THE TRUTH ABOUT MEDICATION RECONCILIATION DOCUMENTATION

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OBJECTIVE

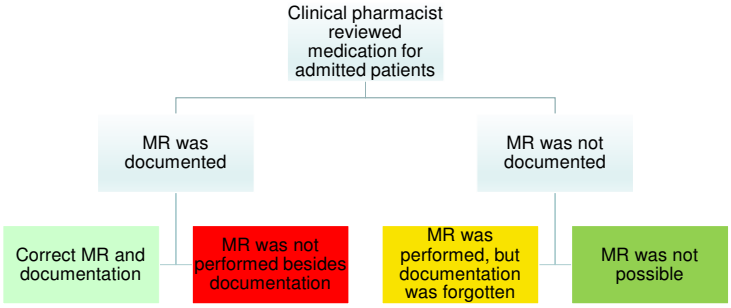
To investigate to what extent the medication reconciliation is actually performed despite documentation and if performed, is actually documented correctly. Furthermore, to investigate if the experience of the physician influenced the results.

BACKGROUND

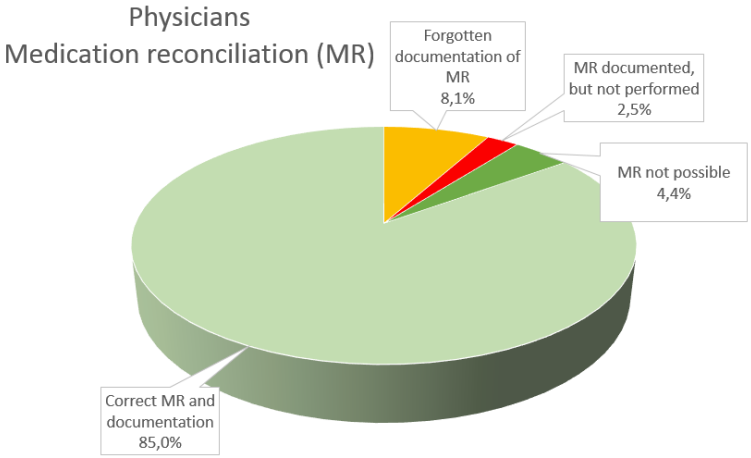
Medication reconciliation (MR) is the process when the medication history is reconciled with subsequent medicine orders in the electronic medication system. Documentation of this is important, as it informs other healthcare personnel, that the physician has considered the medication and that the nurse can safely administer the medication.

The hospital department management receives weekly auto generated reports showing the percentage of patient records with documentation of medication reconciliation within the first 24 hours of admission. According to the local guidelines, it is the physician's responsibility to perform the reconciliation and documentation afterwards. The reports, however, does not tell if the reconciliation was actually performed or was done incorrectly besides documentation.

METHODS



After the baseline (first 18 days) physicians received an e-mail when medication reconciliation was not performed or documented correctly



RESULTS

The pharmacists reviewed 815 patients in total, of which in 66 cases (8,1%) the physician had done medication reconciliation, but not documented it. In 20 cases (2,5%) the physician had documented a medication reconciliation without having performed it. In 36 cases (4,4%), it was not possible for the physician to do a medication reconciliation due to incomplete data. Data were explored to see if new physicians in the ward affected the result, though no association was found.

DISCUSSION

85% of the medication reconciliations were documented correctly and actually performed. The regional goal is 90% medication reconciliations within 24 hours of admission. 4.4% of the medication reconciliations were not possible since the patient was unconscious, suffered from dementia or could for other reason not contribute to the medication history. In Denmark, physicians can access the Shared Medication Record (FMK), which contains the patient´s medication data including current medicines, former medicines and data from pharmacies (distributed medicines). Often this is enough to clarify the actual medication. In 8% of the cases, the physician had done the medicine reconciliation but did not document it. Forgotten documentation causes inconveniences for other health professionals taking care of the patient.
When the physician documents medication reconciliation without having performed it (2,5%), it is a risk for the patient safety. The result might be that the patient receives incorrect doses and/or risks unnecessary side effects - even toxic side effects.

CONCLUSION

The reports showing the percentage of medication reconciliation performed, does not tell the whole truth. In 8% of the cases the physician actually had done the medication reconciliation, but forgot to document it in the medication record, and in 2,5% of the cases the physician had documented a medication reconciliation without having performed it.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