Medication Reconciliation with Pharmacy Technicians

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Disclosure

☐ I am currently serving as the Vice-Chair of the FSHP Council on Technician Affairs.

Objectives

Upon completion of this presentation, the pharmacy technician should be able to:

☐ Describe the steps and problems in medication reconciliation

☐ Understand the importance of medication reconciliation and how pharmacy technicians can help improve this process.

☐ Understand how medication reconciliation can impact a patient after discharge

Question

☐ What is your area of practice?

☐ A. Hospital Setting

☐ B. Community (Retail) Setting

☐ C. Long-term care or physician’s office

☐ D. Not currently practicing

Outline

☐ National Patient Safety Goals

☐ Medication reconciliation

☐ Use of a pharmacy technician

☐ Challenges faced

☐ Overcoming challenges

☐ Patient Impact

National Patient Safety Goals

☐ What are National Patient Safety Goals (NPSG)?

☐ Joint Commission standards that help accredited organizations address specific areas of concern in regard to patient safety

☐ For hospitals there are 7 areas of focus for 2014: improving staff communication; using medicines safely; use alarms safely; prevent infection; identify patient safety risks; prevent mistakes in surgery

(The Joint Commission, 2014)
National Patient Safety Goals

- NPSG.03.06.01 addresses using medicines safely by instructing hospitals to maintain and communicate accurate patient medication information.
  - Why is this a focus?
    - There is evidence that medication discrepancies can affect patient outcomes.
    - Medication discrepancies can affect patient outcomes in both the inpatient setting and at discharge

(The Joint Commission, 2014)

Medication Reconciliation

- Why is medication reconciliation important?
  - Serves as a base for the provider
    - Types of ailments, diseases, or conditions the patient has
    - Where the patient is in therapy
    - Allows the provider to determine what should or should not be continued during admission
    - Allows the provider to look for potential drug interactions that may cause or has caused an adverse reaction

(The Joint Commission, 2014)

Medication Reconciliation

- What is medication reconciliation?
  - The process of comparing a patient’s medication orders to all of the medications that the patient has been taking

- What is the purpose of medication reconciliation?
  - To avoid errors like omissions, duplications, dosing errors, and drug interactions

(The Joint Commission, 2014)

Errors

- Error Rates and Statistics
  - More than half of patients have at least one unintended medication discrepancy at hospital admission
    - 6% of discrepancies have severe harm potential
    - 33% of discrepancies have moderate harm potential
    - 61% of discrepancies have no harm potential

- What is discrepancy?
  - Any missing or incorrect medication information and is a marker for potential adverse drug events

(Agency for Healthcare Research and Quality, 2012)

Errors

- What are the causes for errors in taking a medication history?
  - Performance deficits
  - Inaccurate transcription
  - Omissions
  - Improper documentation
  - Communication problems
  - Workflow disruptions

(Agency for Healthcare Research and Quality, 2012)
<table>
<thead>
<tr>
<th>Medication Reconciliation</th>
<th>Common Problems</th>
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</thead>
<tbody>
<tr>
<td>□ Why have a pharmacy technician perform a medication history or medication review with patients?</td>
<td>When nurses are required to do the medication history there tends to be a variety of problems:</td>
</tr>
<tr>
<td>□ Clinical knowledge</td>
<td>□ Impossible to train every nurse on doing medication reconciliation properly when they are having to deal with multiple patients with multiple needs.</td>
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<tr>
<td>□ Patients tend to forget</td>
<td>□ Not paying attention to detail</td>
</tr>
<tr>
<td>□ Nurses overwhelmed</td>
<td>□ Constant work interruptions</td>
</tr>
<tr>
<td>□ Patients overwhelmed</td>
<td>□ Lack of medication knowledge</td>
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<tr>
<td>□ Patients not telling the nurse or physician how or what they REALLY take</td>
<td></td>
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<tr>
<td>□ Overlooking nutraceuticals and OTC meds</td>
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<tr>
<td>□ What is another reason to have a pharmacy technician perform a medication history or medication review with the patient?</td>
<td>We have looked at who inputs the medication history, but we have not looked at the source of information.</td>
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<tr>
<td>□ Your information is only as good as your source.</td>
<td></td>
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<td>□ Not every patient walks around with a current medication list in case of emergency.</td>
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<tr>
<td>□ Patients who do have a list typically do not put what medications they are taking over the counter as well as the nutraceuticals they take.</td>
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<td>□ Patients think they know everything they take.</td>
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<th>Medication Reconciliation</th>
<th>Barriers</th>
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<tr>
<td>□ When taking medication information for a patient, what components do we look for?</td>
<td>What are some common barriers to obtaining a med history?</td>
</tr>
<tr>
<td>□ Drug name</td>
<td>□ Unable to remember</td>
</tr>
<tr>
<td>□ Formulation</td>
<td>□ Language</td>
</tr>
<tr>
<td>□ Dose</td>
<td>□ Clinical Condition</td>
</tr>
<tr>
<td>□ Route</td>
<td>□ Does not want to discuss medications</td>
</tr>
<tr>
<td>□ Frequency</td>
<td>□ Unreliable historian</td>
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<tr>
<td>□ PRN indication</td>
<td>□ Patient carries an outdated list</td>
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</table>
Barriers
What are some other barriers?
- No primary doctor
- Not being honest
- Omission of OTCs
- Panicked patient
- Patient takes medications not prescribed to him
- Patient feels like he is being interrogated about his medications

Medication Reconciliation Technician
How does this work?
- If the patient is admitted through the ED, the MRT review the medication history profile with the patient, appropriate family member, or skilled nursing facility, while the patient is still in the ED.
- For directly admitted patients, the MRT goes to the patient’s room to discuss his medication history.
- For medications that the patient is unable to verify, the MRT contacts the patient’s primary physician or pharmacy to obtain the correct information

Pharmacy Technician
After seeing the different difficulties in dealing with medication reconciliation, what are some other reasons for having a pharmacy technician in a position that can have a significant impact on patient care?
- Time
- Resources
- Ability to pay attention to detail
- Patients feeling more comfortable talking to us than talking to the nurse or physician

Challenges
What challenges were faced in the creation of this position?
- Administration and providers questioning the ability of a pharmacy technician to perform the job and perform well
- Resentment from nurses
- Not a lot of information about the use of pharmacy technicians in medication reconciliation
- Not knowing how to interact with patients
- Having pharmacist supervision

Medication Reconciliation Technician
- Depending on the facility, the role of the Medication Reconciliation Technician (MRT) may vary.
  - Some hospitals have the MRT stationed in the Emergency Department (ED) and perform the history.
  - Other hospitals have the MRT do medication history reviews with the patient while the patient is in the ED.
  - Some hospitals have the MRT doing reviews and taking histories for patients in the ED and those admitted to the floors.

Overcoming Challenges
How did we overcome these challenges?
- Doing presentations and giving numbers on the amount of patients seen and the number of mistakes in the medication histories
- Providers seeing the interaction between the patient and pharmacy technician
- Learning how to interact with patients
- Open communication between the pharmacists and the pharmacy technician
Patient Impact

- Allows the patient to interact with someone from pharmacy.
- Gives the technician a chance to educate the patient on the importance of keeping a current medication list with them at all times.
- A pharmacy technician working in this position has the ability to stop an adverse drug reaction and improve patient care.

Patient Impact

- NPSG.03.06.01 states that at the end of a patient’s hospital stay, the importance of medication management should be explained to the patient; this include providing a patient with a list of medications to continue or discontinue as well as follow up instructions.
- The list takes into account what the patient was taking before hospitalization, during hospitalization, and what to take after hospitalization.

References


Ending Note

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Challenges are what make life interesting, and overcoming them is what makes life meaningful.