A medicines reconciliation process in frail elderly people

García Yubero C, García de Santiago B, Barro Ordovás JP, Llorente Gutierrez J , Hernández A. Hospital Universitario Infanta Sofía. Pharmacy department. SS.de los Reyes (Madrid). Spain

BACKGROUND

Medication reconciliation may be effective to reduce clinically important medication errors among high-risk patients such as frail elderly polymedicated people.

OBJECTIVE

To standardize a home medication reconciliation process in frail elderly people admitted to the hospital

METHODS

In this two-month pilot study, in a 280-bed hospital, a reconciliation process was designed by a multidisciplinary team. The study included all frail elderly people who were admitted to the hospital (people over the age of 80 years and afflicted with physical or mental disabilities that may interfere with the ability to independently perform activities of daily living).

Geriatricians obtained medical information to verify home medications by interviewing patients with the help of nurses and also from other medical reports. Pharmacist were acknowledged of these patients by the electronic consultations made to them by geriatricians. Pharmacists verified their medical records with current inpatient's orders and identified all discrepancies related to reconciliation, and if appropriate, notified attending physicians.

RESULTS

Baseline characteristics	
• N patients	45
• Age (y), mean (SD)	87.8 y (4.6)
• Medications reviewed on admission: total; mean per patient(SD)	356, 7.9 (2.9)

Consultations to pharmacist were done in 86,7% of patients.

Pharmacist reviewed all the consultations

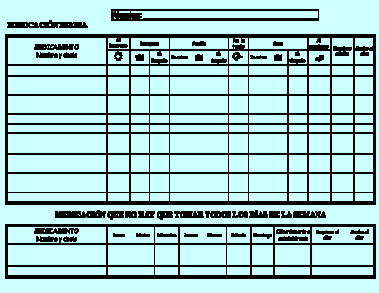
Discrepancies were detected in 41% patients:

a) Prescription of a drug non included in the hospital formulary (23,1% of patients). The substitution of these drugs proposed by pharmacists were accepted by physicians in 44,4% patients.

b) Other kind of discrepancies (related to effectiveness, safety, appropriate use) were detected in 5 patients (12,8%). The degree acceptance of these pharmaceutical interventions was positive in just one patient. The rest was either negative or not assessed by physicians.

One hundred percent of discharged patients included in their medical report a list of active drugs and also, specific recommendations about interrupting former medications were given in.

The hospital pharmacist created a patient discharge medication grid to aid with medication-taking practices at home. This patient aid includes a table containing information on the drugs such as names, dosages, administration times, and indications.



CONCLUSION

Medication reconciliation developed by a multidisciplinary team has been found to be useful to detect and reduce home medication discrepancies when frail old patients are admitted to the hospital. Therefore, it is recommended to implement a multidisciplinary reconciliation process for reduction in discrepancies when patients are admitted to the hospital. It will be interesting to implement the same process, involving a pharmacist, once the patient is discharged.

GRP-003

Conflict of interest: Nothing to disclosure