Quality Improvement Activity: (Medication Reconciliation)

A 45 – year – old female arrived at 0600 on the Day Surgery unit for her procedure. The patient was scheduled to have an implanted cardioverter – defibrillator placed so she would no longer have to wear her life vest. The patient's surgery was not on the schedule until 1200 so the nurse and her student did not pick up the patient until 1045. When they entered the room the IV nurse was starting the patient's ordered fluids and documenting the IV placement. As the nurse began the admission questions she asked the patient about allergies, her preferred pharmacy, when she last had anything to eat or drink, and then began reconciling the patient's medications. When going over the patients' medications the nurse asked when the patient last took her Aspirin and she said she stopped taking in 5 days ago, as she was instructed to do by the doctor. As the nurse continued to move down the list of medications, she noticed that the patient was on Amiodarone and Brilinta. When the nurse asked when was the last time you took this medication the patient said this morning with a sip of water. The nurse asked the patient if she was told by her physician to stop taking the Brilinta, and she said no just the Aspirin. Then the patient asked "why?". The nurse responded with "Brilinta is a blood thinner so I'm trying to figure out why he told you stop taking the Aspirin and not the Brilinta.". The patient then stated that they were never prescribed a blood thinner. The nurse then asked the patient if they had brought their medications with them. When the nurse looked at the medications and asked which ones were new medications the patient pointed to the Amiodarone and Brilinta, and then the nurse informed the patient that Amiodarone is an antidysrhythmic and restated that Brilinta was a blood thinner. The patient was then very upset and said that when she went to the Doctors office last time, he had prescribed her one new medication and that he never discussed either of those medications with her. The nurse then said that she was going to call the Doctor and try to get the situation figured out. When the nurse was on the phone with the doctor, he said that because she was taking the Brilinta that the surgery would need to be canceled and rescheduled, and that the office had no record of him prescribing the patient those medications. The nurse then informed the still upset patient that the Doctor had canceled her procedure. The patient then became angry and the nurse asked to see the prescription bottles again. When looking at the bottle she saw that the medication was prescribed to this patient and that the doctors name was on the bottle. The nurse then empathized with the patient and gave them instructions, per the doctor's order, to stop taking the Amiodarone and Brilinta. Then gave her instructions to keep the bottles and take them to her next appointment so they could track down a reason for the mistake. The patient then got dressed and was discharged with a new appointment with the physician's office.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?

In this scenario it was not the Day Surgery environment that was lacking it was the physician and his office. Not only should the physician or his Nurse Practitioner have caught the mistake, but it should have been caught when the patient went to pick up the medication from the pharmacy. This was the first time she had been prescribed either medication, and she would have needed instructions on how to take the medication as well as confirming that she knew what the medication was for. This is not a common occurrence, and none of the other nurses on the unit had seen anything like this happen before.

What circumstance led to the occurrence?

The root cause was that the physician prescribed the wrong medication. It was assumed that the physician prescribed this patient medications that were meant for a different patient. The circumstances that lead to the mistake being caught was a nurse who was very diligent in reconciling her patients' medications, and taking a second to realize that the patient had been instructed to stop one blood thinner but not the other. Then investigated further into the issue and found the cause to be the physician prescribing the wrong medications.

In what way could you measure the frequency of the occurrence? (Interviewing nurses, examining charts, patient surveys, observation, etc.)

This was a medication error and was reported. There is a record of this mistake just like there is a record for other medication errors, and that data can be collected and organized to determine the frequency of the occurrence.

What Evidence bases ideas do you have for implementing interventions to address the problem?

There is already a system of checks put in place to prevent events like this from happening. Such as the pharmacist checks the doctor and then the nurse checks the pharmacist and the doctor. However, in this case I think the doctor should have slowed down and spent more time explaining the medications that he was prescribing for the patient, and then the pharmacist should have asked the patient if they had ever taken the prescribed medications before. Not only is it important for the physician, pharmacist, and the nurse to be on the lookout, but I think that we need to teach patients the importance of taking an active role in their health care. By doing this I think that many errors could be avoided.

How will you measure the efficacy of the interventions?

The effects of the intervention can be measured the same way that the error is measured. Through the data collected from the medication error reports, and more specifically the prescribed medication errors reported.