

How Does Using Medication Reconciliation Prevent Errors?

- By providing a reconciliation, you can help participants avoid medication errors such as omissions, duplications, dosing errors or drug interactions
- It should be done during every transition of care in which new medications are ordered or existing orders are rewritten. Transitions in care include changes in setting, service, practitioner or level of care

This process includes five steps:

1. Develop a list of current medications
2. Make clinical decisions based on the list review and participant interview
3. Verify medications are “the right drug, with the right dose, at the right time”
4. Create a list of suggested changes for the prescriber
5. Communicate suggested changes for the prescriber to appropriate caregivers and to the participant

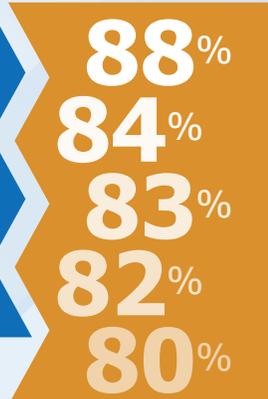
5
steps

- Accurate and complete medication reconciliation can prevent numerous prescribing and administration errors
- Failure to reconcile medications may be compounded by the practice of writing “blanket” orders, such as “resume pre-op medications,” which are highly error prone and are known to result in adverse drug events. Such orders are explicitly prohibited by the Joint Commission’s Medication Management standards (MM.3.20)
- Medication errors related to medication reconciliation typically occur at the “interfaces of care”—when a participant is admitted to, transferred within, or discharged from a health care facility
- Furthermore, the home care department of one hospital discovered that 77 percent of all participants were discharged with inadequate medication instructions

- Medication reconciliation systems and processes have successfully reduced medication errors in many health care organizations.
- The Institute for Safe Medication Practices (ISMP) has received numerous reports of errors found during medication reconciliation; its Medication Safety Alert newsletter (dated April 21, 2005) includes a sampling of errors that resulted from failed communication.
- Following medication errors identified in September 2004, the United States Pharmacopeia (USP) added three "Causes of Error" to its MEDMARX® reporting program to capture errors involving medication reconciliation failures. From September 2004 to July 2005, USP received 2,022 reports of errors found during medication reconciliation. Of those reports, 66 percent occurred during the participant's transition or transfer to another level of care, 22 percent occurred during the participant's admission to the facility, and 12 percent occurred at the time of discharge.
- Of the types of errors found during medication reconciliation reported to MEDMARX, the majority involved improper dose/quantity, followed by omission error and prescribing error. Other less frequently reported types of error included: wrong drug, wrong time, extra dose, wrong participant, mislabeling, wrong administration technique and wrong dosage form.

- The causes of errors found during medication reconciliation reported to MEDMARX included:

1. Performance deficit (performance that falls short of expectations): nearly
2. Transcription inaccurate/omitted:
3. Documentation:
4. Communication:
5. Workflow disruption:



- USP also published several examples of reconciliation failures during participant admission, transfer and discharge.
- Medication reconciliation is a key initiative in the Institute for Healthcare Improvement's (IHI) 100,000 Lives Campaign.