EMERGENCY NURSES ASSOCIATION

Position Statement

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Medication Management and Reconciliation in the Emergency Setting

Description

Medication reconciliation remains a patient safety issue worldwide. In the United States, The Joint Commission (TJC) began pivoting focus from medication reconciliation towards overall medication management when introducing the seven foundations for safe quality transitions of care in 2013 (Agency for Healthcare Research and Quality [AHRQ], 2019). Medication management ~~is~~ as one of the foundations broadly includes activities such as verification, prescribing, administration and monitoring used in conjunction with the current National Patient Safety Goals (NPSG) on medication reconciliation. Medication management is intended to safeguard patients from medication errors and adverse drug events (ADEs) during transitions between care settings, including emergency departments, urgent cares centers, other ambulatory emergency settings or other types of care settings (AHRQ, n.d., 2019; Labson, 2015; Mekonnen, McLachlan, & Brien, 2016; Nguyen, C; Nguyen, T., et al., 2017; TJC, 2006, 2013, 2016, U.S. Centers for Medicare & Medicaid Services [CMS], 2018; World Health Organization [WHO], n.d., 2019). Medication management is more than just an accurate medication history or reconciliation. The three phases of the reconciliation process are imperative to ensure effective medication management and obtaining an as complete and accurate medication history is the first step (AHRQ, n.d.). Medication management and reconciliation in the emergency setting is a collaborative effort between nurses, physicians, pharmacists, and patients to reduce risk for patients in healthcare settings and at home (AHRQ, n.d., 2019; Mardani et al., 2020; Mekonnen, McLachlan, & Brien, 2016; TJC, 2013, 2016, 2020, Ortmann et al., 2021). This process requires that healthcare providers, including emergency nurses, communicate clearly with patients and their caregivers about the importance of maintaining an accurate medication list (Mardani et al., 2020; Mekonnen, McLachlan, & Brien, 2016; TJC, 2015). An accurate medication list includes all medications including prescriptions, over-the-counter (OTC) medications, supplements, herbals, medicinal marijuana, known allergies and last dose.

For patients who present to emergency care settings, an accurate medication history is imperative for patient safety and to enable appropriate evaluation and treatment. However, in the often busy and chaotic emergency setting where time is essential, obtaining accurate and complete medication history can be an arduous process. With medication information coming from multiple sources (patient, family, caregivers, multiple pharmacies, etc.) and other conflicting or competing patient care issues, errors in the communication of significant information at key transition points are possible and can be problematic (Institute for Safe Medication Practices Canada [ISMP Canada], 2021; Lee et al., 2015; Mardani et al., 2020; Markovic et al., 2017; Mekonnen, McLachlan, & Brien, 2016; Redmond et al., 2020; WHO, 2019). Most patients who present to an emergency department enter through the hospital's triage area. Triage is a process to rapidly sort patients based on patient acuity and resources needed (Emergency Nursing Association [ENA] & American College of Emergency Physicians [ACEP], 2017; Gilboy et al., 2020). Triage is intended to identify life-threatening or high-risk situations that require immediate intervention to save

lives. When triaging patients, the emergency nurse obtains a brief assessment along with any other relevant medical history and may obtain a focused medication history pertinent to the chief complaint. A more comprehensive medication history (the first phase of the reconciliation process) ~~can~~ should be obtained after the initial triage process and stabilizing care prior to admission or other disposition. Evidence demonstrates that collecting a medication history during triage is more likely to result in errors in the patient record than pharmacy-led acquisitions of medication information (Digiantonio et al., 2018; Hart et al., 2015; Markovic et al., 2017; Mazer-Amirshahi et al., 2011). In two studies, omission of medications or doses were the most frequent errors attributed to nurses completing the medication history (Digiantonio et al., 2018; Hart et al., 2015). These findings are due in part to time constraints. Evidence shows that completing an accurate and complete medication history can take 20 to 79 minutes (Digiantonio et al., 2018; Nguyen, C., et al., 2017; Patel et al., 2018; Rubin et al., 2016). The time constraints lead to debate about whether the emergency care setting is the appropriate place to obtain a detailed medication history (Lee et al., 2015).

Many studies and authoritative bodies in the United States as well as internationally indicate that pharmacists or pharmacy technicians are best suited to compile the medication history and subsequently complete the reconciliation process (AHRQ, 2019; American Society of Health-System Pharmacists [ASHP], 2011, 2018; Digiantonio et al., 2018; Hart et al., 2015; International Pharmaceutical Federation (FIP), 2020, 2021; Kramer et al., 2014: Markovic et, al., 2017; Mekonnen, McLachlan, & Brien, 2016; National Institute for Health and Care Excellence [NICE], 2015, Nguyen, C, et al., 2017; Nguyen, T. L., et al., 2017; Ortmann et al., 2021; Patel et, al. 2018; Rubin et al., 2016; WHO, 2019 & n.d.). Position statements from multiple prominent healthcare associations are substantiated by research findings. When pharmacists or pharmacy technicians are available in the emergency setting, their participation in medication management not only improves the medication reconciliation process but effectively improves patient safety and reduces medication errors in the hospital setting (ACEP, 2020; ASHP, 2011, 2018; Benjamin et al., 2018; FIP, 2020, 2021; Ortmann et al., 2021). Despite these findings, there are still significant challenges to establishing a dedicated pharmacy staff present in the emergency setting to participate in the medication management process.

In addition to time constraints, there are numerous barriers experienced by emergency nurses in collecting medication histories, including high patient volumes and patient care activities. Not only is the emergency care setting not the most opportune time to collect an accurate medication history, but emergency nurses should not perform the actual reconciliation phase as this is completed by the licensed independent provider (LIP). Emergency nurses can actively contribute to the medication management process through their performance of assessments, interventions, reevaluations, patient education, and discharge. Emergency nurses play an important role in empowering patients to understand the role they play in the medication management process as well as helping them to understanding the potential risks of drug/drug or drug/food interactions (U.S. Food and Drug Administration [FDA], 2019; Labson, 2015; Mardani, Griffiths, & Vaismoradi, 2020; Redmond et al., 2020; TJC, 2015). Emergency nurses can educate patients and/or their caregivers on the importance of maintaining and keeping with them an accurate medication history including, dosage and frequency of all prescriptions, OTC drugs, supplements,

medicinal herbs, and other substances (U.S. FDA, 2019; Redmond et al., 2020; TJC, 2015). Additionally, emergency nurses are in a position to advocate for best practices in the medication management process to ensure patient safety.

ENA Position

It is the position of the Emergency Nurses Association that:

1. Medication management is a collaborative partnership between multiple healthcare disciplines including nurses, physicians, and pharmacists

2. Ideally, pharmacists or pharmacy technicians are the preferred clinicians to complete the medication history and medication reconciliation.

3. Emergency nurses can support medication management by collaborating with prescribers and facilitating two-way communication regarding any medication changes, additions, or deletions to the patient's current medication regime to patients, families, caregivers and/or transferring facilities especially the elderly polypharmacy and other high-risk patients.

4. Emergency nurses can support medication management by collaborating with providers to ensure that daily medications are ordered and being administered to admission patient being held in the department.

5. Emergency nurses obtain an accurate and complete medication list if possible after the initial triage process.

6. Triage is intended to rapidly identify life-threatening or high-risk situations. Thus, collection of comprehensive medication history can be delayed and performed after the patient is stable.

7. Emergency nurses educate patients, their families, and caregivers on the importance of keeping an accurate medication list with them at all times.

8. Emergency nurses participate in policy and guideline development to assure optimal medication management processes are developed.

9. Emergency nurses collaborate with pharmacists and facility leadership to advocate for pharmacy-led medication management as best practice.

Background

Medication reconciliation is a complex multi-pronged process. The Joint Commission (TJC) National Patient Safety Goal (NPSG) #8 to *"accurately and completely reconcile medications across the continuum of care,"* (TJC, 2006. p. 2) has evolved since first introduced in 2005. When first announced, there was little direction as to the who, what, when, where, and how to complete the process, which led to, and continues to create, confusion amongst emergency nurses and other healthcare providers (Institute for Safe Medication Practices [ISMP], 2006; Lee et al., 2015). As initially defined by TJC, the process of medication reconciliation was intended to reduce discrepancies and prevent medication errors but was complex, laborious, and did not necessarily result in accurate information (Lee et al., 2015; Markovic et al., 2017). Because of difficulty in implementation the lack of proven strategies for success TJC, in 2011, suspended the original NPSG and incorporated medication reconciliation into NPSG #3 (AHRQ, 2019). This safety goal acknowledges the challenges of reconciliation yet still requires a "good faith effort" to obtain a medication history (the first step) on arrival and then comparing it with those medications that are prescribed (the reconciliation stage). This is done to identify and resolve discrepancies and to improve the safe use of medications across the continuum of care (AHRQ, n.d., 2019; Labson, 2015; TJC, 2020). Factors such as unreliable patient provided information, inaccurate information from outside sources, and ineffective communication amongst healthcare providers have been identified as barriers to collecting accurate medication histories (Digiantonio et al., 2018; ISMP, 2006; Monte et al., 2015; Redmond et al., 2020). According to the Institute for Healthcare Improvement (IHI) (IHI, 2015, 2021) and ISMP (2005) inaccurate medication histories may cause up to 50 percent of all medication errors and as much as 20 percent of the ADEs seen in the hospital setting. Furthermore, numerous studies have found that medication histories collected by nurses or healthcare personnel other than pharmacy staff were less accurate (Hart et al. 2015; Monte et al., 2015), had higher rates of discrepancies (Digiantonio et al., 2018; Kramer et al., 2014), and higher rates of omissions (Rubin et al., 2016) compared to pharmacy staff-led history collection. Preventing medication errors, ADEs, or other harm to patients resulting from an inaccurate medication history should always be the primary goal of medication management regardless of what specialty completes the task.

Emergency department medication reconciliation and management in the United States and internationally is complex. Policies aimed at both are impacted by various factors including the country of origin, the accrediting body used by each hospital, and the various regulatory agencies definitions of what medication reconciliation or medication management entails, all have influence over policies and protocols in the emergency department. The International Pharmaceutical Federation (FIP) (2021) lists six different definitions of medication reconciliation. Regardless of these factors accurate medication history, management, and reconciliation depends on emergency nurses around the world to understand their individual facility, country, and regulatory agency guidelines, policies, and procedures.

Overall, medication management is a collaborative, cooperative partnership between multiple healthcare disciplines, including nurses, physicians, and pharmacists, to ensure medication safety through effective communication. It is essential that information given to a patient, family, caregiver, transferring, or

receiving facility include changes, additions, or deletions to the patient's current medication regime. Emergency nurses need to continue advocating for patient safety measures that protect the patient and enable the nurse to be actively engaged in processes without unnecessary barriers.

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