DEVELOPMENT OF TRANSMURAL PHARMACEUTICAL CARE IN A GENERAL HOSPITAL

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Background and importance

Transitions between different care settings can be a source of medication errors. To avoid these errors, information about new medications must be shared between different care providers.
Medication reconciliation involves comparing the patient's chronically taken medications with newly prescribed medications to ensure continuity of patient care at all transition points.
The PACT project, an integrated care project, proposes to carry out medication reconciliation according to a structured methodology using envelopes (1).

<u>At hospital admission : blue envelope</u>
- The complete and updated medication scheme produced by the community pharmacist

➡ To be given to the care staff on the day of hospitalization

<u>At hospital discharge : green envelope</u>
- The new prescriptions and the new medication scheme produced by the doctor

➡ To be given to the community pharmacist

Objectives

🎯 To set up and evaluate the impact of pharmaceutical interventions aiming to implement the PACT medication reconciliation system at hospital discharge.

Material and methods

Quasi-experimental study (2)

AUDIT 1
16/11/22 → 25/11/22

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PHARMACEUTICAL INTERVENTIONS
28/11/22 → 09/12/22
- Awareness visits
- Real-time interventions
- Seminars

⬇

AUDIT 2
07/12/22 → 16/12/22

Evaluation of the similarity between the 2 groups (audit 1 and audit 2) in terms of:
- Demographic and clinical characteristics
- Medication characteristics

→ Student test, Chi Carré test

Evaluation of the impact of pharmaceutical interventions by comparing:
- Rate of green envelopes delivered to the patients

→ Chi Carré test

Identification of reasons for non-delivery of green envelopes

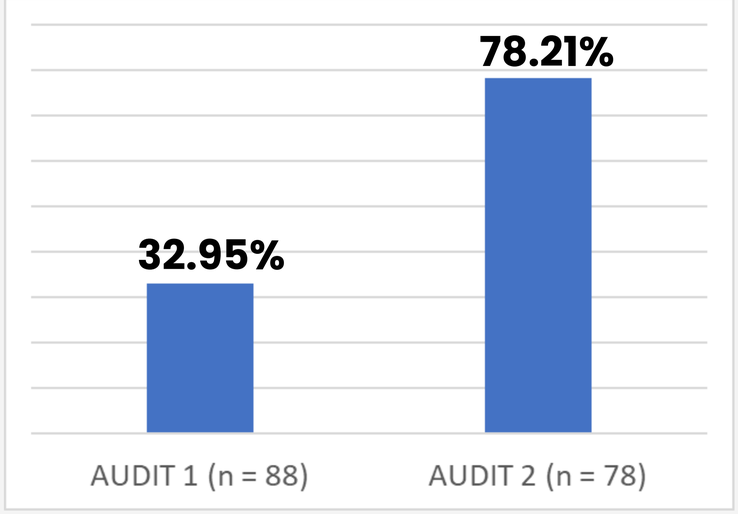
Inclusion criteria
- Patients hospitalised in
  - Geriatrics 1 and 2
  - Medicine 1 and 2
  - Rehabilitation 1 and 2
- And back to their residence

Exclusion criteria
- Patients transferred to another hospital unit

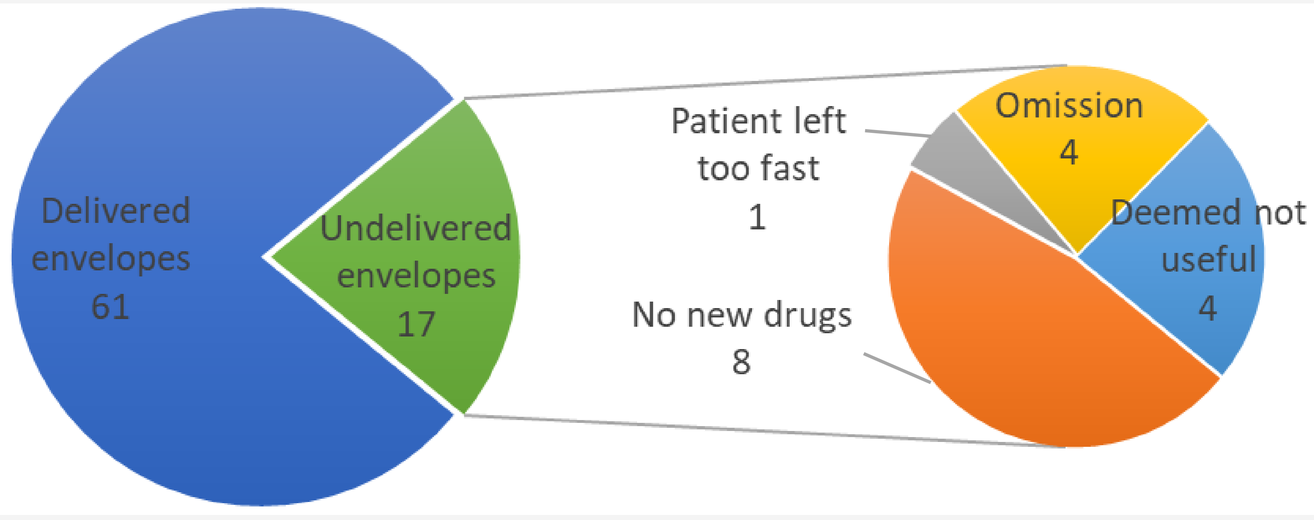
Results

The two groups were similar in terms of demographic and clinical characteristics.
Regarding medication characteristics, the analysis confirmed the similarity between groups, except for the number of newly prescribed medicines (Audit 1: 2.9 ; Audit 2: 3.6 ; p = 0.04) and the number of medicines to be stopped after hospitalization (Audit 1: 0.5 ; Audit 2: 0.9 ; p = 0.03).

Rate of green envelopes delivered (p < 0.001)



Audit 2 - Green envelopes undelivered: reasons identified



Conclusion

This work highlights the importance of developing the role of integrated care pharmacist coordinator to strengthen the communication on patient medications.

References

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2. Pardo A, Demeester R, et al. Impact of implementing a global collaborative physician pharmacist strategy on prophylactic antibiotic practices in a university hospital centre. Eur J Hosp Pharma 2019;26(Suppl 1):A100

4CPS-190