# CLINICAL PHARMACIST IN THE MULTIDISCIPLINARY TEAM IN THE INTENSIVE CARE UNIT IMPROVES THE QUALITY OF MEDICINE THROUGHOUT THE PATIENT'S HOSPITAL STAY

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### Background

Critically ill patients in the intensive care unit (ICU) are particularly vulnerable to errors in medication management, and each care transition increases the risk of medication discrepancies.

### **Objectives**

- Develop a workflow for clinical pharmacist in the multidisciplinary ICU team.
- Improve the documentation of medication lists, optimize medical treatment and avoid drug-related problems (DRPs).

## Conclusion

The clinical pharmacist contributed to less medication errors and DRPs and improved documentation of the medication lists throughout the hospital stay.



## **Materials and Methods**

### **Preintervention control cohort**

TIS

- 34 patiens in ICU 2020 – spring 2021
- Retrospective review of patient records

#### Registration in both cohorts Quality score of medication list: •When transferred from ICU inhospital

• In the discharge summary

### Intervention cohort

- 23 patiens in ICU autumn 2021
- Review patient records
- Registration of DRPs

### Clinical pharmacist:

- Medication reconciliation
- Medication review
- ICU team member





