Service Priorities and Programmes

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Admission Medication Reconciliation by Pharmacists – A Pilot Service Targeted for Elderly Patients

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Introduction

Patients often receive new medications or have changes made to their existing medications at transitions of care, such as during hospital admission. While most of these changes are intentional, unintended changes and discrepancies can occur for a variety of reasons. Medication reconciliation (MR) upon admission rectifies any drug-related problems (DRPs) via a complete review of patients' drug profile and clinical conditions, especially in elderly patients where polypharmacy is common. Following the success of our discharge MR in November 2014, an admission MR program was launched in October 2015 to provide complete clinical pharmacy service to target patients.

Objectives

A best-possible medication history (BPMH) for each patient is obtained and compared against medications ordered for the in-patient stay to ensure accuracy and completeness of the drug profile. In addition, pharmacists reviewed clinical notes and laboratory results to ensure the appropriateness of drug choices and dosages, and to identify any omissions or unintentional prescribing.

Methodology

Pharmacists provided admission medication reconciliation to patients under the care of Geriatric Team in a medical ward, most of which were elderly home residents. Pharmacists reviewed the medications ordered for patients within 24 hours of admission to identify any DRPs including omissions, "8 wrongs" (drug, dose, frequency, route, duration, drug interactions, allergy, or therapeutic duplication), discrepancies, or unintentional prescribing. For any DRPs identified, pharmacists contact prescribers in order to clarify any missing information or to rectify any potential problems.

Result

From October 2015 to January 2017, 730 hospital admissions were identified during

service hours in the target patient group, with a total of 7437 medications were reconciled within 24 hours of admission. Thirty-five DRPs (0.47%) were identified and rectified, including omissions (22.9%), “8 wrongs” (57.1%), discrepancies (14.3%), and unintentional prescribing (5.7%). The acceptance rate of pharmacist recommendations by prescribers was 100%.