

A MEDICATION RECONCILIATION PROTOCOL PERFORMED BY PHARMACISTS: IMPACT ON HOSPITAL DISCHARGE SUMMARIES

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BACKGROUND

Medication reconciliation (MR) is one of the measures with greater impact on safety in the use of the drug. Reconciliation errors appear frequently in the transitions between the different levels of care, especially at hospital discharge.

Purpose

Evaluate the impact of a medication reconciliation project performed by pharmacists on medical discharge summaries.

MATERIAL AND METHODS

A protocol was performed to support the MR at discharge by the Pharmacy Service in a 350-bed Hospital and developed over 4 weeks.



THE PHARMACIST WENT TO HOSPITALIZATION AREA FROM MONDAY TO FRIDAY AT THE END OF THE MORNING AND HE MADE THE MR PRIOR TO DISCHARGE.

He conducted a structured pharmacotherapeutic interview with the patient to know the home medication prior to admission and later discussed with the physician the new medication that would be added and if there was any modification of the previous medication.



A REPORT WITH ACTIVE PRINCIPLE, DOSAGE/POSOLGY, AND PHARMACOTHERAPEUTIC RECOMMENDATIONS WAS ELABORATED

The medical discharge summaries were reviewed and a database was developed where were included demographic variables (sex, age, no pre-admission drugs) and as primary endpoint if the physician included in his summary all medication of the patient (complete summary), as well as whether there was any treatment with a finite duration, if this was included in the instructions to the patient.



PRE-INTERVENTION GROUP

We also selected a sample of discharged patients before the pharmacist's intervention to compare both groups. Bivariate analysis and logistic regression analysis using SPSS software

RESULTS

VARIABLES	PRE-INTERVENTION GROUP	POST-INTERVENTION GROUP	p
Patients (N)	28	27	
Median age (IQR)	65.2 years (50.4-71.6)	77.9 years (61.1-84.2)	0.004
Sex	66.7% men	51.7% men	0.653
Median number of drugs prior to admission (IQR)	4 (0-10)	8 (5-12)	0.028

Regardless of the age of patients **IN THE POST-INTERVENTION GROUP, THEY ARE ABOUT 4 TIMES MORE LIKELY TO HAVE A COMPLETE MEDICAL DISCHARGE SUMMARY** (OR:3.97 95%CI:1.18-13.3)(p=0.026).

THE PERCENTAGES OF MEDICAL REPORTS WITH DURATION SPECIFIED IN PRE AND POST-GROUPS WERE, RESPECTIVELY, 0%VS.18,5%(p=0.023)

CONCLUSION

The participation of the pharmacist improves the process of MR at discharge, favoring that it's performed in a greater number of patients and that information provided at discharge is more complete.

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