Home Visits Detect 62% More Medication Discrepancies

A study published recently in the Journal of Nursing Care Quality finds that adding in-home nurse visits to the medication reconciliation program detects 62% more medication discrepancies.1 Medication discrepancies rank as a serious problem for millions of adults post hospital discharge. One of the complications is that few patients arrive at the hospital equipped with complete information about their home medications - especially patients admitted through the emergency department.2 Foster and colleagues found that 72% of adverse events after hospital discharge were adverse drug events. Medication reconciliation programs have strong potential to reduce hospital readmissions, improve patient safety, and improve patient health.3-7

Linda Costa, PhD, RN, of Johns Hopkins, and colleagues studied a medication reconciliation program for adults discharged from the hospital with four or more prescriptions.1 All participants had to be discharged to home, chronically ill, cognitively intact, and English-speaking. Their intervention included both pre-discharge and post-discharge work for coordinating medication lists and educating patients and family. Nurses called families 48 hours after discharge to provide additional medication adherence coaching and identify possible medication discrepancies. Additionally, nurses made home visits after the telephone follow-ups. The home visits discovered 62% more medication discrepancies that were undetected by the telephone follow-up. Overall, despite the additional efforts in the hospital, medication discrepancies were found with 67% of patients post-hospital discharge. Most discrepancies were patient-level, nonintentional non-adherence. Nursing follow-up was able to correct all medication discrepancies identified, and, through this in-home follow-up program, there were no readmissions related to medication non-adherence.

Other key findings from Costa’s study include:
- 100% of patients lost their written discharge instructions.
- Patients who follow up with their primary care physicians shortly after hospital discharge achieve greater medication adherence. Many patients who would benefit from medication reconciliation are not homebound. These patients should be scheduled for PCP follow-up shortly after hospital discharge.
- Several family members commonly share the care of the chronically ill patients. Coaching the caregivers responsible for the medication regimen is important in resolving discrepancies.
- The home offers a relaxing, conducive environment for patient education.
- In-home visits identify additional, correctable health hazards (e.g. using gas stoves as heating sources, rodent infestations, poor lighting).

When you have homebound patients with a probability of medication discrepancies, make a referral to Care Corp Home Health & Hospice. As a standard part of our home health care, our nurses will do the following for your patients:
- Ensure timely follow-up with the PCP.
- Take a careful inventory of all medications and supplements used by your patient. With access to medicine cabinets and kitchen cabinets, our nurses are well positioned to get the most accurate accounting possible.
- Emphasize the importance of persistence with treatment.
- Review the signs and symptoms of toxicity.
- Identify and overcome patient concerns about side-effects, costs, delivery, and other obstacles.
- Develop individualized medication-taking systems by utilizing access to the home environment. This can be as simple as taping a reminder note to the bathroom mirror. Knowing your patient’s daily routine and having access to their home environment enables Care Corp nurses to tailor adherence strategies specifically to a patient’s lifestyle.
- Coach family caregivers.

Please offer Care Corp Home Health & Hospice to your patients.
References


