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Estimating the information gap between emergency department records of community medication compared to on-line access to the community-based pharmacy records.

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Tamblyn R, Poissant L, Huang A, et al. Estimating the information gap between emergency department records of community medication compared to on-line access to the community-based pharmacy records. J Am Med Inform Assoc. 2014;21(3):391-8. doi:10.1136/amiajnl-2013-001704.
https://psnet.ahrq.gov/issue/estimating-information-gap-between-emergency-department-records-community-medication-compared

A cornerstone of the medication reconciliation process is assembling the best possible medication history—the gold standard list of a patient's prescription and over-the-counter medications. This cohort study, conducted in an emergency department (ED) in Quebec, compared the medication history obtained by ED staff with the gold standard list of dispensed medications from their community pharmacy. The overall concordance between the two medication lists was poor, and most concerningly, more than 75% of patients had at least one medication noted in their pharmacy list that was not known to the ED. These errors of omission occurred most frequently for medications that were prescribed episodically (i.e., antibiotics) or on an as-needed basis (i.e., pain medications). The development of health information exchanges that give hospital providers direct access to pharmacy records could prevent such errors. A serious medication error due to a problem with medication reconciliation is described an AHRQ WebM&M commentary.