



Service Priorities and Programmes
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Evaluation of Medication Reconciliation Service Given by Clinical Pharmacists in Oncology Wards

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Introduction

Medication reconciliation (MR) is a strategy to ensure medication safety. It involves the building up of a complete list of medications that a patient is taking and to compare it with the list of medications prescribed to the patient at point of transit of care, for example on admission to hospital, during ward transfer, or discharge from hospital. MR service is part of the routine clinical pharmacy service provided by clinical oncology pharmacists in Princess Margaret Hospital (PMH).

Objectives

To evaluate the medication reconciliation (MR) service given by clinical pharmacists in oncology wards at Princess Margaret Hospital (PMH) in Hong Kong.

Methodology

The evaluation was based on a retrospective review of MR interventions made by oncology clinical pharmacists from 1 April 2016 to 31 March 2017 documented in an electronic database in the PMH Pharmacy Department website. The evaluation consisted of 1) investigating the total number of MR interventions done within the study period; 2) investigating the acceptance rate of MR interventions by the prescribers; 3) categorizing and analyzing MR interventions based on their nature and therapeutic class of medications involved.

Result

A total of 223 MR interventions over the 12-month study period from 1 April 2016 to 31 March 2017 were reviewed. The total number of patients admitted in the 2 oncology wards within the captioned period was 3218. The acceptance rate was 100%. The most common drug-related problem identified was omission error (78%), followed by unjustified change of medications (8%) and addition error (6%). The most frequently involved therapeutic groups were cardiovascular system (30%), followed by nervous system (20%) and gastrointestinal system (15%).