**Service Priorities and Programmes**

**Electronic Presentations**

**Convention ID:** 188
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# The Roles of Clinical Pharmacist on the Medication Management in the Integrated Discharge Service Programme

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**Keywords:**
Clinical Pharmacist
Medicine Management
Integrated Discharge Service Programme

## Introduction

The Integrated Discharge Service Programme (IDSP) has been initiated at QMH since the beginning of 2012. This multidisciplinary approach intends to enhance active planning for discharge, improve medication compliance and prevent hospital re-admission in high-risk elderly patients.

## Objectives

To investigate the significance of roles of Clinical Pharmacist in the IDSP programme by performing medication reconciliation (MR) service, medication review during hospitalization, regular ward round with the multidisciplinary team, compliance check and providing advice on any medication related queries, aiming to ensure safe and effective use of medicines.

## Methodology

The retrospective study carried out by collecting activity data include all clinical services performed by Clinical Pharmacist on the eligible IDSP patients recruited on medical wards, all telephone calls and case referral received from the Case Manager (CM) between April 2012 and March 2013.

## Result

MR Service was performed on 742 patient episodes with the mean age of 81.7 years old (range 59-107) taking an average of nine medications. Unintended discrepancies were found on 10% of prescriptions at discharge and 5% on admission. 84 patients (11.3%) found to have doubtful or poor drug compliance. Those using pillbox had a better drug compliance ($p<0.05$, chi square) even though they have greater number of discharge medications ($p<0.05$, independent t test). However, drug compliance failed to show any association with the number of admission ($p>0.05$, poisson regression). 70% of all interventions made during hospitalization were classified as clinically significant according to assessment tool used in Hospital Authority. Amongst half of the interventions 75% of those were on renal dosage adjustment. 235 drug enquiries

were received in the study period – 76 (32.3%) on the change of drug therapy and 74 (31.5%) were clarification of drug indication. A total of 42 patients were referred by CM, 30 (71.4%) needed direct education from Clinical Pharmacist at the hospital and the rest received drug advice over the telephone. Clinical Pharmacist is a value member in the IDSP team by improving the medication safety and therapeutic outcomes in high risk elderly patients. This can also be used to develop a working model for a Geriatric Pharmacist in the future.