Effective medication reconciliation in the Emergency Department

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Purpose: The purpose of this poster is to demonstrate how pharmacy's involvement with Medication Reconciliation Process improves the effective management of accurate patient information to be used in the treatment process.

Methods: The pharmacy department utilizes pharmacists and pharmacy technicians in the Emergency Department to collect and assess medication information to be used to care for the patient. This is the primary piece of the process that is required to effectively treat the patient who is seen in the emergency department by a multi-disciplinary team. When a patient enters the emergency department, the patient and/or patient's family are interviewed by a pharmacist or pharmacy technician regarding the medications they are taking. This includes all prescription medications, OTC products, herbals and supplements. This is entered on a "Medication Reconciliation Form" that is reviewed by the pharmacist and assessed for problems with medication names, doses, duplications, contraindications, incomplete information, or any other issues that need to be addressed. In order to complete the form, it is often necessary to contact the patient's primary care physician, extended care facility or community pharmacy to assist in getting complete and accurate information. Any medication information from previous hospital visits is available to assist in gaining a complete assessment of the patient's medication history. When the form has been assessed and is felt to be as complete and accurate as possible, it is then submitted to the physician to make a determination on what medications are to be continued and which ones will be stopped. The physician then signs the form and it becomes the order for any medications that are to be continued. The pharmacist enters all the medications listed on the signed form as a category called "Home Meds" which highlights these entries in light green on the patient's profile. The medications that were deemed to be stopped are discontinued in the order entry process. This entire list of medications is available to the physician at the discharge process so that a comprehensive medication list is available from which orders can be written for all the items to be continued when the patient is discharged. If the physician decides to change a medication listed on the reconciliation form, the medication on the form is stopped and a new order is required. Likewise if the physician decides to add a new medication, a new order is required. This form becomes a permanent part of the patients chart.

Results: In 2006 Bronson Hospital Pharmacy staff working in the Emergency Department assumed a significant role in completing and assessing medication reconciliation for patients being seen in the ED. Prior to this active role, the rate of accurate medication reconciliations completed in the Ed was about 50%. Many of the reconciliations had missing data, misspelled medications, doses and frequencies that needed to be questioned and medication information that had to be clarified. In 2007 and 2008, pharmacy staff utilizing technicians and pharmacists assumed the primary role of completing the medication reconciliations in the ED. The accuracy and completion rate had risen into the 80% range and by the end of 2007 was in the mid 90% range. The results in 2008 were in the mid to upper 90% range. That trend continues into 2009.
Conclusion: The Emergency Department at Bronson accounts for over 40% of all the patients admitted to the hospital. This represents a significant amount of medication reconciliation data that becomes the groundwork for treating patients in the hospital setting. The accuracy and completion of data in the emergency department improves patient safety, better outcomes and quality of care. The information gained at the admission point helps to create a much more accurate picture of a patient's medications that can be used to continue care at the discharge process. This throughput helps to ensure the continuity of care process.