Can I see your medications, please?

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Objectives

• Define the term ‘medication reconciliation’ and explain why this is an important National Patient Safety Goal.
• List strategies to accurately perform medication reconciliation in hospice care
• Verbalize when medication reconciliation must be performed.

Medication Reconciliation

• Definition:
  The process of comparing a patient’s new medication orders to all of the medications the patient has been taking.
NPSG # 8
To "accurately and completely reconcile medications across the continuum of care"

• 8a) Implement a process for obtaining and documenting a complete list of the patient’s current medications upon the patient’s admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list. [Note: While this safety goal does not require a separate form for the medication list, many organizations have found it useful to develop and implement one or more forms to support the medication reconciliation process.]

• 8b) A complete list of the patient’s medications is communicated to the next provider of service when a patient is referred or transferred to another setting, service, practitioner or level of care within or outside the organization.**

What’s the point?

• Performed to avoid medication errors such as:
  • Omissions
  • Duplications
  • Dosing errors
  • Drug interactions
The Joint Commission's sentinel event database includes more than 350 medication errors resulting in death or major injury. Of those, 63 percent related, at least in part, to breakdowns in communication, and approximately half of those would have been avoided through effective medication reconciliation.

Medication errors related to medication reconciliation typically occur at the "interfaces of care"—when a patient is admitted to, transferred within, or discharged from a health care facility. Furthermore, the home care department of one hospital discovered that 77 percent of all patients were discharged with inadequate medication instructions.

Medication reconciliation systems and processes have successfully reduced medication errors in many health care organizations. Pharmacy technicians at one hospital reduced potential adverse drug events by 80 percent within three months by obtaining medication histories of patients scheduled for surgery.
4) When the patient is unable to actively or fully participate in the medication reconciliation process and has requested assistance from another person(s) (e.g., family member, significant other, surrogate decision maker), involve the authorized person(s) in the medication reconciliation process. This involvement should occur at all interfaces of care, and on admission to and discharge from the facility.

When should medication reconciliation occur?

• At every transition of care:
  – Changes in setting
  – Changes in service
  – Changes in level of care

What does this mean for hospice?

• On admission:
  • You must compare the medication orders you receive on referral with all the medications* the patient has in the home.
  • If there are discrepancies you must consult with the patient’s physician.

* Medications in these references include prescription medications, over-the-counter medications, vitamins, herbals, nutriceuticals, and others.
Ongoing Reconciliation

• For home hospice patients every visit to the patient must include the question “Have there been any changes in your medication regime?”

This includes not only any medications started but also any changed or stopped.

Is this really a big deal?

• Well…. do you get surveyed? You need to do this.
• More importantly- studies have shown that there are frequently medication mistakes made with transfers.
• Let’s look at a real case. The names have been changed.

John Smith

• 64 year old with ES CHF.
• Admitted to the hospital on 8/16/09 with severe exacerbation of CHF.
• Multiple medication changes and additions made with reasonable control achieved.
• Discharged from acute care 8/24/09.
• Admitted to hospice 8/25/09.
The Admission

• The nurse has an H&P and discharge orders.
• The nurse asks to see the bottles of all medications the patient has been taking.
• She writes down all the medications they bring to her.
• The significant other and the patient confirm the accuracy.

Here’s the mistake…

• The nurse neglected to look at the discharge medications.
• 6 new medications had been added.
• 3 current medications had the doses increased.
• The patient and significant other had not looked at their copy of the discharge instructions.

What happened next?

• 6 days later the patient is admitted GIP for exacerbation of CHF.
• Pt is in severe respiratory distress.
• Significant other is in severe emotional distress.
• Discussion held with patient and S.O. about the missed medications and advised that we would start them right away, but…
The Outcome

• The patient and S.O. refuse any new medications. They state they are “sick and tired of fighting this”.
• Nurse, MSW, Chaplain, and Medical Director all involved in discussions with patient and family.
• They remain adamant that they do not want any treatment.

Two weeks later…

• Patient still alive but now bed bound, confused, lungs failing, slowly dying.
• Family needing much support, second guessing the decision to not restart medications but honoring the patient’s choice.
• All hospice staff needing support with the belief that “we” did this to him.

What is the required process?

• There is no specific requirement other than that it be done.
• Every agency is free to develop their own process.
• You must have a policy/procedure that spells out your process.
• You must adhere to your policy.
• Every patient. Every time.
Sample policy – Ray Hickey Hospice House

• **GENERAL:** Patient Safety is a priority. Medication reconciliation is a vital piece of safe patient care.
• **POLICY STATEMENT:** Medication Reconciliation will occur on admission to the hospice house regardless of level of care.
• **PURPOSE:** To maintain accurate medication administration.
• **PROCEDURE:**
  • Medication lists/records will be requested prior to admission. If the patient is being transferred from SWMC or any other facility or agency the their admission medication reconciliation will be requested along with the discharge medication orders.
  • The admitting nurse will review medication orders for appropriateness and accuracy and transfer medications to the hospice house medication form. This completed form will be reviewed with the patient and/or family and they will be asked about home medications.
  • If the patient and/or family are unsure of the medications at home they will be asked to bring all medications in to be reviewed.
  • The nurse will call the physician with any unresolved discrepancies.
  • Algorithm Pharmacist will review medications prior to IDG.
  • If the patient is admitted with comfort medication orders only the admitting will review this with the pt/family. If in agreement, there is no need to review home medications.
  • Once medications are reviewed with the patient or family they will sign the medication form to indicate agreement.
  • The medication form is then faxed to the physician for signature.
  • Upon the discharge or transfer of a patient a copy of the reconciled medication list will be given to the patient, the receiving facility/agency and the primary care physician. The RN will document this on the discharge instruction sheet.

Sample policy - continued

• What are you doing in your agency?
• If time allows… hospice covered versus non covered medication discussion