Developing a procedure for medication reconciliation and review on admission to geriatric wards

ABSTRACT

Objective: To develop a procedure and tool for medication reconciliation and review of geriatric patients’ medications on hospital admission.

Methods: Action research, with literature review, and physicians, nurses and clinical pharmacists as experts, was used in the collaborative development process that first identified problems in the current admission process and then developed a procedure and tool in a medium-sized secondary care hospital. The use of the procedure and the tool was piloted; the final versions were developed based on the outcomes of the pilot.

Results: Several problems were identified in the admission medication process, including patients not having an up-to-date home medication list and problems with polypharmacy. To solve these problems, the experts recommended that clinical pharmacists should reconcile and review patients’ medications. A medication reconciliation and review procedure and tool were developed and piloted. The final tool comprised the following sections: Patient Background, Patient Interview, Reconciled Medication and Medication Review, and Cautions with Medication. As part of the implementation, a new page was created for the pharmacists’ medication reconciliation and review notes in the electronic medical record. The study emphasized the central role of the clinical pharmacist in the healthcare team.

Conclusions: The role of a clinical pharmacist in the multidisciplinary healthcare team should be increased to promote medication safety. The study introduces a novel tool and procedure for medication reconciliation and review that has been developed and piloted with a multidisciplinary healthcare team. The tool and the clinical pharmacist-led procedure were found feasible to use and central to the rational use of medicines.

Key words: Medication reconciliation, medication review, hospital admission, geriatric patients, clinical pharmacist, medication safety
INTRODUCTION
Medication discrepancies, defined as unexplained differences between documented regimens across different sites of care may give rise to adverse drug events (ADEs) (Pippins et al. 2008). Unintentional medication discrepancies are often due to errors in taking a medication history or not reconciling a list of medications. Medication reconciliation at different stages of health care has been recognised to reduce ADEs and discrepancy rates (National Prescribing Centre NPC 2008, Meguerditchian 2013). Sometimes viewed as time consuming (Meguerditchian 2013), medication reconciliation also helps to identify medication errors between transitions of care, thus, preventing ADEs from occurring (Haig 2006, Pippins et al. 2008, Meguerditchian 2013, Institute for Safe Medication Practices ISMP 2017). Other benefits of medication reconciliation have been shown to be, for example, the potential avoidance of medicines-related admissions to hospital, improved multidisciplinary team-working and greater patient involvement in their own care (National Prescribing Centre NPC 2008).

Admission to, and discharge from, hospital are shown to produce a large number of discrepancies in patients’ drug therapy (Climente-Martí 2010). Thus, medication reconciliation should occur at these points of transfer, or ideally throughout a patient’s hospital stay (Knez et al. 2011). This is important especially for geriatric patients. If a list of medications is not correct at hospital admission, such problems can carry over to the discharge medication (Karapinar-Carkit et al. 2010) and cause medication errors and harm to the patient on other wards or even after discharge.

Especially in the treatment of older patients, it is not enough to reconcile the list of home medicines without questioning their appropriateness (Quénébec 2013). It is important also to review whether all the medicines are clinically appropriate to be continued at admission, during the hospital stay and at discharge. The aim of the study was to develop a tool and a procedure for medication reconciliation and medication review of older patients at admission to a primary care geriatric ward.

METHODS
Context of the study
The study was conducted in the city of Lahti located near to the capital area in Finland between February 2011 and May 2013. In 2017, the city had a population of 119,000 of whom 24% are aged ≥ 65 years (Tietoa Lahdesta 2017). The study site was Lahti City Hospital, providing secondary care services to older patients. The participating wards were an acute secondary care ward with 40 beds and an acute rehabilitation primary care ward with 30 beds. In early 2017, the Lahti City Hospital was incorporated into the Päijät-Häme Joint Authority for Health and Wellbeing integrating primary and secondary care further. The permission for conducting this study was obtained from Lahti Social and health services. At the time of the study, no ethics approval was required as this study was regarded as a service development.

Study design, participants and methods
An action research based method comprising six stages (Table 1, Figure 1) was utilised (Baum 2006). The study process consisted of research, action and participation, typical to action research. The aim was to achieve a standardised medication reconciliation and review procedure. Consequently, a multiprofessional research team of researchers (n=2), academic supervisors (n=2), chief physicians (n=2), and clinical pharmacists (n=2) of the hospital were involved in the development of the tool and the procedure. The study and its stages are described briefly in Table 1 and Figure 1.

Stages of the study
Stage 1: Literature search for, and narrative review of, medication reconciliation and review procedures applicable to admissions to geriatric wards
The aim of the literature search and review was to gather national and international guidelines for, and examples of, existing tools and procedures for medication reconciliation and review. This was to support the development of the first version of the tool and procedure for the Lahti City Hospital. After having searched for actual guidelines, tools and procedures, the literature search was extended to include articles from peer-reviewed journals. The following search terms were used for data screening independently and as a combination: “medication reconciliation”, “medication review” and “admission”.

Stage 2: Interviews with physicians, nurses and clinical pharmacists
Following the literature search and review, several interviews were conducted with healthcare staff of Lahti City Hospital. Two physicians, three nurses and two clinical pharmacists were purposively selected to be interviewed individually as expert informants due to their experience in patient admission to geriatric wards as in Smith (2010).

A semi-structured interview guide was developed based on a) the literature found in Stage 1 and b) several discussions with the research team consisting of academic and practising experts in medication safety (Ritchie et al. 2005, Smith 2010). In the individual interviews, the informants were invited to describe their previous experiences of, opinions on, expectations for, challenges with, and solutions for, the medication reconciliation and review on admission. The interviewees were also asked to describe how clinical pharmacists could contribute to the medication reconciliation and review process on admission. The interviews were conducted by two researchers (LHR and AN). The interviews were audio-recorded and transcribed verbatim. Qualitative framework analysis was employed in the analysis of all interviews (Ritchie et al. 2005, Smith 2010).

Stage 3: Developing a tool and procedure for medication reconciliation and review
Based on the literature search and review (Stage 1) and the interviews (Stage 2), the researchers (AN and LHR) developed the first versions of the procedure and the tool for medication reconciliation and review for the participating hospital wards. Detailed instructions were developed for the procedure to ensure that different healthcare professionals, such as pharmacists and nurses, would operate in a standardised way. The research team further refined the procedure and the tool (Appendix 1) before the pilot as is usual in action research.

Stage 4: Piloting the medication reconciliation and review procedure and the tool
The medication reconciliation and review procedure was piloted in two parts to ensure the feasibility of the use of the tool (Appendix 1). The two clinical pharmacists who had participated in the interviews in Stage 2 conducted the pilots during patients’ admission to the two wards. The pharmacists were provided with detailed instructions for completing the medication reconciliation and review to ensure they operated in a standardised way.

Altogether eight patients, whose medication was reconciled and reviewed according to the procedure under development, were included in the pilots. The medication reconciliation and review procedure was observed by one of the researchers (AN) on the first
Table 1. Outline of the stages of the study to develop a tool and procedure for medication reconciliation and review of geriatric patients on hospital admission.

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Purpose of the stage</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Literature search and review on (inter)national medication reconciliation and review models.</td>
<td>To identify (inter)national models and experiences on the topic to inform the development and implementation of the tool and procedure for medication reconciliation and review.</td>
<td>Literature search and narrative review</td>
</tr>
<tr>
<td>2</td>
<td>Assessing current medication reconciliation and review practices and needs for their development on admission to the geriatric ward.</td>
<td>To identify possible problems in the current medication process on admission to the geriatric ward; potential improvements that interviewees could suggest to solve those problems.</td>
<td>Interviews of informants (physicians (n=2), nurses (n=3) and clinical pharmacists (n=2)) involved in the development and piloting of the tool in a geriatric ward of the study hospital; qualitative framework analysis of the interviews.</td>
</tr>
<tr>
<td>3</td>
<td>Developing a tool and procedure for medication reconciliation and review.</td>
<td>To develop a preliminary medication reconciliation and review procedure and tool</td>
<td>Research team discussions, utilising the literature review and interviews with informants.</td>
</tr>
<tr>
<td>4</td>
<td>Piloting the medication reconciliation and review procedure and the tool.</td>
<td>To explore how the tool and the instructions for the procedure worked in practice.</td>
<td>Observations and feedback from the ward pharmacists: Clinical pharmacists (n=2) completed four reconciliations and reviews. The use of the tool was observed by the student researcher.</td>
</tr>
<tr>
<td>5</td>
<td>Feedback discussions with physicians.</td>
<td>To explore the opinions of the doctors working on the ward during the first pilot on the functionality of the tool and the procedure.</td>
<td>Feedback discussion with the student researcher and physicians (n=3).</td>
</tr>
<tr>
<td>6</td>
<td>The development of the final version of the tool and the procedure.</td>
<td>To use the feedback obtained from the two pilots and to get approval from researchers and practical team for the final tool and procedure.</td>
<td>Feedback discussion with researchers (n=2), clinical pharmacists (n=2) and the geriatrician.</td>
</tr>
</tbody>
</table>

Stage 5: Feedback discussions with physicians

Three physicians who had been working on the study wards during the first pilot were purposively selected to feed back on their perceptions of the medication reconciliation procedure and the tool discussions with one of the researchers (AN). Specific open questions were presented to extract information about medication reconciliation on admission, the role of the clinical pharmacist in medication reconciliation and review procedure and what kind of medication-related issues are important on admission of both pilots to gather information on how pharmacists operated and to ensure the feasibility of the tool. The first pilot was conducted in January 2013 and the second in March 2013. The two clinical pharmacists also provided their feedback to the research team. As is usual in action research, further changes to the procedure and the tool were based on the observations of the researcher and the experiences of the clinical pharmacists who piloted the use of the medication reconciliation and review procedure and the tool and were discussed with the research team.

* The key contents in the Table are selected from the presented medication reconciliation models in relation to the focus of the present study.

Table 2. International medication reconciliation models adapted from the literature.

<table>
<thead>
<tr>
<th>Source of the model</th>
<th>Country</th>
<th>Main contents *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Commission (JC) 2013</td>
<td>USA</td>
<td>The following steps should be covered in the reconciliation process: obtaining information on the current medications, identifying and resolving discrepancies, providing written information on the medications at the time of patient discharge from the hospital.</td>
</tr>
<tr>
<td>Institute for Healthcare Improvement (IHI) 2013</td>
<td>USA</td>
<td>The medication reconciliation process should include three steps: medication verification (collection of medication history), medication clarification (ensuring that medications and doses are appropriate), medication reconciliation (documentation of changes in the orders).</td>
</tr>
<tr>
<td>National Patient Safety Agency (NPSA) 2007</td>
<td>UK</td>
<td>Medication reconciliation should be done to all adult patients admitted to hospital. Pharmacists should be involved in medication reconciliation as soon as possible after admission.</td>
</tr>
<tr>
<td>National Prescribing Centre (NPC) 2013</td>
<td>UK</td>
<td>NPC suggests prioritizing medication reconciliation to certain patient groups; those with long-term conditions, those aged 65 years and over, those on four or more medicines or on complex dosing regimens. The process comprises the “3Cs” - collecting, checking and communicating on the medications.</td>
</tr>
<tr>
<td>World Health Organization (WHO) 2007</td>
<td>International</td>
<td>Reconciling medication should happen within 24 hours of admission. The process should be multidisciplinary and involve patients and their careers. Points of transition that require special attention are: • Admission to hospital • Transfer from the emergency department to other care areas (wards, intensive care, or home) • Transfer from the intensive care unit to the ward • From the hospital to home, residential aged care facilities or to another hospital.</td>
</tr>
</tbody>
</table>

* The key contents in the Table are selected from the presented medication reconciliation models in relation to the focus of the present study.
sion. The physicians were also asked whether they would prefer to receive the medication reconciliation and review recommendations electronically or by paper from the clinical pharmacists.

Stage 6: Feedback discussion with clinical pharmacists and development of the final medication reconciliation and review procedure and the tool
After the second pilot the research team and the two clinical pharmacists held a feedback discussion as described in Ritchie et al. (2003) and Smith (2010). In the discussion, the researchers received feedback on the feasibility and usability of the procedure and the tool. The final versions of the tool (Appendix 1) and the procedure (Appendix 2) were developed by the research group based on the feedback discussions at stages 5 and 6.

RESULTS

Literature review
The international medication reconciliation models and guidelines relevant to the development of the medication reconciliation and review process in this study are presented in Table 2.

Interviews with physicians, nurses and clinical pharmacists
The main themes raised in the individual interviews of physicians (n=2), nurses (n=3) and clinical pharmacists (n=2) were: a) problems in the current medication process and b) the role of the clinical pharmacist. The interviewees recommended that the role of the clinical pharmacist should be significantly increased in the hospital admission process. The tasks should focus more on medication reconciliation and review, and patient care. Other proposals for clinical pharmacists’ contribution to patient care in the admission process were: patient interviews about their medication and possible encountered problems, and identification of symptoms that might be attributed to drug-related problems (DRPs).

The interviewees were concordant regarding the problems experienced, such as lack of an up-to-date process were patient interviews about their medication and guidelines relevant to the development of the medication reconciliation and review process. The interviewees recommended that the role of the clinical pharmacists be present on the wards more often to contribute to patient care with their expertise. This was perceived pivotal to improving patient safety and facilitating both nurses’ and physicians’ work. Additionally, one of the physicians suggested that clinical pharmacists could perform clinical medication reviews focussing on the indications of drugs, their potential interactions and inappropriate medications prescribed to older patients (for example suitability of medicines according to the age and kidney function of a patient). The interviewed clinical pharmacists thought this could be helpful in identifying and solving DRPs (Table 3). During the first pilot, the clinical pharmacists fed back that the procedure was time consuming.

Feedback discussion with physicians between the pilots
Physicians (n=3) participating in the study found the medication reconciliation and review procedure completed by the clinical pharmacists in the first pilot central to the rational and safe medication use. The physicians suggested a concept in which the clinical pharmacist would document their medication therapy related notes and recommendations into the electronic medical record. In this way, also other physicians working at the hospital and other health care providers in outpatient care could later access the notes and recommendations. One of the physicians suggested that a specific page in the electronic patient record should be created for the notes for the medication reconciliation and review; this was implemented. The physicians emphasised that the clinical pharmacists should not only document but also discuss any identified DRPs and recommendations to solve them with the physician in charge of any patient’s treatment. They also suggested that pharmacists should prioritise the recommendations for medication changes for each patient.

Development of the final version of the tool and procedure through the feedback discussion with the clinical pharmacists
The interviewees (n=7) found the medication reconciliation and review procedure to be very useful in solving DRPs among older patients on admission. The clinical pharmacists agreed with the physicians’ opinion suggesting that a specific page should be created for the mediation reconciliation and review in the electronic medical record to promote information transfer. This would support the medication reconciliation and review in a structured way so that the physician could easily see which DRPs are to be addressed.

Consequently, the final versions of the tool and procedure were developed based on the findings of all the previous stages of the study. The final version of the tool (Appendix 3) comprised four main sections: (1) Patient Background (e.g. reason for admission and laboratory data), (2) Patient Interview (e.g. experiences of symptoms from, and problems with, medicines), (3) Medication Reconciliation and Review (i.e. identified DRPs), and (4) Recommendations (i.e. actions to solve DRPs). The final medication reconciliation and review procedure recommends that all parts of the process are completed by a clinical pharmacist who provides recommendations for any medication related changes required to the physicians.

DISCUSSION
Our study introduces a tool and a procedure for medication reconciliation and medication review of older patients’ medications on admission to the geriatric ward of a secondary care hospital. This study also presents a practical action research based method for developing and implementing clinical pharmacy services through multidisciplinary collaboration in clinical environments where such approaches to medication care are novel. The literature describes, similarly, multidisciplinary teams, involving pharmacists, using sophisticated models of medication optimization in countries pioneering in clinical pharmacy (Gillespie et al. 2009, Hellstrom et al. 2012, Kaboli & Fernandes 2012).

The practitioners and nurses interviewed in the study expressed an urgent need for clinical pharmacists as operators in medication reconciliation and review to assure safe and rational use of medications. Special value was attributed to the clinical pharmacists in their contribution to addressing the suitability of medicines according to the age and renal function of a patient, suitable dosages and forms of medication and identification of clinically relevant interactions. Indeed, many studies have recognized

Table 3. Perceived problems in the current medication process and suggested improvements based on the interviews of physicians (n=2), nurses (n=3) and clinical pharmacists (n=2) at first stage of the study.

<table>
<thead>
<tr>
<th>Perceived problems in the current medication process</th>
<th>Suggested improvements to the medication process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients do not remember which medicines they are taking</td>
<td>A clinical pharmacist could interview the patient, family members, physicians and other healthcare professionals and check patient records.</td>
</tr>
<tr>
<td>Patients do not have an up-to-date home medication list with them on admission</td>
<td>A clinical pharmacist could interview the patient, family members, physicians and other healthcare professionals and check patient records.</td>
</tr>
<tr>
<td>Patient medical records are not accurate, up to date, or have discrepancies between different care settings (e.g. care homes, primary and secondary care, and private and public healthcare providers)</td>
<td>A clinical pharmacist could reconcile the medication on hospital admission.</td>
</tr>
<tr>
<td>Polypharmacy (increased risk of therapeutic duplication, interactions, prescribing without indication or inappropriate therapy)</td>
<td>A clinical pharmacist could clinically review the medication.</td>
</tr>
<tr>
<td>Incorrect medication, incorrect dose, route, or frequency especially in aged patients</td>
<td>A clinical pharmacist could clinically review the medication.</td>
</tr>
<tr>
<td>Differentiating between co-morbidities and adverse side effects</td>
<td>A clinical pharmacist could have an important role in identifying whether the patient is suffering due to illness or having an adverse side effect, even the rare adverse effects could be noticed.</td>
</tr>
</tbody>
</table>

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the important role of a clinical pharmacist in these processes of care (Beckett 2012, Aag 2014, Leguelin-Blache 2014). Moreover, it is reported that clinical pharmacists collect more complete and accurate information on patients’ medications when compared to nurses and physicians due to the consultation of more information sources in medication reconciliation processes (Lizer & Brackhill 2007, Steurbaut et al. 2010).

Our study is timely as the number of older patients needing primary care level hospital care with special expertise in geriatrics is increasing in Finland as well as in all over the world. Geriatric patients in particular have usually many DRPs and, therefore, there is a specific need to ensure that medications are reconciled and reviewed during their stay in hospital (Knez et al. 2011, Spinewine et al. 2012, Bulajeva et al. 2014). It is reported that the geriatric patients benefit most from medication reconciliation and medication reviews (Gillespie et al. 2009, Steurbaut et al. 2010, Mueller et al. 2012). Indeed, the medication reconciliation and review procedures were combined to ensure that up-to-date information of patients’ medications and possible discrepancies are brought to the attention of the physician during the hospital admission. This represents a more thorough approach to medication optimization and ensuring medication safety while many hospitals have limited the process to medication reconciliation (Nester et al. 2002, Gleason 2004, Beckett 2012). The admission phase of the medication process has been identified as especially prone to medication errors due to insufficient information about the patients’ previous medications (Tam et al. 2005, Steurbaut 2010). This emphasizes the importance of the identification of patients’ up-to-date medication lists. Equally important would be to cover possible inappropriate medications, interactions or other DRPs in the current medication to avoid further discrepancies with the newly prescribed medications during the hospital stay (Karapinar-Carkit et al. 2010). Moreover, DRPs are a common reason for hospital admissions, especially in geriatric patients (Gillespie et al. 2009, Smart et al. 2010, Chau et al. 2016).

The participating physicians called for clearer and more accessible documentation of medication-related problems identified by the pharmacist on hospital admission. The physicians suggested that there should be a clearly identified place in the electronic medical records for a ward pharmacist to document their notes and recommendations in a standardised way. This has been identified as a central success factor of a well-functioning medication reconciliation and review procedure also in other studies (Gillespie et al. 2009, Steurbaut et al. 2010, Meguerditchian 2013, Leguelin-Blache 2014). Indeed, medication reconciliation and review on admission improves the quality and safety of medication use throughout a patient’s hospital stay until discharge (Knez et al. 2011). Electronic medical records shared between primary and secondary care enable also primary care physicians to read notes written by clinical pharmacists. Thus, the procedure can also benefit the quality and safety of medication use of the home-dwelling aged – a healthcare domain that would urgently need adoption of clinical pharmacy services in many countries (Chau et al. 2016).

**Strengths and limitations**

While the study was conducted on two geriatric wards, providing secondary and primary care services, in a Finnish middle-sized hospital, the laws and regulations governing healthcare are universally valid, and, thus, the admission processes and practices might not vary too much across different settings in Finland. Indeed, the medication reconciliation and review procedure and the tool could be transferable to other healthcare settings in Finland and to other countries as the development of the procedure and the tool was based on international models (Table 2). Thus, with some additional local adaptation, the tool could also be useful for medication reconciliation and review of geriatric patients in all types of wards and settings. With the number of geriatric patients steadily increasing in Finland and many other countries, the need for the use of expertise of clinical pharmacists, and the development procedure and the tool, in patient care increases.

The tool was piloted independently by two clinical pharmacists on a secondary and primary care ward, representing the possibility for different ways of reconciling and reviewing medications, and hence, influencing the findings of the study. Indeed, the different experiences and perspectives of the clinical pharmacists provide rich data (Ritchie et al. 2003) on the feasibility of the use of the medication reconciliation and review procedure and the tool in practice, enhancing the feasibility of their use in other settings. On the other hand, no clinically relevant differences in the clinical pharmacists’ contribution to patient care were observed in the pilots, showing the medication reconciliation and review were completed in a standardised way.

While the experiences of this study might not be directly transferable into countries and healthcare systems where pharmacists involved in multidisciplinary teams are not an everyday practice, this practical action research based method for developing and implementing clinical pharmacy services can also be used in settings where such approaches to medication care are novel. Our study successfully employed an action research based method facilitating the development and implementation of an innovative medication reconciliation and review procedure and tool. The central key benefit of the chosen method was its ability to involve and commit local healthcare professionals, physicians, nurses and pharmacists in the development of the procedure and the tool and in the change of their own and their co-workers’ practices.

**Recommendations**

The present work and previous studies have found medication reconciliation time consuming (Meguerditchian 2013). Thus, standardisation of the medication reconciliation process and more well-organised use of health information tools could improve the efficiency of the process. While our medication reconciliation and review study might be too comprehensive and time consuming (time consuming for the first use at the start of the service) for use at admission of every aged patient, the alternative courses of action would be to develop a shorter procedure with a simple check-list outlining the most central items to be covered on admission for all geriatric patients and target a more limited group of geriatric patients, for example, based on screening of DRP-related admissions (Gillespie et al. 2005, Aag et al. 2011). In our research, the current procedure on admission might not be too comprehensive and time consuming (this was the case). Hence, the medication reconciliation and review procedure might be too comprehensive and time consuming for the current research to identify which patients benefit the most from the current medication reconciliation and review procedure on admission.

There is also a need to promote the use of clinical pharmacists and their competence in patient care teams. While the number of clinical pharmacists is on the increase in Finnish hospitals (Scheep 2018), the numbers might not be sufficient for every patient to benefit from clinical pharmacist-led medication reconciliation and review. In the future, medication reconciliations and medication reviews should be documented electronically to facilitate sharing and transferring the most accurate information on patients’ medications between different healthcare professionals and settings, and patients and their carers.

**Conclusions**

The study introduces a novel tool and procedure for medication reconciliation and review on hospital admission of geriatric patients that has been developed and piloted with a multidisciplinary healthcare team, using an action research based method. The tool and the clinical pharmacist-led procedure were found feasible to use and central to the rational use of medicines. While multidisciplinary team work ensured the implementation, medication reconciliation and reviews were recommended to be completed by clinical pharmacists who provide their medication-related recommendations to the physicians.
Tavoite: Tutkimuksen tavoitteena oli kehittää työkalu ja toimintamalli lääkityksen arviointiin iäkkäin potilaan potilaan tultaessa perusterveydenhuollon osastolle.

Aineisto ja menetelmät: Työkalun ja toimintamallin kehittämisessä käytettiin toimintatutkimusmenetelmää. Tutkimus tehtiin keskikokoisessa terveyskeskus sairaalassa. Kehitysprosessin osallistuivat yhteisössä työskentelevät hoitajat ja osastofarmaseutteja (n=7). He tunnistivat ongelmia nykyisissä osastolle tulon yhteydessä tehtävissä lääkityksen arvioinnissa ja kehitettiin alustavan työkalun versio.


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APPENDIX 1. Tool for Medication Reconciliation and Review on Admission for Pharmacists

Date: ________________________    Patient code: ________________________

Starting time for collecting preliminary data: ________________________

Time pharmacist used collecting preliminary data: ____ minutes

Basic patient data:

Year of birth: ________________________

Gender: [□ Female   [□ Male

Date of admission: ________________________

Reason for admission: _________________________________________________________________

Other diagnoses: ___________________________________________________________________

__________________________________________________________________________________

__________________________________________________________________________________

Place where admitting:

[□ Primary care   [□ Home care services   [□ Nursing home   [□ Long-term institution

Admitting from central hospital  [□ No  [□ Yes

Medicine allergies:  [□ No  [□ Yes: _______________________________________________

Kidney function:  GFR _____ ml/min    classification ___________

Length: ___________ m    BMI: __________ kg/m^2

<table>
<thead>
<tr>
<th>Blood pressure (sitting)</th>
<th>result/date</th>
<th>result/date</th>
<th>result/date</th>
<th>comments</th>
</tr>
</thead>
</table>

| Pulse                    |             |             |             |          |
|                          |             |             |             |          |

| Weight                   |             |             |             |          |

>
Number of deleted medications ____________  

**Medication reconciliation:**  
Patient code: ____________

**PATIENT INTERVIEW:**
Starting time of interview: ____________  
Time pharmacist used interviewing the patient: ____________ min  
What's the reason you are in hospital?  
__________________________________________________________________________________

What kind of condition have you had at home /in nursing home?  
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Patient is asked to tell which medicines or over-the-counter-medicines she/he is using, when, why and what is the dose. Patient is asked if she/he is using any creams, inhalations, nasal sprays, sleeping pills etc. In your medication record there is a medicine like this (name of medicine), have you been using it? (The aid is medication list in the electronical medication record, which is enclosed to this form. All the notes are made to this medication list.)

In which indication do you use this medication?  
__________________________________________________________________________________

Further notes:  
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

With who do you speak about your medicines? From who do you ask about your medicines?  
Have you got advices using your medicines?  
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________


<table>
<thead>
<tr>
<th>Laboratory test</th>
<th>result/date</th>
<th>result/date</th>
<th>result/date</th>
<th>Reference value</th>
</tr>
</thead>
<tbody>
<tr>
<td>P-Krea</td>
<td></td>
<td></td>
<td></td>
<td>50-90 μmol/l</td>
</tr>
<tr>
<td>P-X</td>
<td></td>
<td></td>
<td></td>
<td>3,5–4,4 mmol/l</td>
</tr>
<tr>
<td>P-Na</td>
<td></td>
<td></td>
<td></td>
<td>137–144 mmol/l</td>
</tr>
<tr>
<td>P-INR</td>
<td>varfarin treatment: 2-3,5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| B-Hb            | f: 117–155 g/l  
m: 134–167 g/l |
| E-MCV           |             |             |             | 82-98 fl       |
| P-CRP           |             |             |             | <10            |
| B-Trom          |             |             |             | 150–360 E9/l   |
| P-Alb           |             |             |             | 40-69 y: 36-45 g/l  
|                 |             |             |             | over 70 y: 34-45 g/l |
| P-Gluk          |             |             |             | 3,9-6,4 mmol/l  |
| P-Hba/A1c       |             |             |             | 20–42 mmol/ml  
|                 |             |             |             | DM: 42–53 mmol/ml |
| P-ALAT          |             |             |             | 10–45 U/l       |
| P-Bil           |             |             |             | 4-20 mmol/l     |
| P-BNP           |             |             |             | <100           |
| P-Uraat         |             |             |             | 155–400 mmol/l  |
| P-Kol           |             |             |             | <5,0 mmol/l     |
| P-Kol+HDL       |             |             |             | > 1,00 mmol/l   |
| P-Kol-LDL       |             |             |             | < 3,00 mmol/l   |
| P-Trigly        |             |             |             | < 2,00 mmol/l   |
| S-D-25          |             |             |             | 25-175 nmol/l   |
| Ca++            |             |             |             | 1,05–1,20 mmol/l |
| S-B12-Vit       |             |             |             | 140–490 pmol/l  |
| S-TSH           |             |             |             | 0,4-4,0 mU/l    |
| S-T4-V          |             |             |             | 9-19 pmol/l     |
| fE-folaat       |             |             |             | <360 nmol/l     |
| S-GT            |             |             |             | f (> 40 v): 10-75 U/l  
|                 |             |             |             | m (> 40 v): 15-115 U/l |
Do you take care taking your medicines yourself or is someone helping you? Do you use any medications aids (for example dispenser)? In which stages do you feel you need help?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
How have you managed with your medicines? What kind of problems you may have had with your medicines?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Have you had any symptoms (at home /nursing home) related to your illnesses or any other symptoms?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Do you smoke?  No  Yes: How much? ________________
Do you use alcohol?  No  Yes: How much? ________________
Is there something you would like to talk related to your medicines?
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Other notices:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
The medication reconciled and medication review:
Patient code: ____________ Starting time of medication reconciliation and review: ____________
Time pharmacist used in medication reconciliation and review (does not include tasks to do prior meeting the patient or patient interview): ____________ minutes

<table>
<thead>
<tr>
<th>Nr</th>
<th>Indication</th>
<th>S/T/K/I</th>
<th>Consumption</th>
<th>Problem (code + description)</th>
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<td></td>
<td>Not knowledge about use</td>
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</tbody>
</table>

S = Regularly used medication  
T = On demand medication  
K = Cure  
I = Self care medication  

A. unnecessary medication  
B. need additional drug therapy  
C. medication without effectiveness  
D. incorrect dose, too low  
E. incorrect dose, too high  
F. incorrect length of therapy  
G. incorrect frequency  
H. incorrect dosing time  
I. adverse effect  
J. interaction  
K. therapeutic duplication  
L. incorrect medicine  
M. problems with compliance  
N. need for monitoring  
O. need for counselling  
P. another problem, specify (choose all the suitable alternatives)

Any problems with reconciliating medication:

- [ ] No  
- [ ] Yes, description:

______________________________

______________________________

Notices:

______________________________

______________________________

Cautions with medication:

Patient code: ____________

<table>
<thead>
<tr>
<th>Medicine (number)</th>
<th>Cautions and change suggestions:</th>
<th>Change suggestions approved:</th>
<th>Approved with changes and/or later:</th>
<th>Rejected with arguments:</th>
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</table>

Immediate  
Later  
Not at all

Approved with changes and/or later :

Immediate  
Later  
Not at all

Rejected with arguments:  

Immediate  
Later  
Not at all
Appendix 2. Instructions

Medication reconciliation and review

1. HOW TO CHOOSE PATIENTS: Amongst the patients admitted, those who fulfill the following criteria will be selected:
   • over 65 years
   • severe diseases and/or using at least 5 medicines when admitted
   • is capable to communicate with a clinical pharmacist (for example, no problems with language or acute confusion)

The choice of suitable patients is made by a physician, nurse or clinical pharmacist. To avoid overlapping work the choice of patient is announced to a physician and nurses caring for the patient or who in other cases would clarify the medication.

2. CODING THE PATIENT: The patient chosen will be given a patient code and the code will be documented on both a coding list and on each page in the data collection form.
   for example 1001A (ward 1, patient 001, clinical pharmacist A) or 2001B (ward 2, patient 001, clinical pharmacist B)

3. PATIENT BACKGROUND DATA: The patient background data will be entered on the first page of the data collection form. The medical records and other sources available are used as the source of information.
   • The calculator in the Renbase-data base is used for determining the GFR-value.
   • Only essential laboratory values are documented.

Time taken for collecting and documenting the patient background data and deleting unnecessary medicines in the medicine list will be documented in the upper part of page one of the data collecting form.

4. INTERVIEWING PATIENT: The patient is interviewed using questions on page two of the data collecting form and with the help of the medication list in the medical records (Pegasos). The medication list used will be attached to the data collecting form. A/the family member or other career can be interviewed if necessary. It is meant to take about 20 minutes to interview the patient. Time consumed in interviewing the patient will be documented in the upper part of page two in the data collecting form.

5. MEDICATION RECONCILIATION: Current medication will be reconciled with information obtained from the previous point of care, with help by interviewing the patient and/or family member, medical records, medication packages the patient possibly has with him/her, prescriptions or administration aids. The medication reconciled will be documented in the medication list used when interviewing the patient. Medicines in the medicine list will be numbered sequentially to enable them to be marked with numbers in a table in the data collecting form (pp. 3-5).

The medication list will be attached to the data collecting form.

6. MEDICATION REVIEW:
   (table in data collecting form pp. 3–5):
   1) Indication: It will be established if there is an indication of medication. The purpose is to find out whether the medication is necessary for the patient.
   2) Starting date of medication: It will be established whether medication use has started over or under a year ago. Also the starting date of the medication will be documented if it’s available. With this data it is possible to review whether a new symptom could be an adverse drug reaction. New medications started within a year will more likely cause new adverse drug reactions than those started over a year ago.
   3) Regularity of medication use: It will be established whether the physician has meant the medication to be used regularly, as a cure or only if needed. In this part it will be documented if the medicine is a without prescription medicine.
   4) Medication use: It will be established, based on patient interview data, how a patient really uses a medicine. Is a patient using a medicine or not? If a patient is not using the medicine ordered for them, it will be documented “should be in use”. If a patient is using the medicine which should have been stopped, it will be documented “should not be in use”. If it is not clear, based on the patient interview, how the patient is really using the medicine, it will be documented “no knowledge of use”. If the medication is paused for example for a hospital stay, it will be documented “paused”.
   5) Recognition of the problem: Possible drug-related problems will be determined using at least SFINX–PHARAO- and Renbase-databases in Terveysportti, Duodecim medicine database and Fimea medicine database for the elderly.

   To determine potential problems the following will be checked:
   • Are all the medicines necessary for the patient?
   • Are there any missing drugs in the medication list which should be in use concerning the diagnosis and care guidelines?
   • Are the medicines suitable for the patient and is the dosage suitable, taking account of age, indication and possible liver or renal impairment?
   • Has the patient medicine duplications?
   • Are there any interactions between medicines?
   • Are the dosing times and intervals correct?
   • Do symptoms or laboratory values indicate that the medication doesn’t have sufficient effect?
   • Could some of the symptoms in the patient have an adverse drug reaction?

6) Making a change suggestion: The recognition of a drug-related problem could trigger a change suggestion to solve the problem. Change suggestions and other items taken into account will be documented in a table on a data collecting form (page 8).

Time consumed for reconciling and reviewing medication will be documented on a data collecting form page 3. It will not include time consumed for collecting patient background data or patient interviewing, which have been documented in earlier pages.

7. DISCUSSION ABOUT CHANGE SUGGESTIONS: When the medication reconciliation and review has been carried out, detected items and possible medication change suggestions resulting from them will be discussed together with the physician responsible and with a nurse, if needed. The physician will approve or reject the change suggestions. A decision made by the physician and arguments for rejecting the decision and possible changes for approved suggestions will be documented in the data collecting form (p. 6). In addition, it will be documented whether the physician approved the changes to be done at once or later.

It will be documented in the medical records whether the patients’ medication has been reconciled and reviewed and which notes were made in optimization and which medication changes were made or are planned to be done. If there has been a discussion with the physician responsible about notes and changes it will be enough to write a short description. If there has been no time to meet the physician or changes are meant to be carried out in the next step of care, a more accurate description will be recorded about notes and change suggestions. Therefore the next step of care will get the information about medication changes and can implement them when necessary.