



## MEDICATION RECONCILIATION (LONG TERM CARE)

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*now!*

### Goal

THE GOAL OF MEDICATION RECONCILIATION IN LONG TERM CARE (LTC) IS TO REDUCE THE POTENTIAL FOR ADVERSE DRUGS EVENTS (ADES) AND PATIENT HARM BY IDENTIFYING AND RESOLVING DISCREPANCIES AND IMPROVING DOCUMENTATION IN DRUG REGIMENS AT CARE TRANSITIONS SUCH AS ADMISSION TO LTC

### Background

Incomplete or inaccurate medication information is a critical issue reflected in a growing number of LTC studies. A 2007 survey of continuing care nurses and pharmacists in Alberta found:

- 75% of the time medication information was NOT legible and complete
- 90% of the time information was NOT available to tell if the prescribed medications were appropriate for the resident's diagnoses.
- 40% of the time medication information DID NOT arrive the same day as the resident's admission.<sup>1</sup>

In a 2004 study by Boockvar the incidence of ADEs caused by medication changes at transfer between facilities was 20%. ADEs due to medication changes occurred most often upon transfer from the hospital back to the LTC facility. Incomplete or inaccurate communication between facilities was identified as a potential factor in these occurrences. Their recommendation was to implement medication reconciliation, at the time of admission back to the long-term care facility.<sup>2</sup>

A 2006 study by Boockvar, found that the possibility of having a discrepancy related adverse drug event was less likely in the group of residents who had medication reconciliation performed by a pharmacist with physician communication upon transfer from acute care to long-term care compared with the group that did not.<sup>3</sup>

In Phase 1 of the *Safer Healthcare Now!* campaign acute care medication reconciliation teams made significant improvements in reducing discrepancies and preventing potential errors. Expanding implementation of medication reconciliation to long-term care and community care organizations in Phase 2 will further help to close communication gaps in medication information transfer thus improving resident safety across the continuum of care.

### Intervention

Medication Reconciliation in long-term care is a formal process of:

- At admission, obtaining a complete and accurate list of each resident's current and preadmission medications - including name, dosage, frequency and route (BPMH).
- Using the BPMH to create admission orders or comparing the list against the resident's admission orders, identifying and bringing any discrepancies to the attention of the prescriber for resolution.
- Any resulting changes in orders are documented and communicated to the relevant providers of care and resident or family member wherever possible.

### Intervention Measures

**Mean number of UNDOCUMENTED INTENTIONAL Discrepancies (Documentation Accuracy)**

Goal: Reduce baseline in area of focus by 75%.

**Mean number of UNINTENTIONAL Discrepancies (Medication Error)**

Goal: Reduce baseline in area of focus by 75%

**Percentage of Residents Reconciled upon admission**

Goal: 100% of residents reconciled upon admission

<sup>1</sup> Earnshaw, K et. al. Perspectives of Alberta Nurses and Pharmacists on Medication Information Received. July 29, 2007

<sup>2</sup> Boockvar K, Fishman E, Kyriacou CK, et al. Adverse events due to discontinuations in drug use and dose changes in patients transferred between acute and Long-term care facilities. Arch Intern Med. 2004;164:545-550

<sup>3</sup> Boockvar K et. Al. Medication Reconciliation for Reducing Drug-Discrepancy Adverse events Am J Geriatr Pharmacother. 2006;4:236-243

# MEDICATION RECONCILIATION

## From Admission to Discharge in Long-Term Care



### ADMISSION

**AT ADMISSION:**

The goal of medication reconciliation at admission is to ensure that all medications ordered are complete, accurate and congruent with what the resident was taking prior to admission to the facility and that any discrepancies with the medications ordered are intentional.

**Compare:**

Best Possible  
Medication History  
(BPMH)  
vs  
Admission orders  
to identify and resolve  
discrepancies

### TRANSFER

**AT TRANSFER:**

The goal of medication reconciliation at internal transfer is to ensure that all medications orders are completely and correctly transferred with the resident to the transferring unit and that any discrepancies with the medication list are intentional.

**Compare:**

Most Current  
Medication List  
vs.  
New Transfer  
Orders  
to identify and resolve  
discrepancies

### DISCHARGE

**AT DISCHARGE:**

The goal of medication reconciliation at discharge or external transfer is to communicate an up-to-date, complete and accurate list of the resident's current medications, thereby equipping the next provider of care with adequate information to perform medication reconciliation.

**Communicate:**

Most Current  
Medication List  
and  
Recent changes  
(Include new medication orders, adjusted  
doses and discontinued medications)  
to the next care provider

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