By Kurt A. Patton, MS, RPh

Meeting TJC's 2009 Requirements for **Medication Reconciliation**

The Joint Commission has had a requirement for medication reconciliation in its standards since 2005, but each year it remains one of the most frequently scored issues in hospital surveys. Many hospitals started out in 2005 simply figuring out how to collect the data, determining who was going to collect the information, and then revising the reconciliation form multiple times as they experienced difficulty with different aspects of the process. Today, every hospital has a form and a process, but meeting the Joint Commission's requirements in their entirety remains a struggle. With the publication of the 2009 hospital standards manual, we see there is both bad news and good news. Some additional rigor has been added to the nature of the review that is conducted upon admission. The good news, however, is that requirements have been simplified for procedural areas that only use short-term medications either during, or immediately after, the procedure.

Summary of Requirements

The first step to achieving compliance is to fully understand the requirements. For 2009, the Joint Commission has reformatted its standards and numbering system, thereby creating a new learning curve. The standards are organized around the admission process, the referral process to another provider, the discharge process and the new minimal use process. Oddly enough, the in-hospital transfer requirements are contained within the standard that for the most part addresses the admission reconciliation process. I suggest the following simplified steps to look at the requirements and remember what they are.

1. Collect a medication reconciliation list for every patient given medication, anywhere in your organization.

2. Analyze the medication reconciliation list obtained from each patient to determine:
   a. For inpatients, should we continue, stop, substitute, or add medications?
   b. For outpatients, does the patient's home medication list conflict with planned treatments in the outpatient setting?

3. Provide copies of the medication list to:
   a. The patient at the time of discharge from the inpatient setting.
   b. The patient at the time of discharge from a procedure area if we have changed the list by prescribing a new chronic medication or requiring the patient to stop one or more of their existing medications.
   c. The patient's primary care physician or next provider of care if we have changed the list.
   d. The receiving unit for intra-hospital transfers between levels of care, such as from the ICU to the floor.

New Requirements For 2009

The simplified requirements listing described above is perhaps helpful for the purposes of remembering what has to be done, but there are important, less obvious nuances contained in both the Joint Commission's elements of performance and frequently asked questions. One important change for 2009 concerns analysis of the medication list during admission to an inpatient hospital setting. Previously, if we had the list and someone reviewed and signed off on that list we thought we were done. The Joint Commission has added an explicit requirement for 2009 stating that any "discrepancies, omissions, duplications, adjustments, deletions or additions are reconciled and documented." This means that if the patient reports that they are taking five medications and you choose to continue only four of them during their inpatient stay, you have to document that this was intentional rather than an oversight. The Joint Commission does not dictate how to do this, but staff should know where to look to demonstrate that an intentional decision was made, as opposed to an error of omission. If you use your medication reconciliation list

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as an order form and the physician documents C/D for continue or discontinue next to each medication, you have documented your decision-making. If you do not use the reconciliation form as an order sheet, then documentation of decision-making should be in either the order sheet or a progress note. The absence of prescribing on the order sheet is not sufficient documentation to demonstrate that there was not an error of omission.

There is a second new documentation requirement for 2009 concerning hospital-to-hospital or other care setting transfers. As in previous years you are expected to send the list of medications the patient is stabilized on, but new for 2009 you also need to include information about who to call in the event the next care setting has a question about the medication regimen. Contained as a note within this patient transfer Element of Performance (EP) is a third new requirement: The Joint Commission now expects the facility to ensure that the medication regimen is a component of all patient care handoffs within the organization. However, no specific documentation of this effort is required.

A fourth new requirement for 2009, which does require documentation, concerns discharges from the hospital. As in

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previous years, the patient must be provided with a copy of the list, but new for 2009 is a requirement to explain the discharge list and to document the interaction. This EP also requires that patients be educated as part of this process to discard any older versions of their medication reconciliation listing. The easiest way to do this is to print the advice on each form and be sure to date the form so patients or families will know which list is most current.

Also new for 2009 is a standards tagging process where specific elements of performance are identified with a D, showing that the Joint Commission is specifically looking for documentation of effort for that EP. This should become a very helpful tool in the future, but for now it may be misleading. There are many requirements where the body of the EP says record and document, but there is no D tag on the element of performance. So be cautious as you begin to note these tags for 2009. Read the EP carefully to find those that either directly say document, or where it is in your best interest to document so that the details are evident to everyone reviewing the chart.

Minimal Use Settings

Probably the most significant change for 2009 is the creation of an approved definition and set of simpler requirements for settings that only minimally use medications. For example, a patient who comes in for an outpatient procedure such as the excision of a mole might receive some local anesthetic or perhaps a short duration analgesic or antibiotic. As with all patients that enter the organization and will receive medications, we must gather a medication list. However, in the minimal use setting if we are not going to change their chronic medications or prescribe something long term, there is no need to provide copies to patients, or send copies to the next provider of care. If, however, you prescribe some new medication for long-term use, or order the patient to stop some chronic medication, the full reconciliation process must then be instituted.

Continuing Problem Areas

While there are some new requirements that need to be addressed by January 1, 2009, there are also some long-standing requirements that continue to cause difficulty for organizations. One such difficulty concerns Latin abbreviations, both approved and unapproved. We have to remember that the patient's copy of the medication reconciliation instructions cannot contain any Latin abbreviations, such as those indicating frequency. Rather, the instructions must be understandable to the patient. If you use Latin abbreviations, you run the additional risk that someone will use the prohibited qd in the frequency field. Some organizations have patients complete their own medication reconciliation work sheet and retired nurses and physicians often use these prohibited abbreviations. One simple way to avoid Latin entirely is to use a simple structured frequency field as follows: _______daily. With this format, neither the staff person conducting the reconciliation interview, nor the patient will be tempted to use Latin; it is simply easier to write in 1, 2, or 3 daily.

Another chronic medication reconciliation problem is discrepant information. This occurs when one caregiver conducts a medication reconciliation interview and documents the list of medications. Another caregiver then documents a second, non-matching list in a subsequent assessment and no reconciliation of the discrepant information is conducted. A common place to find discrepant information is in the admission history and physical. While we may learn additional information from the patient or family as the patient settles in, we must have a method to reconcile and create one comprehensive and accurate listing. The best way to accomplish this is to revisit and update the medication reconciliation form as you acquire new or additional information and details about their medication regimen.

A third common mistake is failing to merge admission list information with currently stabilized medication information onto one complete listing at the time of discharge. Often the patient's home list is given back to them, along with several new prescriptions. This is not sufficient, however, as the standard requires one comprehensive list be created with instructions outlining which medications are to be discontinued, which are to be restarted, and which new medications must be obtained from the patient's pharmacy. All of this information should be placed on one form with clear instructions. It is not sufficient to direct the patient to speak with their primary care physician after they get home from the hospital.

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Keep in mind that the final MAR (or other reconciliation information) received with a patient transferring from another hospital or care setting is the current medication listing for reconciliation. You may wish to conduct your own interview with the patient concerning home medications to decide if any of those should be restarted, but at a minimum you must reconcile the listing of current medications sent from the other hospital or care setting, and then make and document decisions about which medications you want continued.

In Conclusion

Lastly, as with any Joint Commission standard, you will have to fulfill your own hospital's expectations and policy requirements. If your policy states that you will complete the reconciliation process in eight hours or in 24 hours, then you must comply with that timeframe. In addition, you must document if you have made an attempt to complete the process but were unable to do so due to patient or family recollection difficulties. For example, if the patient says they take drug "X" but they don't know the strength, be sure to document "unknown" or "could not recall" so that it does not appear as though you failed to complete the form or reconciliation interview.

With a clear understanding of both the new requirements for medication reconciliation, as well as the existing requirements that have proved challenging, you can ensure a successful and compliant reconciliation process. ■

Now the owner of Patton Healthcare Consulting, LLC, Kurt A. Patton, MS, RPh, served as executive director of accreditation services at the Joint Commission for over seven years, until his retirement in December 2005. Before joining the Joint Commission, Patton was the deputy director for the Division of Strategic Initiatives and Managed Care in the New York State Office of Mental Health. Previously, he served as the administrator for a state-operated behavioral health managed care program and as the director of the Bureau of Health Services. Patton earned his bachelor's degree in pharmacy and his master's degree in institutional administration from St. John's University.

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