

SIMI WINTER SCHOOL 2016

NUOVI PARADIGMI DI CURA PER IL PAZIENTE ANZIANO COMPLESSO

Definizione del ruolo della figura del farmacista ospedaliero

Parte II

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A transition from one health care setting to another increases the risk of **medication errors**

MEDICATION DISCREPANCIES

Medical discrepancies

Causes:

- Poor communication
- Loss of important information

Consequences:

- Adverse drug events
- Increased hospital stay
- Early readmission after discharge
- Use of other health care resources

Is ***MEDICATION RECONCILIATION*** alone
sufficient to reduce
postdischarge clinical outcomes?

Need for multidisciplinary

Pharmacists are most likely to contribute to improved patient outcomes by closely collaborating with nurses.

Interventions are especially effective when performed in close collaboration with physicians

Tailoring the intervention

Assessing patient knowledge of the prescribed medication and compliance

EXTENSIVE PHARMACIST INTERVENTIONS

in hospital and primary health care settings

PHARMACIST DISCHARGE LETTER

containing:

- all in-hospital changes (with rationale)
- monitoring needs
- expected therapeutic goals
- outstanding drug-related problems (with suggested actions)

Follow-up telephone call
to reinforced in-hospital provided interventions

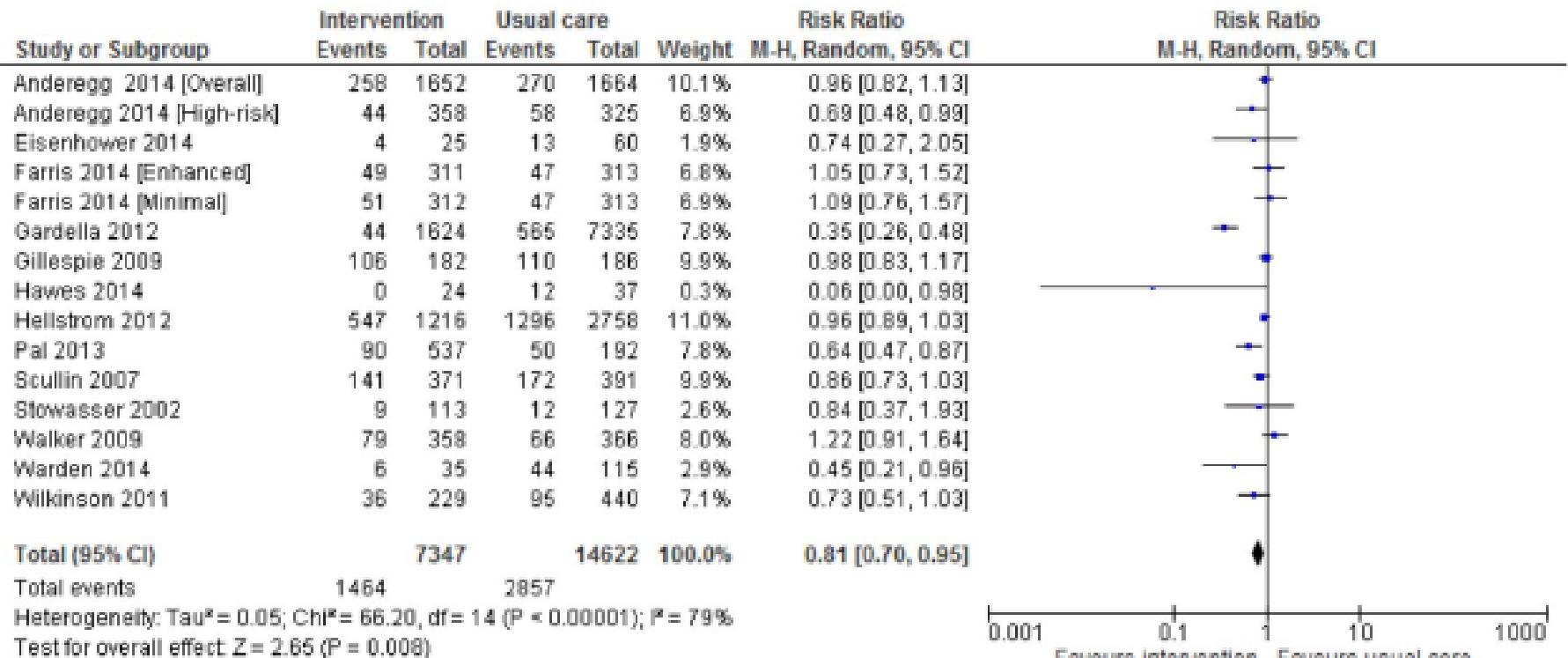
Active feedback to primary care providers

Information

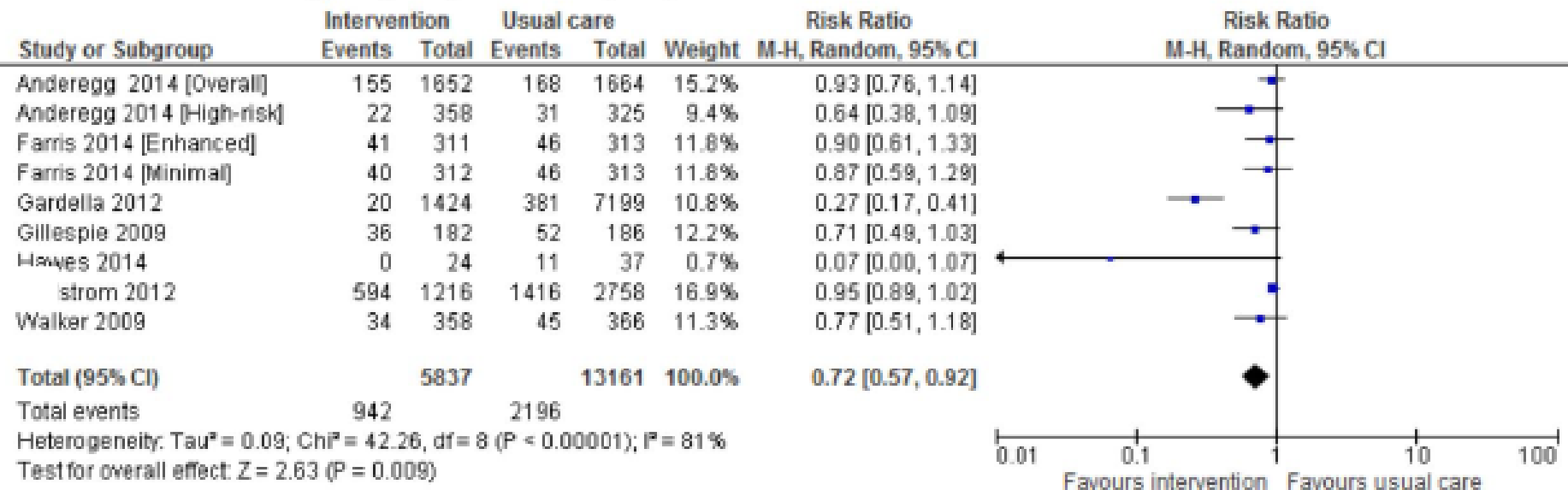
BMJ Open Effectiveness of pharmacist-led medication reconciliation programmes on clinical outcomes at hospital transitions: a systematic review and meta-analysis

Alemayehu B Mekonnen,^{1,2} Andrew J McLachlan,^{1,3} Jo-anne E Brien^{1,4}

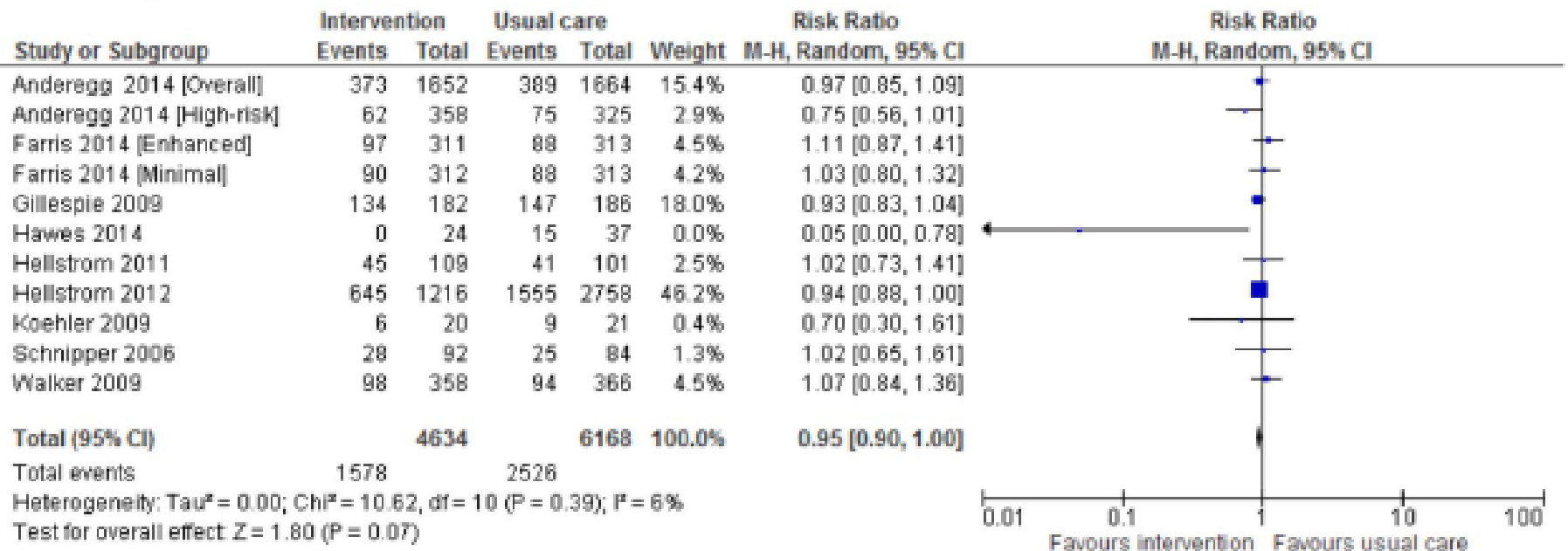
All-cause readmission



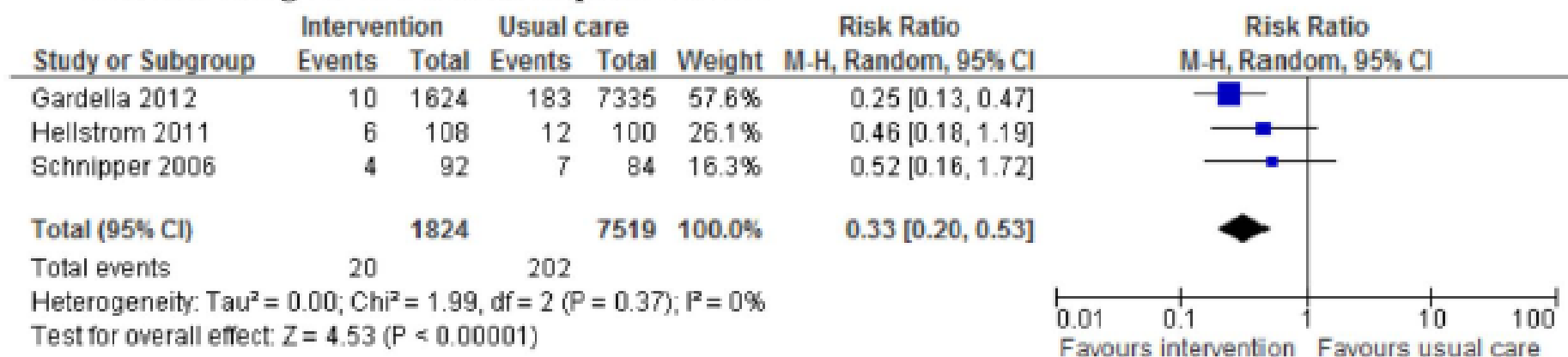
B All-cause emergency department (ED) visits



C Composite rate of readmissions and/or ED visits



Adverse drug event-related hospital revisits



All-cause mortality

