Transition of care: a set of pharmaceutical interventions improves hospital discharge prescriptions from an internal medicine ward

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Abstract

Background & Purpose: Continuity of care between hospitals and community pharmacies needs to be improved to ensure medication safety. This study aimed to evaluate whether a set of pharmaceutical interventions to prepare hospital discharge facilitates the transition of care.

Methods: This study took place in the internal medicine ward and in surrounding community pharmacies. The intervention group’s patients underwent a set of pharmaceutical interventions during their hospital stay: medication reconciliation at admission, medication review, discharge planning. The two groups were compared with regards to: number of community pharmacist interventions, time spent on discharge prescriptions, number of treatment changes.

Results: Comparison between the groups showed a much lower (77% lower) number of community pharmacist interventions per discharge prescription in the intervention (n=54 patients) compared to the control group (n=64 patients): 6.9 versus 1.6 interventions, respectively (p < 0.0001); less time working on discharge prescriptions; less interventions requiring a telephone call to a hospital physician. The number of medication changes at different steps was also significantly lower in the intervention group: 40% fewer (p < 0.0001) changes between hospital admission and discharge, 66% fewer (p < 0.0001) between hospital discharge and community pharmacy care, and 25% fewer (p = 0.002) between community pharmacy care and care by a general practitioner.

Conclusion: An intervention group underwent significantly fewer medication changes in subsequent steps in the transition of care after a set of interventions performed during their hospital stay. Community pharmacists had to perform fewer interventions on discharge prescriptions, thus improving continuity of care.

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