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Title: *Evaluation of the Transitions of Care Process between Ranken Jordan Pediatric Bridge Hospital and Outside Hospitals*

Abstract:

Background: Within healthcare, it is common for patients to move between healthcare practitioners and settings as their healthcare needs and conditions change. This process is known as “transitions of care”. It is estimated that 60% of all medication errors occur during this process. Children with medical complexities and/or chronic health conditions have an even greater risk due to their frequent encounters within the health care system and have been labeled as an important high-risk group to monitor for medication errors.

Objective: To evaluate medication errors and discrepancies that occur as patients transition between Ranken Jordan Pediatric Bridge Hospital and outside hospitals prior to and following implementation of a pharmacist-led intervention.

Methods: A single-center, retrospective chart review conducted to evaluate medication errors involving children with medical complexities who transitioned between Ranken Jordan Pediatric Bridge Hospital and outside hospitals. Patients were excluded if they were admitted from home, discharged to home, or died during their stay at Ranken Jordan. Electronic health records were reviewed to evaluate admission/discharge status, outside hospital involved, quantity of patient medications from sending facility, the presence of a medication discrepancy or error, and the cause of the medication inconsistency.

Results: During the first phase of data collection, 20% of admitted patients experienced a medication discrepancy; while 27.3% of discharged patients experienced a medication error and 27.3% experienced a medication discrepancy. Throughout the second phase of data collection, 18.75% of admitted patients and 87.5% of discharged patients experienced a medication discrepancy. There were zero medication errors during this period.

Conclusion: This study was able to strengthen existing relationships and build rapport with other facilities and pharmacists. Collaboration and communication are essential for safe patient care. This is especially important in children with medical complexities on a multitude of medications that if not managed diligently, can lead to potential harm from the very medications that are meant to help their conditions. This is evident within the study as medication errors decreased as communication between pharmacists increased following the intervention.