27th - 29th March 2019 | Barcelona, Spain
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MEDICATION RECONCILIATION PROGRAMME PERFORMED IN A GENERAL AND DIGESTIVE SURGERY SERVICE

Mondelo García C, Gutiérrez Urbón JM, Margusino Framiñán L, Martín Herranz MI.

Pharmacy Service. Instituto de Investigación Biomédica de A Coruña (INIBIC), Complexo Hospitalario Universitario de A Coruña (CHUAC), Sergas. Universidade da Coruña (UDC). As Xubias, 84. 15006 A Coruña, Spain.

Background

- Care transitions are critical points regarding medications errors because of the high number of treatment modifications that are carried out.
- Medication reconciliation (MR) and providing accurate information to the patients about their treatment can help prevent medication errors and consequently improve quality of care.

Objective

- Our objective is to analyse discrepancies found between patients' current medication and treatments prescribed during hospitalisation to reduce these through the intervention of the hospital pharmacist.

Methods

Prospective study from 1 June to 1 October 2018

Patients included: 100% patients admitted to the General and Digestive Surgery Service of a university hospital during the study period who met all the inclusion criteria (>65 years old and >4 current medications as home treatment).

- At admission, the hospital pharmacist reviewed the **patient's electronic medical records** and **interviewed** the patient or the primary caregiver to obtain the accurate list of current medication. The hospital pharmacist contacted the physician to solve discrepancies which were classified in: **omission, duplicity, wrong dose and wrong pharmaceutical form**.
- Medications involved were classified according to the **ATC classification**.
- Patients who accepted, received **written information** about treatment at discharge and answered a **satisfaction survey**.
- This study has been approved by the regional **clinical research ethics committee**.

Results

- ✓ **127 patients**
- ✓ **51.2% male**
- ✓ **Median age (range):80.1 (66.0- 93.3) years old.**

Mean hospitalisation time ±SD: 11.7±9.5 days.
Median of medicines number as home treatment/patient (range): 7 (5–14) medicines.
Median of discrepancies found at admission/patient (range): 2 (0–4) discrepancies.

Only **7.9%** of patients **did not present any discrepancy**

Discrepancies classification	Number	Percentage
Omission	196	91.6%
Wrong dose	14	6.5%
Wrong pharmaceutical form	3	1.4%
Duplicity	1	0.5%
TOTAL	214	100%

Discrepancies solved: 108 (50.8%)
Discrepancies unsolved: 106 (49.2%)

Almost half of unsolved discrepancies (47) were omissions of **lipid-lowering agents in primary prevention** which are not usually prescribed during admission.

Main ATC groups with discrepancies	
Cardiovascular system	116 discrepancies (54.2%)
Nervous system	25 discrepancies (11.7%)

Satisfaction survey evaluation (67 patients): **8.6/10 points**.

Conclusions

- MR is an is an effective measure to reduce medication discrepancies. Hospital pharmacist intervention identified discrepancies, improving the quality of prescription during admission.
- Most unsolved discrepancies were statins in primary prevention.
- Cardiovascular and nervous system were the ATC groups with the most discrepancies.
- Patients report a high satisfaction rate.

5PSQ-144