Pharmacology Update: Transitions of Care and Medication Safety
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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

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 regimen
  - Not having the ability to pick up the medication
  - Lack of knowledge of the medication including side effect profile

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

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

Conclusion

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

References

- Institute for Safe Medication Practices. (2012, November 15). Reduce rehospitalisations with pharmacy programs that focus on transitions from the hospital to the community