



Service Priorities and Programmes Electronic Presentations

Convention ID: 360

Submitting author: Miss SHUK CHING TSANG

Post title: Pharmacist, Princess Margaret Hospital

Medication Reconciliation in Oncology Wards

NG V(1), YIP Y T Elton(1), TSANG Jenny S C(1), CHAN K H(1), CHOI Adrian Y F(1), YIU T T(1), CHAN S K(1), WONG K W(1).

(1)Pharmacy Department, Princess Margaret Hospital

Keywords:

Clinical Pharmacy

Clinical Pharmacist

Introduction

Safe and effective use of medications is of high importance when it comes to patient safety. Medication errors commonly occur during transitions in patient care such as hospital admission and discharge. According to the Joint Commission of United States, medication reconciliation is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. The purpose of medication reconciliation is to avoid medication errors such as drug omissions, therapeutic duplications, dosing discrepancies, or drug interactions. It is done at every transition of care in which new medications are prescribed or existing medications are continued.

Objectives

To analyze the interventions implemented by the clinical pharmacist during the process of medication reconciliation in the oncology wards.

Methodology

A full-time clinical oncology pharmacist performs medication reconciliation on new admissions and discharges on Monday to Friday, 9-5pm in the oncology wards. This process comprised of the following: (1) Obtain a list of currently active medications; (2) Obtain the list of medications being prescribed on admission or discharge; (3) Compare the medications on the two lists; (4) Search for unintentional discrepancies and make clinical decisions to optimize drug treatment according to the patient's current condition; (5) Reconcile any discrepancies with the prescribers, propose interventions to improve drug treatment, (6) Communicate the changes in the drug regimen to the patient or caregivers. A retrospective, observational analysis was done from the period of June 2015 to May 2016, evaluating the types of interventions proposed by the pharmacist during the process of medication reconciliation.

Result

A total of 203 interventions were proposed during the process of medication reconciliation upon hospital admission and discharge in the aforementioned time period. The most common intervention is adding or resuming a missing drug (75%),

followed by changing the dosage or frequency (10%), changing drug (6%), discontinuing an unnecessary drug (4%), changing treatment duration or time of administration (2.5%), therapeutic duplication resulting in discontinuing a drug (2%), and drug interaction resulting in separating administration times (0.5%). The majority of drug discrepancies that arose during patient care transition points were drug omissions and incorrect dosages. This could be due to complicated drug histories with multiple changes to drug regimen previously. Therefore, medication reconciliation performed by the pharmacist is critical in ensuring safe and effective use of medications.