Pharmacy Technician's Letter
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Incorporate Discharge Med Rec Into Your Practice

You'll hear buzz about **expanding pharmacy's role at discharge**.

A new study suggests that pharmacist-led discharge med rec in high-risk patients reduces readmissions at 7 days.

This adds to other positive data. For example, a prior study suggests that a transitions-of-care pharmacist helping from admission through discharge saves $12 for every $1 of pharmacist time.

Although overall evidence is mixed, pharmacist involvement at discharge may help. Consider incorporating these strategies.

Develop a process for identifying patients going home. For example, discuss daily on medical rounds...or with the nurse manager. Work with IT to build a flag once discharge orders are completed.

Focus on high-risk patients...most data are limited to them.

For instance, look for patients admitted for heart failure, COPD, or other diagnoses linked to readmission...or those with more than 5 admissions in the past year.

Ask IT if risks can be pulled into your clinical flow sheet. Or consider using your EHR's readmission risk tool, if available.

Implement reconciling discharge meds as a practical first step.

Look for omissions, such as held home meds that should be restarted...and check durations, such as antibiotic courses that need stop dates.

Also fix therapeutic interchange duplicates...and stop leftover meds, such as antipsychotics started for ICU delirium.

Then if resources allow, expand patient education...and add postdischarge calls. Involve pharmacy residents and students to help, if possible.

Use "meds-to-beds" if your hospital has a program...to help patients leave the hospital with their medications in hand.

See our *Transitions of Care* resource for more on reducing errors at admission, transfer, or discharge to outside facilities. And browse our *Transitions of Care Resource Hub* for other tools.

Key References:

-BMJ Open Qual. 2022 Mar;11(1):e001560
-Ann Pharmacother. 2016 Aug;50(8):649-55
-J Hosp Med. 2016 Jan;11(1):39-44

Hospital Pharmacist's Letter. June 2022, No. 380619

Cite this document as follows: Article, Incorporate Discharge Med Rec Into Your Practice, Pharmacy Technician's Letter, June 2022

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