

RESULTS OF A MEDICATION RECONCILIATION PROGRAMME IN COMPLEX CHRONIC PATIENTS AT HOSPITAL DISCHARGE

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BACKGROUND AND IMPORTANCE

Hospital discharge has been described as the care transition in which a major number of incorrect prescriptions occur. Discharge medication reconciliation aims to prevent discrepancies when comparing the in-hospital with the discharge electronic prescription.

OBJECTIVES

To assess the incidence of unjustified discrepancies during a medication reconciliation programme by pharmacists in complex chronic patients (CCP) at hospital discharge.

MATERIAL AND METHODS

This was a cross-sectional study where we assessed unjustified discrepancies between the in-hospital prescriptions (which are summarised in the discharge report) and the electronic prescriptions for all CCP from April 2019 to May 2019.

Data were obtained from the discharge report prescriptions and the electronic prescriptions. Unjustified discrepancies were assessed according to the medical records. CCP were defined as patients with chronic diseases and comorbidities due to socioeconomic, cultural and environmental situations interfering with the decision and the need to implement specific plans.

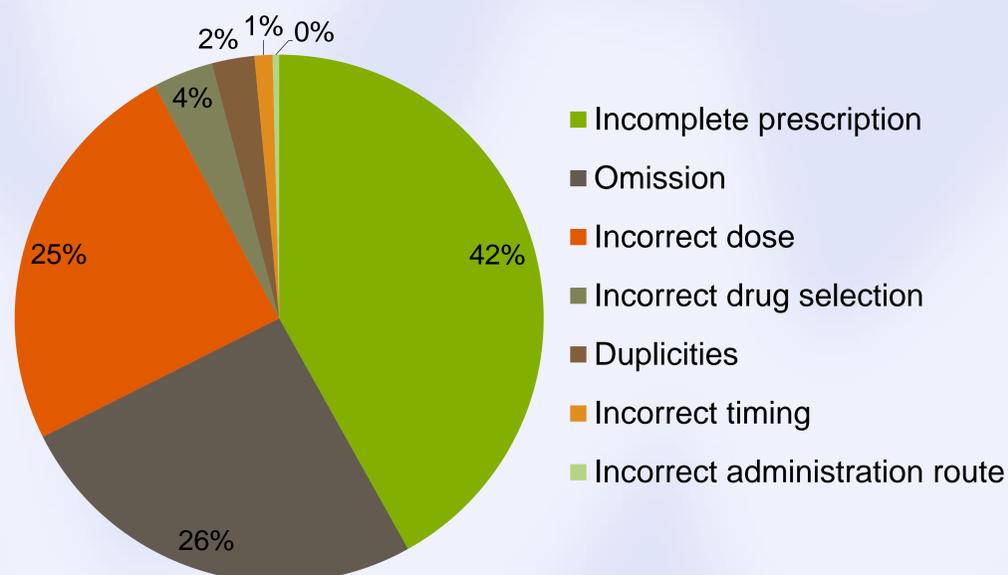
Discrepancies were classified according to: (i) incomplete prescription, (ii) omission, (iii) incorrect dose, (iv) incorrect drug selection, (v) duplicity, (vi) incorrect timing and (vii) incorrect administration route.

RESULTS

We analysed the discharge prescriptions of 97 patients. Mean age was 81.7 ± 9.7 years and 50 (51.6%) were women.

Seventy-seven (79.4%) patients were admitted to medical wards and 20 (20.6%) to surgical wards. A total of 272 discrepancies were found in 77 (79.4%) patients with a mean of 2.8 ± 2.8 discrepancies per patient: 114 (41.9%) discrepancies were related to incomplete prescription, 70 (25.7%) to omission, 67 (24.6%) to incorrect dose, 10 (3.7%) to incorrect drug selection, 7 (2.6%) to duplicities, 3 (1.1%) to incorrect timing and 1 (0.4%) to incorrect administration route.

DISCREPANCIES



CONCLUSIONS

We found that about 80% of patients presented at least one unjustified discrepancy. Medication reconciliation is a major component of safe patient care in any environment. Therefore, education of healthcare professionals and implementation of tools such as electronic reconciliation software could be useful to improve safety.



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