Medication Reconciliation on the Mental Health Unit, Central Newfoundland Regional Health Centre.

In 100% of hospitals and related healthcare settings, pharmacists will ensure that medication reconciliation occurs during transitions across the continuum of care (admission, transfer and discharge).

I currently work as the clinical pharmacist assigned to our mental health unit at the Central Newfoundland Regional Centre, in Grand Falls-Windsor, NL. Our inpatient unit consists of 20 beds, and we have five staff psychiatrists. My duties include attending multidisciplinary team rounds with our psychiatrists and the mental health care team and completing an assigned section of the Minimum Data set-Mental Health (MDS-MH). The MDS-MH is a standardized assessment tool that is used by mental health professionals to describe client performance and capacity. It enables a service provider to assess key domains of function, mental and physical health, social support and service use (Canadian Institute for Health Information definition). Finally, I play a key role in facilitating the medication reconciliation process on admission, transfer and discharge.

In 2006, we identified that medication reconciliation was going to be a required operational practice for accreditation. The mental health unit was identified as an ideal location to begin implementation as it had a dedicated pharmacy presence (myself), who had an established relationship with psychiatrists and nursing, and a patient population whose “non-psychiatric” medications were at risk of being overlooked on admission. Baseline data was obtained February 8, 2006 to May 12, 2006 (n=129), which determined the following:

- Mean # of undocumented intentional discrepancies: 1.51
- Mean # of unintentional discrepancies: 0.52
- Medication reconciliation success index: 64%

Based on the collected data, we were clearly not meeting generally accepted targets. Consequently, I assembled the Mental Health Med Rec team, consisting of the unit team leader, a psychiatrist (ad hoc), a staff nurse, the Safer Healthcare Now coordinator, two staff pharmacists, and myself and the unit nursing manager as the team’s co-chairs. We created a Med Rec Improvement Charter, and established our target values:

- Decrease the number of intentional and undocumented discrepancies by 75 %
- Decrease the number of unintentional discrepancies by 75%
- Increase the success index to ≥95 %

To achieve these goals, the team utilized the Communities of Practice on the Safer Healthcare Now website, and created a "Best Possible Medication History and Admission Medication Orders" form, which enables the “proactive” approach to medication reconciliation (see below).
As the majority of patients admitted to our unit already have admission orders written before the medication process can be conducted, most of our medication reconciliation occurs “retroactively”. I perform the medication reconciliation process on admission exclusively at the present time.

I also collect and submit our data to the Safer Healthcare Now website on a quarterly basis. Running charts can then be printed and shared with the team (see below).
Results: The red line represents the goal determined by our baseline data. The green line represents the mean number of undocumented intentional discrepancies per patient. It was determined that to attain our goal, changes made to a patient’s drug regimen on admission must be better documented, which may require additional education for our psychiatrists.
Chart #2 Medication Reconciliation on Admission – Mental Health Unit
Mean Number of Unintentional Discrepancies per Patient

Run Chart

Results: The red line represents the goal determined by our baseline data. The green line represents the mean number of unintentional discrepancies per patient. There were no unintended changes (i.e., errors) between home medications and admission orders for medications on admission since December 2011. Thus, our goal has been reached at the present time.
Results: The red line represents the goal determined by our baseline data. The green line represents the success index. Since January 2012 (and even prior to that month) >90% of all medication orders have no discrepancies between the home medications and admission orders and/or the orders are clearly documented as to the reason for the change; a 100% success index was attained in October 2010 and in April 2012.

Once the process of medication reconciliation was established for admission, our attention was focused on discharge. In April 2011, a survey was FAXed to all community pharmacies (27) within our health authority region, to get an idea of their expectations for a patient’s seamless discharge into the community. Only 7 pharmacies replied, but a common theme was their desire for information regarding which medications were discontinued in hospital, and which medications were changed.
In response to the survey results, a “Best Possible Medication Discharge Plan” was created using the Communities of Practice and with input from all members of the Mental Health Med Rec team (see below):
This form also serves as the patient's discharge prescription. The psychiatrist must now document the medication changes that occurred while in hospital so that this information can be conveyed to the community pharmacy. In addition, a copy is also sent to the patient’s family doctor, and the patient’s psychiatrist in the community, thus keeping all of the patient’s healthcare providers “in the loop”. This form has now replaced the usual hospital discharge prescription, so we have 100% adherence to medication reconciliation of discharge.

Although we don’t have a formal medication reconciliation form for transfer, patients who are admitted to our unit from another service or facility have their medications reconciled by the mental health pharmacist on transfer.
Our medication reconciliation process on our mental health unit can certainly be considered a success story. Since inception, we have decreased the number of unintentional medication changes to zero, and we have met the expectations of our community counterparts with respect to discharge prescriptions. I hope that the success on our unit will serve as an example and model to the rest of our health care facilities.