



Service Priorities and Programmes Electronic Presentations

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Medication Reconciliation for discharged patients in a medical ward

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Introduction

According to the Australian Council on Healthcare Standards (ACHS) EQulP6 Hong Kong guide, the provision of appropriate information about safe effective use of medications is a significant factor in the organization's reduction of medication-associated risk. The World Health Organization (WHO) recommends that health professionals should encourage patients to be actively involved in their own care and the medication use process by educating patients about their medication and any associated hazards. It also recommends health professionals to provide patients with information and/or education on all prescribed medications in verbal and/or written form. In view of this, pharmacy piloted the medication reconciliation service for discharged patients in one medical ward of North District Hospital.

Objectives

- To review and compare patient's discharged medications with all in-patient and home medications
- To provide a discharge medication summary sheet which highlights the changes in patient's medication
- To provide drug counseling to patients and/or carers at discharge

Methodology

Ward faxes the list of patients intended to be discharged home on that day to pharmacy. Patients to be discharged to OAH or transferred to other hospitals are excluded from this service. After the physician prepares the discharge summary and prescription, pharmacist performs medication reconciliation and prepares a discharge medication summary sheet for these patients. Pharmacist then goes up to the ward and counsels the patients and/or carer on all their discharged medications and issue the discharge medication summary. The discharge medication summary sheet provides information on patient's discharged medications as well as highlighting "keep record" medications and discontinued medications. The indication of each drug is listed on the summary sheet. Patients can take the medication summary sheet home for reference.

Result

The service starts from November 2017. Up to December 2017, 45 cases were

reviewed and 27 patients were counseled verbally and were given the discharge medication summary sheet by pharmacists. In this early stage, several cases of unintended discrepancy in the discharge prescriptions were detected and intervened timely without reaching the patients. Physicians, ward nurses, patients as well as carers expressed appreciation and support for the service. Evaluation of this service will be conducted in the near future.