

# **Accuracy of Discharge Patient Medication Lists**

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## **Abstract**

**Background:** Pharmacist-led medication reconciliation can help prevent errors in medication lists. Accurate medication lists have been shown to reduce emergency department visits and hospital readmission. Therefore, ensuring medication reconciliation processes are effective and patient medication lists are accurate can reduce hospital admissions and healthcare costs overall. The purpose of this research is to improve patient care by identifying discrepancies in discharge medication lists to assess the accuracy of discharge patient medication lists.

**Methods:** In this retrospective chart review, subject's medication lists were evaluated for discrepancies that may have occurred at any point during the admission, especially at discharge. The investigators collected prior to admission (PTA) medication lists, inpatient medication orders (IPO), and discharge summary (DS) medication lists for each subject to identify discrepancies between them. Chart notes and lab results were also reviewed when necessary for any documented medication changes and relevant diagnoses. Data elements included the following: total number of medication discrepancies found; mean number of discrepancies found; total number of discrepancies between PTA medication list and inpatient medication orders; and total number of discrepancies between inpatient medication orders and the DS medication list. The primary endpoint was the mean number of medication discrepancies found.

**Results:** A total of 42 subjects' charts were reviewed, and a total of 50 medication discrepancies were found. Of these 50 discrepancies, 9 were between PTA medication lists and IPO, and 41 were between IPO and the DS medication list. The mean number of discrepancies found was 1.19.

**Conclusion:** This study identified many errors in the medication reconciliation process, specifically on the discharge medication lists. While there were limitations to the study design in terms of the cause of these discrepancies, the findings from this study show that it would be beneficial to consider how the medication reconciliation process could be improved. Staff education on how to best utilize the pharmacy staff in medication reconciliation, as well as increasing the involvement of pharmacists in transitions of care, especially at discharge, may help prevent medication errors like the ones found in this study, leading to improved patient care.