



## **Sequest targets JCAHO requirements and Recommendations for Medication Reconciliation**

One of the objectives of the JCAHO System Tracer for Medication management is to evaluate the medication reconciliation process during “hand-offs” from one level of care. Joint Commission surveyors target a client/client/resident receiving a specific medication. The review begins with the individual’s clinical/medical record then follows the medication process throughout the system. The review focuses on compliance with requirements of the NPSG Goals for 2008 which include:

### **Goal 8(a): Accurately and completely reconcile medications across the continuum of care.**

Implementation requirements for this goal include establishing a process for obtaining and documenting a complete list of the client's current medications upon the client's admission to the organization and with the involvement of the client. This process also includes a comparison of the medications the organization provides to those on the list.

### **Goal 8(b): A complete list of the client’s medications is communicated to the next provider of service when a client is referred or transferred to another setting, service, practitioner, or level of care within or outside the organization. The complete list of medications is also provided to the client upon discharge.**

Implementation requirements for this goal expect that, at a minimum, reconciliation must occur any time the organization requires that orders be rewritten and any time the client changes service, setting, provider or level of care and new medication orders are written. For transitions not involving new medications or rewriting of orders, the organization should determine whether reconciliation must occur.

Medications that need to be communicated to the next provider, organization, level, or setting of care include all medications that the client is to take following discharge or transfer, not just the prescription medications that are "ordered" at discharge. The list of "discharge medications" provided to the next provider or organization should already have been reconciled against the list

of medications the client was receiving during treatment as well as against the original list of medications the client was taking prior to admission.

The Joint Commission also recommends that health care organizations consider:

1. Placing the medication list in a highly visible location in the client's chart and including dosage, drug schedules, immunizations, and allergies or drug intolerances on the list.
2. Creating a process for reconciling medications at all interfaces of care (admission, transfer, discharge) and determining reasonable time frames for reconciling medications. Clients, and responsible physicians, nurses and pharmacists should be involved in the medication reconciliation process.
3. At discharge, in addition to communicating an updated list to the next provider of care, provide the client with the complete list of medications that he or she will be taking after discharge, as well as instructions on how and how long to continue taking any newly prescribed medications. Encourage the client to carry the list and to share the list with any providers of care.

Organizations will better enable the reconciliation process by clearly defining their continuum(s) of care. Use of TIER's Continuum of Care model provides a solid framework for designing your organization's reconciliation process to cover all service settings including inpatient, emergency and urgent care, residential, partial, day, outpatient and, continuing care. This model enables staff to track admission, transfer, and discharge between programs and within levels of care.

Once admitted the client is assigned to a specific program and, if desired, a level of care for that program using TIER Workflow System's "Program Admission Log (PAL)" which is below:

The screenshot shows the 'Program Admission Log (952)' window. At the top, the client's name 'Ayers, Jane R' is displayed in a yellow bar with a 'Cancel' button. Below this, there are two tabs: 'Program Assignment' and 'Level of Care'. The 'Program Assignment' tab is active. The form contains the following fields:

- Date: 09/19/2005
- Location: Inpatient Center (dropdown)
- Program: Inpatient Services (dropdown)
- Admission Status: Voluntary (dropdown)
- Program Admission Date: 09/19/2005, Time: (empty)
- Program Discharge Date: 10/04/2005, Time: (empty)

Below these fields is a section for 'Staff Assigned' with an 'Add' button and a table:

Staff Name	Start Date	End Date
Canter, William	09/19/2005	10/04/2005

At the bottom, there are fields for 'Transferred to' (Counseling), 'Location' (Counseling Center), and 'Program Transfer Date' (10/04/2005). A 'No. of Days in Program' field is set to 16. A 'Transfer Pgm' button is present. A blue message at the bottom reads: 'Client was Successfully Transferred.'

At each transfer point medication reconciliation can be triggered and relevant information displayed for providers. In this manner, the provider at the next program or level of care can compare the medication list and related history prior to modifying, discontinuing or ordering new medications. This review should be signed off by the new provider. For more information, refer to the steps described below.

## Steps for medication reconciliation

1. Collect a complete list of current medications (including dose and frequency along with other key information) for each client on admission.
2. Validate the medication list with the client (whenever possible).
3. Assign primary responsibility for collecting the list to someone with sufficient expertise, within a context of shared accountability.
4. Use the medication list when writing orders.
5. Place the reconciling form in a consistent, highly visible location within the client chart (easily accessible by clinicians writing orders).

6. Assign responsibility for comparing admission orders to the medication list, identifying discrepancies, and reconciling variances to someone with sufficient expertise.
7. Reconcile medications within specified time frames (within 24 hours of admission; shorter time frames for high-risk drugs, potentially serious dosage variances, and/or upcoming administration times).
8. Adopt a standardized form to use for collecting the medication list and for reconciling the variances (includes both electronic and paper-based forms).
9. Develop clear guidelines for each step in the reconciliation process.
10. Provide access to drug information and pharmacist advice at each step in the reconciliation process.

About the Author: Leonard J. Brink, ACSW is the founder of Sequest Technologies, Inc. He was Associate Director with the Joint Commission on Accreditation of Healthcare Organizations from 1978 to 1983 (JCAHO) and retired from JCAHO Behavioral Healthcare Accreditation Services Program in 2005. Leonard has a Masters degree in social work from Tulane University with extensive clinical practice and healthcare administration experience in psychiatry, mental health and substance abuse services. During his extensive career in healthcare, Leonard has consulted with over 1,600 organizations and has conducted numerous lectures, workshops and seminars across the U.S.