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LETTER TO THE EDITOR:

AUDIT OF QUALITY OF DOCUMENTATION OF MEDICATION RECONCILIATION AT DISCHARGE FROM HOSPITAL

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Medication reconciliation aims to reduce prescribing errors by ensuring the accuracy of prescribed drugs, particularly undocumented intentional or unintentional discrepancies [1]. According to Wilkin et al [2], an audit of electronic discharge summaries from a regional hospital found that 68% had at least one medication discrepancy, with almost half related to medication omissions. Of these, a third had moderate potential clinical significance, while half had minor clinical significance [2]. We performed an audit of discharge summaries of patients discharged from Geriatric Medicine in Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital, Brunei in June 2020 to assess the quality of documentation of medication reconciliation at discharge.

All patient discharge summaries were available through the national medical electronic records system (Bru-HIMS). The quality of medication reconciliation at discharge was assessed using the standards set out by the Specialist Pharmacy Service of the National Health Service (NHS) in the United Kingdom [3]. The best practice toolkit specifies the following standards for the discharge summary: patient demographics including address and details of their General Practitioner, reason for admission and allergies should be documented. Medication details should include units, frequency, route and formulation, indication and duration for treatment, and follow-up medication review required. Medication reconciliation should also be performed on discharge, explicitly stating medication changes with the clinical reason for prescribing; and if drug monitoring is required. Permission was obtained from the head of Geriatric Medicine to access the clinical notes for the purposes of conducting the audit.

There were 30 patients discharged from Geriatric Medicine in RIPAS Hospital in June

2020, with 233 medications prescribed. All discharge summaries contained patient details, including their full name, date of birth and two patient identifiers. However, the patient's address and details of their General Practitioner were not automatically generated in the discharge summaries. The reason for admission was documented for all patients. While all four patients with drug allergies had these documented, the remaining 26 (87%) did not mention that the patients had no known drug allergies.

In terms of medications, 192 (82.4%) had their generic name with dosing details in correct units, frequency, route and formulation. Only 3 (1.3%) had the indication for their use explicitly specified, while 189 (81.1%) had clear documentation on the duration of prescription and when medication review was required. Pharmacy-led medication reconciliation was documented for 5 (16.7%) of the 30 patients on admission. While our hospital policy mandates pharmacist review of all prescriptions on discharge, including medication reconciliation, there was no indication on the discharge summaries that this occurred. None of the dose changes or discontinued medications were highlighted on the discharge summaries. Only one (3.2%) of newly commenced medications during admission was clearly indicated with a clinical reason for the prescription. One (3.3%) patient required therapeutic drug monitoring (for warfarin), which had clear instructions documented on the discharge summary.

There were several aspects identified which required improvement. Firstly, the patient address and their General Practitioner were not available on the discharge summaries; as well as a statement specifying allergy status for those without drug allergies. There is a pre-set template for electronic discharge summaries in our hospital; this should be updated so that these necessary details to meet the quality indicators are automatically generated in the discharge summaries. Indications for medications, modifications such as dose changes, starting or stopping medications, and the need for drug monitoring were poorly documented. Junior doctors are currently provided formal training on discharge summary documentation, emphasising the importance of accurate discharge medications. It is important to ensure a shared responsibility among clinicians (doctors, nurses and pharmacists) to avoid discrepancies in medications prescribed for patients [4].

Pharmacy-led medication reconciliation on admission was also identified as an area for improvement. Since the audit, the pharmacy department has allocated a designated pharmacist to each medical ward for medication reconciliation. Finally, this audit should be repeated to evaluate the effectiveness of these interventions on

improving the quality of medication reconciliation on discharge.

Conflicts of Interest:

The authors have no conflicts of interests to declare.

REFERENCES:

1. Rosli N, Teo SP. Reducing medication error and polypharmacy in older people. Asian J Gerontol Geriatr 2020;15(2):86-90. Doi: 10.12809/ajgg-2020-411-ra
2. Wilkin ME, Knight AT, Boyce LE. An audit of medication information in electronic discharge summaries for older patients discharged from medical wards at a regional hospital. Pharm Pract Res 2018;48(1):76-79. Doi: 10.1002/jppr.1340
3. Specialist Pharmacy Service, National Health Service. Improving the quality of medicines reconciliation. A best practice resource and toolkit. Version 1.1 – June 2017. United Kingdom NHS, 2017. www.sps.nhs.uk/wpcontent/uploads/2015/06/Medicines_Reconciliation_Best_Practice_Standards_Toolkit_Vs1.1_June-15-links-updated-Aug-17.pdf
4. Rangachari P, Dellsperger KC, Fallaw D, Davis I, Sumner M, Ray W, et al. A mixed-method study of practitioners' perspectives on issues related to HER medication reconciliation at a health system. Qual Manag Health Care 2019;28(2):94-95. Doi: 10.1097/QMH.0000000000000208.