

Whose Job Is It, Really?

A Multidisciplinary Approach to Completing Inpatient Medication Reconciliation

by

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Mini-Case 1 – June

June is a 77-year-old, markedly obese Caucasian woman with chronic systolic heart failure, hypertension, and type 2 diabetes mellitus. She presents with complaints of worsening shortness of breath for one day, associated with mild nonproductive cough. She denies any chest pain, fever, chills, and hemoptysis. Her home medications include lisinopril 10mg daily, carvedilol 3.125mg twice daily, furosemide 20mg daily, metformin 500mg twice daily and low-dose aspirin daily. On physical examination her blood pressure is 160/94 mmhg and heart rate is 85 bpm. Heart sounds are normal with no added sounds, S3 or S4. She has regular rate and rhythm. On lung exam she has bibasilar rales. Labs show elevated pro BNP of 25000 pg/ml, troponin I less than 0.02 ng/ml. Chest x-ray shows cardiomegaly and bilateral interstitial infiltrates. Electrocardiogram shows normal sinus rhythm with no ST-segment changes and no QT prolongation. Echocardiogram shows an ejection fraction of 40% with diffuse hypokinesia. Initial diagnosis of acute exacerbation of chronic systolic heart failure is made. You are the resident assigned to this patient. You have not done her medication reconciliation (MR) yet, but plan to do so.

Discussion Questions

1. What is MR? What are the most effective practices for MR in a hospital setting?
2. Discuss the importance of MR.
3. What are the barriers to implementing MR in the hospital setting?



June developed chest pain on hospital day 2. EKG showed ST elevation in leads V1 and V2, troponin I was now elevated to 2.5 ng/ml. She was diagnosed with ST elevated myocardial infarction (STEMI). She underwent an emergent left heart catheterization with stents placed in left anterior descending artery and circumflex artery. She recovered completely without any further complications and was discharged on day 7 from admit. On discharge she was instructed to continue her home medications except for carvedilol, which was increased to 12.5 mg twice daily and Plavix 75 mg daily was added. Patient was instructed to follow up with the cardiologist in one week.

Discussion Question

4. What are the various points in an inpatient setting where MR should be implemented? Which health care professional should lead and contribute to it?

Mini-Case 2 – Davis

Davis, a 68 year old African American man, was brought to the hospital by his son due to altered mental status. Past medical history is consistent with hypertension, hyperlipidemia, type 2 diabetes mellitus, asthma, and osteoarthritis. He lives alone but his son, who lives in the same town, visits him regularly. This morning his son found him to be confused and disoriented. The initial admission medication list was incomplete as the son was not sure of all the medication his dad was taking and the patient was unable to provide an accurate list of meds due to his mental status.

Discussion Question

5. How would you obtain an accurate and a complete medication list in such a situation?



CME Questions

1. As of January, 2016, The Joint Commission put forth medication reconciliation as National Patient Safety Goal (NPSG) No. 3 in an effort to minimize adverse events caused during these types of care transitions.
 - a. True
 - b. False

2. What instructions should be given to a patient at discharge regarding medications?
 - a. To give a list to their primary care provider.
 - b. To update their own list when medications are discontinued, doses are changed, or new medications (including OTC medications) are added.
 - c. To carry their medication information at all times in case of an emergency.
 - d. All of the above.