Accurate medication records are central to delivering safe, effective clinical care. Drug-drug interactions, drug-disease interactions, incorrect doses, omissions and duplications are often attributed to outdated and incomplete medication lists. In emergency situations, medical records may serve as the only source of information on a patient’s medications, thereby performing a critical function in that person’s care.

Furthermore, medication lists represent one of the most important components of an electronic health record (EHR) since they are used for filling refill requests, assessing quality, performing research, and for informing computerized clinical decision support.

Maintaining accurate medication records is a challenge. A multitude of factors such as patients’ lack of knowledge of their medications, physician and nurse workflows, and lack of integration of patient health records across the continuum of care — all contribute to a lack of complete medication reconciliation. In addition, patients change their medications frequently, often visit more than one physician and may use undocumented over-the-counter medications. Both patient and provider interventions are necessary to facilitate a collaborative approach to medication management.

Medication Reconciliation

The process recommended for providers to maintain the most complete and accurate list possible of a patient’s current medications is known as “medication reconciliation”.

Medication reconciliation is a formal, standardized process that includes the following steps:

- Develop a medication form or format most workable for your group.
- Engage the patient in the process
- At each patient visit obtain a complete, accurate list of the medications the patient is taking, and compare this list to the list documented in the medical record.
- Ask the patient about medications he/she may be taking from other providers and add these to your list.
- Ask the patient about medications he/she may no longer be taking and delete these from your list.

A comprehensive list of medications should include all prescription medications, herbals, vitamins, nutritional supplements, over-the-counter drugs, vaccines, diagnostic and contrast agents, radioactive medications, parenteral nutrition, blood derivatives, and intravenous solutions (hereafter referred to collectively as medications). Over-the-counter drugs and dietary supplements are not currently considered by many clinicians to be medications and thus are often not included in the medication record. As interactions can occur between prescribed medication, over-the-counter medications or dietary supplements, all medications and supplements should be part of a patient’s medication history and included in the reconciliation process, which in turn creates the potential for error.

Commonly overlooked medications include birth control pills, inhalers, eye drops, patches, herbal medicines and medications prescribed by other physicians. As you gather this information, ensure that each drug’s brand name, generic name, strength and frequency are documented with the current date.

- Provide the patient with an updated copy of his/her medication list after performing medication reconciliation at each visit.
- Look for opportunities to provide the patient with additional education about their medications.

With consistent and proper use, a simple medication list can become a very powerful part of the chart providing countless benefits, such as the following:
Efficient charting: Because the medication list can be updated via a few check marks, it makes documentation quicker and easier. Reviewing it at each visit requires less time than documenting each medication in the progress note. The physician can simply refer to the medication list in the note (“the medication list is reviewed today with the patient”), thus saving time and money in dictation costs.

Safer refills: When patients require prescription refills, the medication list makes it easy to check that the patient is receiving the correct prescription. Physicians and nurses do not have to search through pages of progress notes as the information is clearly displayed at the front of the chart.

Improved Communication with other physicians: The medication list can easily be photocopied and sent to other doctors involved in the patient’s care so they can see the patient’s medication history. This improved information-sharing between physicians can prevent dangerous medication errors.

Information recall: A patient’s medication list is often a snapshot of his or her medical history. Reviewing the medication list with the patient helps the physician recall past treatments. This is particularly helpful when a patient presents with a recurring problem.

Allergy documentation: Ideally, allergies should be documented in one place in the chart. What better place than the medication list? The allergy list should describe the type of reaction and include the date by each allergen.

Summary

An effectively maintained medication list through the process of medication reconciliation makes practicing medicine easier, may help facilitate improvements in the quality of patient care, and may also help reduce medication errors. While a perfectly accurate medication list cannot be attributed to a single intervention or tool, a collaborative approach involving education, accountability, and technology can go a long way in helping patients and their providers tackle the challenge of medication safety together.

MagMutual Risk Management and Patient Safety Consultants invite our policyholders’ questions. If you wish to discuss issues related to this article, or have other questions please call us at 1-800-282-4882, and ask for Risk Management.

Related topics: Medication Management, NPSG

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The Joint Commission; Medication reconciliation: sentinel event alert. 2006

Webinar: Maintaining a Medication List [2]

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