



Case Study

facility discharges to nursing homes and rehab centers. IS was able to develop a discharge-to-home form that patients could use as take-home prescriptions. Similarly, the inter-facility discharge form includes all of the patient's current medications, including IV therapy. However, IV therapies are placed on a separate page to remind the provider to substitute them for oral formulations as appropriate. One column on the report indicates whether or not a patient has a medication at home, in order to assist retail pharmacists in filling the patient's prescriptions. At discharge, the nursing unit secretary prints the form for the physician, who then compares the home and hospital medications and reconciles them one last time.

In the final phase of the discharge process, we must provide a list of current medications to the patient and also the next provider of care. In our current process, the unit secretary manually writes the discharge medications on a home medication card and sends a copy of the discharge form to pharmacy. Pharmacy evaluates the form and makes changes in the automated medical record, thus providing an accurate, current list of the medications at discharge. All chart records are also scanned into the automated medical record at discharge.

In the future, we will automate our process of providing the patient with their home medication list. The unit secretary or resource nurse will make edits to the home medication list in the automated medical record and then print a form, developed by our IS department, that contains the current medications the physician wants the patient to continue taking.

Our nursing staff is responsible for providing the medication list to the next provider of care. For patients continuing treatment within the Innovis system, they designate home medications in our automated medical record's follow-up appointment documentation. If the patient is being discharged to a provider outside of the hospital and clinic system, the health information management department faxes the list to the next provider of care.

Conclusion

Internal audits have revealed high rates of completeness and accuracy across our medication reconciliation process. By utilizing the follow-up database,

fewer patients are missed and data is more accurately recorded. Pharmacist control over the admission medication profile has improved the accuracy of the initial home medication information intake, and diligent work by pharmacy and nursing upon admission has helped us improve and expedite the medication reconciliation process upon transfer and discharge. ■



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