

ACTION

FOR SAFER MEDICAL CARE



Medication reconciliation

Medication reconciliation is the process of working with patients, family, and other healthcare professionals to ensure accurate and comprehensive medication information, including over-the-counter or non-prescription medication, is communicated across transitions of care. It is an emerging area of focus in patient safety and a recurring theme in CMPA cases.

→ CONSIDER THIS...

A patient with a history of thromboembolic events, myocardial infarction and on long-term anticoagulant therapy with warfarin, is admitted for pacemaker and defibrillator implantation. The warfarin is stopped prior to the procedure and heparin is started. Three days later, an MIBI test is performed. As the test is negative for ischemia, the cardiologist discharges the patient but does not resume the warfarin. The patient subsequently has an ischemic stroke with permanent right hemiplegia and aphasia. A legal action follows and experts are critical that the cardiologist did not consult the patient's medical records and did not ascertain that the patient still required anticoagulant therapy. A settlement was paid by the CMPA on behalf of the cardiologist.

→ WHAT DOES THIS MEAN FOR CMPA MEMBERS?

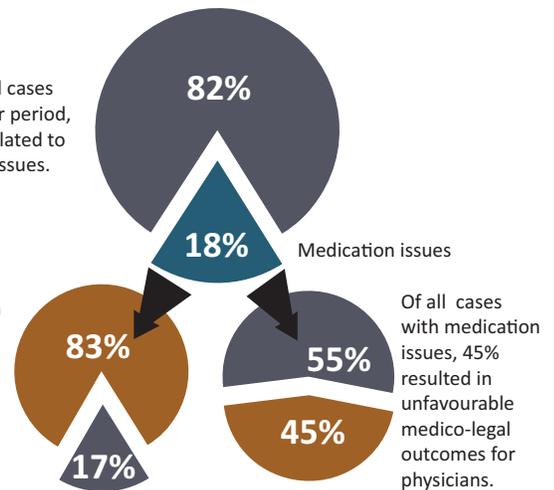
Communicating effectively about medications is necessary to the delivery of safe care. Physicians should be familiar with their role and responsibilities relative to medication reconciliation. These will depend on the institution and the physician's role on the healthcare team. Medication reconciliation is equally important in non-acute settings, such as community clinics, long-term care facilities, and home care.

Physicians should involve their patients and, when appropriate, families in medication reconciliation.

When physicians make changes to a patient's medication, they should discuss these with the patient, assess the patient's understanding, and document the change and discussion in the health record.

Of all CMPA medico-legal cases over a 5-year period, 18% were related to medication issues.

Of all cases with medication reconciliation issues, 83% resulted in unfavourable medico-legal outcomes for physicians.



58% of the patients involved in medication reconciliation related cases, died or had serious clinical outcomes.

Statistics are based on a recent 5-year study of CMPA medico-legal cases.

CMPA's experience and research identifies the following factors for medico-legal cases related to medication reconciliation:

- 62% of the patients involved were aged 60 years or older.
- Many patients had multiple co-morbid conditions (e.g. hypertension, diabetes, previous coronary artery disease and myocardial infarction, chronic obstructive pulmonary disease).
- Other patients had Alzheimer's disease or dementia.

→ ISSUES TO CONSIDER

The CMPA has found medication reconciliation issues were present at all 3 transitions of care — admission, in-hospital transfer, and discharge.

Admission

- incomplete or inaccurate medication history obtained
- inappropriate or inaccurate continuation of medications
- inappropriate modification of the medication regimen

In-hospital transfer

- pre-admission, transfer, or new medications inadequately assessed

Continued

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- medication not ordered on transfer to another level of care (e.g. post-operative)
- medication intentionally not prescribed and reason not documented
- medication order not transcribed

Discharge

- medication taken pre-admission, new medications started in-hospital or on discharge, or 'held' medications not assessed and not prescribed
- inadequate follow-up for medications requiring monitoring (e.g. IV antibiotic, anticoagulant)
- inadequate patient medication education

The CMPA has also identified system and communication factors that impact medication reconciliation. System issues include inadequate hospital policies for medication management upon transfer and lack of systems to verify that medications are properly documented, ordered, or transcribed. Communication issues include poor exchanges (i.e. verbal and written) between physicians about changes to medication orders or regarding discrepancies; poor communication between physicians and other team members; and patients or family members not involved when taking a medication history.

→ RISK REDUCTION REMINDERS

Medication reconciliation is a formal process to help ensure accurate and comprehensive medication information is communicated across transitions of care. Effective medication reconciliation reduces adverse events. The following points can assist physicians in managing risk.

1. The patient's medications and dosages should be confirmed with the patient or, where appropriate, with a family member. This should include a review of any over-the-counter or non-prescription medications.
2. A structured process should be followed for medication reconciliation at admission, transfer, and discharge.
3. When discharging a patient, changes in medication(s) should be communicated to the patient, the family as appropriate, and the primary care provider taking care of the patient in the community.
4. The ordering physician should be contacted if there are any questions about the medication(s) ordered.
5. Medication reconciliation is important in all healthcare settings, not only in acute care.

→ LEARN MORE BY ACCESSING THESE RESOURCES

CMPA articles

*Collaborative care and medication monitoring: Who's responsible?
Medication management, healthcare*

CMPA Good Practices Guide

Medication reconciliation

Also see:

Accreditation Canada, the Canadian Institute for Health Information, the Canadian Patient Safety Institute, and the Institute for Safe Medication Practices Canada (2012). Medication Reconciliation in Canada: Raising the Bar – Progress to date and the course ahead. Ottawa, ON: Accreditation Canada. http://www.cihi.ca/CIHI-ext-portal/pdf/internet/MED_RECONCIL_EN

Safer HealthCare Now! Medication reconciliation. Retrieved from:

<http://www.saferhealthcarenow.ca/EN/Interventions/medrec/Pages/default.aspx>

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