26th Congress of the EAHP

Ganador del Premio a la Excelencia en la Gestión Pública. XIV edición

Abstract Number: 5PSQ-148

TANDEM PROJECT: TRANSITIONS OF CARE AND MEDICATION RECONCILIATION IN HIGH-RISK PATIENTS

Ortega Navarro C, de Lorenzo Pinto A, García Sánchez R, Torroba Sanz B, Herranz Alonso A, Sanjurjo Sáez M.

Servicio de Farmacia. Hospital General Universitario Gregorio Marañón. Instituto de Investigación Sanitaria Gregorio Marañón (IiSGM). Madrid, España

OBJECTIVES

The implementation of medication reconciliation programs is a quality standard in health centers according to recommendations of patient safety organizations to reduce medication errors during transitions of care (TOC).

Main objective is to implement a medication reconciliation program in high-risk patients admitted to a tertiary hospital. Secondary objective is to promote patient safety by detecting medication errors that occur during TOC.

MATERIALS AND METHODS

Selection of high-risk patients by two clinical pharmacists physically present in the Emergency Department.

At admission:

- advanced medication review by pharmacist
- interview to the patient or carers (to obtain a complete and accurate home medication list)
- potential prescribing error: pharmacist makes a pharmacotherapy recommendation (PR) to the physician

At discharge:

- pharmacists review the medication list on the discharge plan
- interview to the patient via telephone within 72 hours post discharge to confirm that they have understood the new treatment plan
- If the pharmacist detects an error, he makes a PR directly to the patient.

RESULTS

At admission: 789 patients included (February 2018 - September 2021).
Pharmacists made a total of **1140 PR** to physisians (1,5 per patient). Acceptance rate: 92,5%

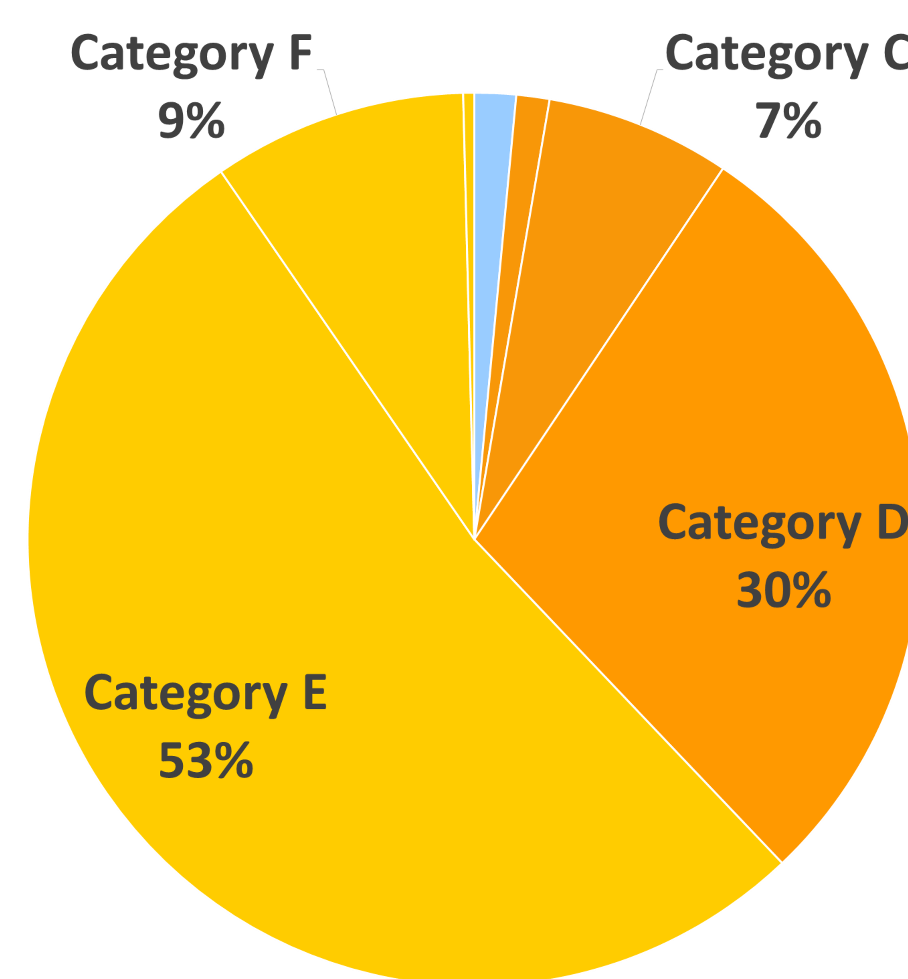
Table 1. Patients´ characteristics

	N = 789
Age, mean (SD)	81 years (9,7)
Sex, % women	53,3%
Number of home medications, mean (SD)	11,2 (4,3)

Table 2. Types of prescribing errors at admission

Error	N = 1140
Omission of a drug	37,3%
Wrong drug	23,6%
Wrong dose	21,0%
Wrong frequency	11,2%
Others	6,9%

Graph 1. Severity of prescribing errors (NCC MERP severity index)



At admission, 707 (**62%**) prescribing errors could have caused **harm** to the patient (Category ≥ E).

At discharge:

277 patients interviewed by a pharmacist

46,9% did not understand at least 1 aspect of the discharge medication list

✓ 336 pharmacotherapy recommendations to patients
✓ **65%** of the detected errors could have caused **harm** (NCC MERP severity index Category ≥ E).

CONCLUSION AND RELEVANCE

We have successfully implemented a medication reconciliation program in high-risk patients that allows us to detect medication errors at admission and discharge.

cristina.ortega@salud.madrid.org

www.madrid.org/hospitalgregoriomaranon/farmacia

@farma_gregorio