Fondazione Monasterio
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Medication Reconciliation practice at transitions of care: a new challenge or opportunity for the clinical pharmacist?

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What was done?

Medication reconciliation at hospital discharge is essential for the prevention of medication discrepancies and patient harms. Hospital pharmacist has been recognized as one of main healthcare providers that can support the physicians in this activity.
Since 2016 the medication reconciliation process is performed by physicians and clinical pharmacists before home discharge from the Heart Hospital, Fondazione Toscana G.Monsaterio (Italy).

Why was it done?

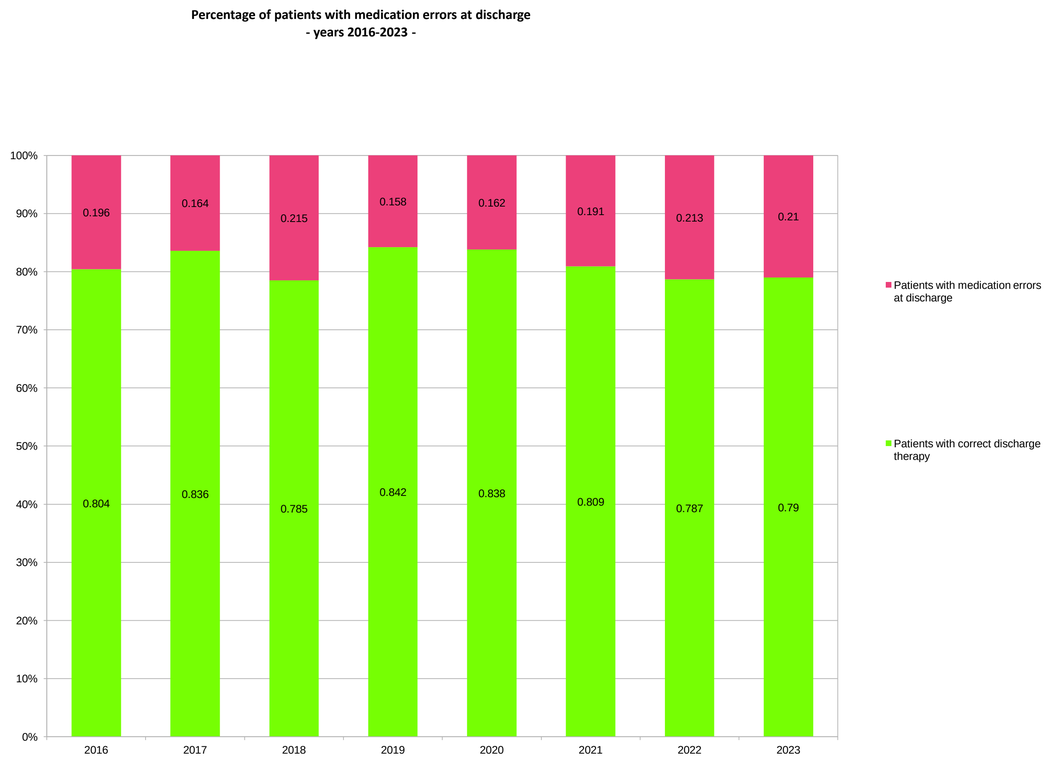
Several data suggest that pharmacists and physicians collaboration, direct pharmacist interaction with patients or caregivers through medication reconciliation and discharge counseling decreases the number of adverse drug events (ADEs) and plays an overall positive role in transitional care.
Our aim is to demonstrate the constant necessity of pharmacist led medication reconciliation in order to maintain high standard of care and safe medication use.

How was it done?

A shared pre-discharge prescription review program has been activated with all doctors, so when the final lists of drug prescriptions are ready, the pharmacist examines them and suggests improvements or corrections to the doctor before the discharge letter is delivered to patients. Among the unintentional discrepancy observed, the most frequent were omissions of chronic therapy, lack of information about suspension for Low Molecular Weight Heparin or antibiotics.

What has been achieved?

A strong collaboration between physicians and clinical pharmacists has been achieved as we shared the results of this improvement. The same activity has been required and extended to the pediatric ward where the demand of simple, clear and complete information is even more crucial since the particular inter-individual variability and fragility of this population.



What next?

We would like to improve the prescription review program also at admission in order to minimize drug omissions and at transition between different wards or different hospitals with the aim of improving communication between health care settings

CPS13340

Keywords:
Clinical pharmacy, Discharge prescription, Drug prescribing and dosing, Prescribing errors, Patient safety, Medication error.