PS-027

Medicines Reconciliation at Emergency Department Discharge

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Objectives

Transitions in care, admission to and discharge from the hospital put patients at risk for error as a result of poor communication and information loss.

Our goal is to assess the feasibility of a medication reconciliation programme at patient discharge from the Emergency department (ED) in a third level teaching hospital.

Methods

Pilot study carried out over three monts. Elegible patients were located in the Non-admission Observation ward (NAO, ward # 3, ED).

ED adults 2012: 99075 visits
NAO ward: 4087 admissions
3393 discharges

Patients characteristics (NAO, 2012):
52% women
Age 64 years (SD 22)
Charlson I 2,4 (SD 1)
Lenth of stay: 1,63 days

Electronic medical records
Physician order entry

Selection criteria

8,30 to 9,30 a.m.
Age ≥ 65
Polipharmacy ≥ 5 drugs
Comorbidity ≥ 3 diseases
Other risk factors

Before patient discharge, the emergency pharmacist (EP) is asked on electronic request (eR) to adjust drug therapy with the most accurate list of out-patient current medication.

EP Medication reconciliation process involves:

Electronic medical records and prescription databases review
Structured patient interview (prescribed and non-prescribed medicines)
Caregiver consultation if necessary at 11 am
Communication with the medical team
Medicines counseling to patient

Results

n= 35
24 women, 11 men
Mean age: 80 years (65-92)

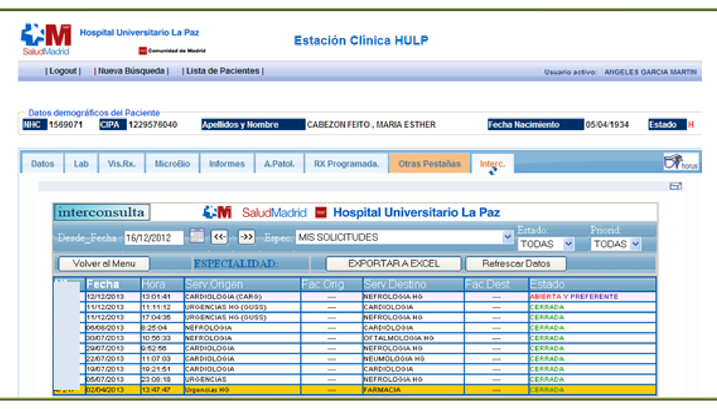
Comorbidity: 6,3 diseases per patient
Cardiovascular diseases, chronic obstructive pulmonar disease, pielonefritis, hemato-oncologic impairment, thromboembolic disease, etc.

Chronic hepatic or renal disease:
11 patients

1 – 3 eR to EP per day

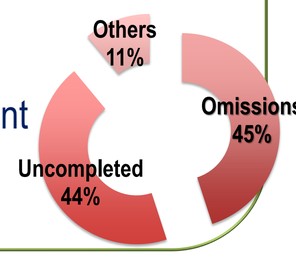
35 eR answered by the EP

Reconciled drugs: 444 drugs, 12.7 per patient



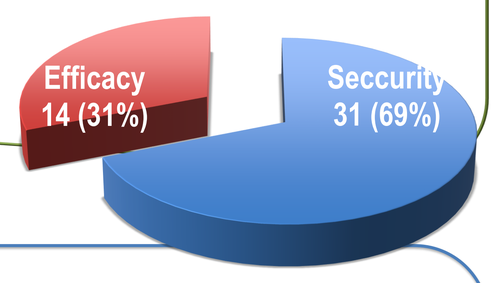
Differencies in number of drugs (current medication) between EP review and ED admission report:
2,7 (0 – 18) per patient

170 Discrepancies, 4.9 per patient
33 Patients with at least one discrepancy
76 Omitted drugs, 2.2 per patient
75 Incomplete prescriptions, 1.9 per patient



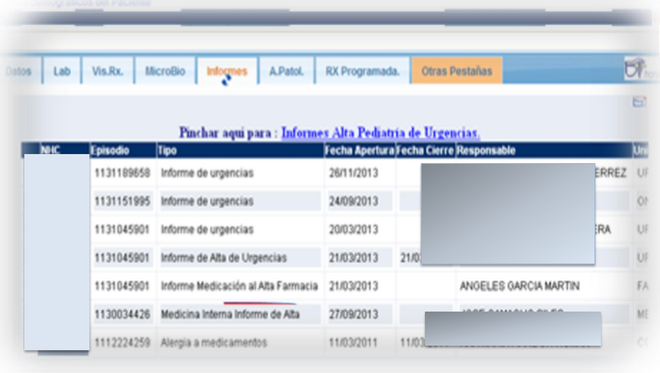
Potentially adverse drug events: 45

20 Patients involved
25 (55.6 %) resolved before discharge
12 drug – related problems due to overdose



Updated and accurate drug information report was integrated into hospital´s electronic records in 35 patients

12 patients receive written and verbal drug information at discharge
8 out of 12 patiente were provided with a drug therapy report



Postdischarge patient follow-up

The medication reconciliation process generated new medical orders in the primary care setting in 7 patients.
5 out of these 7 patients were provided by the EP with scheduled medication reports before ED discharge.

Discussion and Conclusions

The small sample size is due to the fast-paced environment. This makes, at a time, discharge communication critically relevant

Medication reconciliation should be bundled with other interventions: patient counseling about discharge plans, coordination of follow-up appointments and postdischarge telephone calls

Medication reconciliation at ED discharge is feasible in the NAO ward but difficult to carry out in a busy ED setting

Reconciliation by EP may improve drug therapy, preventing adverse drug events across transitions in care

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