Making great strides in medication safety

Medication Reconciliation Steering Committee Members with the MedRec poster. From left: Marita Tonkin, chief of Pharmacy Practice; Wendy Seroski, educator; Patty McEwen, educator; Michelle Barnard, educator; Debbie Mings, clinical nurse specialist; Ruth Lee, chief of Nursing Practice at MUMC, Ann-Marie Turner, administrative assistant.

Something as small as a pill can mean the difference between life and death for patients.

Forgetting to prescribe medication that will improve a patient’s health, or prescribing a medication that interferes with another medication a patient is already on, are both examples of preventable adverse events that can harm or complicate the care of a patient.

The purpose of Hamilton Health Sciences’ Medication Reconciliation (MedRec) corporate initiative is to prevent those adverse events from happening.
Medication Reconciliation involves creating the most complete and accurate list possible of all medications a patient takes at home (including name of medication, dosage, frequency and route.) This can be done by talking to the patient and his or her family, reviewing any medications the patient brought to his or her hospital appointment (something that patients are encouraged to do), or contacting the patient’s family physician or community pharmacist, just to name a few.

Once the list is complete, it is consulted whenever medications are ordered for the patient throughout his or her hospital stay (including admission, transfer or discharge). If any discrepancies or conflicts are found, they are brought to the attention of the prescriber and changes are made to prevent adverse reactions. Any changes are officially documented and caregivers are encouraged to communicate these changes to each other.

“It’s not just the pharmacist’s job or the nurse’s job. It’s about communicating together,” said Marita Tonkin, chief of Pharmacy Practice and a MedRec project leader. “The most frustrating thing for patients is being asked the same thing over and over. So this initiative is about getting the information right and sharing it.”

The Ministry of Health’s MedsCheck Program is a tool that patients with a chronic condition who are taking three or more medications are encouraged to take advantage of. Each year they are entitled to a consultation with a community pharmacist to help them better understand how their prescribed medications and any over-the-counter medications interact. During this consultation, the pharmacist creates a thorough list of medications that the patient is on and gives it to the patient for future reference.

“If patients bring this list with them to the hospital, then caregivers just need to double check this list instead of starting from scratch creating a new one,” said Ruth Lee, chief of Nursing Practice at the McMaster site and a MedRec project leader. “It’s not the best time to try and remember all of your medications when you’re sick.”

The MedRec initiative is at different stages of implementation at each HHS site. The inpatient pediatric wards piloted the initiative starting in 2005 and much work has been done since then to bring the practice into other units across HHS.

As an Accreditation Required Organizational Practice (ROP), all clinical areas must have a Medication Reconciliation process in place by the spring 2011 survey date:

- For Inpatient units – a process for MedRec on admission
- For Emergency Departments – a process for MedRec for clients with a decision to admit
- For Ambulatory services – a MedRec process for patients who have their medications discontinued, altered or prescribed.
The Medication Reconciliation Steering Committee has been providing tools and assistance to the areas that are beginning their journey with this initiative – including the creation of a comprehensive Intranet site dedicated to this important patient safety initiative.

On November 3, the steering committee hosted an education day called “Connect the Dots: Medication Safety from Research to Practice.” All staff were welcome to attend an educational event in the MUMC main lobby, and nurses and pharmacists were welcome to register for a more intimate presentation by MedRec experts later that day.

As attendees learned during the education event, MedRec and other medication safety initiatives will continue to evolve as HHS’ eCARE projects roll out. For example, Computerized Provider Order Entry (CPOE) will allow health care providers to enter medication orders and send them directly for review by the pharmacist in real time.

“Through CPOE, reminders, dosage calculators, warnings about drug interactions, allergies and adverse reactions can be included prior to ordering, making the process safer, more complete, and immediately legible,” said Chris Probst, director of Clinical Informatics.

“There is no doubt that Medication Reconciliation will prevent adverse events and save lives,” said VP Professional Affairs and Chief Nursing Executive Nancy Fram. “The success of this initiative is dependent on the dedicated, interprofessional teams who are working hard to make this patient safety standard a reality.”