One Academic Medical Center's Approach to Effective Medication Reconciliation At The Point Of Transfer

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Medication Reconciliation/Orders Transfer Protocol at Stony Brook University Hospital

Purpose
The intent of the pilot was to develop a transfer reconciliation process that would serve as a bridge between paper documentation and the implementation of CPOE in 2003. The process focused on patient transfers from CCU to ICU. The pilot of transfer was selected due to the difference in level of patient acuity between the two units. Inpatient medication reconciliation and most mediations were automated to reconcile.

Observed Improvements
- Staff became more aware of what roles pharmacy was able to provide and how pharmacy’s responsibilities were split into “preventer” department.
- The pharmacy had to respond to the need for nursing attention to medication parameters (i.e. when medications were held or reconstituted).
- The staff became moresinglenotewhat the future of EMR would look like, making the assimilation process easier.
- Communication between pharmacy and the unit was more frequent and productive (i.e. medications that were not being given but were in the medication profile were identified and corrected in a more timely manner than before the pilot).
- Better liability owed each interpretation of physician’s orders versus the time it requires to find the log and clarify the orders. This benefit would remain in CPOE.
- Use of the current medication History and Reconciliation Form was a part of the Orders for Transfer Report process. This enhanced the comprehension of the process, however, there was focus activity in completing forms prior to patient transfer.

Pilot Process Findings
A total of 235 patient transfers were audited to determine the strengths and weaknesses of this process. Hourly documentation was improved. The results of the pilot revealed pertinent information about the transfer process.

Conclusions
- The medication reconciliation process in the ICU and the ICU improved significantly.
- The heightened awareness and behaviors that were demonstrated during the pilot process have continued, resulting in a more accurate process for all patients.
- Physician education is ongoing to compensate for the rotation of resident physicians.
- Nurse education continues to be a part of the refresh training.
- Collaboration between physicians and nurses continue.

Taskforce Recommendations:
- The transition between medication reconciliation as a paper process and the RPM occurred in January 2009. Prior to “go live” medication reconciliation was done on each patient every 24 hours using a sticker system to identify and transfer patient.

NEW PROCESS
- Nursing collects the home medicine list upon admission. Physician updates either medications as an assessment process.

The transition between medication reconciliation as a paper process and the RPM occurred in January 2009. Prior to “go live” medication reconciliation was done on each patient every 24 hours using a sticker system to identify and transfer patient. All patient’s medications were recorded on the prior day to go live.

The ICU and ICU transitioned well. They have achieved 80-90% documented completion of the point of transfer medication reconciliation process on the CPQ report. A pointer for those processes that remained unprovided other issues have not yet embraced the pilot of transfer process to the same extent.

- The staff report behaviors learned during last summer’s pilot process persist and overall compliance with medication reconciliation.
- There is an increased awareness by the nurses to ensure completion of medication reconciliation.
- Collaboration between physicians and nurses continues.
- There is a conscious effort to complete the process.
- There is an appropriate transfer time frame.
- If a patient is transferred from another cell, the physicians are aware.
- Attentive physicians stress medication reconciliation with the transfer and Residents.
- During “down-time”, a form is used that was formatted similar to the Transfer Order Form.
- The familiarity of the down-time form allows the staff to know what to look for and early medication reconciliation as needed.