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Discharge plan for patient with heart failure: it is worth to have a clinical pharmacist in the team

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Objective: A study on the effectiveness of a multidisciplinary discharge plan (DP) to lower early readmission of patients with heart failure is running in the Internal Medicine Service of our tertiary care hospital (LEAR-HF study). The DP team includes a physician, a nurse and a clinical pharmacist (CP). The goal of the present sub-analysis is to highlight the targets of the CP's intervention aimed at preventing drug-related problems after hospital discharge and improving continuity of care.
Methods: For each patient, CP provides medication reconciliation:
- patient's interview on medication knowledge and adherence,
- check for discrepancies between admission record and home medication,
- check for discrepancies between discharge order and home medication,
- medication plan for the patient, his general practitioner and community pharmacy.
We documented discrepancies (type, number), CP's recommendations and time of intervention.
Results: Within the first 2 months of study, the DP has been achieved for 26 patients. Only 19 (73%) got complete CP's intervention. Mean intervention time per patient was 71 min. We found 49 discrepancies (1.9/patient) on admission record and 47 (1.8/patient) on discharge order (*table 1*). Over 55 CP's recommendations, 49 (89%) have been followed by physician in charge.
Conclusion: CP's intervention is useful and easily accepted by physician, despite necessitating substantial work. Medication reconciliation is a key contribution to the DP. Main challenge resides in difficulty to perform medication reconciliation if the patient is rushly or unexpectedly discharged, leading to incomplete intervention and waste of time for the DP team.

	Observed discrepancies	
	Admission§	Discharge¶
Types	n (%)	n (%)
Omission	22 (9.6%)	4 (1.8%)
Addition	6 (2.6%)	3 (1.3%)
Substitution	11 (4.8%)	28 (12.3%)
Dose	5 (2.2%)	2 (0.9%)
Frequency	3 (1.3%)	1 (0.4%)
Formulation	-	1 (0.4%)
Timing	1 (0.4%)	8 (3.5%)
Others	1 (0.4%)	-
Total	49 (21.5%)	47 (20.6%)

Table 1 : Discrepancies observed between: § home medication and hospital admission record, ¶ home medication and discharge order. %: percentage of reconciliated drugs. Total was 228 (8.8/patient).

[table 1]