Medication Reconciliation Isn’t Easy or Quick

Dear Dr. Jeff:

Meetings of our quality assurance committee often report on our medication-reconciliation rate. Apparently, our rates are good, so I don’t need to worry! But as someone new to LTC, I wish I understood what they are talking about, although everyone else seems to expect that I do. Could you explain?

Dr. Jeff responds: It is always better to know what you don’t know than to think you know what you don’t. You are probably already a long step ahead of many of the other committee members.

Many facilities use a form of some kind to list medications at key transition points in a resident’s care. If the form has been completed and signed by someone, the facility considers medication reconciliation (sometimes known as “med rec”) done. The proportion of those forms that is routinely completed is probably the statistic being reported.

Medication reconciliation is considered by many to be a key feature in the quality-of-care transitions. Its real goal is a confirmation that a patient’s medication regimen is rational and consistent from one care site to another.

This double check should occur at each transfer, including admission from the community, transfer from acute care to subacute care or LTC, transfer from unit to unit within a facility, and discharge back to the community.

A 2005 Archives of Internal Medicine article demonstrated that more than half of all patients during hospital admission had one or more unintended medication discrepancies, which was the physician intended to discontinue. The discharge summary should list the medications recommended for use after discharge, but the MAR may not.

But when medication doses or the prescribed antibiotic are different in each version, which list should the nursing home admitting physician attempt to reconcile?

Some hospitals try to improve things through a special form (providing yet another list) that focuses on the indications for each medication. Unfortunately, the people completing this form can indulge in a peculiar process that I call “back diagnosis,” in which a patient is immediately assigned diagnoses that seem appropriate for the medications being received:

A patient receiving iron is labeled with iron deficiency, a patient on a proton pump inhibitor must have either a peptic ulcer or gastroesophageal reflux disease.

But Wait, There’s More

Finally, another unique medication list may be provided by the patient or family. In my experience, this list often includes an extraordinary variety of medications not on any hospital form, from chemotherapy drugs to cardiac medications and especially eye drops for glaucoma.

Sometimes, medications legitimately differ for a given indication because the hospital was trying to improve on what the patient had been taking at home, but often the change is an artifact of conflicting formularies. It is important to note that due to a hospital’s bulk-purchasing contracts, medications may be dramatically different from the pattern in the community. One common example of this is esomeprazole (Nexium), which is the least expensive among proton pump inhibitors for many hospitals and the most expensive at community pharmacies.

Optimists have predicted that electronic health records (EHRs) will solve most of these problems. Unfortunately, the failure to implement a single, universally-compatible EHR means that there is little likelihood that the one in the hospital will soon be transferable to community physicians or community pharmacies.

Information technology in nursing homes is very much a work in progress, because clotting function has any evidence base or whether a suggested medication-safety requirement because, it is quite different. For example, a patient with atrial fibrillation might not be on an anticoagulant because he refused, because she previously had a bad reaction, because a prescriber decided the risk outweighed the benefit, or because it was being held back at the time of hospital discharge because clotting function had been excessively suppressed. The approach to each of those circumstances would, of course, be quite different.

Similarly, when an apparently inappropriate medication appears on the list or a dosage seems unusual or even outside of best practice, we need to question that as well. LTC staff need to protect residents by picking up the telephone and asking questions.

Call the hospitalist, the cardiologist, the community physician, the home care nurse. Question whether a listed diagnosis has any evidence base or whether a suggested medication has any known efficacy for the patient you see in front of you. In the end, good medical care is the best form of medication reconciliation.

By Jeffrey Nichols, MD

A well-trained and highly competent hospitalist may never have been inside a nursing home or heard of the Omnibus Budget Reconciliation Act of 1987 regulations. Diabetic management, medication reconciliation requirements, pain medications, and bowel regimens all should change as patients transition from acute care to subacute care or LTC. Sleep medications that might have been marginally appropriate during the stress of acute illness probably should be tapered or discontinued in the nursing home.

Under the worst of circumstances, a board-certified family physician or internist attending the patient in the nursing home may change discharge recommendations written by a fourth-year medical student and then be challenged by a patient or family for doing so.

Appropriate prescribing in LTC requires both the clinical skills of an experienced physician and the analytic skills of an expert detective. We need to ask patients and families about medication use before hospitalization, including herbal supplements and over-the-counter drugs.

When an apparently needed medication is missing, we need to question the absence. For example, a patient with atrial fibrillation might not be on an anticoagulant because he refused, because she previously had a bad reaction, because a prescriber decided the risk outweighed the benefit, or because it was being held back at the time of hospital discharge because clotting function had been excessively suppressed. The approach to each of those circumstances would, of course, be quite different.

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Dr. Nichols is the medical director of Our Lady of Consolation and Good Samaritan Nursing Homes in Suffolk County, N.Y., and senior vice president for clinical effectiveness of the Catholic Health Care System of Long Island. He invites your questions for possible discussion in this column, to caring@elsevier.com. You can also comment on this and other columns at www.caringfortheages.com, under “Views.”