

# CASE EXAMPLE

## CASE EXAMPLE #8 — Part 1

### Going above and beyond to reconcile the medication list

See added safety strategies on page 2

#### CASE EXAMPLE

An 89-year-old white female patient, with a history of chronic congestive heart failure, coronary artery disease, and aortic stenosis was seen in the Emergency Department (ED) after experiencing shortness of breath for two weeks when lying down flat in bed.

During the triage process, it was determined that she was hypoxic and required oxygen. A CT of her chest also identified a large pleural effusion that would require a thoracentesis to be performed urgently. The ED physician shared this update with the patient's daughter who informed the ED physician that their mother was currently on Eliquis® and asked if that could increase the risk of bleeding with this invasive procedure. The ED physician replied, "I didn't realize she was taking Eliquis®."

Later, upon successful and safe completion of the thoracentesis and improvement in the patient's oxygenation status, the patient was admitted and transferred to an inpatient medical unit. Soon after, the Nurse Practitioner (NP) who was covering for the hospitalist group arrived to assess the patient. After asking the patient how long her shortness of breath symptom had been present, she also asked about her current home medications. Although the patient had Lasix and Lopressor on her home medication list, the NP decided to contact the local pharmacy where the patient's prescriptions were routinely filled. Upon reaching the pharmacist, the NP not only asked what medications were being filled by the patient, she also asked when the prescriptions were last filled. It was then discovered that the Lasix and Lopressor were last filled two months ago. The response was very helpful in determining a potential contributing factor to the patient's symptoms. By the time these prescriptions had run out, the onset of her symptoms was noted to occur about 1-2 weeks afterward.

On the day of the patient's discharge, the cardiologist came to see the patient and reviewed the patient's list of current medications as well as any changes in medications that the patient would be taking after discharge. The cardiologist did make a change in the beta-blocker that the patient was taking while in the hospital, from metoprolol tartrate (short acting) to metoprolol succinate (Toprol XL – long acting).

The nurse reviewed the discharge instructions, including the final list of home medications, with the patient and her daughter. The instructions included two follow-up appointments with the patient's primary care provider (PCP) and the cardiologist.

The following week, the patient's daughter went with the patient to the follow-up appointment with the PCP. To prevent confusion on the home medications the patient was instructed to take, the daughter printed a home medication list, including the reason for each medication. When the printed list was shared with the PCP, a few changes were made in the patient's EMR to reflect the recent changes. A few days later when the patient went to see the cardiologist, a new medication (Aldactone) was added to her home medications based on the assessment. The patient added this new medication to her printed list, with the date and the provider who ordered the medication.

Although the organization is responsible for having a medication reconciliation process, which includes reviewing the patient's home medications, the ED physician wasn't aware of the patient being on Eliquis – a blood thinner and a high-risk medication – prior to sending the patient for an invasive procedure.

If the NP had solely relied on the patient's home medication list that was in the electronic medical record (EMR) and had not take the extra time to call the patient's local pharmacy and ask what medications the patient had and when they were last filled, the actual reason for the patient's recent onset of symptoms may not have been determined.

Since the hospital, cardiologist and PCP use a different EMR, they were unable to share or compare the patient's home medications via the EMR. When the patient sees different providers who don't use the same EMR, medication errors can easily occur due to the inconsistencies with the information the patient is given.

**Note:** This case example is an actual event that occurred to a family member of a Joint Commission employee. The employee and her family have given permission to The Joint Commission to share their loved one's story.

## CASE EXAMPLE #8 — Part 2

### Going above and beyond to reconcile the medication list

A look at  
safety strategies

#### CASE EXAMPLE

An 89-year-old white female patient, with a history of chronic congestive heart failure, coronary artery disease, and aortic stenosis was seen in the Emergency Department (ED) after experiencing shortness of breath for two weeks when lying down flat in bed.

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On the day of the patient’s discharge, the cardiologist came to see the patient and reviewed the patient’s list of current medications as well as any changes in medications that the patient would be taking after discharge. The cardiologist did make a change in the beta-blocker that the patient was taking while in the hospital, from metoprolol tartrate (short acting) to metoprolol succinate (Toprol XL – long acting).

The nurse reviewed the discharge instructions, including the final list of home medications, with the patient and her daughter. The instructions included two follow-up appointments with the patient’s primary care provider (PCP) and the cardiologist.

The following week, the patient’s daughter went with the patient to the follow-up appointment with the PCP. To prevent confusion on the home medications the patient was instructed to take, the daughter printed a home medication list, including the reason for each medication. When the printed list was shared with the PCP, a few changes were made in the patient’s EMR to reflect the recent changes. A few days later when the patient went to see the cardiologist, a new medication (Aldactone) was added to her home medications based on the assessment. The patient added this new medication to her printed list, with the date and the provider who ordered the medication.

Transitions of care are ripe for potential errors in medication reconciliation, whether it’s from one caregiver to another (a “handoff”) or to another level of care, including transfer from one unit to the next in the same facility, or to another facility. For this reason, before a transition takes place, it’s important to give the patient an updated medication list if any medications have been added or stopped.

Due to the number of providers that patients may see and the different EMRs that exist in various healthcare settings, there is a high risk that medication errors can occur – not only in healthcare facilities but also in the home. In order to prevent confusion:

In healthcare settings – During any care transition, the updated home medication list should be available and be referenced when writing orders for a hospital stay.

In the home – Ideally, the patient and the patient’s advocate should keep an accurate and current list of home medications and have the list available to show each healthcare provider the patient sees.

When reconciling the patient’s home medications in the ED, it is important to make sure the providers determine if there are any medications that have been taken (or missed) recently that could have the potential for complications or contraindications for a planned procedure, such as thoracentesis for a patient on a blood thinner, as in this case example, or tPA for a patient on an anticoagulant.

When conducting medication reconciliation, it is important to consider both the what and the how of the process. The what is reviewing the patient’s home medication list. The how is going one step further – taking the time to call the patient’s local pharmacy and ask what medications the pharmacy fills for the patient and when they were last filled.

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