Elite Learning Podcast

Behind the Chart:

How Medication Reconciliation Stops Medication Errors

From admission to discharge — a practical, pharmacist-led guide to catching medication errors before they harm patients

🕒 Listen time: ~60 minutes • 👥 Audience: RNs, APRNs, nurse leaders, new grads, all healthcare providers • 🎧 elitelearning.com/ce-podcasts

🎙 Featured Voices

HOST	GUEST
Mackenzie D. Butler DNP, MSN, RN-BC Head of Nursing Products, Colibri Group Adjunct Faculty, College of Saint Benedict & St. Scholastica DNP in Educational Leadership, Indiana State University Professional interests: healthcare simulation, technology-enhanced learning	Ekaterina Kossykh-Burrows Pharm.D., BCPS PharmD / Clinical Pharmacist Transitions of Care Pharmacist, Upstate New York Hospital ~20 years of clinical pharmacy experience Specialties: Transitions of Care, Geriatrics, Diabetes, Heart Failure Experience across pharmacy tech, ED, and clinical pharmacist roles

📖 What You'll Learn

- Why nurses are the linchpin of medication reconciliation — and where errors most commonly occur
- What to collect beyond name, dose, route, and frequency — including refill patterns and specialist-prescribed meds
- Three categories of questions to uncover hidden, OTC, and non-standard medications
- EHR and EMAR red flags that signal a medication may not be what it appears — or may not be taken at all
- When to pause before administering a medication — and how to safely verify high-alert drugs
- Why older adults and polypharmacy patients are especially vulnerable — and how prescription cascades develop
- The gold standard for handoff communication and practical discharge teaching strategies
- A real de-identified case study of a system-level med rec failure — and how one hospital fixed it

💡 Key Takeaways

- **Medication reconciliation is one of the highest-impact safety processes in healthcare:** Studies show 30–80% of admission medication lists contain discrepancies — rising to 80% in geriatric patients. Up to 20% of those errors cause measurable patient harm. The Joint Commission added med rec to National Patient Safety Goals in 2005; CMS mandates it for transitions of care.

- **Nurses are the linchpin of the med rec process:** Nurses spend the most time with patients and have the closest relationships. That proximity makes them uniquely positioned to surface inconsistencies, catch hidden mistakes, and bring discrepancies to light before they compound throughout a hospital stay.
- **Errors don't just happen at admission — they multiply at every transition:** Up to 50% of floor transfers introduce a new medication error. With 27% of patients transferring once, 46% twice, and 28% three or more times during a stay, the cumulative risk is significant. Discharge AVS documents carry discrepancies in 20–80% of cases.
- **Go beyond name, dose, route, and frequency:** Refill patterns, how patients actually take their medications, pill-splitting difficulties, crushing and mixing practices, pillbox or blister pack use, and specialist-prescribed medications that don't cross over to primary care are all critical — and frequently missed.
- **Three question categories uncover what patients don't think to mention:** Action-oriented questions (how are you taking it, who helps you), category-based questions (what do you take for pain, sleep, allergy, cold, digestion), and probing questions (what do you take it for, which specialist prescribed it) together surface OTC medications, supplements, homeopathic remedies, and dosing irregularities.
- **EHR and EMAR red flags are hiding in plain sight:** No refills or too-many refills, notes indicating prior auth issues on active medications, problem-med mismatches (CHF diagnosis with no CHF medications), allergy-medication conflicts, long oral medication lists with no topicals or drops, and gastric bypass patients on extended-release formulations are all signals worth investigating.
- **Trust your gut — and know when to pause:** Large numbers of pills, unexplained dose or route changes, routes that don't match the drug, unmatched labs, EHR pop-up alerts, IV push medications, and weight-based dosing in patients under 40 kg are all situations that warrant a pause before administering.
- **High-alert medications require deliberate, structured attention:** Name it, notice it, point to it — research shows this simple act rewires attention and reduces errors. Run the five rights. Confirm monitoring is in place. Know your look-alike/sound-alike medications. Practice mental associations: when you see a drug, what automatically comes to mind?
- **Older adults and polypharmacy patients carry compounding risk:** Altered drug distribution, renal and liver changes, multiple specialists, and environmental factors (who is actually managing the medications at home?) all increase vulnerability. Prescription cascades — medications added to treat the side effects of other medications — are common and easy to miss.
- **The gold standard for handoff communication is combined verbal and written:** Verbal-only handoffs result in lost information once the phone is hung up. A written checklist prepared before the call, communicated verbally to a nurse who also has the list, is the evidence-based standard. Never assume med rec was completed — especially post-ICU or for intubated patients.
- **Discharge teaching should start early and prioritize high-risk medications first:** Review the AVS before entering the room. Flag active medications not on the discharge list, new medications without clear patient education, dose changes that may confuse patients, supply gaps, and first-dose timing. Lead with the highest-risk medications — you don't know how much time and attention you'll have.
- **Know your hospital's Transitions of Care Pharmacy program:** Many nurses don't realize this resource exists. Pharmacists are available to take complex med recs, answer questions, and support discharge counseling. You don't have to struggle through a complicated medication list alone.

☑ Do This Next

- Learn your hospital's med rec policy and know where to find the standardized checklist.
- Practice the three question categories (action-oriented, category-based, probing) with your next admission.
- Build your personal "muscle memory" list for high-alert meds — know the labs, monitoring, and look-alikes automatically.
- Find out if your hospital has a transitions of care pharmacy program — and how to refer patients to it.
- Start discharge education early for patients on anticoagulants, insulin, or other high-risk medications.
- Share a "good catch" story with your team — and document what questions or steps led you there.

? 3 Quick Med Rec Screening Questions

Use these with any patient during admission, transfer, or discharge to quickly surface high-risk medication situations:

1. Refill and adherence check: 'Are you currently taking all of the medications on this list? Are there any you've stopped, run out of, or are taking differently than prescribed — and if so, why?'

2. Hidden medications check: 'What do you take for pain, sleep, allergies, cold or cough, or digestion? Do you take any vitamins, supplements, herbal or natural remedies, or anything prescribed by a specialist that might not be on this list?'

3. Setup and support check: 'Who helps you manage your medications at home? How do you organize them — do you use a pillbox, blister pack, or another system? Is there anything about taking your medications that has been difficult or confusing?'

⚑ Red Flags & Cautions

⚑ A nurse collects only name, dose, route, and frequency — missing OTC medications, supplements, specialist-prescribed drugs, and adherence issues not captured in the pharmacy record.

⚑ A medication discrepancy is identified at admission but not escalated — allowing the error to compound through transfers and discharge.

⚑ A nurse assumes med rec was completed by a previous team — especially dangerous post-ICU, post-OR, or for patients who were intubated and unable to provide a history.

⚑ EHR pop-up alerts are overridden without understanding why they appeared — removing a critical safety layer.

⚑ Discharge education is delivered in the final hour before a patient leaves — leaving no time for teach-back, family involvement, or questions about new medications and dose changes.

⚑ A medication is listed as active in the EHR but has no refills, a prior auth hold, or a conflicting dose in a recent visit note — without any follow-up to confirm the patient is actually taking it.

Med Rec Clinical Spotlight

★ **The Scale of the Problem:** Studies from 2018–2019 found discrepancies in 30–80% of admission medication lists. More recent studies (2022) still show 40–60% of lists contain errors. In geriatric patients, that rate can reach 80%. A 2022 study found that floor transfers — including OR, PACU, and ICU — introduce a new medication error in up to 50% of cases. With nearly half of all patients transferring twice during a stay, the cumulative risk is substantial.

★ **The Prescription Cascade:** A prescription cascade occurs when a medication causes a side effect that is misidentified as a new condition — and treated with another medication. Example: Gabapentin causes confusion, confusion is attributed to hospital delirium, a new medication is added to treat the delirium. The original cause is never identified. Nurses are well-positioned to catch these cascades because of their continuous patient contact and observation.

★ **The Three Sources of Truth:** When medication lists conflict, the most reliable approach is to triangulate three sources: the PCP medication list and pharmacy refill record, a direct patient and caregiver interview, and the MAR from any prior facility or nursing home. Agreement across all three sources produces the most accurate picture of what the patient is actually taking — and what the provider intends them to take.

★ **Provider Intent as the Standard:** One hospital's Transitions of Care program resolved ongoing disagreement about what belongs on a medication list by adopting 'provider intent' as the standard: the list reflects what the provider intends the patient to take. Medications the patient is taking but that have been discontinued are noted in additional comments. Medications that are intended but not being taken are flagged with a note — not removed. This creates a transparent, actionable record.

★ **The Tikosyn Case Study:** A patient was discharged continuing their home Tikosyn — a high-risk antiarrhythmic — but a chart review revealed the medication had not been administered for nearly a week during the admission. The root cause could not be determined. The hospital's solution: an automated alert now notifies the clinical pharmacist any time a patient is admitted on or started on Tikosyn, prompting a daily check of labs and administration status. A half-minute daily review prevents a potentially life-threatening gap.

Conversation Starter

"Think about the last medication discrepancy you caught — or one you wish you had caught sooner. What made it visible, or what made it easy to miss? What one question, habit, or system change would have made the difference — and what would it take to build that into your practice starting this week?"

Nurse Leaders: Consider hosting a unit conversation around: "How does our current med rec process hold up at admission, during transfers, and at discharge? Where are the gaps — and do our nurses know how to access pharmacy support when they need it?" Use the responses to identify training needs, checklist gaps, and opportunities to connect nursing more directly with your Transitions of Care Pharmacy team.

🔗 Resources & Links

• Joint Commission National Patient Safety Goals: jointcommission.org • Institute for Safe Medication Practices (ISMP): ismp.org • American Society of Health-System Pharmacists (ASHP): ashp.org • Beers Criteria (AGS): americangeriatrics.org • EQUATOR Network (reporting guidelines): equator-network.org	• Episode page: elitelearning.com/ce-podcasts • Apple Podcasts • Spotify • CE courses: EliteLearning.com • YouTube • EliteLearning.com • ISMP High-Alert Medications List: ismp.org/recommendations/high-alert-medications-community

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