MEDICATION RECONCILIATION PROGRAMME PERFORMED IN A GENERAL AND DIGESTIVE SURGERY SERVICE
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Background
- Care transitions are critical points regarding medications errors because of the high number of treatment modifications that are carried out.
- Medication reconciliation (MR) and providing accurate information to the patients about their treatment can help prevent medication errors and consequently improve quality of care.

Objective
- Our objective is to analyse discrepancies found between patients’ current medication and treatments prescribed during hospitalisation to reduce these through the intervention of the hospital pharmacist.

Methods

Prospective study from 1 June to 1 October 2018

Patients included: 100% patients admitted to the General and Digestive Surgery Service of a university hospital during the study period who met all the inclusion criteria (>65 years old and >4 current medications as home treatment).

- At admission, the hospital pharmacist reviewed the patient’s electronic medical records and interviewed the patient or the primary caregiver to obtain the accurate list of current medication. The hospital pharmacist contacted the physician to solve discrepancies which were classified in: omission, duplicity, wrong dose and wrong pharmaceutical form.
- Medications involved were classified according to the ATC classification.
- Patients who accepted, received written information about treatment at discharge and answered a satisfaction survey.
- This study has been approved by the regional clinical research ethics committee.

Results

- 127 patients
- 51.2% male
- Median age (range): 80.1 (66.0-93.3) years old.

<table>
<thead>
<tr>
<th>Discrepancies classification</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omission</td>
<td>196</td>
<td>91.6%</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>14</td>
<td>6.5%</td>
</tr>
<tr>
<td>Wrong pharmaceutical form</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>Duplicity</td>
<td>1</td>
<td>0.5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>214</td>
<td>100%</td>
</tr>
</tbody>
</table>

Discrepancies solved: 108 (50.8%)
Discrepancies unsolved: 106 (49.2%)

Mean hospitalisation time ±SD: 11.7±9.5 days.
Median of medicines number as home treatment/patient (range): 7 (5–14) medicines.
Median of discrepancies found at admission/patient (range): 2 (0–4) discrepancies.

Only 7.9% of patients did not present any discrepancy

Almost half of unsolved discrepancies (47) were omissions of lipid-lowering agents in primary prevention which are not usually prescribed during admission.

<table>
<thead>
<tr>
<th>Main ATC groups with discrepancies</th>
<th>Number of discrepancies</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Cardiovascular system</td>
<td>116</td>
<td>(54.2%)</td>
</tr>
<tr>
<td>Nervous system</td>
<td>25</td>
<td>(11.7%)</td>
</tr>
</tbody>
</table>

Satisfaction survey evaluation (67 patients): 8.6/10 points.

Conclusions
- MR is an is an effective measure to reduce medication discrepancies. Hospital pharmacist intervention identified discrepancies, improving the quality of prescription during admission.
- Most unsolved discrepancies were statins in primary prevention.
- Cardiovascular and nervous system were the ATC groups with the most discrepancies.
- Patients report a high satisfaction rate.