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Detailed documentation in clinical pharmacy – too much effort?

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OBJECTIVE

Documentation systems are essential to picture the input of clinical pharmacist activities in the multiprofessional health care team . A rated documentation system in 8 Viennese hospitals was implemented within the hospital trust, to show the value of detailed documentation in relation to the pharmacist´s time expenditure.

METHODS

All Patient´s charts on two neurologic wards were each once weekly reviewed for drugrelated problems and for potential of reducing polypragmasy (> 10 prescribed drugs) to a required minimum from July to December 2014. Following completion of the documentary report. (table 1)

table 1

Documentation of drug concerned recognition by pharmacist											added ratings just for this project	
date	ward	nr. of checked patient	nr. of drugrelated problems	time per ward in minutes + written record per visit	intervention	code for problem	code for intervention	ATC	accep tance	costred uction	number of patients with more than 10	number of drugs reduced/visit
05.07.2014	neurology B1	24	8	40 + 35	Terbutalin Turbohaler only during period of E-COPD	5	2	R	2	1	4	4
					Cipralex administration in the morning, not evening	8	6	N	1	2		
					painmanagement for patient on phenprocoumon better with metamizol or paracetamol	6b	3	B	1	2		

RESULTS

523 patient files checked and 198 interventions set on 26 ward visits. With 13% of these patients > 10 medications prescribed and in average 1 to 4 drugs reduced. Subsequent to each visit approx. 35 minutes for documentation required. 73% of all therapeutic interventions accepted by medical staff. 20% needed further drug information efforts. Most relevant rates: 35% stop of medication without indication and 14% for dosage adjustments. Pharmacist-estimated cost savings follow-up costs (51%).

figure 1

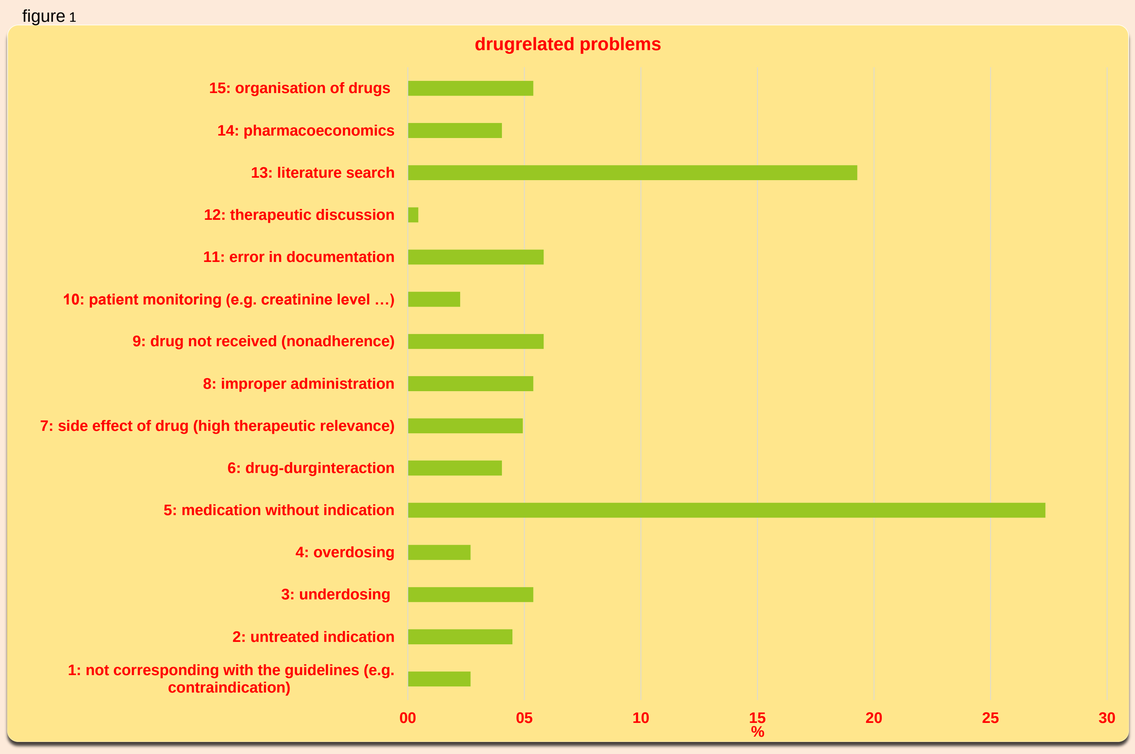


figure 2

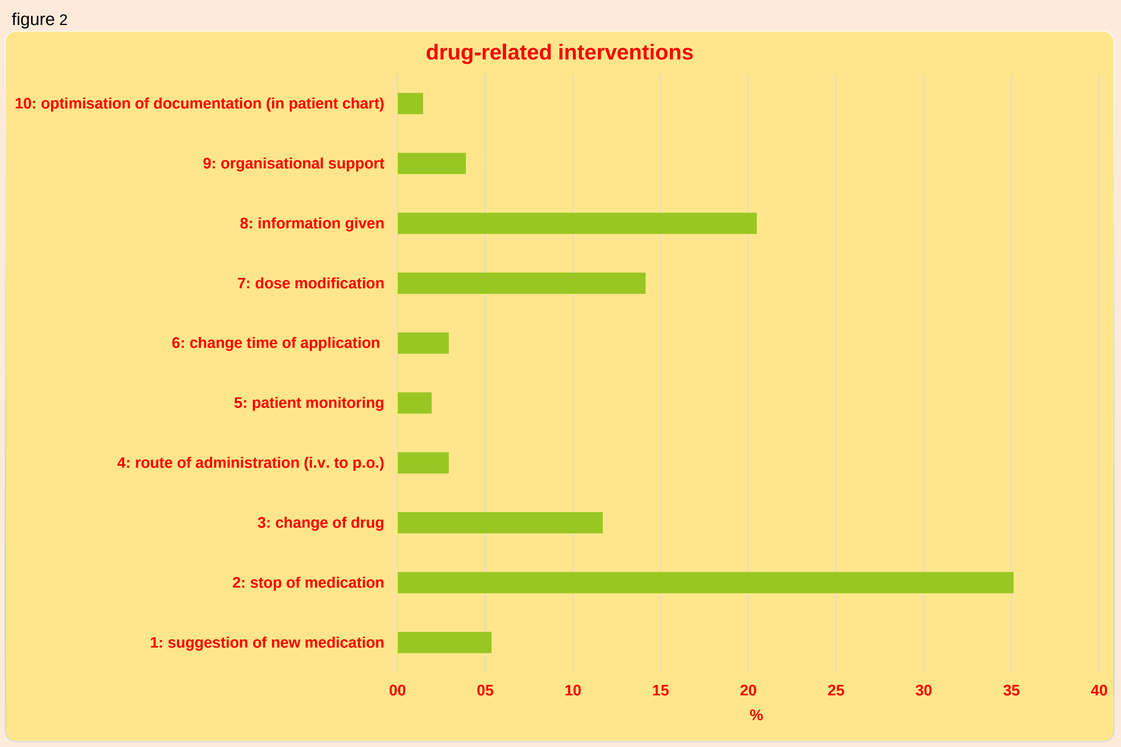


figure 3

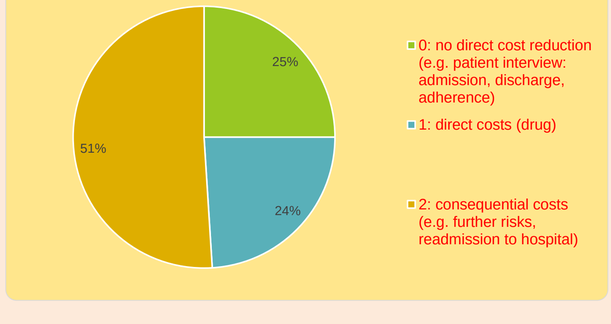
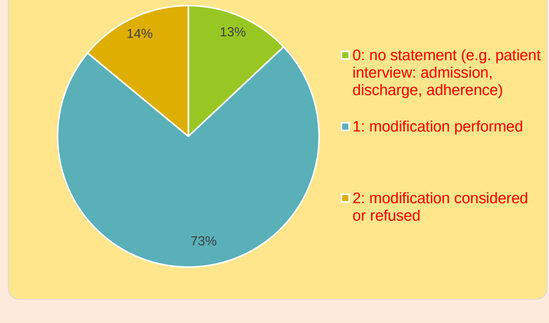


figure 4



DISCUSSION

A documentation system is standardized to be completed equally. Nontheless there are different points of view to classify an intervention and are arguable. The organisational und documentational support on the ward easily gets lost in clinical workaday and is underestimated.

CONCLUSION

With a minimal timed input for this comprehensive documentation system a maximum significance was achieved in the hospital trust and can be compared. A numerical cost-effectivity analysis is not essential for planning future clinical directions, but can be added. In order to enhance the efficiency of documentation and data analysis, computerization and evaluation of the frequency of data collection are eligible.

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