MEDICATION RECONCILIATION AT EMERGENCY ADMISSIONS AND DISCHARGE

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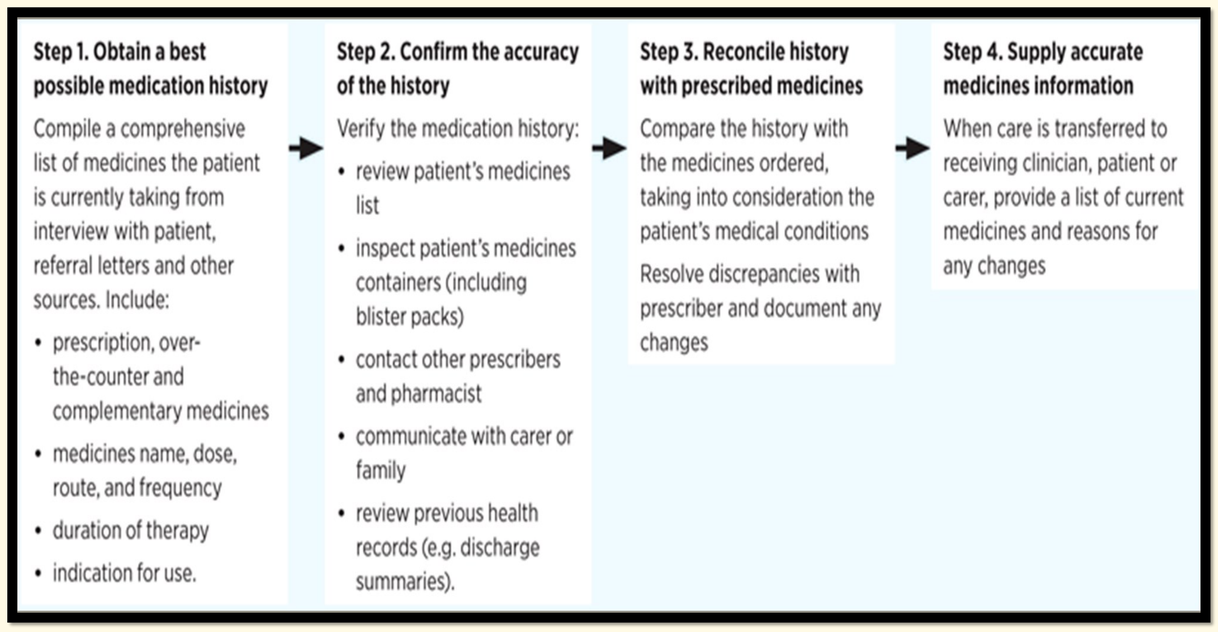
INTRODUCTION:

According to the Joint Commission, "Medication reconciliation is defined as the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. It should be done at every transition of care in which new medications are ordered or existing orders are rewritten."

A reconciliation record usually includes the name of the medication, dosage, frequency, and route of administration, as well as known allergies to medication. Medication



RATIONALE

There are different doctors in different departments of the hospital, if the patient is transferred from one department to another, the doctor at the receiving end should know current medication that the patient has been taking before being shifted. To avoid medication error, it is necessary to implement the process

OBJECTIVES

1. To analyze the frequency and type of reconciliation omissions during emergency admission and discharge of the patient.
2. To check the doctors' compliance on medication reconciliation process on the parameters such as, dose, frequency, route, usage of abbreviation.
3. To evaluate the patient record system for doctor's notes on medication reconciliation.

RESEARCH METHODOLOGY

The study included all the patients admitted (400), from 2nd April to 1st June, in the emergency department and discharged (600) from the hospital. Their records were examined to analyze the reconciliation errors.

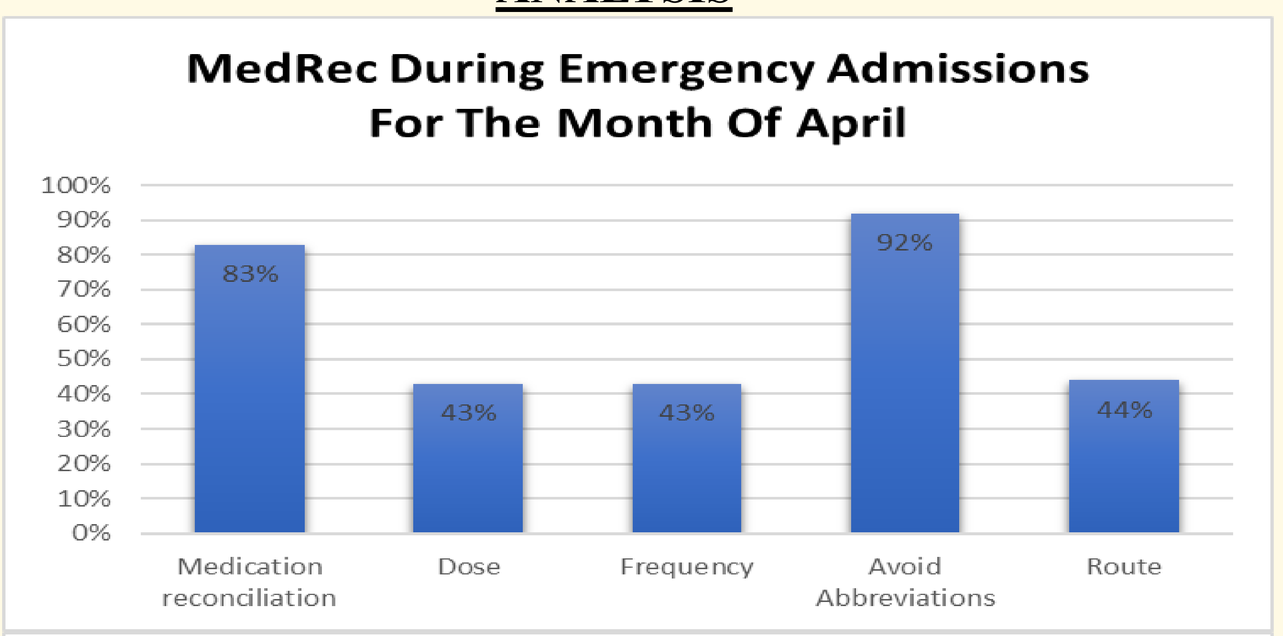
Study Design: Observational Study.

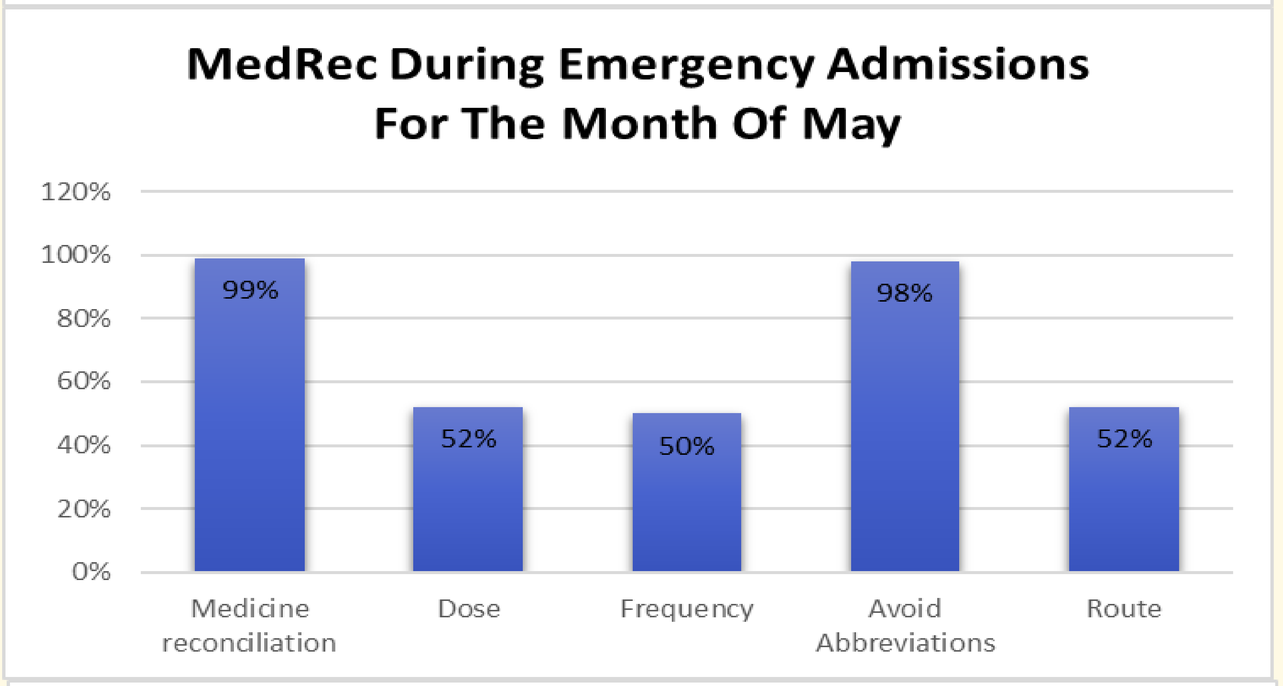
Study area: Emergency department

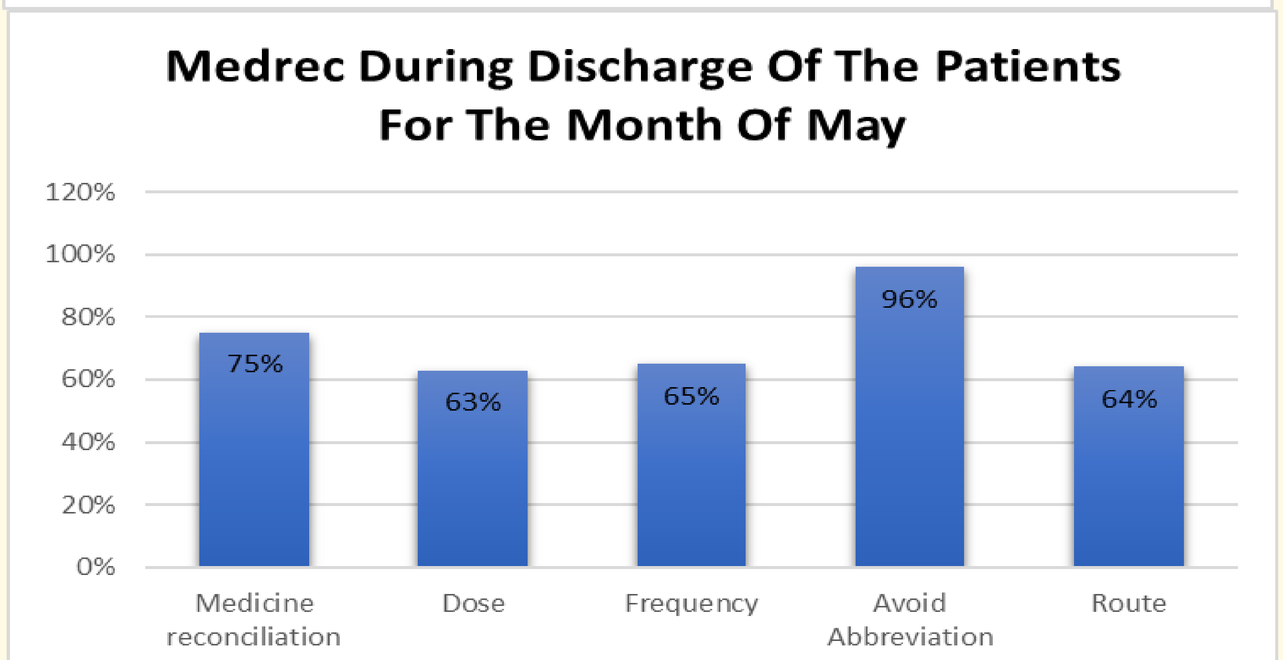
Duration of the study: 2 Months

Data collection: Data was collected from the Computerized Patient Record System (CPRS)

ANALYSIS







OBSERVATIONS

1. Omission of doses and frequencies of the medicines and using abbreviations in the notes was the most common error.
2. Doctors did medication reconciliation but did not list out the medicines in the CPRS.
3. Some doctors did not write the medication reconciliation notes in the CPRS and also missed out the medicines that the patient was taking during his stay in the hospital.
4. Doctors did not mention the complete names of the antibiotics and analgesics in the discharge summaries of the patients.

RECOMMENDATIONS

1. Best possible medical history should be taken from every patient. The doctors need to be oriented to the importance of best possible medical history and medication reconciliation.
2. There should be a compulsory column of medication reconciliation in the CPRS, this will ensure that doctors prepare the list of current medication and transfer it to the CPRS.
3. All the medicines that the patient was taking before coming to the hospital, during his stay and medicines to be taken after leaving the hospital should be updated in the CPRS and discharge summaries to prevent adverse drug reactions.