Pharmacology Update: Transitions of Care and Medication Safety

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Introduction

- One-fifth of Medicare beneficiaries are rehospitalized within 30 days and more than one-third within 90 days.
- Causes of this rehospitalization:
  - Confusion of the new medication regiment
  - Not having the ability to pick up the medication
  - Lack of knowledge of the medication including side effect profile

2015 National Patient Safety Goals

- NPSG 3 - Improve the safety of using medications
  - Maintain and communicate accurate patient medication information
  - Reduce negative patient outcomes associated with medication discrepancies
  - Coordinating information during transitions in care both within and outside of the organization, patient education on safe medication use, and communications with other providers

Review of Literature

Unintended Medication Discrepancies at the Time of Hospital Admission

- N= 151; 81 patients had at least one unintended discrepancy
  - The most common error was omission of a regularly used medication
  - Over 1/3 of the discrepancies had the potential to cause moderate to severe discomfort or clinical deterioration

Medications At Transitions and Clinical Handoffs (MATCH Study)

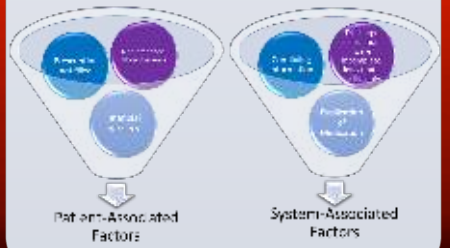
- 85% of patients had errors originate in medication histories, and almost half were omissions
  - Cardiovascular agents were commonly in error
  - If undetected, 52.4% of errors were rated as potentially requiring increased monitoring or intervention to preclude harm

Post-hospital Medication Discrepancies

Geriatric Nurse Practitioner performed 375 comprehensive medication assessment on patient's 65+ at their home within 72 hours after discharge

– A total of 14.1% of patients experienced one or more medication discrepancy

Associated Factors



Clinical Exemplars

Inpatient Admissions

- Medication orders were compared with preadmission medication use based on:
  - Medication vials with label
  - Interviews with patients & caregivers
  - Outpatient healthcare providers
- Medication history performed by admitting nurse, reviewed by unit-based pharmacist in collaboration with attending physician

Inpatient Discharges

- Pre-admission and in-patient medications compared with discharge orders and written instructions
- Pharmacists reviewing hospital records, consult with inpatient providers, provide discharge counseling
- Pharmacists performing follow-up telephone calls post-discharge

Outpatient Settings

- Written and verbal discharge instructions to be hand deliver to outpatient provider
- Computer generated discharge summaries
- Physical inspection of medication vials with label and/or prescriptions

Pharmacy

- Community pharmacists working with local hospital, in collaboration with hospital pharmacists and inpatient care providers

Community Resources

- Identify high-risk patients to provide in-home consultation with a pharmacist after discharge to manage drug therapy
  - Facilitates care for up to 90 days via telephone support

Conclusion

- Assess for risks and barriers
- Provide education about treatment regiment to the patient on a continuum
- Ensure comprehension by patient
- Provide opportunities for interprofessional collaborate in all areas of healthcare
- Provide documentation of treatment regiment to all parties timely

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