FRAMEWORKS
in Health and Quality

Schizophrenia Relapse Reduction Program

Medication Reconciliation for People With Schizophrenia

This resource is provided for informational purposes only and is not intended as reimbursement or legal advice. You should seek independent, qualified professional advice to ensure that your organization is in compliance with the complex legal and regulatory requirements governing health care services, and that treatment decisions are made consistent with the applicable standards of care.

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Medication reconciliation is a patient-centered process focusing on patient safety that requires an interdisciplinary, collaborative approach.[1,2]

What Is Medication Reconciliation?

Medication reconciliation is the comprehensive evaluation of a person's medication regimen any time there is a transition of care, a change in site of care, existing orders are rewritten or adjusted, or a change in therapy.[1,2]

The primary objective is to avoid medication errors, which include[1,2]:

- **omissions**
- **duplications**
- **dosing errors**
- **drug interactions**

Reconciliation consists of reviewing a person's complete medication regimen at admission or when the person is first seen and comparing it with the regimen being considered for the new setting of care or discharge. It includes both prescription and nonprescription medications. This evaluation can also serve as a way to observe compliance and adherence patterns.[1,2]

The Impact of Medication Reconciliation

When there is a lack of consistency in documenting medication histories and performing medication reconciliation, a variety of medication-related problems may occur.

Evidence suggests that:

- **An estimated 1.5 million preventable adverse drug events (ADEs) occur annually as a result of medication errors, incurring an estimated cost of more than $3 billion (2006 dollars) per year in extra hospital costs.[3]**
- **An estimated half of all hospital-related medication errors and 20% of all ADEs in the hospital have been attributed to poor communication at transition points and interfaces of care.[4]**

The goal of medication reconciliation is to obtain and maintain accurate and complete medication information and use this information within and across the continuum of care to help ensure safe and effective medication use.[2]

The Challenge of Schizophrenia and Medication Reconciliation

Medication is an important part of the treatment for schizophrenia, and the timely and accurate prescription, receipt, and use of medication is key for a person with schizophrenia. Missing doses, duplicating therapies, or taking medication incorrectly can lead to serious problems for patients, including worsening of symptoms, relapse, and hospitalization. It can also interfere with a person's opportunities to participate in rehabilitative, educational, and vocational programs.[5]

As a person with schizophrenia moves from inpatient care settings to community-based services, continuity of therapy can be at risk. Too often, treatment histories have not been transferred from one provider to another, or patients have an insufficient supply of medication, which may lead to an interruption in or even a discontinuation of care.[5]

In one survey (N=76) of psychiatrists, discharge planners, and intake coordinators across 4 states, it was found that 50% of people with schizophrenia who were discharged from a sampling of psychiatric hospitals did not appear to participate in the community-based programs to which they were referred.[5]

The Medication Reconciliation Process – Hospitals, Physicians, and Community Mental Health Centers Working Together

Hospitals, physicians, and community mental health centers (CMHCs) should all work together in obtaining and sharing medication information. As people with schizophrenia move from different sites of care, the need for this information is great.

Effective medication reconciliation requires coordinated communication and a process of continuous quality improvement.[2]

The CMHC is often dependent on the hospital and the patient/caregiver for receipt of medication information. Likewise, the CMHC may be an important source of medication information for hospitals in the event of hospitalization of a person with schizophrenia.

As hospitals, physicians, and CMHCs work collaboratively, the following reminders may help to improve the reconciliation process:

- **Involving the person with schizophrenia/caregiver, create a complete list of his or her current medications (prescription and nonprescription) at admission or entry to your site of care whether a hospital, physician, or CMHC.[6]**
- **Compare medications ordered for, administered to, or dispensed to the person with schizophrenia while under the care of the organization with those on the list. Resolve any discrepancies.[6]**
- **Hospital teams should give physicians and/or the CMHC advance notice about a discharge and invite them to discharge-planning meetings.[5]**
- **Hospital teams should ensure the medication list is reconciled and communicate it to the physician and/or CMHC. Include[6]:**
  - **medications the patient was taking upon admission**
  - **any new medication or changes to the medications that occurred during the inpatient stay, including any discontinuations/deletions or suspensions**
- **The complete list of medications should also be provided to the person with schizophrenia and/or his or her caregiver upon discharge from the hospital.**
- **The physician and CMHC should check the medication reconciliation list again to make sure it is accurate and in concert with any new medications to be ordered or prescribed, and communicate/reinforce all changes to the person with schizophrenia and/or his or her caregiver.**

Example Medication Reconciliation Forms

These medication reconciliation forms are examples of a comprehensive approach to tracking medication at admission and discharge. These examples can serve as guidelines to reassess your medication reconciliation procedures or to supplement your existing forms.

At Admission

Admissions Medication Reconciliation Form

☐ STAT

Patient Name: _____

Prior to admission, list below ALL of the patient's medications including over-the-counter medications and herbal supplements. New medications and medication changes should be written on this form also.

Obtain complete medication list.

Source of Medication List: (check all used)

☐ Patient medication list
☐ Patient/family/caregiver recall
☐ Medication administration record from facility
☐ Primary care physician list
☐ Previous discharge papers
☐ Other

Dose Resolution:

☐ Called pharmacy
☐ Called primary care physician
☐ Reviewed bottle

Allergy	Reaction

Medication history recorded/verified by: _____ Date: _____

Enter patient's complete medication list including any for schizophrenia.

Medication Name	Dose (mg, mcg, etc)	Route (PO, GT, SC, IV, IM)	Frequency	Last Taken (Date/Time)	Outpatient: Preadmission **Inpatient:** Complete as PHYSICIAN ORDER on admission	Reason for Medication
☐ On no medications at home ☐ Unable to obtain history Reason:						
					C DC N	

Indicate whether each medication should be continued or discontinued or if it is a new order.

C=continued; **DC**=discontinued; **N**=new order.

The above medications have been reconciled to determine if any items should be discontinued because of contraindications or interactions with treatment or new medications.

Outpatients:

Medications reconciled at admission: _____ Date/Time: _____

Medications reconciled at discharge and instructions provided to patient: _____ Date/Time: _____

Inpatients:

☐ Verbal/Telephone order: _____ Date/Time: _____

Physician signature: _____ Date/Time: _____

Nurse signature: _____ Date/Time: _____

Be sure to capture the full medication list on the Discharge Medication Reconciliation Form (see page 6).

At Discharge

Discharge Medication Reconciliation Form

Patient Name: _____

☐ Stat Account/Patient #: _____

Room/Bed: _____ Age: _____ ☐ Male ☐ Female

Medication Name	Dose (mg, mcg, etc)	Route (PO, GT, SC, IV, IM)	Frequency	Last Taken (Date/Time)	Outpatient: Preadmission **Inpatient:** Complete as PHYSICIAN ORDER on admission	Reason for Medication
☐ On no medications at home ☐ Unable to obtain history Reason:						
Preadmission Medications						
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
Hospital Medications						
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
Discharge Medications (Those continued, restarted, or newly ordered)						
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	
					C DC N	

C=continued; **DC**=discontinued; **N**=new order.

☐ Verbal order ☐ Telephone order: _____ (Print name) Date/Time: _____

Physician signature: _____ Date/Time: _____

Nurse/Discharge planner signature: _____ Date/Time: _____

Enter the patient's complete medication list including those the patient was taking prior to admission and those ordered while hospitalized.

Indicate which medications were discontinued, or changed that should be continued or restarted at discharge. Also include any new medications that may have been ordered at discharge. Remind the patients that any discontinued medications should no longer be taken.

Schizophrenia can have a profound effect on patients' lives and on the lives of those who care for them. Since medication and adherence to it play such a potentially big part of successful treatment, it is important that treatment teams continue to work together to help address any medication reconciliation issues.[5]

Additional Resources

TeamSTEPPS: This comprehensive program, available through the Agency for Healthcare Research and Quality (AHRQ), helps treatment team participants at the facility level to improve communication and teamwork skills. It provides materials and a training curriculum. http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/instructor/essentials/implguide.html.

The Joint Commission Center for Transforming Healthcare: Formed in 2009, the Center analyzes the causes for disconnects in care and aims to improve patient hand-offs by offering targeted solutions to the problems that occur during transitions in care. www.centerfortransforminghealthcare.org.

The Schizophrenia Patient Outcomes Research Team (PORT) Treatment Recommendations: The recommendations are specifically designed for treating patients with schizophrenia and are based on existing scientific evidence. http://www.ahrq.gov/research/findings/final-reports/schzpatt/recommendations.html.

Joint Commission Accreditation Program: Hospital National Patient Safety Goals: The Joint Commission issued the National Patient Safety Goals for Behavioral Health, which include key metrics on medication reconciliation. http://www.jointcommission.org/standards_information/npsgs.aspx.

References: 1. Chen D, Burns A, for the American Society of Health-System Pharmacists. ASHP – APhA Medication Reconciliation Initiative Workgroup Meeting: February 12, 2007: Summary and Recommendations. http://www.ashp.org/s_ashp/docs/files/MedRec_ASHP_APhA_Wkgrp_MtgSummary.pdf. Published February 12, 2007. Accessed January 14, 2014. **2.** American Pharmacists Association and American Society of Health-System Pharmacists. Improving Care Transitions: Optimizing Medication Reconciliation. http://www.pharmacist.com/sites/default/files/files/2012_improving_care_transitions.pdf. Published March, 2012. Accessed January 22, 2014. **3.** Institute of Medicine. *Preventing Medication Errors*. Washington, DC :The National Academy of Sciences; 2007. **4.** Institute for Healthcare Improvement. Medication reconciliation review. http://www.ihi.org/resources/Pages/Tools/MedicationReconciliationReview.aspx. Accessed March 30, 2014. **5.** National Council for Community Behavioral Healthcare. *Consensus Statement on the Continuity of Medication Therapy for the Treatment of Schizophrenia & Other Mental Illnesses*. Washington, DC: National Council for Community Behavioral Healthcare; March 27, 2007. **6.** The Joint Commission. National Patient Safety Goals: Behavioral Health Care Accreditation Program. Oakbrook Terrace, IL: The Joint Commission; January 1, 2014.

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