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EVALUATING THE IMPLEMENTATION OF CLINICAL PHARMACIST SERVICES IN A POST DISCHARGE HOSPITAL-BASED REHABILITATION WARD IN IRELAND

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Background: The number of people over 60 years is predicted to double by 2050. Medicines play a significant role in a patient’s recovery and in the management of many acute and long-term conditions. Patients are living with chronic diseases which require management with medication, such as diabetes, stroke, and cancer. Patients over 60 years are more vulnerable to adverse effects of poly-pharmacy due to declining renal and hepatic function, reduced lean body mass and functional capabilities. Medications should be prescribed appropriately with the intention to have a favourable outcome, to improve mortality, morbidity, and the quality of life of the patient. Inappropriate prescribing of medications leads to poly-pharmacy, adverse drug reactions, poor adherence, prolonged recovery time and poor participation in rehabilitation programmes.

Methods: Clinical pharmacy services were provided to patients in the rehabilitation ward. Medication reconciliation, clinical medication review of medications, participation in MDT meetings, discharge planning including education on medication regimes with patient and primary care services. All interventions were recorded at each stage.

Results: The average number of medications on admission was eleven. On completion of medicine reconciliation, many changes were intentional. 19% of patients had an unintentional change to their medications. On completion of a clinical review 156 drug related problems were identified. 77% of recommendations were accepted by medical team. 57.5% of medications were deemed a STOPP medication and 20.8% were deemed a START medication. On discharge the average number of medications prescribed was six. This represented a 40% reduction in the number of medicines prescribed on discharge.

Conclusion: The inclusion of a clinical pharmacist as a member of the multidisciplinary team on a rehabilitation ward allows for a comprehensive review of patient’s medications. This optimises medications, identifies drug related problems, reduces the pill burden, aids adherence, reduces the possibility of adverse drug reactions and promotes medication safety.