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CONCILIATION AND PHARMACEUTICAL CARE ON DISCHARGE IN THE PSYCHIATRIC PATIENT

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Background and importance: During the pharmacotherapeutic process of patients, various drug-related problems (DRPs) may appear, some inherent to the drug itself and others derived from healthcare. 25% of medication errors in hospitalized patients are due to an incorrect reconciliation of medication at admission[1].

Aim and objectives: 1-Guarantee that patients receive the necessary chronic and hospital medications, avoiding duplications and interactions between them. 2-Promote adherence to treatment through oral and written pharmacotherapeutic information (FTI) upon discharge.

Material and methods: Comprehensive pharmaceutical care for hospitalized psychiatric patients is divided into 2 actions:
1.- Reconciliation of medication at hospital admission: avoid DRPs that occur in the transmission of IFT between the different levels of care through the process called medication reconciliation. This knowledge of the actual medication of the patient acquires special importance and represents an important problem in the hospital admissions of psychiatric patients, especially those with multiple pathologies and polymedication.
2.- Reconciliation and FTI, oral and written, at hospital discharge: the medication prescribed at discharge is compared with that registered during admission and FTI is provided at discharge, oral and written, to the patient and / or caregiver, with the following objectives : -Promote correct pharmacological compliance of patients. -Promote adherence to treatment. -Resolving doubts regarding medication upon discharge of patients. -Provide a complete report of the patient's medication for subsequent healthcare professionals. Patients with> 5 medications, mainly those aged> 65 years, are considered susceptible to FTI at discharge. The main sources of information were: Complete Computerized Clinical History (including primary history), reports from medium/long stay centers, electronic prescription and personal interview with patients and relatives..

Results: The average stay in the Short Stay Unit is 14 days. The most prevalent pathologies are: schizophrenia, followed by schizoaffective and personality disorders. During 3 months all patients admitted to the psychiatric hospital were registered, a total of 123 patients with a mean age of 45.4 years (range 17-86) and an average number of medications/patient of 7. Primary and specialized care medication was reconciled for all of them, resulting in 85 interventions / discrepancies, out of 48 prescriptions. 97.6% (83) were accepted. During the indicated period, 12 patients (9.8%) met the FTI requirements at discharge.

Conclusion and relevance:
- Coordination and direct and active communication between the different healthcare professionals involved in patient care increases the quality of their healthcare.
- The integration of the liaison pharmacist in the hospitalization units allows a safe and efficient use of medicines. Likewise, it brings the work of the pharmacist closer to hospitalized patients, facilitating and expanding pharmaceutical care in the hospital and during care transitions.
- Added value of improving adherence to treatment: the patient is provided with knowledge of their treatment through oral and written information at the time of discharge.

References: Durán-García E, Fernandez Llamazares CM, Calleja-Hernandez MA. Medication reconciliation: passing phase or real need? Int J Clin Pharm 2012 Dec; 34 (6): 797-802.