Résumé

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

Introduction: Continuity of care between hospitals and community pharmacies needs to be improved to ensure medication safety.

Methods: This study, including control and intervention groups, 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; a medication review; and discharge planning. The two groups were compared with regards to the number of community pharmacist interventions, the time spent on discharge prescriptions, and the number of treatment changes during transitional care.

Results: Comparison between the two groups showed a much lower (77% lower) number of community pharmacist interventions per discharge prescription: 6.9 versus 1.6 for the control (n = 64 patients) and intervention (n = 54 patients) groups, respectively ($p < 0.0001$); less time working on discharge prescriptions; and less interventions requiring a telephone call to a hospital physician.

The number of medication changes at different steps in the transition of care 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.