Do You Really Know What Your Patient is Taking? The Importance of Physician Led Medication Reconciliation in Patients with Polypharmacy

Kelly Stewart, MD Candidate 2019, Mike Banker, MD
University of Colorado School of Medicine, Colorado Springs Branch

Background

- An accurate medication list is an important component of patient care in the outpatient setting, emergency department, and inpatient hospital systems.
- Making sure patients have an accurate medication list is a crucial role of the primary care physician.
- It is estimated that primary care physician do medication reconciliations at only 32% of patient visits (1).
- In a recent study, 2.4% of patient’s presenting to the ED had a chief complaint due to an adverse drug event (ADE) or presumed adverse drug event (PADE) (2).
- In patients over the age of 65, approximately 43.6% result in a hospital admission (3).
- Although all adverse drug events cannot be prevented by an accurate medication list, taking the time to do a medication reconciliation at every patient visit gives physicians additional opportunities to avert potentially dangerous medication errors before they result in a hospital admission.

Objectives

- Our aim was to study the prevalence of inaccurate medication lists in patients’ taking five or more medications presenting to the Sangre de Cristo Family Practice Clinic in Canon City, Colorado.
- By implementing required physician led medication reconciliation at every visit, our goal was to have 100% of patients with five or more medications have completely accurate medication lists by the end of March 2018.

Methods

- Quantify the number of patients requiring polypharmacy (5 or more medications) that present to the clinic with inaccurate medication lists.
- Determine which category the medication error falls in: dosing error, missing medication, or medication in which patient is no longer taking.
- Confirm that all patient’s in this study leave the clinic with an accurate medication list after reconciliation.
- Estimate the amount of time needed to do a complete medication reconciliation with a patient presenting on five or more medications.

Results

- Patient Population
  - N=20
  - Age Range = 60 years old – 89 years old
  - Average Age = 78 years old
  - 55% male and 45% female
  - Average number of medications = 8

- Medication Lists
  - Correct
  - Incorrect

- Reason for Medication Error

- Common Medications
  - Dosing Errors: Warfarin, Hypertension, Insulin
  - Old Medications: Antibiotics, PPI, Steroids
  - Missing Medications: Started by other providers

- Average Time for Medication Reconciliation: 1 minute and 12 seconds

Discussion

- 65% of patients presenting to clinic with polypharmacy had inaccurate medication lists.
- This project clearly identified the necessity of physician led medication reconciliation at every patient visit in the primary care setting regardless of chief complaint.
- This also allowed time to clarify any questions or concerns patients” had about their medications that could have lead to dangerous mistakes.
- Physician led medication reconciliation at every visit can easily be implemented in primary care clinics.

Future Directions

- Expand this practice to all patients presenting to clinic regardless of the number of medications.
- Future studies needed to look at if implementing required medication reconciliation at every visit in the primary care setting reduces ED visits and hospital admissions for adverse drug events.

References

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