Service Priorities and Programmes
Electronic Presentations

Convention ID: 159
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Discharge Medication Reconciliation and Medication Summary by Pharmacists
– A Pilot Service Targeted for Elderly Home Residents

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Keywords:
Medication Reconciliation
Discharge Medication
Elderly Home Residents

Introduction
Medication reconciliation can prevent drug-related problems (DRPs) due to incomplete or inaccurate information at transitions of care.

Objectives
This pilot program aimed to provide medication reconciliation service to elderly home residents to enhance patient safety by ensuring the accuracy of the discharge prescriptions and records, and to rectify any DRPs before patients were discharged. In addition, a user-friendly medication summary sheet was designed to highlight any changes made to the medications during hospital stay. This aimed to prevent drug administration incidents due to communication gap regarding dosage adjustments or drug discontinuations during hospital stay.

Methodology
Pharmacists provided discharge medication reconciliation for patients under the care of Geriatrics Team in a medical ward, most of which were elderly home residents. Pharmacists reviewed the patients’ drug profile to identify any unintended discrepancies or DRPs, including omissions, therapeutic duplications, medications without indications, drug interactions, and inappropriate dosages or preparations. Pharmacists provided immediate feedback to prescribers and rectified any DRPs before the patients were discharged. DRPs were also documented and categorized for analysis. In addition, patients who resided in a selected list of eleven elderly homes with Community Nursing Service (CNS) support were also given a specially designed user-friendly summary sheet of discharge medications.

Result
From November 2014 to March 2015, 152 discharge cases with a total of 1693
medications were reconciled. Seventeen DRPs (1.0%) were identified and rectified, including omissions (29%) and inappropriate dosage/frequency/duration (41%). 94% of DRPs were considered potentially harmful to patients if not rectified. Medication summary sheets in Chinese were clearly presented in sections: (1) refill medications, (2) new medications, (3) medications to keep record only, (4) discontinued medications, with symbols, up/down arrows and “X” indicating no changes, dosage/frequency increases/decreases, and discontinuations respectively. The summary sheets thus listed out complete information on changes to medications during hospital stay and provided a clear summary to help the elderly home staff understand the changes and prevent inadvertent drug administration incidents. During the first three months, 53 cases who resided in selected elderly homes were given the summary sheets. CNS nurses and elderly homes were satisfied with the pilot service. This program demonstrated that pharmacist involvement in medication reconciliation during transitions of care could improve patient safety and quality healthcare in elderly patients.