SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

Accuracy of Discharge Patient Medication Lists

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BACKGROUND

- Pharmacist-led medication reconciliation has been shown to help prevent errors on medication lists[1]
- Accurate medication lists, especially at discharge from the hospital, have been shown to reduce hospital readmissions and healthcare costs overall[2, 3]
- This facility has a greater focus on medication reconciliation during admission compared to discharge
- Study Goal:
  - Assess the accuracy of discharge patient medication lists

METHODS

- Retrospective chart review
- Data collection:
  - Prior to admission (PTA) medication list
  - Inpatient orders (IPO)
  - Discharge summary (DS) medication list
- Each patient's medication lists were reviewed with the chart notes to identify any discrepancies in the admission or discharge process

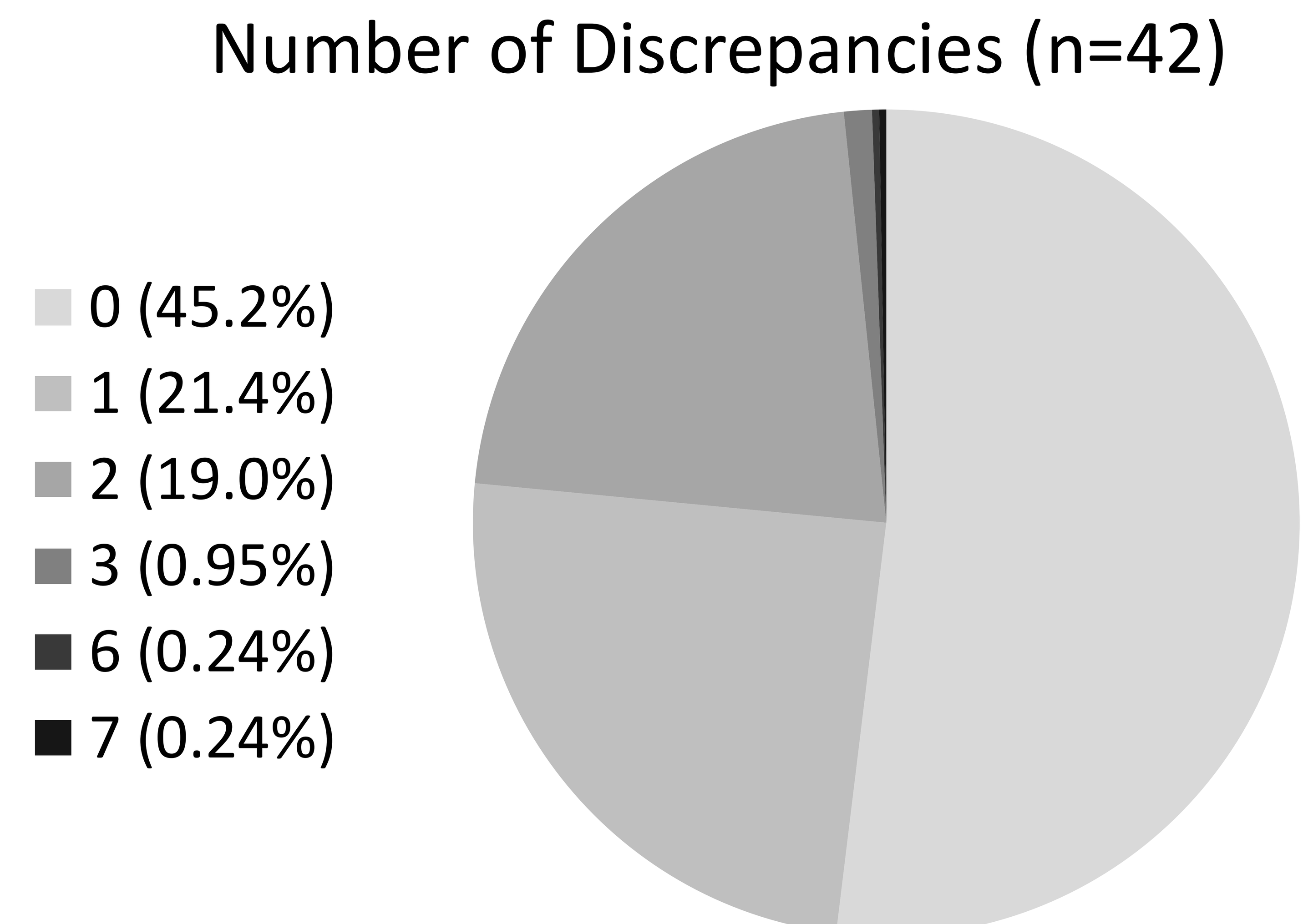
RESULTS

A total of 42 subjects were included in chart review to yield the following results:

Medication List Discrepancies	
Total number of medication discrepancies found	50
Total number of discrepancies between PTA medication lists and IPO	9
Total number of discrepancies between IPO and the DS medication list	41
Mean number of discrepancies found (primary outcome)	**1.19**

- 23 of the 42 (54.8%) subjects had at least 1 discrepancy on their medication lists
  - 14 of those 23 (60.9%) charts had more than 1 discrepancy
- 19 of the 42 (45.2%) subjects had 0 discrepancies

Number of Discrepancies (n=42)



This chart shows the percentage of subjects with a specific number of discrepancies.

CONCLUSION

- Many discrepancies were found on the discharge medication lists
- On average, each patient had at least one discrepancy in their medication lists

These findings show that it may be beneficial to consider increasing the involvement of pharmacists in the discharge medication reconciliation process at this facility to prevent errors in the discharge medication lists.

REFERENCES

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