Change project: Medication Reconciliation

Fall 2014 Graduating class

Nursing 497
Abstract

In order to improve patient safety, keep facility costs down, and meet patient safety goals set forth by the Joint Commission, healthcare facilities need to enact robust medication reconciliation processes. A literature review analyzed the costs and benefits of utilizing a variety of healthcare professionals in medication reconciliation programs. As a result, based on budgetary concerns and professional suitability, Great Plains Healthcare developed a nurse-driven medication reconciliation program that ensures the completion of medication reconciliation on all emergency room patients that are admitted to the facility. Included in this program are the policy and procedure, a six-month implementation timeline, and a budget outlining potential costs and savings to the facility.

Keywords: nursing, medication reconciliation, patient safety goal
Change Project: Medication Reconciliation

Medication reconciliation is a very important task of the hospital admission process. According to the Joint Commission (2006), “medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking” (para. 1). Joint Commission’s National Patient Safety Goal (NPSG) regarding medication reconciliation, 03.06.01, is to pass along the correct information about the medications a person is prescribed, how often they are taking those medications, and comparing current medications to new prescriptions (Joint Commission, 2014). Through successful medication reconciliation, home medications will be continued on admission to a facility and patients will have more knowledge about the medications they are prescribed as well as the importance of bringing an up-to-date medication list to the doctor each time they come.

Our proposed change to support this NPSG is to have medication reconciliation completed on all emergency room admissions within 24 hours which will be accomplished by developing a medication reconciliation nurse position. There will be one nurse available from 0700 to 1930 every day of the week and have the sole responsibility of completing admission medication reconciliation on every patient admitted through the emergency room. With the nurses performing accurate medication reconciliations, the objective is to avoid medication errors such as omissions, duplications, dosing errors, and/or drug interactions.

Mission and Values

Great Plains Healthcare is a rural 200-bed acute care facility. We are located in Northwest North Dakota and are a level two trauma facility. Our facility sees those that we care for as more than their health concerns. As a leading health care provider within the community, we look at all aspects of the individual to provide safe, quality care. We are committed to
improving the quality of health to our community. Our mission is to enhance the quality of care and exceed the needs for those who seek treatment within our facility. Our values consist of the concepts of:

- **PATIENTS**: Exceeding needs of patient within our community is our main goal.
- **RESPECT**: The understanding of qualities and abilities that make each person unique, in providing a healthy environment and treating others with dignity.
- **TEAM**: Understanding that each member of the team is important and collaboration is key. There is no "I" in team.
- **PASSION**: Health care workers dedicated to making a difference, even if it is one patient at a time (Altru Health System, 2014; Trinity Health, 2014).

Our values are upheld by all staff members who work within the Great Plains Healthcare facility (Altru Health System, 2014; Trinity Health, 2014).

For the implementation of this program we need support of administration, emergency room staff, pharmacy, and nurses willing to further their scope of practice by becoming medication reconciliation nurses, for the greater good of the hospital and patients.

**Literature Review**

Medication errors occurring within the health care system are one of the main causes to patient death and injury. The emergency department is where many initial patient interactions occur; therefore, it is vital that nurses and health care professionals are completing accurate medication reconciliation. Literature review describes that pharmacists, register nurses (RN’s), and pharmacy technicians are in a position to successfully complete medication reconciliation.

Pharmacists can successfully complete accurate medication reconciliation due to their extensive education background in medications. Anderegg, Wilkinson, Couldry, Grauer, and
Howser (2014) completed a study that integrated pharmacy teams that included pharmacists, pharmacy residents and students to complete 100% of the medication reconciliation during admissions, transfers, discharges, and high-risk discharges at the University of Kansas Hospital, with a goal to decrease the rates of readmission and emergency department visits in a 30 day period at this hospital. The literature reported that pharmacy teams were not able to meet the 100% medication reconciliation goal, however, the teams completed medication reconciliation on 95.8% of the patients at admission and 69.7% at discharge (Anderegg et al., 2014, p. 1473). The results indicated that the implementation of the teams did not decrease the readmission or emergency department visits, but there was a decrease from 17.8% to 12.3% in preventing high-risk patients from being readmitted (Anderegg et al., 2014, p. 1474).

Registered nurses in literature have also been reported to be in a position to effectively obtain accurate medication histories from patients. Tessier, Henneman, Nathanson, Plotkin, and Heelon (2010) reported that since nurses are at the center of providing patient care and can successfully complete medication reconciliation, the researchers developed a tool to assist nurses in improving the medication reconciliation process.

The tool by Tessier et al. (2010) has a six-step process:

(a) obtaining the demographic information, (b) review the patients current medication list and complete a systems review, (c) complete a “‘what’s missing’” check, (d) probe for more information, (e) complete a final check, and (f) reconcile issues immediately (pp. 607-610).

The results from nurses implementing this tool were that in one hospital after one month the medication errors reduced by 35% and in three months medication errors decreased by 80% due to the completion of medication reconciliation, and there was a 42% to 20% decrease in
discrepancies because patient medication histories were being compared to the medication reconciliation (Tessier et al., 2010, p. 610).

Literature also reported the utilization of pharmacy technicians in obtaining accurate medication reconciliation within the health care setting. Cooper, Lilliston, Brooks, and Swords (2014) reported that with hospital training programs and technician certification, pharmacy technicians could be effective in this role, at the same time being cost-effective to the hospital.

The researchers developed a program to have a pharmacy technician complete medication reconciliation on nursing units, with the completion of 16 medication reconciliations per shift. Therefore, a pharmacist and clinical nurse specialist at a North Carolina community teaching hospital that has 517 beds were in charge in managing this program. The results of implementing the pharmacy technician program showed that greater than 90% of medication reconciliation was being accurately completed and as of 2012 a mean of 21 medication reconciliations were being completed by pharmacy technicians per shift (Cooper et al., 2014, p. 1572).

Policy

The emergency department must develop and adhere to medication reconciliation procedures to maximize safe medication practices on admission through the emergency room. A nurse exclusively for medication reconciliation will be staffed daily from 0700-1930. This nurse is to ensure that good faith efforts, which include utilizing information from multiple sources, are made to obtain accurate medication information from the patient and/or other sources and document this information in a useful way to those who manage medications. This must be completed within 24 hours upon admission to ensure continuity between the patient’s home medication regimen and newly ordered medications. The types of information the nurse may use
to reconcile medications may include medication name, dose, frequency, route, purpose, date and time of last dose, and compliance (University of Texas Medical Branch, 2012).

**Procedure**

Upon the patient’s admission or presentation and with the involvement of the patient or designee, a list of the patient’s current medications is obtained and documented in the patient’s health record. Medications ordered for the patient while under the care of the organization are compared to those on the list.

1. A list of the patient’s current medications is obtained. The list contains the name, dose, frequency, route, purpose, date, and time of last dose, compliance, and additional information as seen on the nurse medication reconciliation. See Appendix B for nurse medication reconciliation. The primary means of obtaining the patient’s current medication information may include:
   a. Patient/parent/caregiver interview
   b. Review of self-completed or patient provided medication list
   c. Great Plains Healthcare medical record
   d. Outside medical records

The medications are documented and reviewed for duplications, omissions, and interactions. This becomes the pre-admission medication list.

2. The medication reconciliation nurse reviews the medication list prior to physician or advanced practice professional (APP) ordering medications during the encounter.

3. In the case that the patient is admitted through the emergency room during the hours that the medication reconciliation nurse is not on duty, he/she will follow-up with the patient on the floor within 24 hours of admission (University of Texas Medical Branch, 2012).
Staff Buy-in

With the initiation of change, there is always resistance that goes along with it. It is necessary to combat this resistance by promoting staff acceptance to the change. This task is one of the responsibilities of the nurse manager.

In order to promote staff buy-in to this new change, the main strategy used will be based on the empirical-rational model. The key point of this model is ensuring that the staff has acquired all of the necessary knowledge related to the change (Sullivan, 2013). The idea behind this model is that people are rational and will accept rationally justified change if they have the appropriate knowledge to do so. In order to accept change, people must understand the benefits that will result. A change agent, who has the necessary knowledge, as well as expert power, is essential to persuade the people that the change will be beneficial to all. By using influence, the knowledge base is transferred from the change agent to the staff members. Once knowledgeable about the proposed change, the staff members will either accept or reject the idea based on its potential risks and benefits (Sullivan, 2013).

Even when staff members receive all of the appropriate knowledge and understand the benefits, some may still remain resistant to the change. The amount of resistance varies from person to person. Sullivan (2013) identified six different types of people in the change process. First, there are the innovators who are open to change and thrive on the concept of new ideas. Second, there are the early adopters who are receptive to change and influence others to accept it. Third, there is the early majority who prefer things the way they are, but can accept the change through persuasion. Fourth, is the late majority who are resistant to change, but will accept the change after the majority demonstrates support. Fifth, are the laggards who slow the process
down, openly voice their negative opinions regarding the change. Lastly, are the rejecters who actively oppose the change in attempt to create division within the organization (Sullivan, 2013).

Resistance to change is expected to a certain degree in all situations and can occur for a variety of reasons. Some staff members are content with the way things are; they believe that change is unnecessary and it will not improve the situation (Sullivan, 2013). Others may resist the change because they dislike or distrust the person responsible for implementing the change. Staff are less willing to accept a new idea if it is not self-initiated because they may feel as though they are being manipulated (Maxwell, 1993). Even if the change is in their best interest, people may not accept it because they do not have ownership over the idea. A few more common reasons why staff members resist change include fear of failure, fear of the unknown, and misunderstanding of the purpose of change (Sullivan, 2013).

In order to promote acceptance to the change and combat resistance, the change agent will implement specific strategies. In this scenario, the change agent is the nurse manager and he or she is responsible for carrying out these tasks. Upon initiation of a change, it is important to present the initial idea to the entire group early on (Sullivan, 2013). This functions to ensure that accurate information is provided. The idea should be presented at a mandatory staff meeting so all members will receive the same information at the same time. Staff should be given an opportunity to present their suggestions, state concerns, and have any questions answered. By taking their suggestions into consideration it will help to give them a sense of ownership over the idea. Another important aspect is to clearly present both the benefits and the risks of the change. This establishes trust with the staff members. It needs to be explicitly expressed how the change will benefit the staff members, the patients, and the organization as a whole (Sullivan, 2013).
Finally, every change implemented will cause resistance on some level. Resistance is a normal part of change, but can become problematic if not managed appropriately. The nurse manager, acting as the change agent, is responsible for managing the resistance. In order to do this, the following guidelines are used (Sullivan, 2013). First, it is important to talk to the individuals who are resistant to the change. The change agent must listen carefully to their opinions to fully understand the reasons for opposition. Second, any incorrect information must be clarified by providing accurate facts that will eliminate misconceptions. Third, one must set clear expectations about the factors that cannot be altered, but keep an open mind regarding suggestions. Fourth, the negative consequences of resistance need to be clearly presented. The main consequence in this scenario would be compromised patient safety due to medication errors or adverse drug events. Fifth, as well as presenting the negative consequences, the positive aspects must also be emphasized. Lastly, it is crucial to maintain an environment of trust and support in order to instill confidence in the staff (Sullivan, 2013).

Initiating change can be a difficult situation for staff members and the organization as a whole. However, if the nurse manager is able to use strategies to promote staff buy-in and appropriately manage resistance, the entire change process will be implemented effectively.

**Timeline**

**January 1st**

For the first month, after developing a plan for change initiation, we would present the project within the organization. We would utilize a presentation to gain leadership support among key stakeholders. We would present background information of medication reconciliation as a patient safety issue. Then, we would discuss current errors and risk factors occurring in Emergency Departments within healthcare facilities. Third, resource justification would be
demonstrated based on current cost of improper medication reconciliation. Finally, we would present our intentional change for staff a nurse who deals only with conducting proper medication reconciliation on new admits (within 24 hours of arrival) during a 12-hour shift (0700-1900) within the Emergency Department.

February 1st

Develop pilot program to be implemented within the Emergency Department at Great Plains Healthcare Hospital. Identification of a new policy and procedure will be established and reviewed regarding medication reconciliation. Information will be presented through an in-service meeting within the Emergency Department for all nursing staff. Education will be provided regarding importance of decreasing errors associated with adverse drug events, cost savings regarding implementation, initiative to hire a new staff nurse to address medication reconciliation on all admits, and future role of the interprofessional team with the change project. Implementation of pilot program begins.

March 1st

Initiate process of hiring several staff nurses to primarily conduct the medication reconciliation process on all new admissions within the Emergency Department. Working hours would be 12.5-hour shifts from 7:00 a.m.-7:30 p.m. Upon staff hiring, orientation of Emergency Department and policy/procedure for current medication reconciliation pilot program will be conducted. New strategies will be designed to address barriers within pilot program.

April 1st

Review pilot program’s current success regarding presumed benefits. Process evaluation audits should be addressed regarding overall discipline and compliance. Three measures will identify correct documentation, percentage of home medications reconciled, and any adverse drug effect
from unreconciled medications on admission (U.S Department of Health and Human Services, Agency for Healthcare Research and Quality [AHRQ], 2012).

May 1st

Focus groups with interprofessional team will be formed regarding attitudes and knowledge of current pilot program implementation (Sullivan, 2013). These groups will help identify and address barriers for low compliance and resistance to change. Barriers will be addressed regarding pilot program. Updating of electronic health record to create easier access and ease of addressing medication administration of new admit.

June 1st

Meet again with key stakeholders for change initiation regarding attitudes, beliefs, financial concerns, and other barriers regarding implementation of pilot program.

June 30th

Final review of pilot program’s current success regarding presumed benefits achieved at a financial and quality level. Process evaluation audits should be addressed regarding overall discipline and compliance. Three measures will identify correct documentation, percentage of home medications reconciled, and any adverse drug effect from unreconciled medication on admission (AHRQ, 2012). Decision will be made of continuation/stabilization or discontinuation of pilot program at Great Plains Healthcare. Expansion of program to other units for transitional care will be implemented.

Budgetary Implications

When creating and implementing a medication reconciliation program, it is important consider the financial aspects of the program. This includes the budget required to implement program in the facility as well as the potential savings that would occur through the prevention of
errors relating to inadequate medication reconciliation. Given that this program requires a nurse to be available for a 12 hour shift per day seven days a week, salary for the position will comprise the bulk of the budget, with no finances required for equipment or software as resources are already available. According to the United States Department of Labor, Bureau of Labor Statistics (BLS, 2014), the average salary for a North Dakota RN is $26.94 per hour. Based on this number the annual cost to the facility for this RN position would be $117,997.20. Using a pharmacy technician in this role, at an hourly wage of $16.64 (BLS, 2014), would have annual expense of $72,883.20. Given that the average wage of a pharmacist in North Dakota is $53.41 per hour (BLS, 2014) the annual cost to the facility would be $233,294.88 if a pharmacist were to staff this role. Although the literature review showed that pharmacist-driven medication reconciliation programs are very effective, due to the superior pharmacotherapy knowledge that pharmacists possess, it is apparent that programs of this nature can be very cost-prohibitive. The literature review also discussed utilization of pharmacy technicians as another effective resource in medication reconciliation completion. The use of pharmacy technicians in this role would be a more cost-effective strategy than using registered nurses, however given that there is inconsistent educational requirements for pharmacy technicians practicing in North Dakota, with no higher than an Associate of Applied Science degree required for licensure, registered nurses would be better qualified to complete this task given their formal educational attainment and clinical experience with medication administration. Furthermore, given that nurses provide more direct patient care than pharmacists or pharmacy technicians, RNs are uniquely skilled in patient communication, making nurses better suited to obtain medication reconciliation information from patients and family members.
Although the proposed budget for this medication reconciliation program is significant, when the potential savings are evaluated, it is easier to see the merit of the program. According to Hakim (2014) medication reconciliation, “Accounts for 46% of all medication errors and up to 20% of ADEs [adverse drug events] resulting from medication errors among hospitalized patients” (p. 39). In the same article, the author states that preventable drug errors are believed to cost the nation nearly $3.5 billion each year (Hakim, 2014). Evaluating this topic on a large scale alone makes the potential savings to a facility that has a robust medication reconciliation program apparent. However, Gleason, Brake, Agramonte, and Perfetti (2012) provide more specific cost benefits in their Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation they created for the Agency for Healthcare Research and Quality (AHRQ). According the data provided by the authors, an estimated 85% of medication errors could be avoided through a medication reconciliation process. With an estimated 2.2 discrepancies per patient and the conservative cost of an adverse drug event is $2500, the savings would quickly add up if only 1% of those discrepancies resulted in an adverse drug event (Gleason et al., 2012). For example, in a facility with 25 emergency room admissions daily, using the aforementioned data, the medication reconciliation program could potentially save a facility $11,687 per day, translating to an annual savings exceeding $4.2 million, a sufficient amount of revenue required to pay the salary for the RN positions in the program. This program would continue to benefit the facility by freeing up time that primary care nurses spend completing medication reconciliation, increasing the amount of direct patient care time available. Additionally, this program would benefit the patients as well, by decreasing the potential for medication errors relating to medication reconciliation, overall increasing patient safety.
Change Process

Change is a process that may be difficult for individuals and organizations to adapt to. The process of change has an impact on the whole organization and on all individuals working there. For this project we worked through the stages of change using a systematic approach implementing the Homans’ stages of group formation as well as the change process. We successfully utilized these tools through the entire project and everyone went through the steps in both processes. The group process is an important part of how well the group interacts and sets guidelines to apply the change process.

The group process as defined by Homans includes four steps that we utilized for this project. The first step in this process is forming, which includes that of creating a group for a specific task. For this project, this step was already completed due to our group being our classmates. The next step is that of storming, in this step, members of the group work to figure out their roles in the process. Our group had some storming in determining the exact topic, as well as figuring out who will do what tasks. This can be a difficult stage, but as a group we all came together to make a final decision. The next step in the group process is norming, which is when standards are set for the group. During this stage we figured out deadlines, as well as the format that things will be submitted to the group. We made sure that everyone was on the same page and answered any questions that anyone in the group had. The next stage is preforming, this is when the work completed to achieve the reason the group was formed. As a class, we each performed the selected tasks that we had decided on as a group. The last stage of the process is that of adjourning, which our class will do when we complete the semester. Homans stages of group process was very pertinent to our project and as a group we worked through the different stages (Sullivan, 2013).
Once the group is established it is then time to work on achieving the overall goal of change that the group was made for. According to Sullivan (2013), the process of causing change goes through many different steps. The steps are assessment, planning, implementation, as well as evaluation (Sullivan, 2013). Through our project we utilized the Joint Commission website at the list of the national patient safety goals. Our group decided on working with the safety goal related to medication reconciliation, as well as performed data gathering to identify the extent of the problem and other background information we deemed necessary. We then planned an intervention that we could implement to prevent medication errors through effective medication reconciliation. The next according to Sullivan’s change process is implementation the part of the project that is creating the process that our intervention would be implemented in real life. The last stage of this process is that of evaluation and part of the project is evaluating the costs as well as benefits associated with making the changes. This project went through all of the different stages of Sullivan’s change process.

In developing a plan for intentional change within an agency it takes a group of team members to collaborate and communicate in order to effectively initiate a safety program staff members will implement. Effective groups take a close look at how members work together, which roles they fill and whether members are contributing equally. After completing the intentional change process the individual groups reviewed how well they met the requirements of the change project. When completing the literature review and associated budgetary considerations, the group utilized data and resources gathered in the beginning phases of the project. By conscientiously communicating and cooperating, the group was able complete all tasks in a timely manner, first through division of labor, followed by careful collaboration. Each member of the organizational mission and values and resources group came together already
understanding what the task at hand was for creating mission and values for the program. This accelerated the process of forming. Then they briefly stormed, normed, and performed with the conclusive agreement upon the mission and values. In developing the policy and procedure for the change project, they used resources from the local hospital as well as searched other facilities to view their policies and procedures. They used these ideas for guidance in developing our own policy and procedure. Overall, this was a relatively simple task. However, this group did encounter some frustration related to the goal of the project. This was easily overcome by a group effort in identifying the specific goal of the project. In the group of identifying strategies to promote staff “buy-in”, things went fairly smoothly, however it may be difficult for every team member to agree on every single concept. They worked together by discussing the topic and made the appropriate edits based on a mutual decision. When developing recommendations for further study, professional skills practiced, and professional growth opportunities experienced, the group utilized available resources such as textbooks, as well as personal reflection. The timeline strategies group went through the phases of change fairly quickly as they were able to form the group, set up expectations and goals, and initiate work towards completing the portion of the change project. After meeting with the class, they adapted timelines based on updated policy and procedures related to the change project and feedback from the unified group. Through cooperation and communication via face-to-face interactions and online resources, the necessary work was completed in a timely manner. Throughout the development of the program, the individual group collaborated with other groups to ensure all necessary work was consistent with the program needs.

Leadership/Management Skills
Throughout the process of creating this medication reconciliation policy change program we have practiced numerous leadership and management skills including a) planning, b) organizing, c) directing, and d) controlling. As a group we practiced planning by deciding what specific tasks needed to be completed, who would be responsible for each step, and how each group would meet their individual deadlines. Our organizational structure determined that each group would be responsible for their own section of the overall project. Lines of communication were kept open to the group as a whole through online resources and in class meetings. Together we made decisions and directed each other in order to motivate each group to complete their assigned tasks by their respective deadlines. At our scheduled meeting times we came together to evaluate our individual progress on delegated tasks within our groups and provided feedback (ATI, 2013, pp.4-5). Overall, this project has helped our class grow as professionals as we practiced our leadership and management skills in order to develop and policy for change.

**Recommendations for Further Study**

The benefit of medication reconciliation policy development is evident in research. As creators of this program, it may be beneficial to investigate and research medication reconciliation policies being implemented throughout North Dakota to see how our program and patient outcomes compare with other agencies. Expanding further and researching medication reconciliation policies across the country could offer additional insight into effective policy development and implementation. To further benefit our agency, time should be taken to link medication reconciliation with other quality initiatives being managed throughout Great Plains Healthcare. In addition, medication reconciliation software could be researched to ensure that the programs being utilized are accurate and efficient.
Conclusion

Through implementation of the program proposed above it can help with reducing medication omissions, duplications, dosing errors, and/or drug interactions. We have identified that medication reconciliation is a very important task of the hospital admission process. As a result, based on budgetary concerns and professional suitability, Great Plains Healthcare created a nurse driven medication reconciliation program that ensures the completion of medication reconciliation on all emergency room visits within 24 hours. The goal of medication reconciliation is to pass along correct information about medications a person is prescribed, how often they are taking those medications, and comparing current medications to new prescriptions. With the support of administration, emergency room staff, pharmacy, and nurses willing to further their scope of practice by becoming medication reconciliation nurses, we will improve patient safety, keep facility costs down, and meet patient safety goals. Patients will have more knowledge about the medications they are prescribed as well as the importance of bringing an up to date medication list to the doctor each time they come into the ER. The Joint Commission’s NPSG are created to help promote patient safety in every setting of the healthcare field and through successful implementation of the program it will promote medication reconciliation. We are committed to improving the quality of health to our community and enhance the quality of care and exceed the needs for those who seek treatment within our facility.
Reference


ATI. (2013). *Nursing Leadership and Management (6th Ed.)*. Leawood, KS: Assessment Technologies Institute, LLC.


Appendix A

Lewin’s Change Tool

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<tr>
<th><strong>Objective/Proposed Change</strong></th>
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<tr>
<td>Medication reconciliation will be completed on all Emergency Room admissions within 24 hours by a registered nurse. We will accomplish this by creating a medication nurse position staffed from 0700 to 1900 who will be responsible for this task.</td>
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<tr>
<th><strong>Rationale For Change To Achieve Objective</strong></th>
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<td>To avoid medication errors such as omissions, duplications, dosing errors, and/or drug interactions.</td>
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<th><strong>Driving Forces…….FORCE FIELD ANALYSIS…..Resisting Forces</strong></th>
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<tr>
<td>*Reduce medication errors</td>
<td>*Hiring additional staff</td>
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<td>*Speed up admission process</td>
<td>*Time for training staff on protocol</td>
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<td>*Ensure accuracy of current medications</td>
<td>*Cost of technology</td>
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<td>*Accelerate inpatient orders</td>
<td>*Accuracy of patient reporting of medications</td>
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<td>*Verify the use of OTC medications &amp; supplements</td>
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<th><strong>Steps For Accomplishment</strong></th>
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<td><strong>Timeline</strong></td>
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<td>Jan. 1  →  Meet with key stakeholders &amp; resource justification</td>
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<td>Feb. 1  →  In-service with interprofessional team &amp; implement pilot program</td>
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<td>March 1  →  Hire new staff for medication reconciliation</td>
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<td>April 1  →  Review program’s success &amp; audit evaluation</td>
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<td>May 1  →  Utilize focus groups &amp; Update HER as needed</td>
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<td>June 1  →  Meet with stakeholders again</td>
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<td>June 30  →  Final review of program &amp; expansion of program throughout transitional process</td>
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<th><strong>Staffing Needs</strong></th>
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<td>Full-time positions (min. 4)</td>
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<td>Policy and Procedure Training</td>
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<td>Medication Reconciliation Training</td>
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<th><strong>Projected Cost</strong></th>
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<td>RN Annual Salary = $117,673.92 at $26.92/hr.</td>
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<th><strong>Expected Savings</strong></th>
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<td>&gt; 4.2 million/yr.</td>
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Appendix B
Process for Taking Medication History