Medication Reconciliation

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Home Health VNA
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The Leaders in Home Health and Hospice Care

Objectives

- The participant will be able to describe medication reconciliation
- The participant will be able to describe contributing factors to medication errors
- The participant will be able to describe the six rights of safe medication administration

Medication Reconciliation

- Medication reconciliation is important to providing quality care
- Medication reconciliation is a three step process
- It is important to identify the barriers patients may have when taking medications and ways to overcome them

Why is Medication Reconciliation so important?

- The number one problem in treating illnesses is patients' failure to take prescribed medications correctly
- In the US, 50-70% of patients do not take medications properly
- 10% of hospital admissions relate to not taking meds properly, 23% of all nursing home admissions

Statistics

- 225 take less than what is prescribed
- 12% do not fill their prescription at all
- 12% do not take the medication at all after buying the prescription
- 29% stop taking the medication before it runs out
- 12-20% take other people's medication

Medication Reconciliation

- Medication reconciliation is the process of identifying the most accurate list of all medications a patient is actually taking – including name, dosage, frequency and route. The information is then used to determine which medications the patient should be taking per physician orders.

Medication Reconciliation Three Step Process

- Verify – Collect an accurate medication list
- Clarify – Clarify any questions about drug/dose/frequency
- Reconcile – Communicate with physician about any identified medication questions or concerns

Health Literacy

- Health literacy is the ability to read, understand and act on health information in order to make appropriate health decisions
- Poor health literacy results in medication errors, impaired ability to remember and follow treatment recommendations, and reduced ability to navigate within the health care system

Health Literacy

- A study of patients aged 60 years and older at two public hospitals found that 81% could not read and understand basic materials such as prescription labels

- Foundation: Health Literacy – YouTube

Health Literacy

- SBAR
- Teach Back

Why focus on medications?

- Medication use has also become increasingly complex
- There has been a substantial increase in the number and variety of medications available
- Medications have different routes of delivery and variable actions (eg long-acting, short-acting)

Why focus on medications?

- Sometimes the same formulation of a particular drug is sold under more than one trade name, which can cause confusion
- Although treatments for chronic disease have improved over the years, there are more patients with multiple co-morbidities that need multiple medications

Why focus on medications?

- This increases the risk of drug interactions, side-effects and mistakes in administration
- The process of delivering medications to patients often involves a range of health-care professionals
- Communication failures can lead to gaps in the continuity process

Medication Error

- **Any preventable event that may cause or lead to inappropriate medication use**
- **A medication error may result in:**
  - An adverse event, in which a patient is harmed
  - A near miss, in which a patient is nearly harmed
  - Neither harm nor potential for harm or patient harm

Medication Administering

- Administering a medication may include obtaining the medication and having it in a ready-to-use form
- This may involve counting, calculating, mixing, labeling or preparing the drug in some way
- Administering always includes the need to check for allergies and to make sure that the correct dose of the correct medicine is given to the correct patient via the correct route at the correct time

Medication Administering Contributory Factors for Medication Errors

- Classic administration errors are the wrong drug being used, or the wrong dose of a drug being given to the wrong patient, by the wrong route, at the wrong time.
- Not administering a prescribed drug is another form of administration error
- Other administration errors include inadequate communication & documentation or calculation mistakes eg for IV drugs

Medication Monitoring

- Medication monitoring involves observing the patient to determine whether the medication is working, being used correctly and not causing harm

Medication Monitoring Contributory Factors for Medication Errors

- Errors in this area include inadequate monitoring for side-effects, not ceasing medication once the prescribed course has been completed or is clearly not helping the patient, and not completing a prescribed course of medication
- There is a particular risk of a type of communication failure when a patient changes, or moves from hospital to community setting or vice versa

Patient Contributory Factors for Medication Errors

- Certain patients are particularly vulnerable to medication errors
- These include patients with specific conditions (e.g. renal dysfunction)
- Patients taking multiple medications, particularly if these medications have been prescribed by more than one health-care provider

Patient Contributory Factors for Medication Errors

- Patients with a number of health problems
- Patients who do not take an active interest in being informed about their own health and medications
- Patients with memory issues (eg Alzheimer patients)
- Patients who cannot communicate well, including unconscious patients

Patient Contributory Factors for Medication Errors

- Patients who do not speak the same language as the staff, are also particularly vulnerable to medication errors

Staff Contributory Factors for Medication Errors

- Inexperienced personnel
- Rushing, as in emergency situations
- Multitasking
- Being interrupted mid-task
- Fatigue, boredom and lack of vigilance
- A lack of checking and double-checking habits can also lead to medication errors
- Poor teamwork
- Poor communication between colleagues

Medication Design Contributory Factors for Medication Errors

- Some medications can be easily confused
- Pills are similar in appearance (eg color, shape)
- Have similar names
- Ambiguous labeling
- Different preparations or dosages of similar medication may have similar names or packaging

Medication Design Contributory Factors for Medication Errors

- Difficult-to-read dose information on vials
- Lack of measuring instruments (e.g. spoons for syrups)

Remember the 6 Rights of Safe Medication Administration

1. **Right person**
   a. Check the first and last name of the patient
   b. Does the name match the medical order?
   c. Does the name match the name on the medical administration record
   d. Does the name on the medication container match?

Remember the 6 Rights of Safe Medication Administration

2. **Right medication**
   a. Check the name on the medication container
   b. Does the medication match the medical order?
   c. Does the medication match the name on the MAR?

Remember the 6 Rights of Safe Medication Administration

3. **Right dose**
   a. Check the strength and dosage
   b. Is it half-tablet, whole tablet or multiple tablets?
   c. Is it alternating doses at different times or on different days?

Remember the 6 Rights of Safe Medication Administration

4. **Right time**
   a. Check the frequency
   b. Was the time-critical medication given within 30 minutes (earlier or later) than scheduled?
   c. If a second dose of a p.r.n. medication is needed is it too early?

Remember the 6 Rights of Safe Medication Administration

5. **Right route**
   a. Check the route
   b. If eye or ear drops is it right side, left side or both sides?
   c. Is the pill sublingual or swallowed? Can it be crushed or chewed?
   d. Have transdermal patches or injection sites been rotated?

Remember the 6 Rights of Safe Medication Administration

6. **Right documentation**
   a. Check that all documentation is complete and legible
   b. Is the medical order current?
   c. Did you document on the MAR immediately after administering medications?
   d. Have you documented results of p.r.n. medications administered?

Remember the 6 Rights of Safe Medication Administration

- Review “Six Rights of Safe Medication Administration” fact sheet

Some ways to make medication use safer

- Check patient allergies prior to administering any medication
- High-risk medications and situations require extra vigilance with checking and double-checking
- Double-checking own and colleagues' actions contributes to good teamwork and provides additional safeguards
- Computerized prescribing does not remove the need for checking

Some ways to make medication use safer

- Computerized systems solve some problems (e.g. illegible handwriting, confusion around generic and trade names), but also present a new set of challenges
- Never administer a medication unless there is 100% certainty about what it is
- Patients should be encouraged to be actively involved in their own care and medication process

Some ways to make medication use safer

- At each visit, ask the patient if there are any problems or issues with medications
- Check all medications for expiration dates
- Patients should be educated about their medication(s) and contribute significantly to improving the safety of medication use
- Teach patient to report any signs and symptoms that may be related to medication adverse or side effects or lack of effectiveness