



Service Priorities and Programmes Electronic Presentations

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Medication reconciliation service for paediatric ward and paediatric intensive care unit at Princess Margaret Hospital (PMH)

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Introduction

Medication reconciliation (MR) has been identified as a major intervention to target and reduce the burden of medication discrepancies and medication errors during transitions in care. Patients are vulnerable when admitted to hospital and medication discrepancies have been reported to contribute for over half of the medication errors. Unintended therapeutic changes are common, and suboptimal communication between healthcare providers at care transitions may subsequently result in medication errors. Moreover, these errors can be more vulnerable to children than adults. Medication reconciliation as a medication safety strategy has been adopted and championed by a number of patient safety organizations worldwide.

Objectives

The aim of medication reconciliation on hospital admission is to improve medication safety by ensuring the medications prior to admission or transfer-in from another unit are prescribed appropriately on admission for the paediatric patients. This is done through obtaining a patient's best possible medication list from various information sources. It involves the taking of a thorough medication history and then comparing with the admission medication orders.

Methodology

Medication reconciliation service is provided to patients admitted to PMH paediatric wards (E4 and paediatric intensive care unit) under paediatric specialties since Dec 2015. The best possible medication list is reconciled by paediatric clinical pharmacist to include all medications that the patient is taking from Hospital Authority, Department of Health, private institutions and clinics as well as self-medications and herbal medicines. Appropriate documents (e.g. latest Medication Administration Record from the previous wards) are consulted if necessary for transfer-in cases. The medication list is then compared with the current medications prescribed in PMH. For any discrepancies found, the clinical pharmacist will investigate based on the available clinical information. The pharmacist should consult the case medical officer for discrepancies if in doubt and provide interventions if necessary. Patient's medication compliance is checked to identify any non-compliance issue.

Result

- Number of admission medication reconciliation performed
- Number of compliance check performed
- Number of patient with compliance problems
- Number of admissions with at least one unintentional prescribing discrepancy
- Total number of unintentional prescri