

# Medicine Information and Patient Discharge

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## INTRODUCTION

Discharge procedures need to be optimal to prevent errors and to promote patient-medication adherence, thus increasing quality of life whilst easing the financial burden. An aspect that is important during discharge is medicine reconciliation and ensuring awareness by the patient of the medication changes.

## AIMS

- To analyse prescribing and treatment changes for patients discharged from Karen Grech Rehabilitation Hospital (KGRH).
- To measure patient knowledge on own medication changes at discharge.
- To examine discharge SOP<sup>1</sup> compliance of pharmacists.

## METHOD

- UREC ethical approval was obtained.
- Patients' medical files were accessed and the medication form was filled out.
- Reconciliation by the clinical pharmacist was observed.
- The patient questionnaire was filled out.

*This was carried out for 30 patients.*

- An expert panel questionnaire analysed healthcare professionals' perception on medicine reconciliation.

*This was filled out by 7 healthcare professionals.*

- Observational visits were carried out to KGRH to measure discharge SOP compliance by clinical pharmacists.

*8 clinical pharmacists were observed.*

## RESULTS

•For 30 KGRH patients, during hospitalisation, addition of a new medication occurred 59 times, changing the dose 41 times, changing the regimen 31 times, whilst stopping a medication occurred 13 times.

•Significant associations were found between drug class and changes in dosage regimen, as well as with changes in dose, route of administration, starting and stopping medications.

•Patients had a mean age of 70.2 years. 14 were female and 16 were male. 29 were aware of changes affected.

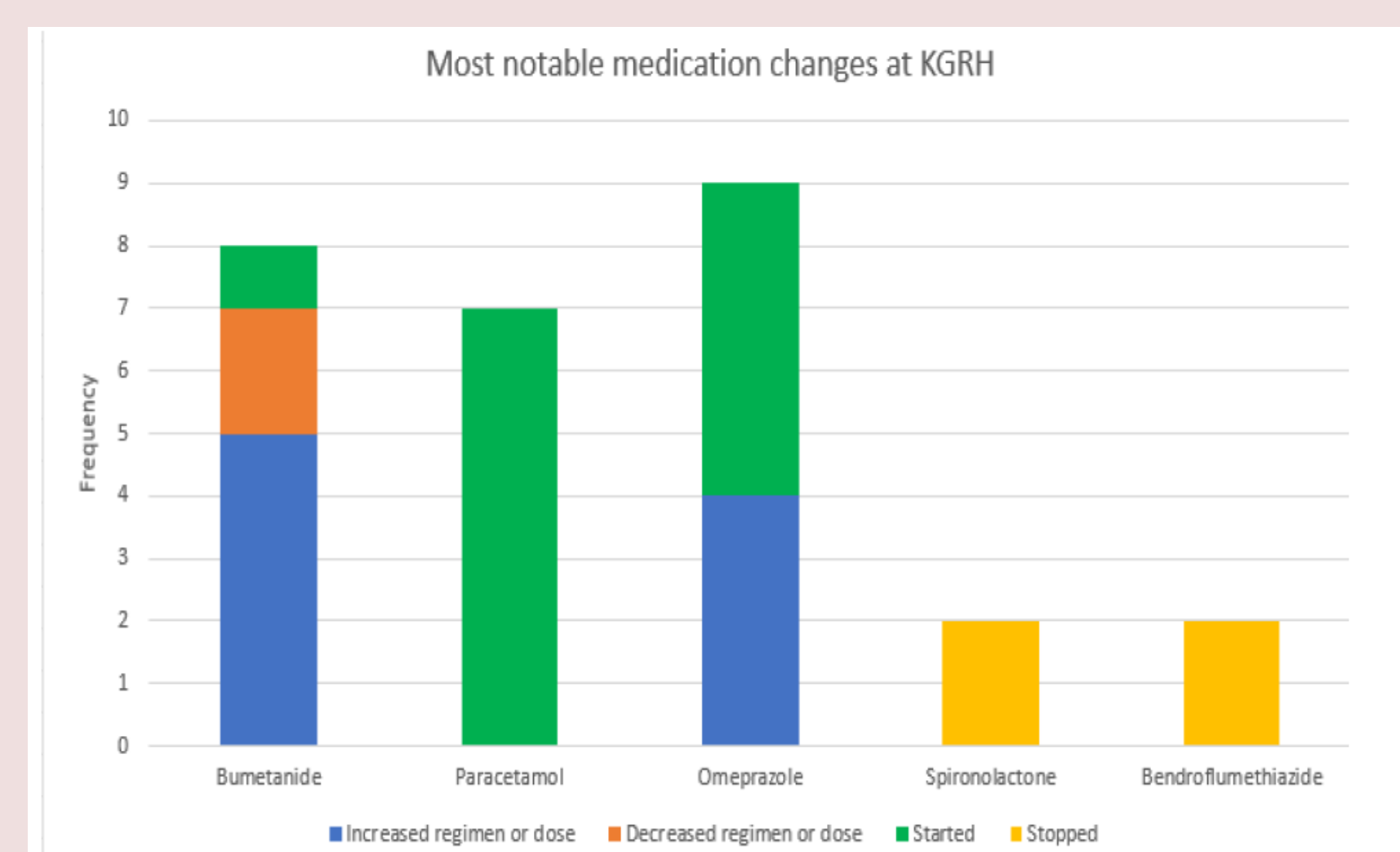


Figure 1: Most notable medication changes (N=30 patients)

## CONCLUSION

The study contributes to reflect on strengths and weaknesses of current discharge processes and to seek patient feedback on these processes. The results obtained from the study can be used to improve the process of medicine reconciliation, particularly on a local level. Using pharmacists and having complete transfer of patient information decreases adverse drug events when care setting transitions occur. The involvement of family members can also increase the accuracy of medicine reconciliation.

## REFERENCES

<sup>1</sup> Wirth F, Mamo M. SOP: Patient discharge. Karin Grech; 2010 May. Report No.: SOP/PHR/007\_01.