Abstract

The Australian Pharmaceutical Advisory Committee guidelines call for a detailed medication history to be taken at the first point of admission to hospital. Accurate medication histories are vital in optimising health outcomes and have been shown to reduce mortality rates. This study aimed to examine the accuracy of medication histories taken in the Emergency Department of the Royal Adelaide Hospital. Medication histories recorded by medical staff were compared to those elicited by a pharmacy researcher. The study, conducted over a six-week period, included 100 patients over the age of 70, who took five or more regular medications, had three or more clinical co-morbidities and/or had been discharged from hospital in three months prior to the study. Following patient interviews, the researcher contacted the patients pharmacist and GP for confirmation and completion of the medication history. Out of the 1152 medications recorded as being used by the 100 patients, discrepancies were found for 966 medications (83.9%). There were 563 (48.9%) complete omissions of medications. The most common discrepancies were incomplete or omitted dosage and frequency information. Discrepancies were mostly medications that treated dermatological and ear, nose and throat disorders but approximately 29% were used to treat cardiovascular disorders. This study provides support for the presence of an Emergency Department pharmacist who can compile a comprehensive and accurate medication history to enhance medication management along the continuum of care. It is recommended that the patients community pharmacy and GP be contacted for clarification and confirmation of the medication history.

Keywords