WP5 Webinar
Medication Reconciliation

Welcome & Introduction

Mr Paul De Raeve
EFN Secretary General
EFN is a PaSQ stakeholder, and within WP5, responsible, together with EPF, for the analysis of the Safe Clinical Practice.

From the data collected on MR, 124 healthcare organisations are implementing the MR SCP.

Interesting EFN leads this webinar on Medication Reconciliation to exchange views and experiences from daily practice, from the field workers, and the existing tools they use to advance the SCP. It supplements the quantitative data.
### WP5 Webinar on Medication Reconciliation

#### 16. To which degree have the process steps of the practice been implemented?

<table>
<thead>
<tr>
<th>Step</th>
<th>Implemented (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “Create a complete and accurate Best Possible Medication History (BPMH)”</td>
<td>73</td>
</tr>
<tr>
<td>2. “Reconcile medications”</td>
<td>79</td>
</tr>
<tr>
<td>3. “Document and communicate any resulting changes in medication orders”</td>
<td>81</td>
</tr>
</tbody>
</table>

- Not at all implemented
- Partly implemented
- Fully implemented
- Varies according to the area
In which ways are patients, their carers or family members currently actively engaged during the Medication Reconciliation process in your HCO?

1. A systematic process of interviewing the patient, carer or family member
   - 35.9%

2. Patients are informed about the intention of the systematic interview process to gather the Best Possible...
   - 29.1%

3. The HCO employs prompts to encourage patients to bring their medication lists or vials with them upon...
   - 19.7%

4. Patients, their carers or family members are handed out information sheets with points to consider.
   - 15.4%

5. Medication counselling is available to patients, their carers or family members.
   - 34.2%

6. Upon discharge, patients, their carers or family members are provided with a discharge medication plan.
   - 37.6%

7. Follow-up with patients, their carers or family members on the recommended medication regimen is performed.
   - 23.9%

8. None of the above measures are in place.
   - 29.1%

9. Other.
   - 3.4%
The importance of medication reconciliation: highlights and practical examples from our experience with post-trauma patients

Ms Monica Haras, MD, PhD

Speaker
Since changing the site of medical care often coincides with a change in the patient’s pathology, it is important to view the medication reconciliation process not only as merely continuing the previous medication (while maybe adding some new therapies), but as adapting it, in full knowledge, to the patient’s current state of health.

This involves a thorough data collecting process, involving all levels and types of communication (physician-patient/care taker, physician-physician, physician-pharmacist, physician-nurse and checking the electronic archives, if available), in order to obtain a detailed history of the pathology and received therapy (doses and duration).

It is important to pay attention to the duration of certain courses of treatment and stop the administration of the drugs at the right time.

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The importance of medication reconciliation: highlights from our experience with post-trauma patients.
The importance of medication reconciliation: practical examples from our experience with post-trauma patients

Antibiotics

- Our work takes place in a Rehabilitation Clinic within a large Emergency Hospital (The Teaching Emergency Hospital “Bagdasar-Arseni” in Bucharest, Romania) and most of our patients are in postacute/subacute states after polytrauma (brain injury, spinal cord injury, fractures, etc.) and they are transferred to our Clinic from ICU or surgical units.

- While in ICU or surgical departments, most of these patients are started on antibiotics, and it is extremely important for us to identify upon admission the exact drug the patient has been receiving and for what duration, because:
  - an antibiotic course that is shorter than optimal will fail to cure the infection and may select resistant strains of bacteria and increase the risk of nosocomial infectionsâ
  - unjustified prolonged or associated antibiotherapy increases the risk of toxicity, emergence of bacterial resistance and severe dysbiosis, such as Clostridium difficile infection, which can be deadly even in adults
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Antihypertensive medication

✓ We also deal with postacute stroke patients and many of them have a long standing history of hypertension.

✓ Again, it is very important to identify the medication the patient has been receiving, because changing the antihypertensive therapy may cause abrupt fluctuations in blood pressure and heart rate and put the patient at risk for severe cardiovascular events.

✓ On the other hand, a significant number of post-stroke patients experience a decrease in their blood pressure, resulting in (postural) hypotension, which further limits their mobility and independence. Continuing the previous antihypertensive therapy would be a mistake in these cases, and the process of medication reconciliation should be combined with careful patient monitoring and take into account the actual changes in the patient’s health state.
Anticoagulant and antiplatelet medications

- Most of our patients receive anticoagulant or antiplatelet medications, for various reasons (recent surgery, immobilization to bed, atrial fibrillation, etc.)

- When a complication occurs that requires surgical intervention (e.g. acute intracranial hypertension) we need to take into consideration the surgical risks of these medications, and our concern is to inform the surgeons (in writing) about the course of treatment the patient has been receiving, so that they can assess the bleeding risk and take the necessary precautions.
These were just a few examples of widely used medications that need reconciliation when changing the site of medical care.

Medication reconciliation is, in our opinion, of paramount importance and particularly difficult when patients are moved from acute to postacute/chronic care units or from surgical to medical units (and conversely).
Students’ perception on Medication Reconciliation

Ms Phebe De Coene
Speaker
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- Pharmacy student at the University of Ghent
- Finishing Master, thinking of PhD
- S&D politician in local government
- Currently performing interviews with elderly on MR
Research Study:
Period: January till May 2014

Interviews

Screening tool to adapt the use of the current medication

6 interviews X 150 students

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Case:

- medication history (available in the Pharmacy) + updated interview of this list

- patient was taken alendronate together with calcium. Calcium inhibits the uptake of alendronate. Both medications were prescribed and needed.

→ The key point is informing the patient on the time schedule on medication intake.
Case

- Do not underestimate your patient as expressed in the following example. During the interview patient must remember 3 words, draw up a clock and then say the words again. She insisted that the words were in the right order.

- Outcome: standard procedure in all community pharmacies the evaluate MR
The concept MR not heard of.
Not prominent present in the courses taught.
References to evaluations lists for medication use in elderly but not in detail.

Interdisciplinary teaching?

Current research?
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Pharmacists’ role in Med Rec

Mrs Stephanie Tohill
Senior Clinical Pharmacist NHSCT

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Role of pharmacist - Admission

- 95% of patients should have a medication reconciliation performed within 24 hours of hospital admission – Institute for Healthcare Improvement (IHI)

- NICE - ‘pharmacists should be involved in medicines reconciliation as soon as possible after admission’

- Clinical pharmacy standards
‘The number of errors, omissions or alternations were found to be considerably lower on pharmacist-written discharge prescriptions (8%) than those written by junior doctors (32%), and a higher proportion of PODs were considered suitable for re-use at discharge.’
Pharmacists write the majority of the discharge prescriptions
Mostly as pharmacist independent prescribers

‘Pharmacist-written discharge prescriptions reduces error rates and improves bed-management, allowing patients to be discharged more quickly. Pharmacists can also take the opportunity of writing the prescription to counsel patients/carers on their medication’

(Moving Patients, Moving Medicines, Moving safely - 2005)
Most Med Rec processes are paper based which have a number of disadvantages

- Details recorded in different formats by different users
- Transcribing errors may occur
- Storage of paper records can be problematic
- Access to paper records can be difficult, particularly if patients move to a different healthcare location
Electronic Solution

• To solve these issues an electronic system was developed in local innovation partnership with NHSCT & Yarra software Ltd
• LIVE throughout the Trust (May 2013)
• Approaching 20,000 med rec records
• Current interfaces with Patient Administration System (PAS), DM+D – NHS drug dictionary & EPICS intervention recording
• Query Database
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Advantages

• Real time updates with patient details
• Medication details are uniform, clear
• Med Rec record is retained indefinitely, can be reprinted and accessed by all users
• Intervention reporting is automatic
• Primary care gets complete list on discharge
• Discharge medication list is pre-populated from the admission med rec and then exported into Immediate Discharge Summary once complete
• Next admission med rec is populated from previous admission
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**DISCHARGE MEDICATION**

<table>
<thead>
<tr>
<th>Patient Details/Addressograph</th>
<th>Name: MR CHARLES TESTADO</th>
<th>MR CHARLES TESTADO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Charles Testado</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address: 45 Any Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postcode: 1100 000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of birth: 00/00/0000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex: Male</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date: 11/03/2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital: Antrim</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward: C6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies/Medicine Sensitivities**

<table>
<thead>
<tr>
<th>Date</th>
<th>Medication/Generic</th>
<th>Allergy Type</th>
<th>Nature of Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/03/2014</td>
<td>Pencilllin</td>
<td>Allergy</td>
<td>Anaphylaxis</td>
</tr>
<tr>
<td>11/03/2014</td>
<td>Sensitivity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discharge Medication**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Route</th>
<th>Frequency</th>
<th>Duration</th>
<th>Comments</th>
<th>Number Dispensed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pencilllin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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</table>

**Additional Information**

- **Clinical Pharmacist Recommendations**: INR on 11/03/14 = 2.0. GP - Please recheck INR on 13/03/14 and review warfarin dose.

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Innovation for improving MedRec
Health Future Vision

Mr Ray Pinto
Senior Government Affairs Manager, Microsoft
rpinto@microsoft.com

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What can you do with HealthVault?

Your health data  Health apps  Personal health devices  Sharing

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Take control of your health

Organize your family’s health information:

- Keep all of your health records in one place
- Keep track of all the details (medications, health history, blood pressure, conditions and illnesses, etc)
- Capture it once, use it again and again
Be better prepared for health consultations and unexpected emergencies

- Be prepared for an emergency by making your health info available.
- Keep your information at your fingertips and access it from any Internet connection, using any device.
- Get more out of your health professionals visits by bringing important data with you.
Create a more complete picture of your health, with you at the centre

- Get your lab results, prescription history, and visit records from a growing list of labs, pharmacies, hospitals, and clinics.
- Track your numbers to help monitor chronic conditions.
- Save and share your medical images.
Nursing good practices management platform: a support for medication reconciliation

Mr Jose Luis Cobos, PhD candidate, MSN, RN
Advisor
Spanish General Council of Nursing

Madrid, 21-03-2014
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**Nursing good practices management platform**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>To educate and train</td>
<td>Safety and confidentiality</td>
</tr>
<tr>
<td>To facilitate clinical decision-making</td>
<td>Traceability</td>
</tr>
<tr>
<td>To facilitate the work in a multidisciplinary team</td>
<td>Interoperability</td>
</tr>
<tr>
<td>To transform information into knowledge</td>
<td>Standardisation / Normalisation</td>
</tr>
<tr>
<td>To facilitate patient autonomy</td>
<td>It avoids 80% of <em>iatrogenia</em> cases.</td>
</tr>
<tr>
<td>To support chronic patients</td>
<td>It supports processes in primary and specialised healthcare</td>
</tr>
<tr>
<td>To ensure patient safety</td>
<td></td>
</tr>
</tbody>
</table>

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Nursing good practices management platform

Knowledge management

- Nursing language:
  - Diagnosis (206)
  - Outcomes (385)
  - Interventions (542)
  - Activities (12,000).

- Patient assessment systems

- 200 normalised care plans (80% of the casuistry in specialized healthcare)

- Devising customized care plans

- Repository with 1,100 nursing procedures/protocols

Management of prescribing

- Databases with 80,000 drugs and healthcare products:
  - Technical index cards
  - Patient information leaflets
  - Incompatibilities
  - Interactions.

- Patient clinical history:
  - (25 variables to avoid iatrogenia cases)

- Prescribing on the basis of:
  - Trade name
  - ATC classification
  - Composition
  - Pharmacological activity
  - Laboratory
  - Nursing language
  - Pharmacovigilance
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- E-care
- Nursing Language
- Care plans
- Medication control
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Nursing Language

- E-care
- Nursing Language
- Care plans
- Medication control

 DIAGNÓSTICOS | RESULTADOS | INTERVENCIONES | PLANES DE CUIDADOS | PROTOCOLOS ENFERMEROS

Consulta | Consulta | Consulta | Consulta | Consulta
Crear Nuevo | Modificar Plan |
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- E-care
- Nursing Language
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- E-care
- Nursing Language
- Care plans
- Medication control
**Conclusion**

The e-care platform is a useful tool for an ethical, autonomous and competent nursing practice allowing medication reconciliation in a safe manner for professionals and patients themselves.

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MedRec in Antibiotic Program, a Bulgarian case study

Dr St Bobcheva & Ms Milena Vladimirova
Webinar on Medication Reconciliation
Antibiotic program (case in Bulgaria)

• The main objective of the program is to improve the quality and safety of medical help by restricting the spread of antimicrobial resistance, using pharmaco-economic approaches in treatment and prevention. Thus patient are provided the optimal antimicrobial therapy and prevention. Antimicrobial agents are used for treatment and prevention of infections. Often the antibiotic therapy is ineffective because of the vast increase of the relative share of poly-resistant microorganism in infective pathology as well as patient with disbalanced in the immune response. A positive causal connection has been proven between the use of antibiotics and the formation and selection of resistant microorganisms.
• The policy on antibiotics is determined by a Commission on drug policy, created by an order of director, and is approved by the director. Updated annually. It includes goals, tasks, organization of hospital structures (hospital pharmaco - therapeutic commission, visiting microbiologist, clinico - microbiological collegium), main components of the antimicrobial therapy with a choice of antibiotic, types of antibiotic therapy - specific, empirical and antibiotic prevention, path of introduction of the antibiotic; dose and dose interval, duration of therapy, side effects, interaction with other drugs, antibiotic combinations, microbiological tests, cost of treatment.
• The most profound change in antibiothic treatment is the so called "SWITCH" therapy - early shift from potential to oral application of the antimicrobial agent, which ensures for optimal effect, reducing the risk of resistance formation in bacteria and the costs for antimicrobial treatment.
• An antibiotic list with groups of antimicrobial treatments is prepared by all doctors in the hospital. Those with limited application - by the head of the respective department. Their prescription is recommended after a microbiological test. Antibiotics, requiring permission are prescribed by the head of the department after a microbiological test and certain pathogens.

• So, many important in two steps: a systematic process of interviewing the patient/family and verification of this information with at least one other reliable source. Also very important patient interviews, tracking of contracts for delivery of medicament's. The antibiotic program applies to all departments and the Four multi-profile hospital for active treatment.

• It is mandatory for all hospitals in Bulgaria. Patients completed informed consent if the patient is in intensive care can not discuss it, but in other cases be informed of the change of therapy his state the reasons that aims to better his treatment.
• Communication and interaction between patients, doctors, pharmacists and other part of the success of the strategy of reconciliation commission on drug policy manual.

• Also very important patient interviews, tracking of contracts for delivery of medicament's. The antibiotic program applies to all departments and the Four multi-profile hospital for active treatment.

• Communication and interaction between patients, doctors, pharmacists and other part of the success of the strategy of reconciliation commission on drug policy manual.

• In terms of patient care, stewardship programs reduce the use and intensity of antibiotics, and are not associated with higher infection rates, longer patient length of stay or worse health outcomes.
• Organization of the functioning is conducted under the Rules of organization, operation and inner regulation of the hospital relevant departments and hospital pharmacy and as well as the Rules of functioning of the Committee on drug policy, approved by the Executive Director. These acts regulate the rules for ordering, storage and dispensation of medical products.

• Of antibiotic program are conducted microbiological tests. The document is prepared by created by order of the director of the hospital. Committee on drug policy and approved by him. The control implementation in the hospital is carried out by the Commission on Drug Policy, hospital epidemiologist and microbiologist. External control is exercised by Regional Health Inspection.
• As an example of appropriate antibacterial therapy would give the following case: A patient with a history of infectious pathology enters the hospital. Starting empirical therapy according to defined rules on the localization of infection and take appropriate material for microbiological examination. After isolation of the causative bacteria is changed according to the treatment showed a sensitivity of the isolated microorganism.
empirical therapy
↓
material for study
↓
pathogen with a specific sensitivity
↓
connecting with the clinician – discussion and switching according to study
↓
relationship clinician – pharmacy
↓
spelling of new therapy
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Engaging patients in MedRec

Ms Juliëtte Kamphuis
Patient representative
Medication Reconciliation definition:

“The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency and route, by comparing the medical record to an external list of medications from a patient, hospital or other provider “

- Well-documented patient safety problem
- Unintentionally introducing changes in patient’s medication regimens
- Preventing incomplete or inaccurate medication information of transitions in care
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“Some personal examples”

“My father uses heart medication and experience side effects. He tells me instead of his physician. He thinks he should not complain about his medication”

“When travelling by plane, I have asked my pharmacist about a medication list for my medication passport. It was not up-to-date, wrong medication was on the list”

“My current pharmacist double checks my medication, to keep my medication list up-to-date”

“I have asthma and spirometry is performed yearly. Every year I ask for printed results. I was given me once, “It is not according to our guidelines to give printed results”, the pulmonary function technician says”.

“I can call anytime my nurse if I experience side effects and I have questions or complaints about my medication”

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“What can go wrong?”

80% of all discharge letters has insufficient medication registration

Up to 27% of the prescription errors in the hospital are caused by an incomplete medication list at admission

Almost 50% of the errors in discharge medication exists of missing medication on discharge prescription.

In 70% of cases, patients, GP’s, and pharmacists provide different medication lists after asking what medication patient is taking
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“What is an actual medication list?”

- all prescribed, dispensed, administered and used medication
- dosages, route, period of use, including early termination or change of medication
- indication of prescribing
- use of drugs or alcohol
- allergies, intolerances and contraindications
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“Creating actual medication list”

Physicians / Nurses → Pharmacists → Health Care Providers → Patient

- prescribe
- process / deliver
- administer

shared responsibility
Role and responsibility of the patient

- the right to inspect and to obtain copies of medical record
- the sole right to authorize others to inspect, retrieve, use and updating of medical record
- need to give all information about health condition that is relevant for care
- gives information about actual use of alcohol, drugs, and (prescribed) medication
- may have a legal representative
“What do patients need?”

- awareness of their role in medication reconciliation
  (public awareness; posters & brochures, TV & radio adds, social media, website)
- actively involvement in the whole process of treatment
  (reinforce the benefits for the patient)
- effective communication with health care professionals
  (trainings for patients and health care professionals)
- easily access to their own medical record
- easy way of collecting their own medication data
Patient Information Cards
communication tool for health care professionals and patients to support the safety of the treatment

developed by NPCF: Netherlands Patient Consumer Federation
to download from website: www.mijnzorgveilig.nl

- Many different patient information cards (search option)
- All care situations and providers in health care
- Easily accessible and possibilities do create their own patient information card
- Guide for both health care providers and patients
Thank you for your attention!

Contact:
jaekamphuis@hotmail.com
nl.linkedin.com/in/juliettekamphuis/
Nurse prescribing and medication reconciliation in Finland

Ms Hannele Tyrväinen, RN, MSc (Health Sciences)
Medication Reconciliation in nurse prescribing education

• Pharmacology and prescribing drugs module
  – Completely same as in medical education – nurse prescriber are aware of patients’ different medicines and their influences

• Drug therapy ethical and juridical knowledge base in treatment – module
  – Risk evaluation assignment
    • Medication risk charting at own work
    • Own responsibility and role as nurse prescriber
    • Lecture on medication errors concerning nurse prescribing
Education continues

• Safe drug therapy in patient situations – module
  – Students examine 12 patients under the guidance of certificated physician and write case diaries where they describe carefully (using EBM guidelines etc. databases)
    • History taking including best possible medication history, status and conclusion
    • Pharmacological therapy (current medication and medications to be prescribed)
      – Need of drug therapy, dosage, duration, effectiveness, interactions, adverse effects, follow-up, prescription,
    • Guidance, documentation and self-evaluation
How can nurse prescriber enhance Medication Reconciliation (Ministry of Social Affairs and Health, decree 1088/2010)

- Nurse is able to prescribe when the need of care is assessed on nurses practice and nurse has examined the patient (10 §)
  - Not possible to prescribe without meeting the patient
  - Complete evaluation of drug therapy adherencing medication reconciliation process
  - Nurse can give patient education in every appointment
  - Nurse can be sure, that patient gets guidance when she prescribes new medication

- Nurse must have possibility to consult a legitimate doctor (25 §)
  - If nurse is unsure in decision making
  - Has no right to start/continue medication which is needed
  - Nurse is not permitted to end regular medication without consulting the physician
How can nurse prescriber enhance medication reconciliation (Ministry of Social Affairs and Health, decree 1088/2010)

• Nurse must follow patients written care plan and instructions of health care unit based on national treatment guidelines and national nurses’ medicine list (25 §)
  – Nurses have electronic databases supporting decision making (eg. EBM guidelines, SFINX-Pharao interaction database) in everyday use
  – Nurses report medicine errors systematic
  – A requirement for the **limited right to prescribe medicines** is a written assignment specifying the medicines that the nurse may prescribe, and possible limitations to the right given by the physician in charge at the health centre where the nurse is employed

• The right for prescription is limited in certain diseases, medication and health care organizations (regulated in decree of Ministry of Social Affairs and Health 1088/2010)
In conclusion the nurse prescriber

especially in nurse’s appointment in health centres (regional nurse) or in long-term patients’ appointment

- Assesses the need of drug therapy on nurse’s practice
- Makes the prescription based on effective drug ingredient, strength and form of the drug
- Assesses the effectiveness of drug and makes an announcement of adverse effect if needed
- Is able to renew a prescription according to patient’s care plan written by physician
- Updates patient’s medication list
- Assesses patient’s regular medication in wholeness
- Has good possibility to monitor if patient takes one’s medication as prescribed – underuse is usual
- Make medication reconciliation, because they meet same patients several times, e.g. diabetics, hypertonia patients, asthmatics mostly have their follow-ups in nurses appointment
- The new role of nurses may also enhance patients’ adherence to medication therapy and own treatment which is weak especially in long-term illnesses
Most common prescriptions and diagnosis (nurses) 7/2012-6/2013

- **Drugs prescribed (altogether 3310 by 81 nurses):**
  - Pivmesilliname (1260)
  - Fenokxylmethylpenicillium (495)
  - Trimetoprime (352)
  - Metformin (187)
  - Simvastatin (142)

- **Diagnosis:**
  - Urinary infection 50 %
  - Other infections (Pharyngitis) 18,1 %
  - Hypertonia 15,7 %
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Open discussion with participants
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Wrap up & Conclusions

Ms Silvia Gomez
EFN

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Thank you for your attention!

More information in:
www.pasq.eu