

New Illinois Learning Collaborative Focuses on Medication Reconciliation

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Most medical errors today result from problems in the complex healthcare system, such as the proliferation of pharmaceuticals with names that sound alike, and the increased likelihood for miscommunication when many individual practitioners care for a patient in multiple care settings. In the wake of the Institute of Medicine's 1999 landmark study, *To Err is Human: Building a Safer Health Care System*,¹ Illinois hospitals, like many around the country, recognized that patient safety is a broad issue that goes beyond any individual caregiver or facility.

The Illinois Hospital Association (IHA), which represents 200 hospitals and health systems, has established the Patient Safety Steering Committee to facilitate guidance and direction for advancing a culture of patient safety in hospitals throughout the state. The committee's charge includes identifying leadership opportunities that contribute to coordinated systemwide safety improvements beyond a single organization.

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IHA initially developed an “Organizational Framework for a Culture of Safety,”² a resource template for hospitals outlining leadership and safety strategies from accreditation authorities, government sources, literature searches, and hospitals' insights. The template serves as a checklist of key organizational components hospitals can use to gauge their efforts to evolve to a culture of safety. More than 90% of Illinois hospital CEOs signed a pledge adopting the framework, demonstrating their commitment to actively promoting patient safety as a top organizational priority.

In spring 2004, IHA compiled a Quality/Patient Safety Data Guide³ as a one-source reference document. The guide summarizes the many state and federal quality and patient safety reporting activities—both mandatory and voluntary—that

involve Illinois hospitals. This document serves as a resource tool for IHA members and shows the public and policymakers the amount of reporting activity that Illinois hospitals are engaged in with industry stakeholders to improve quality and patient safety.

New initiative: Unique learning network on patient safety

At the recommendation of the Patient Safety Steering Committee, IHA will soon launch the Patient Safety Learning Collaborative, based on the model developed by the Institute for Healthcare Improvement (IHI) for supporting organizational change and improving patient care.⁴ Collaborative learning networks involve expert faculty and peer exchanges; the networks provide a mechanism for transferring evidence-based knowledge and information and a dynamic means for supporting cultural changes and team skills-building. The forum speeds the adoption of successful strategies for implementing and disseminating best practices for patient safety by providing real-time access for interaction and collaboration.

While IHA's initiative adheres to the IHI collaborative formula, including face-to-face learning sessions, virtual connectivity and real-time access to organizational coaches, it also adds a unique “homegrown” dimension, benefiting from IHA member safety experts and local connections. IHI faculty and former participants, some serving on the IHA Patient Safety Committee, are lending their time and guidance to the IHA collaborative. The Chicago Patient Safety Forum (CPSF), a community-based coalition dedicated to facilitating system approaches for improving safety and affiliated with the Institute of Medicine in Chicago, also is providing regional expertise and fundraising support to offset program expenses.⁵

Initial focus: Medication reconciliation

IHA has selected medication safety—a key component of patient safety—as the first focused improvement initiative for its regional learning collaborative. The number of prescriptions in the United States is 3.4 billion a year.⁶ Patient injuries and deaths resulting from medication errors are among the most common types of adverse events in hospitals.

Patients who experience adverse drug events (ADEs) have longer, more expensive hospitalizations than those who do not. The Agency for Healthcare Research and Quality (AHRQ) estimates the ADE incident rate is between 2 and 7 per 100 hospital admissions, with a mean cost of \$4,685 per incident.⁷ Patient transfers into, within, and out of the hospital are

high-risk times for adverse medication events. Hospital chart reviews show that up to 60% of ADEs occur at these key transitions in patient care.⁸ One safety strategy, medication reconciliation, has been developed and promoted by researchers, IHI and the Massachusetts Coalition to Prevent Medical Errors as a systems approach to prevent ADEs. In July 2004, the Joint Commission on the Accreditation of Health Care Organizations added medication reconciliation as one of its National Patient Safety Goals for hospitals to implement by January 2006.⁹

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Reconciling medications is a systematic process that develops an up-to-date, one-source medication profile for all caregivers' reference during an individual patient's admission, transfer and discharge. Any discrepancies or inconsistencies revealed by comparing the real-time profile against newly written physician orders are brought to the attention of the physician and, if warranted, changes are made to the orders.

Through this medication reconciliation process, the appropriateness of patients' medications is verified. This improvement process promotes seamless communication among the patient's caregivers and appropriate medication therapy to avoid inadvertent duplications or omissions. The intended outcome is that each patient receives the right medication, in the right doses, at the right time along the continuum of care.

What is the potential impact of reconciling medications? A recent study¹⁰ found that this process reduces the rate of medication errors by 70% and adverse medication events by 15%. Reconciling medications also greatly improves staff efficiency in managing medication orders by reducing nursing work time at admission and pharmacist work time at discharge.

By January 2005, IHA plans to recruit 20-25 hospitals that will designate interdisciplinary teams to participate in the 9-month collaborative. The first learning session is scheduled

for February 2005 with faculty including John Whittington, MD, patient safety officer, OSF Healthcare System, Peoria, Ill and a safety scholar for IHI; Clark Fenn, vice president, Holyoke Hospital; and Bruce Lambert, PhD, associate professor, University of Illinois at Chicago College of Pharmacy and member of the Chicago Patient Safety Forum steering committee.

The regional initiative is an innovative way for the Illinois hospital community to collaborate more closely and exchange ideas, strategies, and lessons learned on preventing patient harm and promoting better patient outcomes—without reinventing the wheel. Collaboration for the IHA initiative is not limited to the hospital community. The effort involves numerous stakeholders and experts, including the CPSF and other Illinois groups.

Over time, the project will demonstrate to the public the commitment of IHA and hospitals to improving patient safety and in advancing the safety culture. It is hoped that the new knowledge and lessons learned can be disseminated and will be useful as a model for the wider hospital community. **NPSF**

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NPSF's Stand Up for Patient Safety Program offers a multifaceted approach to assist hospitals in their patient safety efforts by providing resources and tools to member hospitals on an ongoing basis.

These best practices are supplemented with audio conferences and discussion forums to facilitate their learning and implementation.

Join over 170 hospitals and hospital systems to improve patient safety. Visit the Stand Up for Patient Safety Web site at <http://www.npsf.org/html/StandUp/standup.html>.