Medication Errors and Hospital Admissions, a Tale of Woe

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CASE DESCRIPTION

- Elderly Spanish-speaking patient presents to ED with CHF exacerbation
- Given home dose of Lasix with a good response, discharged without prescription
- One week later calls with worsening symptoms, told to double dose, no prescription given
- Readmitted one week after with CHF exacerbation, given home dose, discharged again without prescription
- Follow-up phone call reveals patient had not received Lasix in pharmacy blister packs for two months

GOAL FOR IMPROVEMENT

- TO improve proper medication regimens for patients as they transition between healthcare settings
- SO THAT patients achieve improved outcomes and reduced hospital admissions caused by medication errors

SMART aim is to decrease the number of discrepancies between discharge medication lists and pill bottles or blister packs produced at one-week follow up with Jefferson PCP by 10% within six months

PROPOSED INTERVENTION

- Force function for inpatient team-to-PCP communication at discharge highlighting key medication changes
- Multidisciplinary team approach to medication reconciliation including pharmacy and social work to ensure patient can afford and understand new medications
- Section for identification of patient’s pharmacy on H&P and mandatory communication with patient’s pharmacy on admission for early identification of patients at high risk for medication error

NEXT STEPS

- Identify key stakeholders in pharmacy and social work departments to form multidisciplinary team to implement interventions
- Meet with IT representatives to establish channel for data collection in EPIC
- Identify pilot group of patients on hospital medicine service with Jefferson primary care providers