HQIC Community of Practice Call:
The Impact of Meaningful Medication Reconciliation on Adverse Drug Events

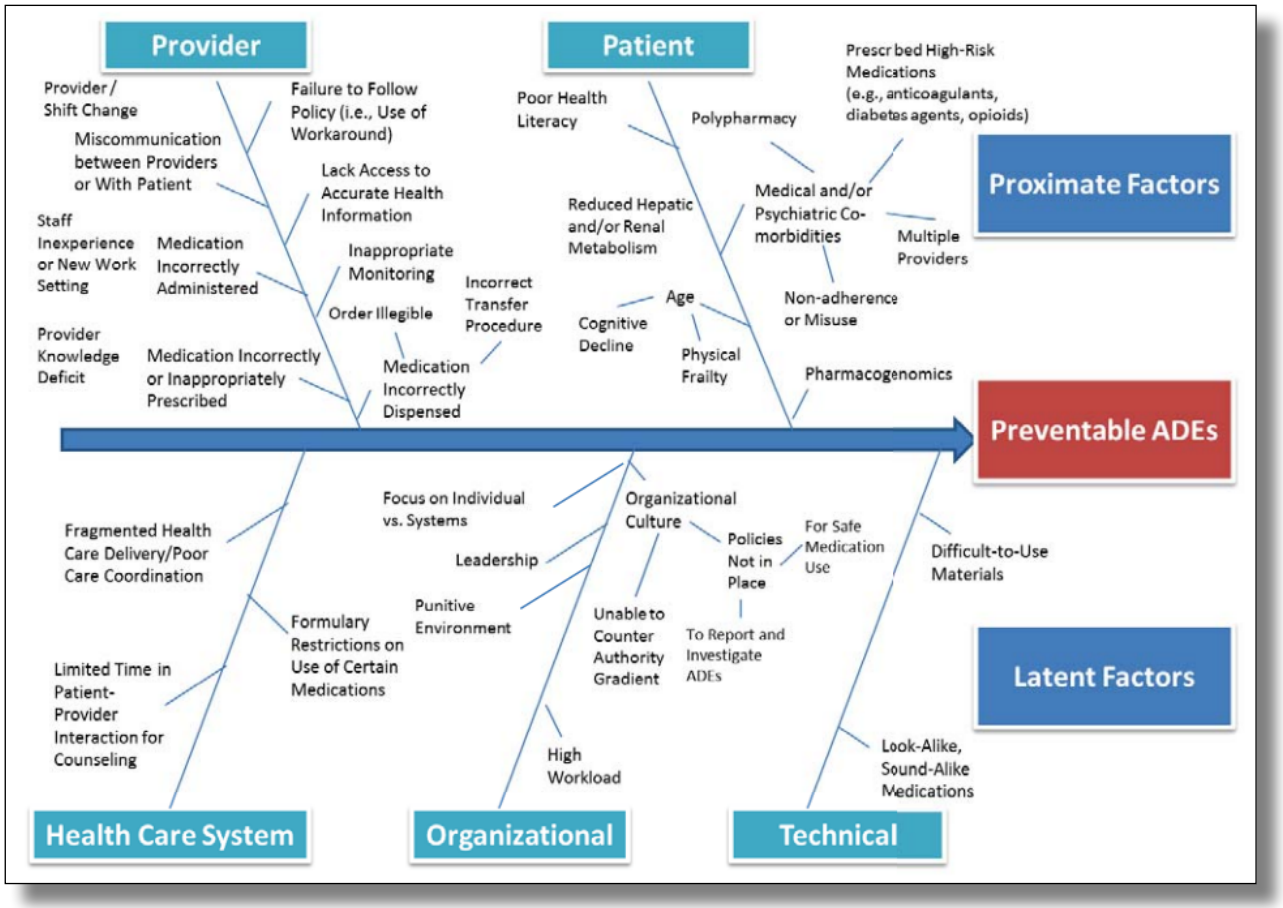
Thank you for registering for and/or attending the HQIC Community of Practice call! Hospital leaders from across the country attended the event. The small, rural, and critical access voice was amplified through sharing of barriers and best practices alike. Furthermore, subject matter experts shared their perspectives and their favorite resources.
Now, it is time to act!

Why Now

The Agency for Healthcare Research and Quality (AHRQ) defines an adverse drug event (ADE) as harm experienced by a patient because of exposure to a medication. ADEs do not always indicate an error or poor quality care, however, it is generally estimated that around half of all ADEs are preventable. ADEs place patients at risk and are costly to the healthcare system. In recent years, the opioid epidemic has highlighted the importance of preventing Adverse Drug Events (ADEs). Multiple initiatives have been developed to promote safe prescribing of opioids including increased patient education and updated prescribing guidelines. Preventing all types of ADEs including those related to opioids, remains a national patient safety priority (AHRQ, 2019).

Review the Data

Fishbone Diagram: National Select Determinants of Preventable Adverse Drug Events



Consider Common Barriers

Review common barriers identified during the webinar and brainstorm ways to mitigate challenges to implementation in your organization.

- Challenges associated with the use of technology such as Electronic Health Record (EHR) workflows, medication scanning devices, and bar codes
- Increased patient census resulting in less time for medication reconciliation with every patient
- Staffing challenges related to the COVID-19 pandemic
- Patient factors such as limited health literacy, language barriers, and/or limited knowledge of the medications they are taking

Perform a Root-Cause Analysis

Fill in the Five Whys template to identify the cause of your hospital's sepsis readmissions.

Fill in the PDSA Worksheet to identify your goal and complete the Plan-Do-Study-Act cycle for test of change and improvement.

Identify Promising Practices

Beginner	Intermediate	Expert
Verify and document a patient's opioid status (naïve versus tolerant*) and type of pain (acute versus chronic) before prescribing and dispensing extended-release and long-acting opioids (page 15).	Provide staff with education on the importance of performing a medication reconciliation and how to complete this task using the EHR (if applicable).	Seek out and use information about medication safety risks and errors that have occurred in other organizations outside of your facility and take action to prevent similar errors. (page 14).
Develop a clear process for a performing medication reconciliation. Consider developing a unique process for certain patient populations.	Develop a process for or revamp your process for gathering sufficient details from each medication error.	Medication safety data and adverse drug event data and learnings are shared on a regular basis with frontline clinical staff, leadership and medical staff (page 4).

Patient and Family Engagement

- Consider the "M in a box" process for promoting patient and family engagement with new medications.
- Consider developing a "Meds-to-Beds" program to streamline the discharge process and eliminate barriers to medication education for patients and families.

Craft Your AIM Statement

Identify your organization's goals related to medication reconciliation and reducing adverse drug events (ADEs). Fill in the blanks with your AIM.

By _____, the **ED** at **(enter your hospital)** will

implement **(intervention)** to improve **ADE-Adverse Drug Events**

by **(how much)** to benefit _____.

Example AIM:

The inpatient medication safety team at my hospital will provide medication reconciliation process education with knowledge check to all nursing staff to achieve a 70 percent completion rate of medication reconciliation at admission by March 31st 2022.

Next Steps

Not sure how to identify your organization's root cause? Need help getting started on implementing your selected intervention? Seeking feedback on your AIM statement?
Reach out to your HQIC quality improvement partner for assistance.

References and Resources

National Action Plan for ADE Prevention | health.gov
Medication Errors and Adverse Drug Events | PSNet (ahrq.gov)
Home | Institute For Safe Medication Practices (ismp.org)
Medication Safety Road Map (mnhospitals.org)
Medication Reconciliation to Prevent Adverse Drug Events | IHI - Institute for Healthcare Improvement

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