Do we really need a pharmacist for discharge medication reconciliation in Geriatrics?

A Retrospective Audit on the Accuracy of Medication Related Information in Discharge Summaries

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Introduction

The accuracy and documentation of medication related information in hospital discharge summaries is often lacking.

The extent of recording on new, ceased or changed medicines is often poor and can negatively impact upon transitions of care and patient safety.

Discharge summaries should include a current, accurate and comprehensive list of medicines and adequate documentation of medication therapy changes made during hospital admission.

Pharmacist interventions (PI) help to improve the quality use of medicines and optimise patient safety.

Objectives

The study aims to:

Assess the impact and severity of pharmacist interventions in the reconciliation of discharge summaries.

Determine if a relationship exists between pharmacist interventions and the discharge destination.

Analyse trends in the documentation of medication changes.

Determine if a correlation exists between the quality of documentation and the discharge destination.

Methods

A retrospective audit of discharge summaries from acute geriatric wards over a three-month period.

Data was collected from draft discharge summaries that contained the pharmacists' handwritten interventions.

Severity of pharmacist interventions were classified as mild, moderate or severe and each intervention was assigned a category based on the severity scaling (Interventions for high risk medications were assessed as severe).

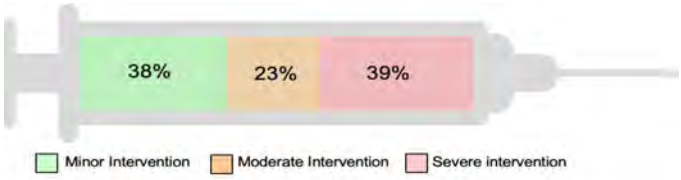
The number of new, ceased and changed medications were recorded and assessed to determine if each medication change was adequately documented on the discharge summary.

Results

Table 1 Pharmacist Interventions & Severity Assessment Results

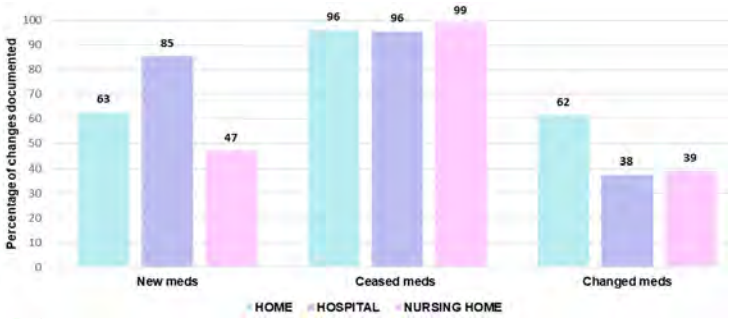
Discharge destination	Total number of successful PI	Number of minor PI	Number of moderate PI	Number of severe PI
Home (n=130)	141	49	38	54
Hospital (n=50)	66	29	17	20
Nursing Home (n=50)	71	26	10	35
Total Sum	278	104	65	109
Total Average	1.21	0.45	0.28	0.47

Figure 1 Percentage of Pharmacist Intervention Severities



p > 0.05 **No statistically significant relationship between the number or severity of pharmacist interventions & the discharge destination**

Figure 2 The Relationship Between Documented Medication Changes & Discharge Destination



p < 0.0001 Statistically significant differences exist between the documentation of new, ceased & changed medications

p < 0.0001 Statistically significant differences between the total number of medicine changes & the documentation of these changes

p > 0.05 No statistically significant correlation between the total number of medication changes & discharge destination

Conclusion

This study reiterated that pharmacist play an essential role in discharge medication reconciliation. Substantial differences were found between the total number of medicine changes made in hospital and the documentation of these changes in the final discharge summary. Ceased medications were most accurately documented as it was specifically mentioned in the discharge template.

Improving documentation quality is an opportunity to improve medication safety during the transitions of care. As a result of this study, steps are being taken to standerdise the discharge templates used to prepare the discharge summaries by junior medical officers at the study site.