Service Priorities and Programmes

Electronic Presentations

Convention ID: 906
Submitting author: Mr Aaron YAM
Post title: Pharmacist, NLTH, KWC

Clinical Pharmacy Service for Medical & Geriatrics In-patient at North Lantau Hospital (NLTH)

Ng V (1), Yam A (1), Cheung E (1)
(1) Department of Pharmacy, North Lantau Hospital

Keywords:
Clinical Pharmacy
Medication Review
Medicine & Geriatrics

Introduction

Pharmacists, equipped with in-depth medication knowledge, are uniquely positioned in a holistic care team to provide expert review of medication regimens to achieve therapeutic outcomes and ensure medication safety. Regular access to bedside clinical progress is paramount to the delivery of such a quality service. The ward clinical pharmacy service was thus launched in November 2014, providing pharmaceutical care to Medical & Geriatrics extended-care patients.

Objectives

Clinical pharmacist aims at performing continuous comprehensive medication review from admission till discharge to provide timely and tailor-made written or verbal suggestions to handle drug-related problems (DRPs).

Methodology

Standardized patient monitoring forms were used to track and trace relevant clinical data. Clinical interventions were documented in standard electronic templates. Clinical pharmacists also participated in weekly multi-disciplinary grand rounds to assist physicians in making holistic therapeutic and discharge plans.

Result

Over a 3-year period (November 2014 – November 2017), 576 interventions were made with 509 accepted by physicians or nurses (acceptance rate 88%). The five most common categories of DRPs were “Dose being too high/frequent” (29%), “Dose being too low/infrequent” (12%), “Missing drugs with clear indication” (11%), “Prescription of contraindicated drugs” (9%), and “Drug interactions” (9%). Of the 509 accepted interventions, 6% involved high-alert medications including Anticoagulants (N=13), Insulins & Oral Hypoglycemic Agents (N=9) and Opioids (N=6). Worsening or improvement in renal function (N= 131) was a commonly encountered trigger for interventions involving drug and dosage change. There were 30 interventions on the choice of drug formulations or drug interactions for regimens involving the use of nasogastric or other tube feeding routes. Pharmacists, in collaboration with the multidisciplinary team, demonstrated a positive impact by identifying, resolving, and

preventing drug-related problems, optimizing both the efficacy and safety of drug treatment. A number of medication near-miss cases involving high-alert medications, which could lead to significant harm to patients, were intervened. Further plans to improve patient safety by implementing medication reconciliation service would be explored.