

Audit of medication lists for elderly patients admitted to a regional hospital

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Aim: To determine the type and number of discrepancies in the medication history information between general practitioners' lists and the actual medication usage of patients aged 65 years or over prior to admission via the emergency department (ED) at a regional hospital in New South Wales, Australia.

Method: This clinical audit was conducted at a 166-bed rural referral hospital. A pharmacist identified patients who were 65 years or over and taking three or more medications prior to admission. Medication discrepancies were considered to be any variation between the medication history obtained by the pharmacist and the GP's medication list. The clinical significance of the discrepancies was assessed in consultation with a general physician.

Relevance: In Australia, 30% of hospital admissions in the elderly population are related to adverse drug events. In rural and regional areas the problem can be exacerbated by the higher proportion of elderly patients and the distance patients travel to access services. Complete medication reconciliation is often difficult to achieve, particularly in the ED. Therefore, GP's lists may be used as the basis for charting medications. Personally controlled electronic health records have been identified as a tool to improve the transfer of medical information at transitions of care. However, this is only useful if it contains accurate, up-to-date information.

Results: Forty-eight patients (mean age 82 years) were included in this clinical audit. The median number of prescribed, regular medications was eight (range: 3–16 medications). Seventy-five per cent (n=36) of patients had one or more discrepancy in their GP's medication list, with the most common number of discrepancies being four. The pharmacist noted 164 discrepancies, with 45% related to non-current medications still being recorded on the GP medication list. The clinical significance of the discrepancies associated with the GP's list was classified as either 'minor' or 'minimum'; however, the potential clinical significance of the discrepancies in 19% of the patients was considered to be 'moderate' or 'major'.

Conclusion: This exploratory clinical audit demonstrates that while a GP's medication list is a useful tool in the medication reconciliation process in many cases, it is not a complete representation of what medications the patient is taking or using prior to admission. This audit affirms the role of the pharmacist in ensuring the accuracy of the medication history at hospital admission.