DISCHARGE MEDICATION RECONCILIATION: EVALUATION OF A 7 MONTHS ACTIVITY

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INTRODUCTION

Pharmaceutical team : pharmacist, pharmacy resident, pharmacy student

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

In addition, since March 2016, a discharge pharmaceutical care is conducted in 3 steps :

- **Dicharge 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 criterias :

- 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
- 23 deaths
- 51 transfers

322 eligible patients

Mean age = 72.3 years
Sex ratio =0.9

- 115 non medication reconciliations

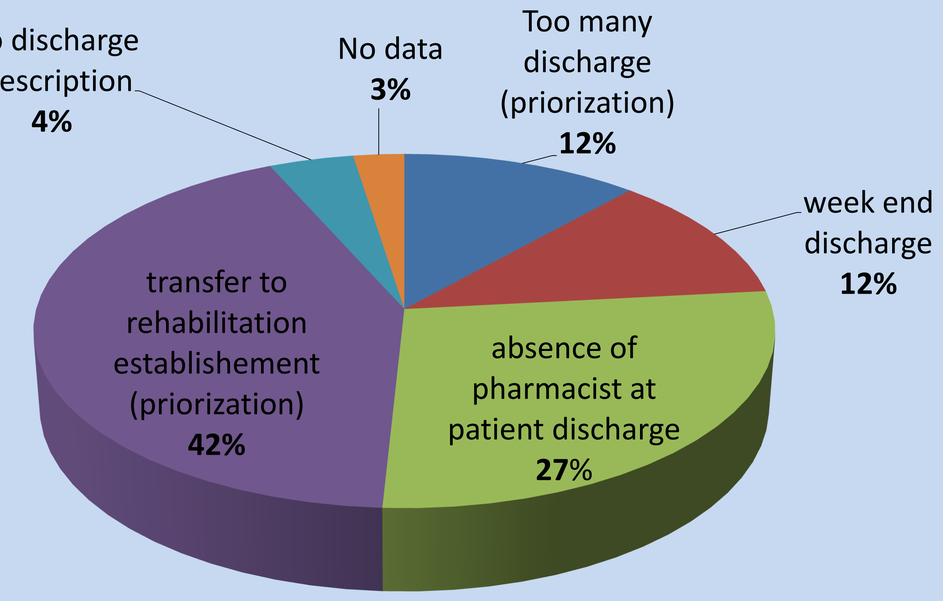
193 (59.9%) individual tretament plan

207 (64.3%) medication reconciliations

148 (46%) pharmaceutical interviews

22 (10.6%) pharmaceutical continuity of care (from hospital to community pharmacy)

REASONS OF NON MEDICATION RECONCILIATION (n=115)



MEDICATIONS DISCREPANCIES

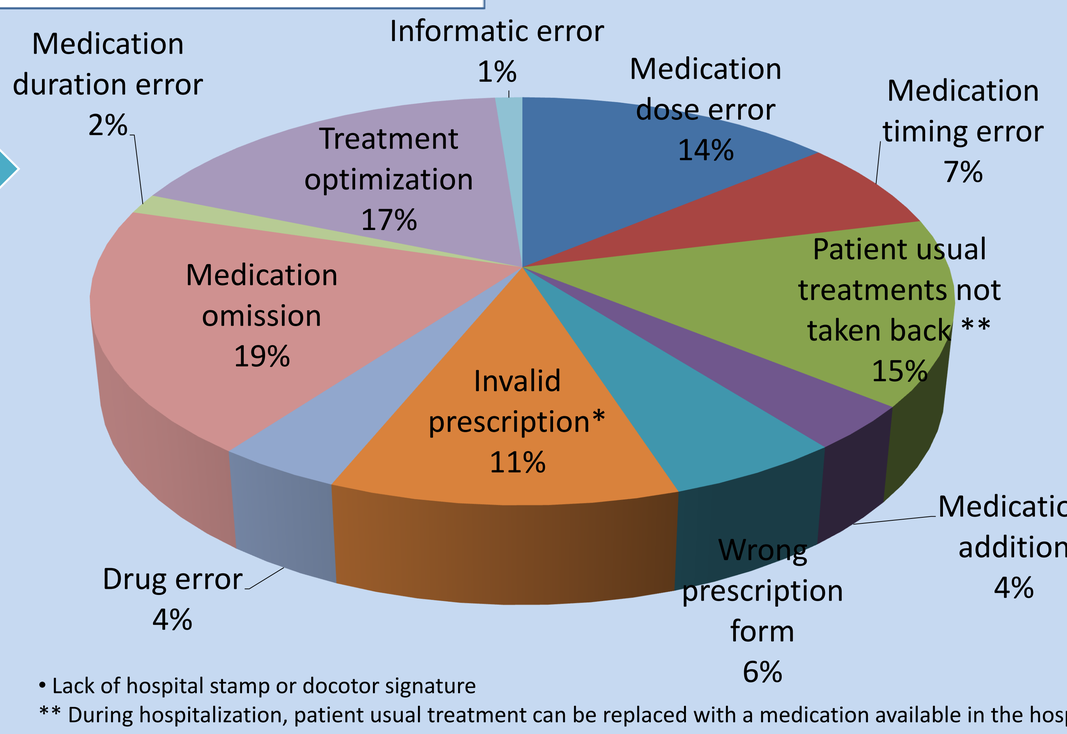
207 analyzed discharge prescriptions → 121 discharge prescriptions ≥ 1 medication discrepancies → 251 unintentional medication discrepancies

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



• Lack of hospital stamp or docotor signature
** During hospitalization, patient usual treatment can be replaced with a medication available in the hospital

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 ¾ 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

- Approximatively **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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