Multidisciplinary Responsibility
  - Avoid over-reliance on Pharmacy
- Standardise
  - Definition, Roles, Time frames, Measures
- Patient Engagement
  - Education

# Nurse Lead Pre-assessment Clinic (PAC)



# Next....

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- Med Rec on discharge
  - Reliant on Med Rec on admission

# Med Rec on Discharge

## Medicines Reconciliation

Please Indicate the source(s) of Medication history:

At least 2 sources, one being the patient if appropriate, are required

- ☐ Patient
- ☐ ECS (check date of last issue)
- ☐ EDD (within last month)
- ☐ GP referral letter
- ☐ Patient's own medications
- ☐ Drug chart from another hospital
- ☐ Nursing home prescription
- ☐ GP prescriptions
- ☐ Relative / carer
- ☐ GP practice (verbal)
- ☐ Other (please specify)

ADMISSION MEDICATION			ACTION		Comments (if medication held or stopped)
Name (Generic)	Dose	Frequency	Hold	Stop	

Note: Unless indicated to stop / hold, medication should be continued on TPAP / discharge.

## Adverse reactions / Allergies

No Known  
Drug ☐ OR  
Allergies

Drug / Substance:

Reaction:

Drug / Substance:

Reaction:

Are you satisfied this medication history is complete and accurate? Yes • No •

If "no", what further action is necessary (contact GP, etc)?

Medicines Reconciliation on Admission verified by? Name:

Signature:

On **Discharge** this Medicines Reconciliation form has been reviewed by

**DOCTOR** (Name):..... Signature:..... Date:...../...../.....

**PHARMACY** (if applicable) (Name):..... Signature:..... Date:...../...../.....

Appropriate communication regarding changes in drug regimen(s) has been given to ☐ Patient ☐ GP (Tick boxes)

# Med Rec on Discharge

On **Discharge** this Medicines Reconciliation form has been reviewed by

**DOCTOR** .....(Name):.....Signature:.....Date:...../...../.....

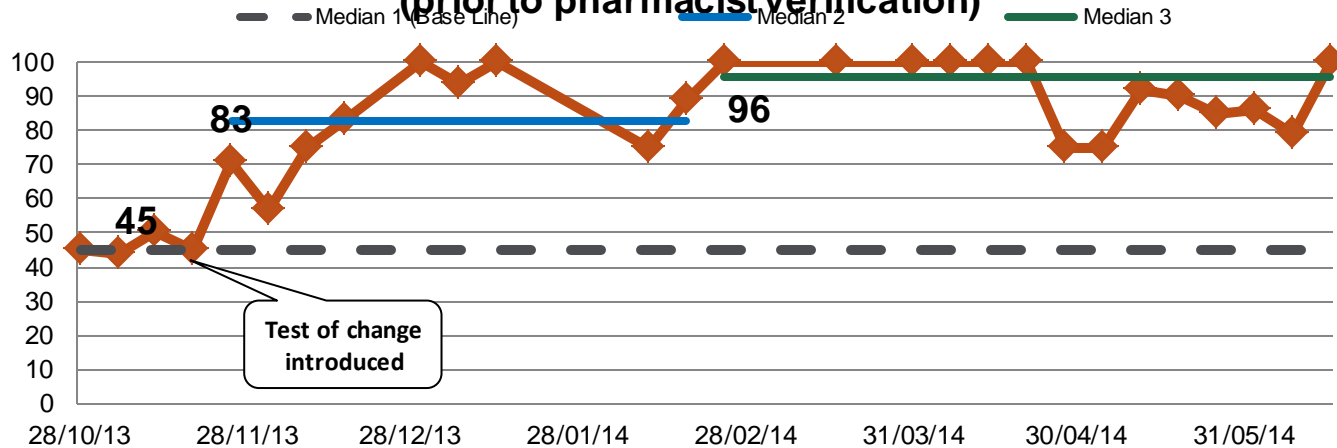
**PHARMACY**(if applicable)---(Name):.....Signature:.....Date:...../...../.....

Appropriate communication regarding changes in drug regimen(s) has been given to ☐ Patient ☐ GP (Tick boxes)



# Med Rec on Discharge

**% of Discharge prescription with accurate drug list & clear communication to the GP regarding any changes in drug history  
(prior to pharmacist verification)**



# Next....

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- Med Rec on transfer
  - Reliant on Med Rec on admission
  - Critical Care Areas

# Med Rec on Transfer

## ICU Medicines Reconciliation Form

<b>Name:</b>  <b>CHI:</b>	Date of Hospital Admission:.....
	Date of ICU Admission:.....
	Date of ICU Discharge:.....

**Please indicate the source(s) of Medication history:**

**At least 2 sources, if appropriate, are usually required**

<input type="checkbox"/> Patient	<input type="checkbox"/> ECS (check date of last issue)	<input type="checkbox"/> EDD (within last month)	GP referral letter
<input type="checkbox"/> Patient's own medications	<input type="checkbox"/> Drug chart from another hospital	<input type="checkbox"/> Nursing home prescription	GP prescriptions
<input type="checkbox"/> GP practice (verbal)	<input type="checkbox"/> Drug chart from another ward	<input type="checkbox"/> Relative / carer	<input type="checkbox"/> Other (specify).....

Medicine (Generic)	Dose	Frequency	Route	Time of initiation of therapy (Place a (✓) in the appropriate box below)			Action During ICU Stay	Plan following ICU discharge
				Prior to hospital admission	Hospital stay prior to ICU admission	ICU		
Bisoprolol	2.5mg	OD	PO	✓			Hold	Re-start
Phenytoin	300mg	OD	NG			✓		Stop
Amoxicillin	1g	TDS	NG		✓		Continue	Stop in 3 days

**Are you satisfied this medication history is complete and accurate?**    Yes                      No

**If "NO", what further action is necessary (contact GP, etc)?**

Medicines Reconciliation completed by?	Doctor:.....	Signature:.....
Medicines Reconciliation verified by?	Name:.....	Signature:.....

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# Medication Reconciliation in Qatar

*A focus to HMC*

# Ministry of Public Health (MOPH)

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Medication reconciliation is one of the Health Service Performance Agreement (HSPA) indicators defined by the MOPH under the Performance and Efficiency Dimension.

# Hamad Medical Corporation

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- HMC is running all governmental hospitals in Qatar (Primary, Secondary and Tertiary)
- 65-75% of medicine use in Qatar takes place in HMC
- It is mandated by HMC policy and JCI accreditation to do Med Rec for all patients upon admission and discharge.

# Medication Reconciliation Policy at HMC

POLICY/PROCEDURE		
TITLE:	PRESCRIBING OF MEDICATIONS	ORIGINAL DATE: AUGUST 2004
IDENTIFICATION NUMBER:	CL 6048	LAST REVISION DATE: NOVEMBER 2015
HOSPITAL(S)	All HMC HOSPITALS / ENTITIES	NEXT REVIEW DATE: NOVEMBER 2018
Sheet No. 6 of 7		

3.24 **Initial medication orders:** (those written immediately after admission) must be compared to the list of medications taken prior to admission (Patient Medication Report):

- 3.24.1 This report is printed from the eMR viewer system
- 3.24.2 The physician must confirm that the report is an accurate record of all medications currently taken by the patient
- 3.24.3 The report must be reviewed and updated (addition of medication, discontinuation, hold, etc) signed and stamped by the physician.
- 3.24.4 For Outpatient Summary (attached active medication list) refer to Policy No CL 6036.
- 3.24.5 A copy of the report is then sent to pharmacy so that, the updated medication profile is used when the initial medication order is reviewed for appropriateness and where possible documented in the pharmacy management system (PMS) by the pharmacist, (Refer to Dispensing Policy CL 6049).
- 3.24.6 For patients admitted from Home Health Care Services (HHCs) to any HMC facility, the transfer referral summary shall contain the complete patient's medication record to update the current patient medication report and be compared with the initial physician's medication order prior sending to the pharmacy.

# Med Rec in HMC

ask Edit View Patient Chart Notifications Options Current Add Help

Patient List Message Center Clinical Pharmacy Tracking Shell Schedule Ambulatory Organizer Med Guide

Tear Off Attach Suspend Exit Calculator Collections Inquiry Charges AdHoc Medication Administration Communicate Patient Education Add

Age: 39 years Dose: Wt 94.850 kg (26/APR/2016) Sex: Male MRN: HMC00170626 Attending: Ammar Madani Shabbeer Ahm...  
Allergies: No Known Allergies Code Status: Isolation: Inpatient Acute Care FN: 0055225461 [Admit Dt: 26/04/2016 11: Blood Type: Nationality: Egyptian]

Medication List Print 0 minutes ago

+ Add Document Medication by Hand Reconciliation Check Interactions

Orders Medication List Document In Plan

Displayed: All Active Orders | All Inactive Orders

Transfer  
Discharge  
Short Term Leave  
Short Term Return

Status  
✓ Meds History ✓ Adm. Meds Rec Disch. Meds Rec

Order Name	Status	Details	Start	Stop	Ord
<b>Active</b>					
ferrous sulfate (Ferrous Sulfate 190mg/60mg Fe) T...	Ord...	190 mg, Oral, Form: Tab, BID, First dose 26/04/2016 13:38:00 AST, dispense from location ON Ward Tw...	26/04/2016 13:38...		
enoxaparin	Ord...	40 mg, Subcutaneous, Form: Inj, Daily, Order Duration: 10 day(s), First dose 26/04/2016 12:50:00 AST, St...	26/04/2016 12:50...	06/05/2016 07:...	
Sennosides A & B (Senna (Sennosides A & B) 12m...	Ord...	24 mg = 2 tab(s), Oral, Form: Tab, Daily, PRN constipation, 26/04/2016 12:40:00 AST	26/04/2016 12:40...		
RABEprazole	Ord...	20 mg, Oral, Form: Tab, BID, First dose 26/04/2016 12:39:00 AST, dispense from location ON Ward Two ...	26/04/2016 12:39...		
Sennosides A & B (Senna (Sennosides A & B) 12m...	Pres...	2 tab(s), Oral, Daily, # 28 tab(s), 0 Refill(s), other reason (Rx)	19/04/2016 11:07...	03/05/2016 11:...	
RABEprazole (RABEprazole 20 mg TAB)	Pres...	See Rx Instructions, Oral, BID, # 112 EAC, 0 Refill(s), DAW	07/04/2016 00:00...	02/06/2016 23:...	
ferrous sulfate (Ferrous Sulfate 190mg/60mg Fe) T...	Pres...	300 mg, Oral, BID, 0 Refill(s), 1/02/2016 10:15:00 AST	01/02/2016 10:15...	30/07/2016 10:...	
RABEprazole	Pres...	20 mg, Oral, BID, 0 Refill(s), 30/08/2015 14:29:00 AST, Tab	30/08/2015 14:29...	26/02/2016 14:...	Adr
ferrous sulfate (Ferrous Sulfate 190mg/60mg Fe) T...	Pres...	190 mg, Oral, BID, 0 Refill(s), 30/08/2015 14:26:00 AST	30/08/2015 14:26...	26/02/2016 14:...	
<b>Inactive</b>					
ferrous sulfate (Ferrous Sulfate 190mg/60mg Fe) T...	Disc...	300 mg, Oral, Form: Tab, BID, First dose 26/04/2016 12:39:00 AST	26/04/2016 12:39...	26/04/2016 13:...	
potassium chloride (POT.CHLOR. 20 Meq IN 5%DE...	Co...	IV, As Indicated, First dose 13/03/2016 00:00:00 AST, Inpatient IV	13/03/2016 00:00...	13/03/2016 00:...	Dos
potassium chloride (POT.CHLOR. 20 Meq IN 5%DE...	Co...	IV, As Indicated, First dose 13/03/2016 00:00:00 AST, Inpatient IV	13/03/2016 00:00...	13/03/2016 10:...	Dos

Details

Dx Table Orders For Signature

PROD: HMC027837 26/04/2016 14:21 A



# Med Rec in HMC

Order Reconciliation: Admission - SALAH EL SAYED ABDEL AAL ABDELMOUETTI

Age: 39 years   Dose Wt: 94.850 kg (26/APR/2016)   Sex: Male   MRN: HC00170626   Attending: Ammar Madani Shabbeer Ahm...  
Allergies: No Known Allergies   Code Status:   Isolation:   Inpatient Acute Care FIN: 0055225461 [Admit Dt: 26/04/2016 11:...]   Blood Type:   Nationality: Egyptian

+ Add | Manage Plans

Status  
✓ Meds History   Adm. Meds Rec   Disch. Meds Rec

Orders Prior to Reconciliation			Orders After Reconciliation		
Order Name/Details	Status		Order Name/Details	Status	
<b>Medications</b>					
<b>enoxaparin</b> 40 mg, Subcutaneous, Daily	Ordered		<b>enoxaparin</b> 40 mg, Subcutaneous, Daily	Ordered	
<b>ferrous sulfate (Ferrous Sulfate 190mq(60mq Fe) TAB)</b> 190 mg, Oral, BID	Ordered		<b>ferrous sulfate (Ferrous Sulfate 190mq(60mq Fe) TAB)</b> 190 mg, Oral, BID	Ordered	
<b>ferrous sulfate (Ferrous Sulfate 190mq(60mq Fe) TAB)</b> 300 mg, Oral, BID	Prescribed		The continued order status has changed since it was reconciled or replaced.		
<b>ferrous sulfate (Ferrous Sulfate 190mq(60mq Fe) TAB)</b> 190 mg, Oral, BID	Prescribed				
<b>RABEprazole</b> 20 mg, Oral, BID	Prescribed		<b>RABEprazole</b> 20 mg, Oral, BID	Ordered	
<b>RABEprazole (RABEprazole 20 mg TAB)</b> See Rx Instructions, Oral, BID, 112 EAC	Prescribed				
<b>Sennosides A &amp; B (Senna (Sennosides A &amp; B) 12mq TAB)</b> 2 tab(s), Oral, Daily, 28 tab(s)	Prescribed		<b>Sennosides A &amp; B (Senna (Sennosides A &amp; B) 12mq TAB)</b> 24 mg, 2 tab(s), Oral, Daily, PRN: constipation	Ordered	

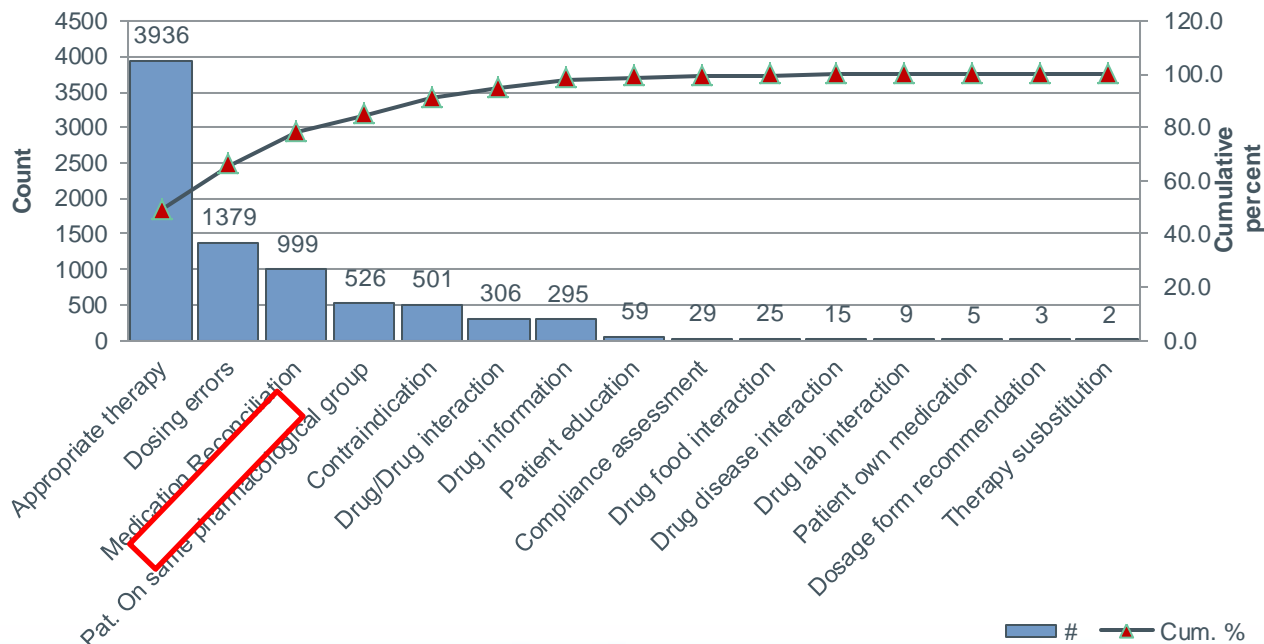
Details

0 Missing Required Details   All Required Orders Reconciled   Dx Table

Reconcile And Sign   Cancel

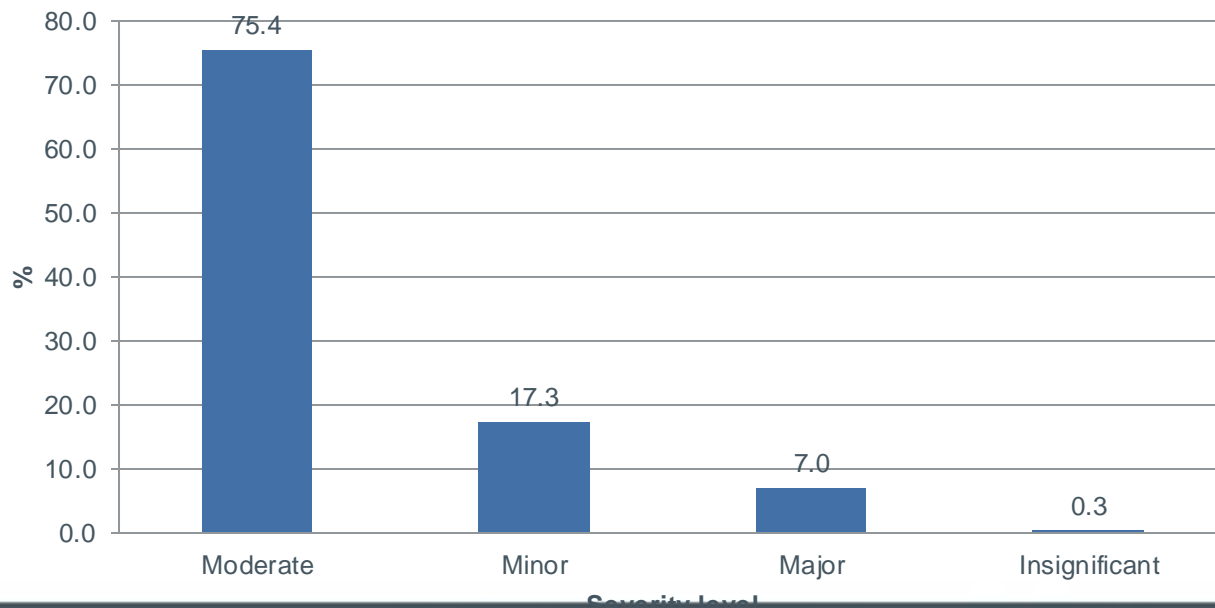
# Med Rec in HMC

Pharmacist interventions: NCCCR, Jan 15- Apr 16, (N=8089)



# Med Rec in HMC

**NCCCR- % Med. Rec. interventions by severity Jan 15-  
Apr 16 (N=999)**



# Efforts to improve Med Rec in HMC

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## Challenges identified following Cerner implementation:

- Physician **unfamiliarity** with the electronic system (**CERNER**).
- **Attending** physicians **leave** medication reconciliation process to be completed by rotating **residents** and do not follow them up.
- **Frequency** of resident rotation (every 3 months). As soon as a resident group is educated, it moves and a new group comes.
- The **value** of medication reconciliation was **not clear** to residents.
- **Reduced pharmacist involvement** in the process following Cerner.
- It's not easy for dispensing pharmacists to review medication reconciliation as it involves **opening** and **closing** of **several windows**.
- Medication reconciliation process is **optional in Cerner** and can be easily skipped which **contradicts** with HMC medication prescribing **policy** that states it is mandatory.

# Efforts to improve Med Rec in HMC

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- A multidisciplinary task force was created in the National Center for Cancer Care and Research (NCCCR) to tackle the low Med Rec compliance rates following implementation of Cerner.
- This task force involves a Physician, Nurses, Pharmacists, Quality Managers/Reviewers, Health Informatics Consultant.
- Generating a daily report through Cerner on the Med Rec status of all inpatients at hospital which is sent to the physician involved in the Task Force to follow up with concerned physicians and also to the Medication Safety Officer.

# Efforts to improve Med Rec in NCCCR

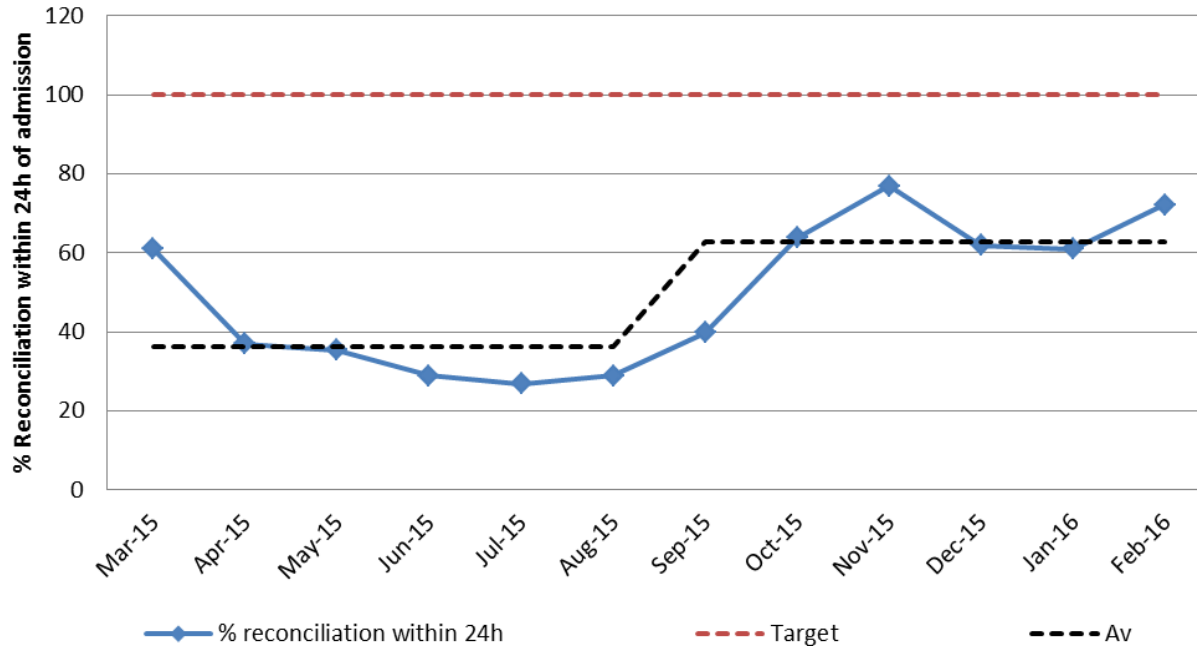
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## Actions Taken:

- 1. Formulation of a multidisciplinary task force:** To discuss/analyze reconciliation data on a monthly basis, identify areas for improvement, and recommend improvement strategies.
- 2. Information sharing:** Discuss monthly data with physicians during routine physician morning meetings to raise the awareness about the criticality of medication reconciliation.
- 3. Policy enforcement:** It's the responsibility of the attending physician to complete the reconciliation process or follow-up with the resident to ensure its completion.
- 4. Promote multidisciplinary collaboration:** Have clinical pharmacist reviews and ensure the completion of the process for patients admitted in the previous day.
- 5. Education:** Include medication reconciliation as an integral part of the rotating residents' orientation.
- 6. Increase frequency of data monitoring:** Monitoring the status of medication reconciliation on a daily basis, and communicate deficiencies to the involved physician. Contacting attending physician if there is resistance.
- 7. System (Cerner) related issues:** Identified and communicated with the CIS team.
- 8. Leadership involvement:** Include medication reconciliation as a hospital quality & patient safety (QPS) indicator to enhance engagement of the hospital leadership.

# Efforts to improve Med Rec in NCCCR

The average rate of medication reconciliation improved from 36.3% in 1<sup>st</sup> first half of the study period to 62.6% in the second half ( $P=0.005142$ ).



# Acknowledgments

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- ADR and Medication Reconciliation Workgroup, NCCCR
- Dr. Mohammed AbdelWahid, Medication Safety & Quality Officer, NCCCR



**Based on our discussion today,  
can you now define  
Medicine  
Reconciliation?**

# WHAT? WHO? WHY? WHEN?



# Definition...

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“Medicines Reconciliation (Med Rec) is a **formal process** in which **healthcare providers** partner with **patients** and their families to ensure **accurate** and **complete** medication transfer across all **interfaces of care**”

The High 5s Project - Standard Operating Protocol. Assuring Medication accuracy at Transition of care: Medicines Reconciliation. WHO. 2007

## Last Tip....

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*“ The well informed **patient** is the **best** Medicines reconciliation tool”*

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