# The Case for Medication Reconciliation Patient Stories

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68 years of age

Retired engineer

Former smoker

Enjoys his garden

Goes to club 2 -3 times a week

Has COPD, hypertension and recently diagnosed with AF



- Presents to ED with exacerbation of his COPD
- Admission history taken by RMO
- Medication history taken with assistance of GP referral letter
- History documented in patient's progress notes





Atrovent 2 puffs qid

Seretide 250mg 2puffs BD

Ventolin 2puffs prn

Frusemide 40mg mane & midi

Cardizem 240mg OD

Amiodarone 200mg OD

Warfarin mdu

Paracetamol prn for joint pain

Voltaren gel recently



Bloods taken
INR 4

Treatment decision documented in notes "withhold warfarin until INR therapeutic"





Atrovent neb 4 hrly

Seretide 250mg 2puffs BD

Ventolin neb 5mg 6 hrly prn

Frusemide 40mg po mane & midi

Cardizem CD 240mg po mane

Amiodarone 200mg po mane

Paracetamol 2 prn for pain

Prednisone 25mg daily for 7 days

Ampicillin 1g IV 6hrly





5 days later

Bruce seen by the team

Decision to discharge

Ambulance booked for 10am next day

9am RMO paged to write D/C script

Script written from current medication chart.

1 month supply ordered

9.15am script arrived in pharmacy

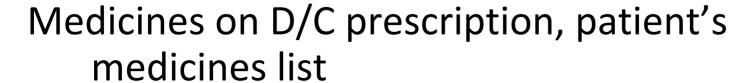






- 9.30am ward staff ring pharmacy inquiring whether Bruce's D/C medications are ready as ambulance arriving at 10am
- 1 month supply medicines dispensed
- Bruce's medicines list prepared in the pharmacy from the discharge prescription and placed in bag with his medicines
- 10am ambulance officer collects Bruce's D/C medicines from pharmacy





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Seretide 250mg 2puffs BD

Ventolin 2puffs prn

Frusemide 40mg mane & midi

Cardizem 240mg mane

Amiodarone 200mg mane

Prednisone 25mg daily for 2 days

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Bruce made an appointment to see his GP the week after he was discharged 5 days following his discharge Bruce suffered a stroke was paralysed down one side and unable to speak



85 years old Lives alone in retirement village Looks after herself Type 2 diabetes, hypertension, hyperactive thyroid – recently commenced on propylthiouracil Fell over in street when shopping Hit her head, ? broken arm Taken by ambulance to hospital



ED very busy

Lillian slightly confused

Nurse took medication history

Used Lillian's medicine's list from previous admission in handbag

Documented in nursing assessment form





Metformin 500mg tds

Daonil 5mg tds

Karvea 150mg OD

Temaze 10mg prn

Panamax 2 prn

RMO Medication history

Documented - see medication chart

Used nurses history to write up chart





Metformin 500mg tds

Daonil 5mg tds

Karvea 150mg OD

Temaze 10mg prn

Panamax 2 prn



Lillian admitted to hospital

Slight concussion

Broken arm for surgery next day

48 hours later

Agitated and confused

**Observations** 

- ↑ Heart rate
- **↑** Temperature

RMO called



Suspected sepsis

Blood cultures taken

Flucloxacillin commenced 1g IV qid

48 hours later

Symptoms worsened

Bloods taken



Endocrinology consult ordered



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Lillian became unresponsive

MET team called

Diagnosed thyrotoxic coma

Tranferred to HDU

Propylthiouracil recommenced

Passed away 12 hours later

