

IMPLEMENTATION OF A CLINICAL PHARMACIST IN AN INTERNAL MEDICINE SERVICE OF A TERTIARY REFERRAL HOSPITAL

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Background

-The presence of a clinical pharmacist in the medical services has shown in numerous previous publications a great additional value in quality and safety of the pharmacological treatment.

-In many hospitals there is still no clinical pharmacist, and the implementation process is the critical stage to be overcome so that this professional activity could be consolidated within the multidisciplinary hospital team.

Purpose

It was proposed to evaluate the degree of activity achieved by a clinical pharmacist newly implemented in an internal medicine service during the first two months from the beginning of its activity.

Material and methods

-The clinical pharmacist carried out the medication reconciliation of the patients with polypharmacy who were admitted to the internal medicine service.

-He also reviewed the patients' treatments daily and carried out the patients' medication reconciliation at discharge.

-All of the interventions were recorded for an initial period of two months, and then analyzed.

Results

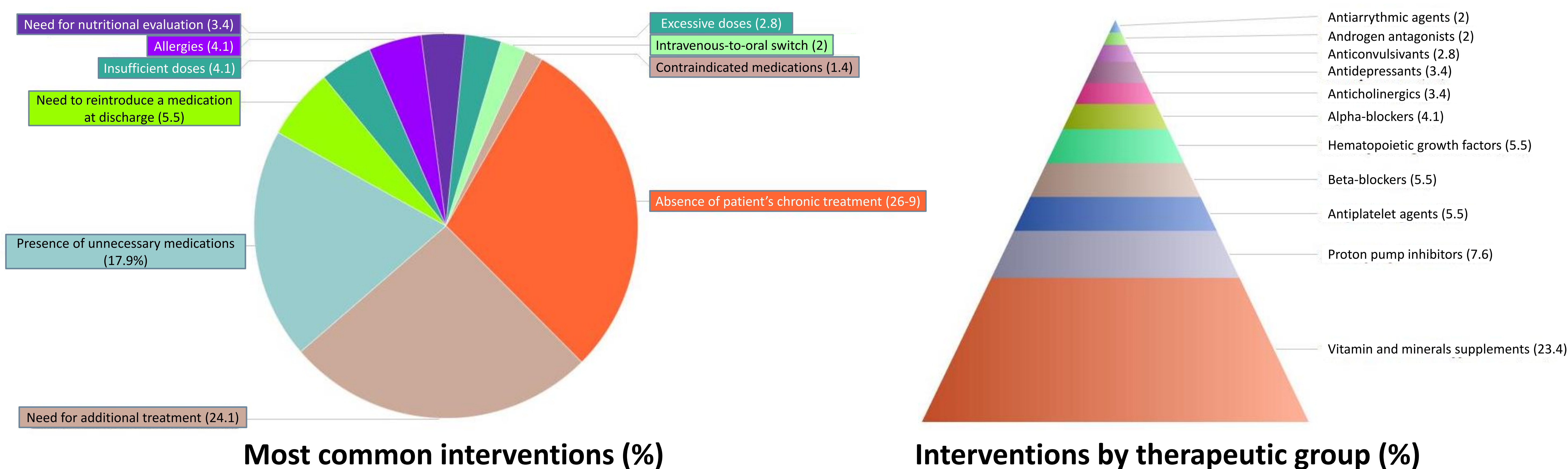
-The treatments of 119 patients were analyzed.

-Each patient had an average of 10 ± 6 medications at admission.

-A total of 145 pharmaceutical interventions were performed, corresponding to 19 different categories.

-The most common interventions were the absence of patients' chronic treatment (26.9%), the need for additional treatment during admission (24.1%), the presence of unnecessary medications (17.9%), the need to reintroduce a medication at discharge (5.5%), insufficient doses (4.1%), allergies (4.1%), need for nutritional evaluation (3.4%), excessive doses (2.8%), intravenous-to-oral switch therapy (2%) and contraindicated medications (1.4%).

-The major therapeutic groups for which interventions were performed were vitamin and mineral supplements (23.4%), proton pump inhibitors (7.6%), antiplatelet agents (5.5%), beta-blockers (5.5%), hematopoietic growth factors (5.5%), alpha-blockers (4.1%), anticholinergics (3.4%), antidepressants (3.4%), anticonvulsants (2.8%), androgen antagonists (2%) and antiarrhythmic agents (2%).



Conclusion

Under the presence of a clinical pharmacist, an average of 1.2 interventions were performed for each patient reviewed. Through these interventions, it was possible to optimize the pharmacological treatment, providing the necessary medicines for each patient, adjusting the doses to their requirements, and preventing medication-related problems.

Acknowledgements

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