CP-165

IMPACT ON HOSPITAL READMISSION OF MEDICATION RECONCILIATION IN POST EMERGENCY GERIATRIC UNIT : A PILOT STUDY

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Background & Objectives

In the current litterature, the iatrogenic effects in ederly people are the most frequent causes of rehospitalisation with a rate between 36% and 40%. Medication reconciliation is an effective strategy to decrease Adverse Drug Events (ADE) at the time of care's transition (admission, transfer, discharge and readmission) which is the source of incomplete and inaccurate medication informations. This process is based on medecine information collection to decrease medication errors at admission, reduce the rate of readmission and allow the drug continuity. The expected impact is a better patient safety and a decrease of healthcare costs.

The objectives are:

- Evaluation of the medecine reconciliation process in ederly by quantification of 30-days post-discharge rehospitalisation
- Analysis of the unintentional medication discrepancies at hospital admission, transfer and discharge
- Evaluation of duration of hospitalisation

Materials & Methods

Monocentric, randomised, prospective study “ConcReHosp” carried out from July 4th, 2016 to December 31st, 2016

Patient included by physicians

Admission reconciliation:
- Review of patient’s informations from several sources.
- Implementation of the best possible medication history (BPMH).
- Comparison of computerised patient’s admission prescription (PAP) and BPMH.
- Identification and analysis of discrepancies regarding omnissions, duplications, contraindications…
- Correction and optimization of patient’s prescription by medical-pharmaceutical collaboration.
- Update of the medication list in PHARMA® software.

Discharge reconciliation:
- Comparison of hospitalised patient’s prescription, BPMH and discharge prescription.
- Identification and analysis of discrepancies.
- Optimisation of discharge prescription by medical pharmaceutical collaboration.

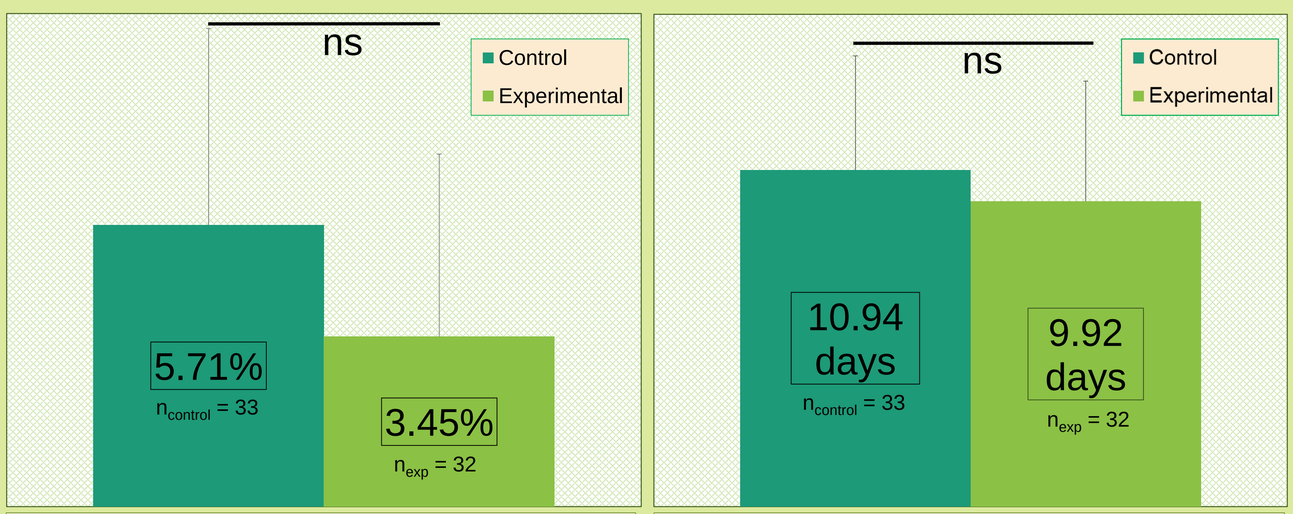
Therapy education:
Inclusion of both oral and written information

Transmission of medical information to other medical professionals (physicians, pharmacists)

Patients call-back for post-discharge follow-up

Analysis of data set:
- 30 days post-discharge re-hospitalisation
- Duration of hospitalisation

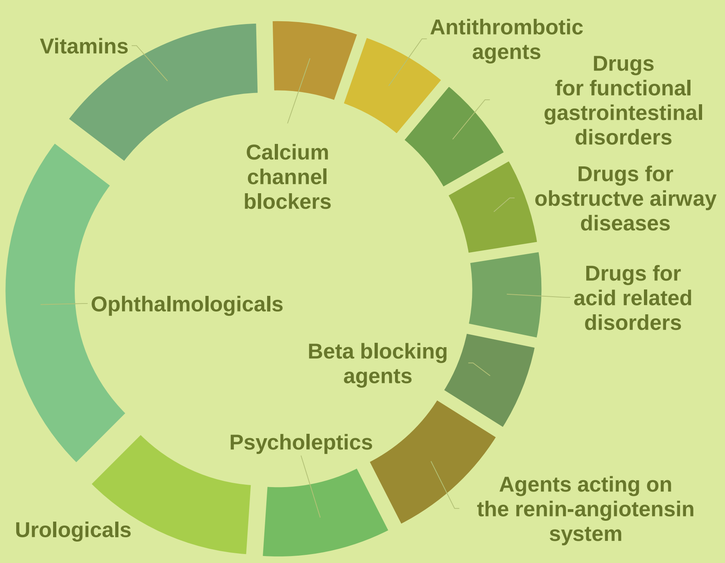
Results

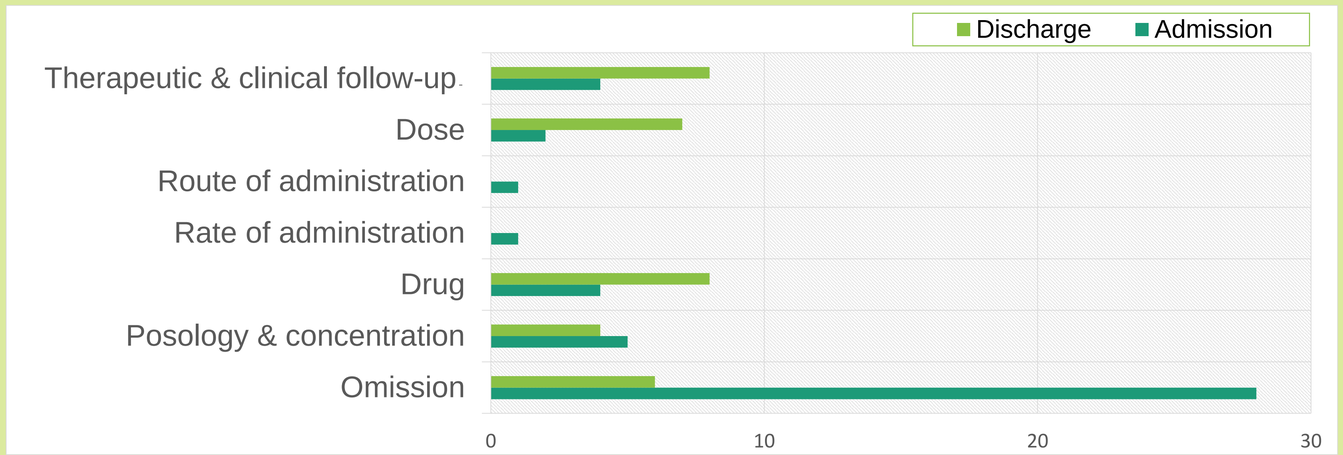


30 DAYS POST-DISCHARGE RE-HOSPITALISATION

DURATION OF HOSPITALISATION

THE MOST INCRIMINATED DRUGS UNINTENDED DISCREPANCIES





TYPE AND NUMBER OF UNINTENDED DISCREPANCIES

→ **The re-admission rate fell to 39.5% and the duration of hospitalisation are decreased to 1.02 days.**

→ **Ophtalmics, Vitamins and Urologicals drugs are the most implicated in unintended discrepancies.**

→ **At admission, the most frequent problem is omission.**

→ **At discharge, the most frequent problems are wrong drugs or follow-up default.**

Conclusion

Medication reconciliation within the post-emergency therapeutic internal medicine department has a positive impact on patient management and so probably in the cost of hospitalisation. The small number of subjects included at the time of the results does not produce significant results, but this study continues with an aim of 1,400 patients.