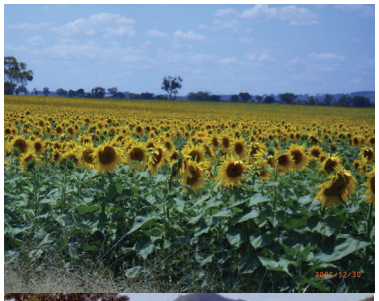





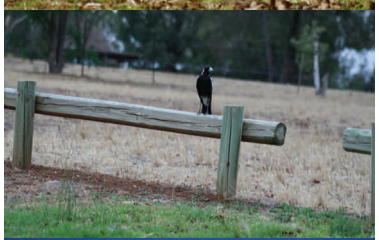


MEDICATION DISCREPANCIES AFTER DISCHARGE FROM A RURAL DISTRICT HOSPITAL: WHAT MEDICATIONS ARE OUR PATIENTS TAKING AT HOME?

HETI HEALTH EDUCATION & TRAINING INSTITUTE

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AIM

To ascertain whether any discrepancies exist between medications documented on discharge from hospital and those reported as taken by the patient within one month, and to gain information as to the extent and nature of any discrepancies that may be arising.

METHOD

This study was a cross sectional survey of 66 medical patients discharged from a 162 bed general rural NSW hospital. Using a telephone questionnaire the study identified whether there were any discrepancies between medications documented in the hospital discharge summary and those reported as taken by the patient within one month of hospital discharge.

RESULTS

Only 5 of the 66 participants (8%) had no medication discrepancies and were taking the medications exactly as described in the discharge summary one month after discharge from hospital. 32% of the changes were intentional discrepancies initiated by their community based treating medical officer. However in 68% of cases medication changes were initiated by the participant - 57% continued a previous medication. This suggests either inadequate admission medication history-taking and reconciliation in hospital – if the discharge summary was incomplete; or inadequate communication of medication changes whilst in hospital, if the changes in the discharge summary were intentional. Eleven per cent of participants omitted a medication they thought unnecessary or didn't know they were to continue, again highlighting inadequate communication.

CONCLUSIONS

Within one month of discharge from a rural hospital 61 participants (92%) were not taking their medication as documented in their hospital discharge summary. Importantly 68% were unintentional discrepancies involving participants either recommencing a previous medication or discontinuing a medication prescribed in hospital because they thought it unnecessary or were unaware it was to continue. This has significant implications for continuity of care and ongoing medication management for the population.

RECOMMENDATIONS

There is an urgent need to examine processes to improve the accuracy of the medication record and to maintain its integrity through ongoing encounters with health care professionals, and thus:

- Medication reconciliation is essential at all points of the health care cycle and should be appropriately supported;
- Improved communication and documentation of medication changes during hospitalisation is required;

For the full report on this project visit our website, follow the link to the Rural Research Capacity Building Program and click on 'view completed projects'

Julie is a pharmacist with over 30 years experience in the NSW public hospital system. At present she is Director of Pharmacy at Shoalhaven Hospital, Nowra. She has a long standing interest in medication management and patient education and particularly in the continuity of care from hospital to the home.

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