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FridayFocus

Medication Reconciliation Post Discharge

Patient safety remains one of the most essential parts of our health care system. When caring for such a large population, safety challenges can and will occur. A problematic concern that seems to arise relatively often in the healthcare system as related to patient care, is medication safety. A common mistake made in regard to medication safety is medication errors. The *National Coordinating Council for Medication Error Reporting and Prevention* defines a "medication error" as follows: "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer." Medication errors are common and often occur when patients move from one healthcare setting to the next. The majority of medication mistakes transpire upon admission, transfer, and discharge. For this reason, medication reconciliation is a crucial aspect in patient care.

When a patient is discharged from a health care facility, his or her medication list should be compared to medications that were being taken prior to hospitalization and documented in the patient's medical record. Reconciling patients' medications can prevent mishaps such as oversights, duplications, and many other adverse events. According to the "*National Committee for Quality Assurance* (NCQA)," documentation in the medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following evidence meets the criteria:

- Documentation of the current medications, with a notation that references the discharge medications (no changes in meds since discharge, same meds at discharge, discontinue all discharge meds)
- Documentation of the member's current medications, with a notation that the discharge medications were reviewed
- Documentation that the provider "reconciled the current and discharge meds"
- Documentation of a current medication list, a discharge medication list, and notation that the appropriate practitioner type reviewed both lists on the same date of service
- Notation that no medications were prescribed or ordered upon discharge

Only documentation in the outpatient chart meets the intent of the measure, but an outpatient visit is not required.

As providers, you understand mishaps can and will happen in health care, however good communication and proper documentation between patient, providers, and outside facilities can lessen the risk of mediation errors. You are tasked with providing the most comprehensive health care conceivable for your patients. Medication reconciliation helps ensure that goal is achievable.

As always, we appreciate your ideas and feedback. Thank you for the quality work you do. All editions of the Friday Focus are available on the SWHP site: https://swhp.org/about-us/news/newsletters/provider-friday-focus.

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