

PHARMACIST-LED DISCHARGE COUNSELING OF MEDICATIONS FROM EMERGENCY DEPARTMENT OF A TERTIARY CARE HOSPITAL

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INTRODUCTION

In an emergency department (ED) of a hospital, the patients are prescribed home medications upon discharge. Also, the patients’ current home medications need to be reviewed so as to rationalize the medication therapy with patients’ current state. Also, the patients’ education regarding their state and therapy becomes necessary. Owing to the chaotic state and time pressure in ED, the risk of medication discrepancies increase during this prescribing phase accompanied by transition of care.

The American Society of Health-System Pharmacist (ASHP) also recommends the development of counselling triage for patients being discharged from ED, so as to:

- Improve the therapeutic outcomes and
- Lessen the risks of adverse events.

Pharmacist can play an effective role in this regards due to their drug knowledge and counselling skills leading to lesser medication discrepancies during ED discharge.

AIM

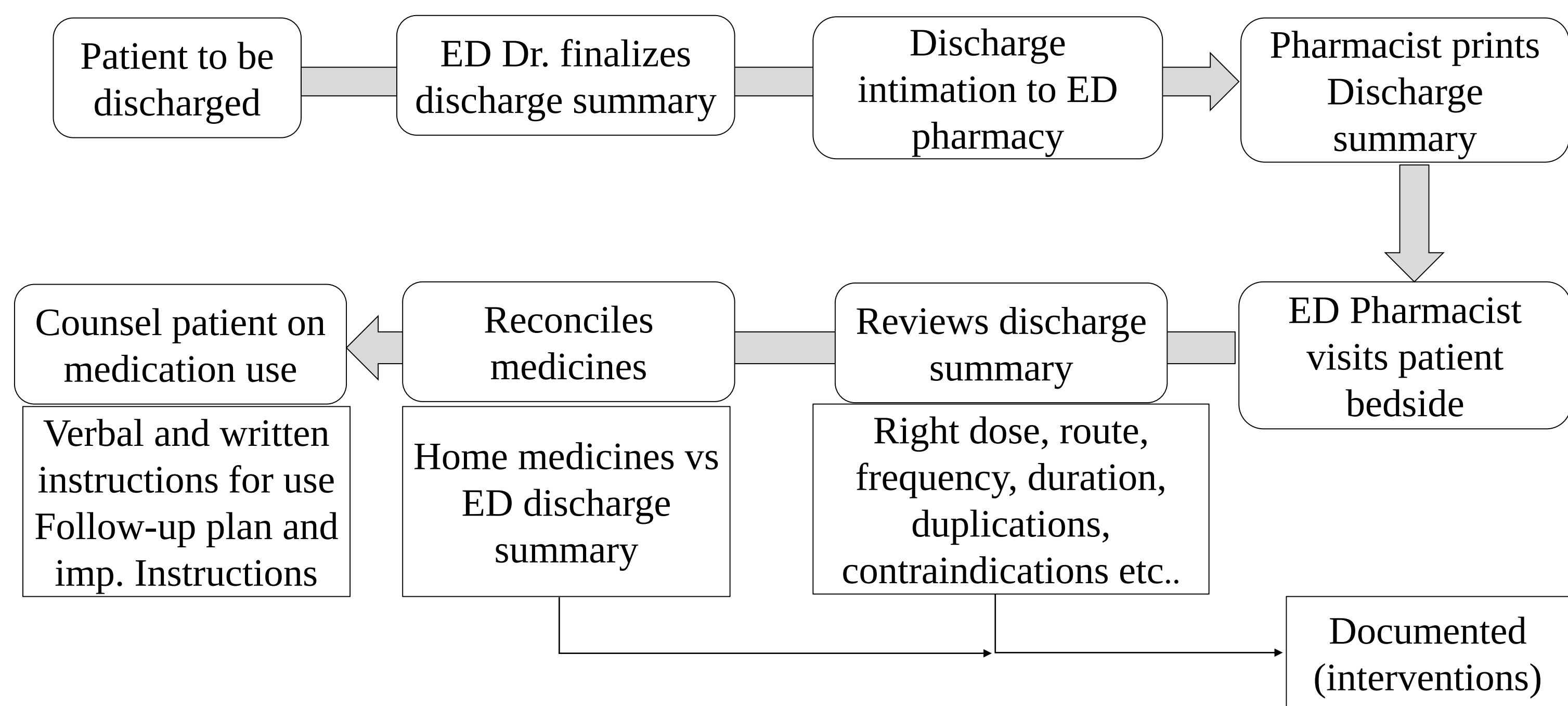
To initiate and implement a medicine counselling & reconciliation service provided by the pharmacist to the patients discharged from Emergency Department of tertiary care hospital as well as to assess the impact of this service on accomplishment of the patient safety goal.

OBJECTIVES

- To determine the total number of prescriptions/patients reviewed and counselled by the pharmacists during the 1-year period.
- To determine the number of medication errors intervened by the pharmacist.

METHODOLOGY

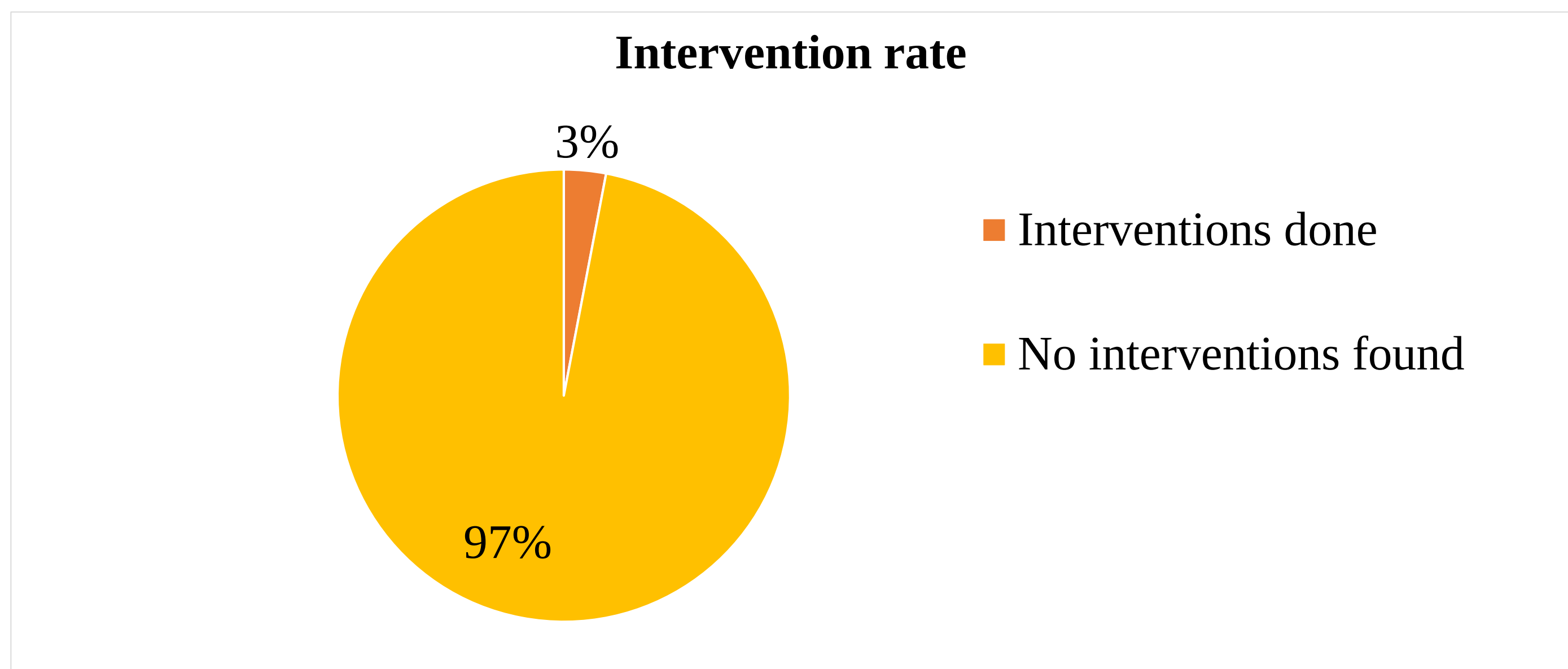
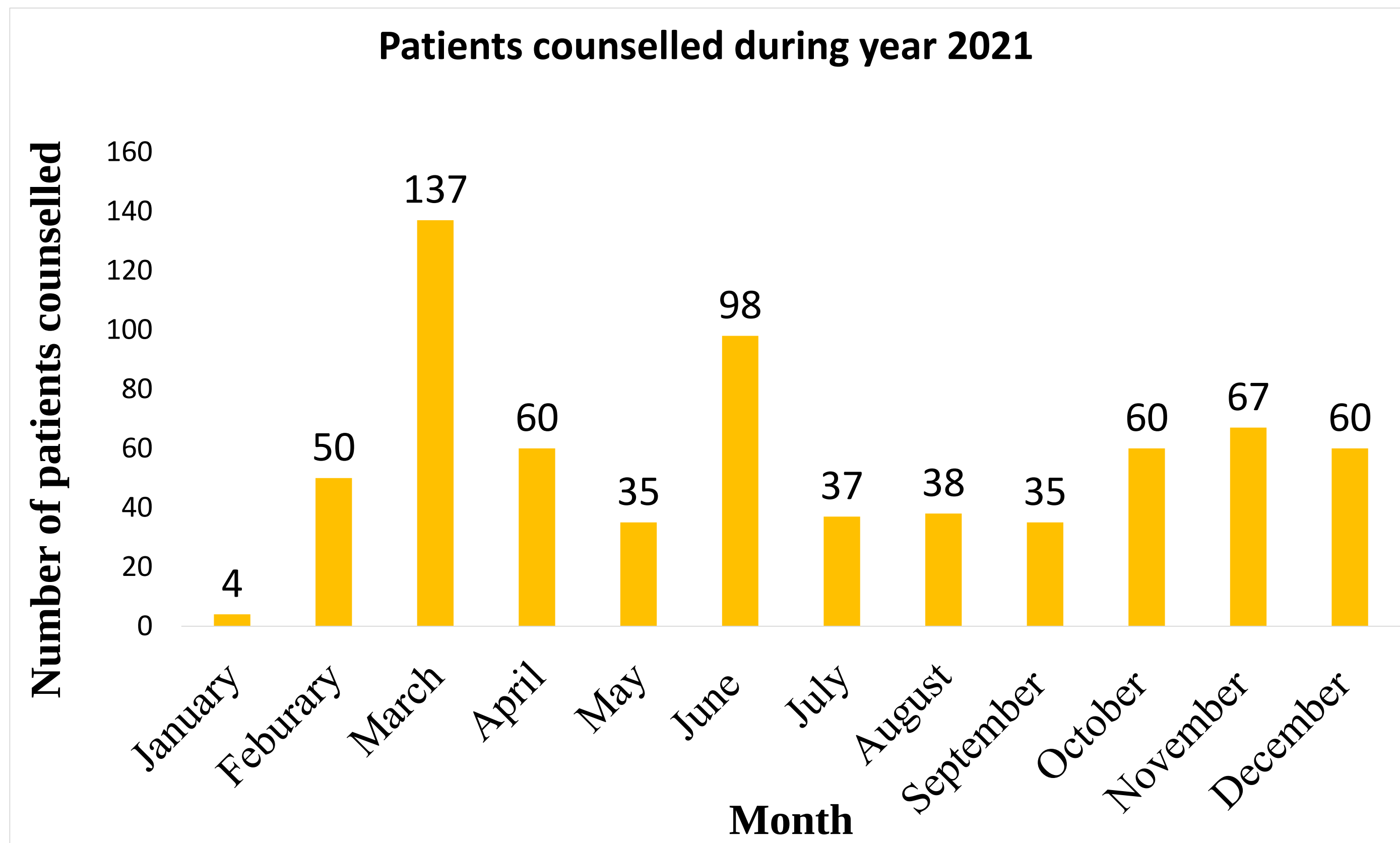
- A pilot study was initiated.
- Pharmacist performed medicine counselling of each patient being discharged from the Emergency Department.
- Initially 1 hour/day and was gradually increased to incorporate the entire 8 hours of morning shift.
- Data was collected over a period of one year, i.e., from January 2021 to December 2021.
- Data of interventions recorded was kept for further analysis.



RESULTS

During 2021, a total of 681 prescriptions constituting 1627 medications were reviewed and patients were counselled.

Among these, 19 (3%) prescriptions were found to have medication discrepancies and were resolved by interventions.



DISCUSSION

Pharmacist-led appropriateness review of discharged patients’ prescriptions, followed by medication reconciliation and counselling was consistently performed throughout the year and proved to enhance medication safety and patient satisfaction.

The most frequently found medication discrepancies were related to:

- Non-formulary drug switching
- Wrong drug selection
- Wrong dosage form selection

Other medication errors less commonly found were:

- Drug omission
- Drug duplication
- Wrong route/frequency
- Dose adjustments (renal)

Patients were seen keenly involved during counselling and presented multiple queries to pharmacists.

Most common concerns included:

- Drug administration timings
- Follow-up esp. the laboratory tests
- Drug-food interactions

CONCLUSION

Thus, review of discharged patients’ prescriptions and subsequent counselling of ED discharge patients by pharmacists is a step forward for ensuring provision of high-quality patient care by:

- Rationalization of pharmacotherapy by reducing medication discrepancies
- Medication reconciliation
- Improving patient compliance with medication regimens

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