

Development Of Medication Reconciliation Tool

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Introduction

The emergency department is one of the most important areas of a healthcare setting or hospital. Whether it is a day or a night, patients seek primary as well as urgent or emergency health care services (Seow, 2013). It is the duty of emergency physicians to give health care to multiple patients at a time no matter which age group they belong to, however, they are only prioritized based on the critical condition of the patients. Some of the common cases that are given priority are sepsis, multi-system trauma, stroke and respiratory disorders. The setting of an emergency department is fast-paced, and the healthcare providers have less time for thinking. It requires them to have deep knowledge about their field of work, and above that, an impressive skill is of utmost importance (Mdedge.com, 2018). Since they are concerned with saving the lives of the patients, they have little luxury of making any mistakes, or their lives could be wasted. Often, patients in a medical emergency are presented to the hospital with no medical history and limited information. Such cases can lead to adverse events, such as the risk of developing a secondary disease. Emergency department overcrowding can consume lots of resources because the availability of patient beds is limited (Asplin et al., 2003).

Our focus here is on the emergency department of Saint Jude Hospital, Fullerton. The ED of Saint Jude Hospital is considered to be one of the finest in Orange County and has been providing its services to the people of Southern California. They have a Primary Stroke Center and a Cardiovascular Receiving Center. They give 24/7 services. The claim is to offer privacy, convenience, and comfort. This paper aims to discuss how the emergency services of Saint Jude Hospital can be made better and more efficient. We will enlist a number of recommendations after conducting a survey of patients, nurses and doctors at Saint Jude Hospital.

Development Of Medication Reconciliation Tool

We will develop a medication reconciliation that will be implemented in a 12-bed surgical ICU. This ICU will receive 1,100 patients per year, which will make an average of 21 patients per week. We will make the team consisting of a doctor, nurse, pharmacist, an Information system representative and a nurse from the participating ICU.

Medical Reconciliation Tool

The members of our team will create a tool for data collection, which will be known as the discharge survey. Its aim will be to evaluate the extent to which medical errors occur in the orders of discharging patients when they leave the surgical ICU. A nurse will be required to complete the data collection tool through the ICU records of the patients and discharge orders when they are discharged from the Intensive Care Unit.

The following are the major questions which were required by the tool to be answered by the nurse:

1. Is the patient currently receiving the same medication as written in the discharge orders?
2. Have the allergies been correctly recorded in the discharge order?
3. Are antihypertensive medicines described to the patients based on evidence for better results along with the use of beta blockers?

If any of these questions get a no answer, then it will be the duty of the nurse to ask the doctor if he intends to make changes to the medicines of the patients. The patient will also be asked about the allergy and home medications. According to this study, medical errors would arise as a result of a physician's making any changes to the discharge orders.

Implementation

The tool will be piloted, tested and then revised according to the requirements. To find out necessary medication errors, two research nurses will evaluate approximately 20 randomly picked patient charts for a period of 10 days. On the basis of the findings, the safety director shall go to the nurse manager and request that the reconciliation process be added to the routine procedure of the ICU discharge. The discharge survey will be revised on the basis of feedback from staff. The clerks of the ICU unit shall place a discharge survey along with every admission chart to the Intensive Care Unit. The survey should be discharged within 24 hours of the admission of the patient to the ICU. If the discharges are not accurate, the nurses will be required to make necessary changes. After 50 weeks, all data should be converted from soft form to hard form. An information system will be developed for the storage and processing of data.

The research will not only help the current facility, but the information will also be disseminated to other facilities, and nurses will be trained accordingly so that more and more people can be facilitated by this research study. A spreadsheet shall be developed, which will contain information about instruments, graphs, and other important data, and it will be made available for the use of other medical facilities in the vicinity to increase its benefits.

Conclusion

The use of medical reconciliation tools will be associated with a large-scale reduction in medication errors (Pronovost et al., 2003). The tool will be automated as part of the routine procedures of the emergency department at Saint Jude Hospital. Through the use of an information system and software, the data will be easily gathered, stored, processed, and made available for Saint Jude Hospital and other hospitals in the vicinity. Since this tool will be developed for the patients who are being discharged from hospitals, the patients will be better off with reconciliation. The medical reconciliation tool will be made an important rather than necessary part of the day-to-day operations of the emergency department at Saint Jude Hospital. The positive and negative aspects will be clearly evaluated, and then changes will be made to the methodology as per requirements.

References

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