

RECONCILIATION AND DRUG INFORMATION TO GERIATRIC POLYMEDICATED PATIENTS AT DISCHARGE USING INFORMATION TECHNOLOGIES

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BACKGROUND

Aging of the Spanish population increases the elderly patient consensus and health care demand in hospitals.

This group of patients has particular characteristics that increase the

risk of medication errors.

PURPOSE

To establish a program which envolved medication reconciliation adapted drug information for elderly patients with polypharmacy at discharge using several electronic resources in order to promote continuity of care and adherence to pharmacotherapy.

MATERIALS AND METHODS



- •The geriatrician selects patients according to three criteria: more than 70 years old, at least five medications at discharge and any difficulty understanding.
- •Doctors fill in an electronic request form to the Pharmacy Department for the completion of the developed "Medication Information Form at Discharge."
- •The pharmacist reviews the treatment prescribed at discharge and reconciles it with the patient's medications during hospitalization via electronic records.
- •The visually appealing and understandable form is submitted electronically to be given to the patient.

RESULTS

April 2011-March 2012
-77,2% women
patients
- Mean age:
88,5 years old

CONCLUSIONS

- **❖555 Drugs were reported** (9.7 drugs/ patient)
 - ❖ 696 were reconciled (12.2 drugs/ patient).
 - ❖There were found 143 discrepancies (2.5 discrepancies/ patient):135 of them were justified (94.4%) and the other 8, were medication errors (0.014%).

Information technologies enable this pharmacist's activity:

- 1.Improving communication between professionals.
- 2.Inserting the "Medication Information Form at Discharge" in clinical documentation.
- 3. Enabling medication reconciliation.
- 4. Adapting the information sheet to the geriatric population.