DISCHARGE MEDICATION RECONCILIATION: 
EVALUATION OF A 7 MONTHS ACTIVITY
C. Bottolis1, J. Giraud2, J-F. Alexandra3, C. Guenée1, P. Arnaud1, C. Tesmoingt1
Pharmacy1 and internal medicine2 unit in Bichat-Claude Bernard Hospital (AP-HP), 75018 Paris, FRANCE

INTRODUCTION
Since 2010 admission medication reconciliation has been performed in all patients of a 30-bed internal medicine unit, from Monday to Friday.

In addition, since March 2016, a discharge pharmaceutical care is conducted in 3 steps:
- Discharge medication reconciliation
- Individual patient treatment plan
- Pharmaceutical interview with patient or/and with his family or caregiver

OBJECTIVE: evaluate this new pharmaceutical activity

MATERIALS AND METHOD
Retrospective study:
- From July 2016 to February 2017
- All patients leaving the unit were included
- Prioritizing patients returning home

Exclusion criteria:
- Death of a patient or transfer to another acute unit

Collected information:
- Age and sex of patient,
- Number of medication reconciliation, interviews and treatment plans,
- Causes of non-reconciliation,
- Medication discrepancies: quantification and qualification

RESULTS

ACTIVITY DESCRIPTION
- 396 discharge patients
- 322 eligible patients
- 115 non medication reconciliations
- 193 (59.9%) individual treatment plan
- 207 (64.3%) medication reconciliations
- 148 (46%) pharmaceutical interviews
- 23 deaths, 51 transfers
- Mean age = 72.3 years
- Sex ratio = 0.9

REASONS OF NON MEDICATION RECONCILIATION (n=115)

- No discharge prescription: 4%
- No data: 3%
- Too many discharge (prioritization): 12%
- Week end discharge: 12%
- Absence of pharmacist at patient discharge: 27%
- Transfer to rehabilitation establishment (prioritization): 42%

MEDICATIONS DISCREPANCIES

- 207 analyzed discharge prescriptions
- 121 discharge prescriptions ≥ 1 medication discrepancies
- 251 unintentional medication discrepancies

- 58.5% of patients have 1 or more medication discrepancies at discharge
- Mean medication discrepancies = 2/prescription
- Range = 1-7 discrepancies
- <5% are considered potentially serious

97.5% of these medications discrepancies have been corrected after pharmaceutical intervention
Uncorrected discrepancies mostly concern a low potential risk for patient, such as medication timing errors

DISCUSSION - CONCLUSION
- All of the patients who received a discharge pharmaceutical care had a discharge medication reconciliation.
- Most of them received a treatment plan and almost 3% had a pharmaceutical interviews (without considering mentally ill people and retirement home’s patient)
- Pharmaceutical intervention allowed to avoid medication discrepancies in more than half discharge prescription
- Approximately a third of the eligible patients did not receive discharge medication reconciliation mainly because of a lack of organization

Structured discharge and coordination between all involved teams (medical, pharmaceutical and administrative) seems to be essential to improve this new activity.

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