L-Università ta' Malta
Faculty of Medicine & Surgery
Department of Pharmacy

Pharmacist-Led Medicine Reconciliation at Diabetes Outpatient Clinic

Charlene Camilleri

Department of Pharmacy, Faculty of Medicine and Surgery, University of Malta, Msida, Malta

email: charlene.camilleri.98@um.edu.mt

INTRODUCTION

Medication reconciliation post-medical consultation can indeed prevent medication errors[1]. During the transitioning between one interface (secondary care), and another (primary care)[2] important medical data can get lost leading to serious consequences. Healthcare professionals are aware that there seem to be gaps in the system which needs to be overcome to ensure a smooth and seamless transition between these interfaces. Harmonization between different healthcare providers will greatly reduce these gaps within the health system[3]. In this study, subsequent to the medicine reconciliation, the patient also benefits from a comprehensive list of medications which forms an important part of the pharmaceutical care plan. This will ultimately target the continuity of care across the secondary and primary care interface.

AIMS

To develop a pharmacist-led service to increase the communication between the hospital specialists in the Diabetic Outpatients at Mater Dei Hospital and the pharmacists within the community setting.

The objectives of this study were:

- Perform medicine reconciliation for 100 patients attending the diabetic outpatient and diabetic education unit of Mater Dei Hospital to identify drug therapy problems (DRPs)
- Develop a Transition-Of-Care Document (ToC) using the comprehensive list which was complied during the medicine reconciliation.

METHOD

Patients attending MDH outpatients were eligible to participate in the study

- A designated person invited the patients to participate in the study and asked for a verbal consent
- The patient was introduced to the researcher

N=100

Written informed consent signed by patient following a brief overview of the study using a designated information sheet

- Patient's data collected using a data collection sheet
- Medicine reconciliation performed
- DRPs were recorded
- Pharmacist intervention sheet compiled
- Questionnaire was given to the patient

A Transition of care document was compiled using the patient's current medication list denoting either

- Change in treatment
- No change in treatment

Transition of care document, together with a questionnaire was sent to community pharmacist via e-mail

Questionnaire was used to assess the effectiveness of the transition of care document

A third questionnaire was presented to 11 healthcare professionals , ranging from diabetic consultants to diabetic specialists and diabetic nurses working within the diabetic outpatient firm

RESULTS

Fig 1: Identified drug related problems N = 193

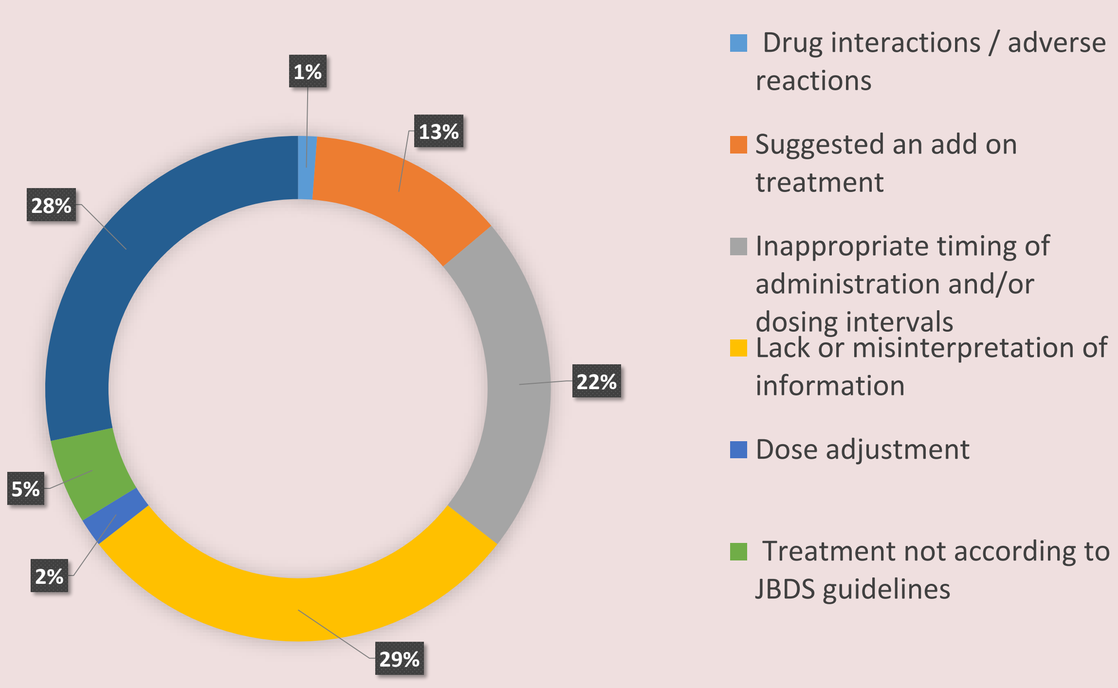
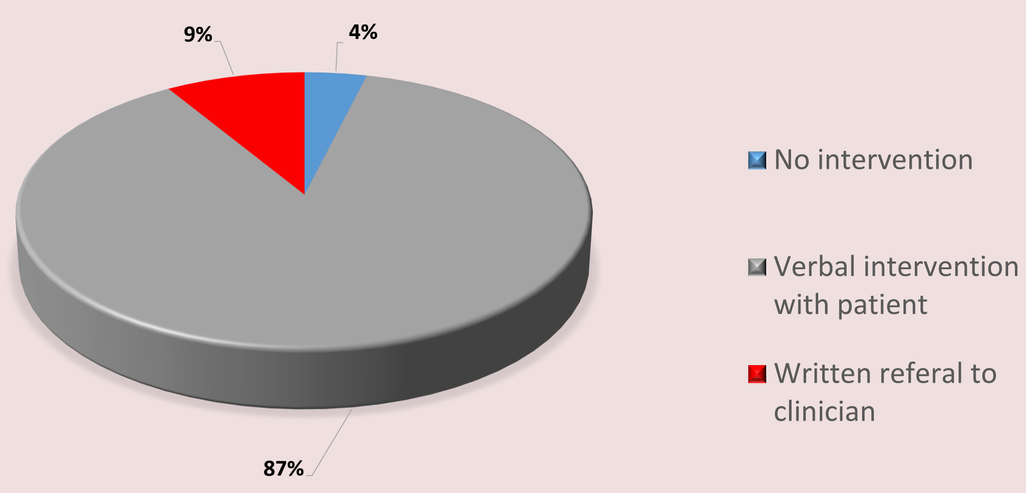


FIG 2: PHARMACIST INTERVENTIONS DURING MEDICINE RECONCILIATION N= 100



CONCLUSION

Through this research, a pharmaceutical care session was offered to patients attending the Diabetes Outpatient Clinic. During the session medication reconciliation was carried out and any drug therapy problems identified and resolved within a multidisciplinary care approach. A transition of care document, developed in this study, was used to list a complete and updated list of current prescription and non-prescription medications to the community pharmacist with whom the patient is registered to collect his/her regular chronic medications on the national health service scheme. The ToC document was disseminated via e-mail to the respective community pharmacist. A ToC document developed in this study is aimed to improve communication between hospital and community pharmacists and hence bridge the gap which currently exist especially during the crucial period of transitioning from one health care setting to another.

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