

Seamless pharmaceutical care for patients using oral chemotherapy agents: a pilot study

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Aims

Unintended medication discrepancies (UMD) seem to occur frequently at the time of hospital discharge, leading possibly to drug related problems [1]. Most oral chemotherapy agents (OCA) have to be delivered by the hospital pharmacy, but often these patients are prescribed other medication which is delivered by the community pharmacist. It might therefore be interesting to perform medication reconciliation at the hospital pharmacy, to check for drug-drug interactions (DDI), and to exchange the medication scheme with the community pharmacist.

Method

A hospital pharmacist performed medication reconciliation for ambulatory patients for whom an OCA was delivered, using a structured approach [2]. The obtained medication scheme was compared with the hospital medical file; number and type of UMD were documented. We screened for DDI by means of two drug databases [3,4]. Recommendations for clinically relevant interactions were discussed with the treating physician. After approval by the patient, the community pharmacist was contacted and the medication scheme was transferred, together with a satisfaction survey.

Results

During 9 weeks, medication reconciliation was performed for 61 patients taking an OCA. Those patients used 441 drugs in total (median 7); 72 (16%) delivered by the hospital and 369 (84%) by the community pharmacy. For these 441 drugs, 166 UMD were found (mean 2.7 per patient). Furthermore, 41 drugs were recorded in the medical file that had already been stopped. It was also noticed that for most OCA, the proper frequency in relation to food (e.g. without meal) was not recorded (not considered as UMD).

Number of patients included	61
Total number of drugs used	441 (median: 7)
Total number of UMD	166 (mean: 2.7)
Number of stopped drugs recorded	41

Type of discrepancy	Number	%
Drug omission	123	74,1%
Dose unknown	30	18,1%
Wrong dose	6	3,6%
Wrong frequency	3	1,8%
Wrong drug	4	2,4%

Sixty drug-drug interactions were found for 34 patients (57% pharmacokinetic and 43% pharmacodynamic interactions), in which 17 OCA (50%) were involved. For 26 of the interactions (43%), a recommendation to the treating physician was formulated, which was accepted in 19 cases.

For 49 patients, the medication scheme was transferred to the community pharmacist, and 20 satisfaction surveys were returned. The majority of the community pharmacists found this communication positive.

Do you think that exchange of medication schemes between the hospital and the community pharmacy...	++	+	-	--
Is helpful to obtain a clear view of the medication of patients on OCA?	95%	5%		
Takes much of your time?	15%	55%	25%	5%
Is a good way to prevent discrepancies between the medication schemes of the hospital and the community ?	90%	10%		
Should become a standard part of the patient counseling by the hospital pharmacy?	80%	20%		
Is helpful until electronic exchange will be possible?	70%	25%	5%	
Will encourage you to maintain medication schemes for these patients in your pharmacy file?	55%	45%		

Conclusion

Medication reconciliation for patients taking OCA seems useful for avoiding UMD. Communication of their medication scheme to the community pharmacy is appreciated until electronic exchange will be possible. Moreover, DDI seem to occur frequently which demonstrates the need for seamless pharmaceutical care in this group of patients. The results of this pilot project were discussed and led to the implementation on a daily basis.

References

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