MEDICATION RECONCILIATION BY PHARMACISTS IN DUTCH CRITICAL CARE PATIENTS

No registrations found.

Ethical review	Positive opinion
Status	Recruiting
Health condition type	-
Study type	Interventional

Summary

ID

NL-OMON20307

Source
NTR

Brief title
TIM

Health condition

medication reconciliation
medication transfer
ICU admission
ICU discharge
Pharmacist,
Medication error,
internally transferred patients within the hospital,
unintentional discontinuation of mediation for chronic diseases,
unintentional continuation of ICU mediation
adverse drug events (ADE),
medication costs,
Patient Data Monitoring System (PDMS),
computerized physician order entry systems with clinical decision support (CPOE/CDS),
medicatieverificatie,
medicatieoverdracht,
IC opname,
IC ontslag,
apotheker,

medicatie fout,
interne overdracht in het ziekenhuis,
onbedoeld discontinueren van chronische medicatie,
onbedoeld continueren IC medicatie,
geneesmiddelkosten,
electronisch voorschrijf system (EVS)

Sponsors and support

Primary sponsor: Apotheek Haagse Ziekenhuizen (AHZ)
Postbus 43100
2504 AC DEN HAAG /
Erasmus MC
Postbus 2040
3000 CA ROTTERDAM
Source(s) of monetary or material Support: both sponsors &
Cooperating Health Insurance Companies
Fund “zorgvernieuwing”

Intervention

Outcome measures

Primary outcome

TRANSFER ERRORS:

-The proportion of patients with one or more transfer error on admission to the intensive care unit

-The proportion of patients with one or more transfer error after discharge from the intensive care unit.

Secondary outcome

ADVERSE DRUG EVENTS:

-Number of potential adverse drug events (caused by medication transfer errors) for patients admitted to the intensive care unit from another hospital ward.

-Number of potential adverse drug events (caused by medication transfer errors) for patients discharged from the intensive care unit to another hospital ward.

Study description

Background summary

SUMMARY

Rationale: Previous studies from our project team have shown that medication reconciliation at the moment of hospital admission or discharge by pharmacy technicians results in increased patient safety. Whether this is also the case at the moment of admission to or discharge from the intensive care unit (internal hospital transfer) is unknown.

Objective: The aim of the study is to show the effect of medication reconciliation by a pharmacist, in patients admitted to and discharged from the intensive care unit on medication errors.

Study design: A one year observational before/after stA one year before/after intervention study design will be used, with medication transfer errors as the primary outcome.

Study population: All patients admitted to the intensive care units of the Erasmus MC Rotterdam and Haga Teaching Hospital The Hague.

Intervention:The intervention consists of medication reconciliation at the moment of intensive care admission and discharge by a pharmacist.

Main study parameters/endpoints:

The proportion of patients with one or more transfer error on admission to the intensive care unit and the proportion of patients with one or more transfer error after discharge from the intensive care unit.
Nature and extent of the burden and risks associated with participation, benefit and group relatedness: The only possible burden will be an interview done by the pharmacy technician to obtain necessary information about the medication history of the patient at the moment of intensive care admission and discharge.

Study objective

medication reconciliation by pharmacists decreases the amount of medication transfer errors in patients admitted to the intensive care

Study design

COSTS:

-Costs involved with the medicationreconciliation process (labour costs pharmacy technician)

-Cost reduction due to preventing errors (medication costs; costs of prevented (potential) adverse drug events, toxicity and/or symptoms per intensive care admission)

-Medical consumption associated with the consequences of medication transfer errors, such as number of intensive care unit days and medical specialist- and nursing staff time, will be recorded and estimated from the hospital's perspective.

-The prevention of adverse events, toxicity and/or symptoms could result in decreased medical consumption which may compensate the increased costs incurred for employing an intensive care pharmacy technician.

Intervention

medication reconciliation at the moment of intensive care admission and discharge by a pharmacist.

Contacts

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Eligibility criteria

Inclusion criteria

-Admitted to the intensive care units of the Erasmus MC Rotterdam and Haga Teaching Hospital The Hague during the study period.

-Admitted to the intensive care units for 24 hours or more.

Exclusion criteria

-No medication before intensive care admission. AND no medication after intensive care.

-(the Erasmus MC Rotterdam): Admitted to the intensive care unit for home treatment mechanical ventilation (so called CTB).

-Admission and discharge within 72 hours inbetween Friday night and Sunday midnight

Study design

Design

Study type:	Interventional
Intervention model:	Factorial
Allocation:	Non-randomized controlled trial
Masking:	Open (masking not used)
Control:	N/A , unknown

Recruitment

NL

Recruitment status:	Recruiting
Start date (anticipated):	06-01-2013
Enrollment:	280
Type:	Anticipated

Ethics review

Positive opinion

Date:	05-09-2013
Application type:	First submission

Study registrations

Followed up by the following (possibly more current) registration

No registrations found.

Other (possibly less up-to-date) registrations in this register

No registrations found.

In other registers

Register	ID
NTR-new	NL3987
NTR-old	NTR4159
Other	MedRec at ICU Transfers : 12-097
ISRCTN	ISRCTN wordt niet meer aangevraagd.

Study results

Summary results
N/A