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

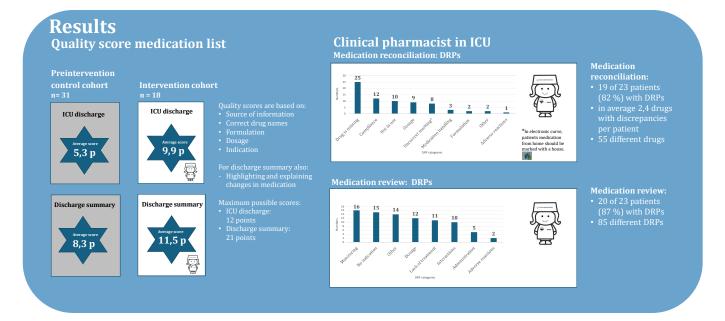
Critically ill patients in the intensive care unit (ICU) are particularly vulnerable to errors in medication management, and each care transition increases the risk of medication discrepancies.

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





