The role of pharmacist in medication reconciliation in General hospital Murska Sobota

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Background Incomplete drug history and poor communication within the health care team are often the cause of medication errors and adverse drug events. Medication reconciliation is the key to reduce the number of medication errors and to provide seamless care.

Purpose The aim of the present study was to demonstrate the benefits of medication reconciliation by implementing it into everyday clinical practice in different departments of General Hospital Murska Sobota and to evaluate the role of the pharmacist in the coordination of patient hospital treatment.

Method The research was conducted in four departments: orthopedic, internal, surgical and infection diseases. Pharmacist daily reviewed the list of newly admitted patients by using the hospital information system Birpis and randomly selected patients that were included in the study. A comprehensive drug history review before admission to the hospital and medication treatment prescribed upon admission was performed. Potential discrepancies were identified. Pharmacist informed the treating physician about the medication inconsistencies and proposed treatment improvements.

Findings 108 randomly selected patients with an average age of 68.3 years were included in the study, among which 103 were receiving at least one drug at the time of the hospitalization. On average 6.35 medications per person were prescribed. In 53.4% of patients enrolled, at least one discrepancy was detected between the medication the patient was taking prior to arrival at the hospital and the one prescribed on the therapy list in the hospital. In total, 138 discrepancies (1.34 discrepancies per patient) were identified. 6 was the largest number of detected inconsistencies in one individual. The most common discrepancy (36%) was omission of a drug that the patient was taking before coming to the hospital. It was also shown that discrepancies were mostly present in medications for cardiovascular diseases (34%), gastrointestinal and metabolic diseases (23.7%) and medications for the nervous system (14.4%). Pharmaceutical intervention addressing the discrepancies in drug therapy was accepted by treating physicians in 55.6% of all cases.

Conclusion The study results show drug therapy inconsistencies and omissions during hospitalization in General hospital Murska Sobota. Medication reconciliations were identified as vital to decrease medication discrepancies occurring during hospitalization.