Impact of a clinical pharmacist at transition of care
A prospective study in an orthopaedic ward of a regional hospital

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Introduction

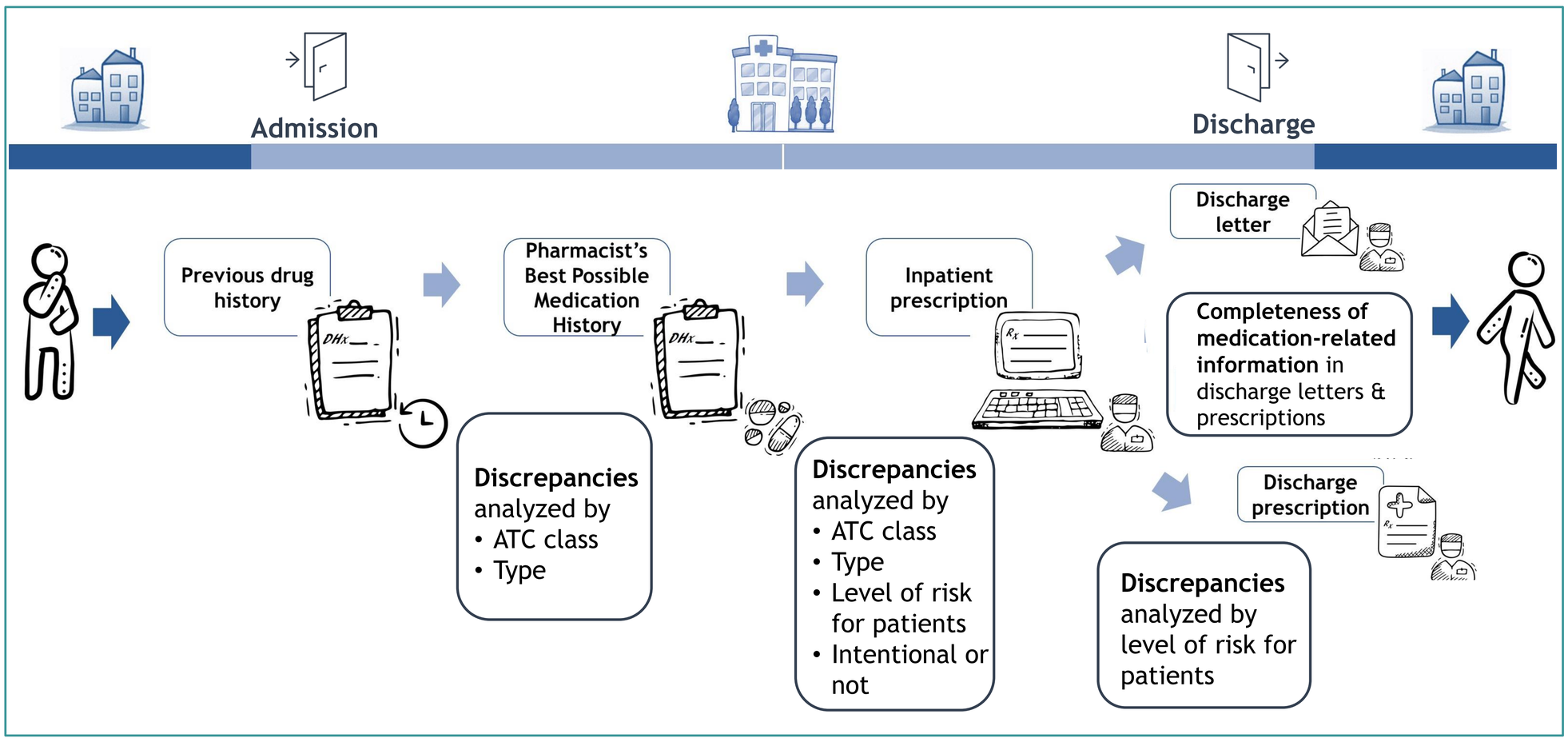
Transition of care (TOC) is a high-risk period for medication errors[1-2]. Discrepancies and incomplete medication information are common on hospital admission and discharge, potentially leading to drug-related problems and adverse drug events at TOC[1-3].

Objectives

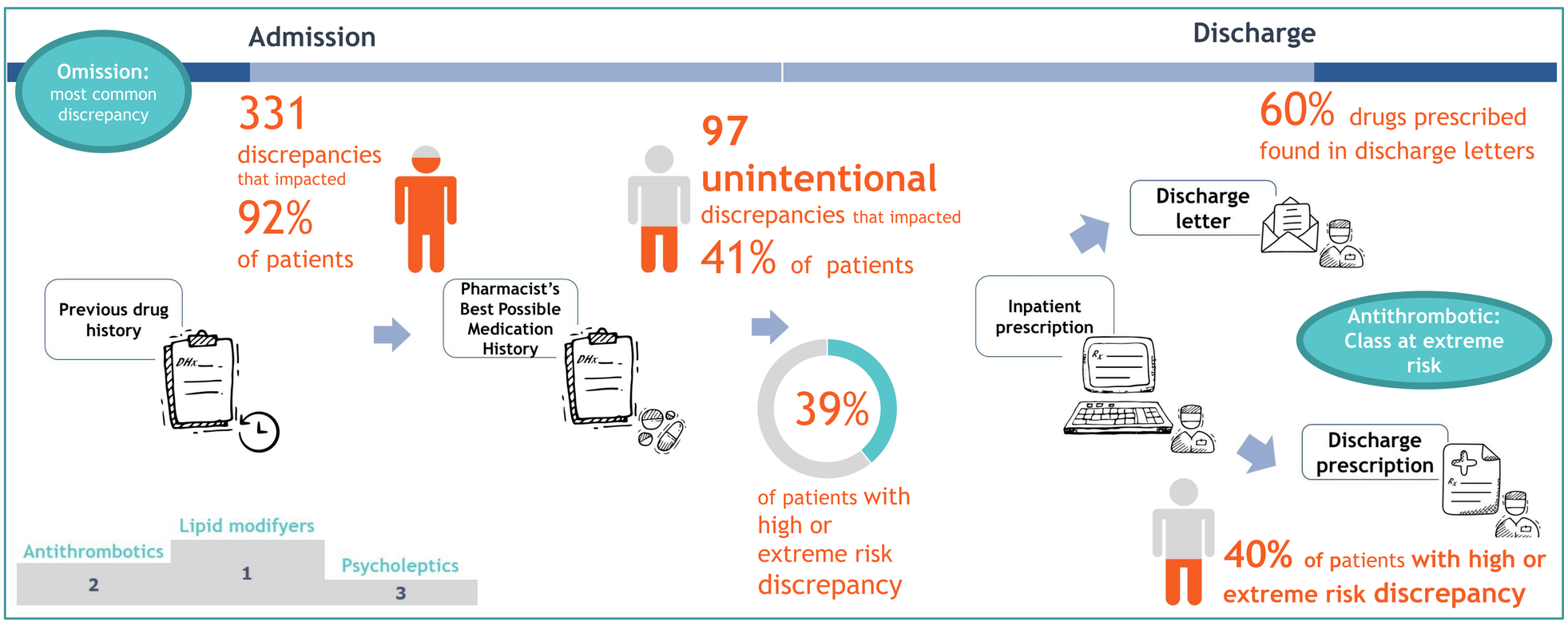
- To identify discrepancies on admission and at discharge and to detect completeness of medication information in discharge documents
- To assess the potential clinical impact of discrepancies

Method

- 4-week prospective interventional study
- 29-bed orthopedic surgery ward of a regional Belgian hospital
- Assessment of risk by clinical pharmacist and internist



Results



Conclusion

Discrepancies and incomplete medication information are real issues at TOC. To improve patient care, the hospital pharmacist is a suitable and valuable healthcare professional.

References

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