The Case for Medication Reconciliation
Patient Stories

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matching medicines at transitions of care

Bruce's Story

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

Bruce's Story

- 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

Bruce's Story

Medication history documented

- 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

Bruce's Story

Bloods taken

INR 4

Treatment decision documented in notes

"withhold warfarin until INR therapeutic"

Bruce's Story

Medication charted

- 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

Bruce's Story

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

Bruce's Story

- 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

Bruce's Story

Medicines on D/C prescription, patient's medicines list

- Atrovent 2 puffs qid
- Seretide 250mg 2puffs BD
- Ventolin 2puffs prn
- Frusemide 40mg mane & midi
- Cardizem 240mg mane
- Amiodarone 200mg mane
- Prednisone 25mg daily for 2 days
- Paracetamol prn

Bruce's Story

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

Lillian's Story

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

Lillian's Story

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

Lillian's Story

Medication history in nursing assessment

- 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

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Lillian's Story

Medication chart

- Metformin 500mg tds
- Daonil 5mg tds
- Karvea 150mg OD
- Temaze 10mg prn
- Panamax 2 prn

Lillian's Story

Lillian admitted to hospital

Slight concussion

Broken arm for surgery next day

48 hours later

Agitated and confused

Observations

- ↑ Heart rate
- ↑ Temperature

RMO called

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Lillian's Story

Suspected sepsis

Blood cultures taken

Flucloxacillin commenced 1g IV qid

48 hours later

Symptoms worsened

Bloods taken

↑ T4

Endocrinology consult ordered

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Lillian's Story

Lillian became unresponsive

MET team called

Diagnosed thyrotoxic coma

Tranferred to HDU

Propylthiouracil recommenced

Passed away 12 hours later

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