Chapter 3

Ward Round Participation

The goal of the ward round is to closely monitor the patient's condition and take immediate intervention to improve the patient condition and avoid death. The doctors are visiting all the patients admitted in their unit in an order beginning from intensive care unit.

The pharmacist being an expert in the matters of drug should be available for the ward round team to decide upon the matters of dosage regimens, formulary interpretations, ADR monitoring, drug-drug interactions, drug-food interactions and drug and poison information services. The availability of pharmaceutical services definitely enhances accuracy of treatment, patient safety and efficacy. The pharmacists in ward round should be ready to interact with doctors and nurses who seek the opinion in the matters of drug related issues. The pharmacists should keep himself abashed latest developments in the field of pharmaceutical care and be confident to help the team to take correct decisions.

DUTIES OF CLINICAL PHARMACIST IN WARD ROUNDS

The clinical pharmacist should take at least two ward rounds daily; one with the doctors and another one with himself alone. In the first ward round he follows the treatment given and checks the formulary for the dose prescribed. Further he may also critically think any possible risk to the patients due to drug administered he will alert the team and prevents the further causality that would have occurred due to nonviability of

Patient-specific Medical Information must be Collected, Organized, Recorded, and Maintained

Pharmacists must collect or generate subjective and objective information regarding the patient's general health and activity status, past medical history, medication history, social history, diet and exercise history, history of present illness, and economic situation. Sources of information may include, but are not limited to, the patient, medical charts and reports, pharmacist-conducted health/physical assessment, the patient's family or caregiver, insurer, and other healthcare providers including physicians, nurses, mid-level practitioners and other pharmacists. Since this information will form the basis for decisions regarding the development and subsequent modification of the drug therapy plan, it must be timely, accurate, and complete, and it must be organized and recorded to assure that it is readily retrievable and updated as necessary and appropriate. Patient information must be maintained in a confidential manner.

Patient-specific Medical Information must be Evaluated and a Drug Therapy Plan Developed Mutually with the Patient

Based upon a thorough understanding of the patient and his/her condition or disease and its treatment, the pharmacist must, with the patient and with the patient's other healthcare providers as necessary, develop an outcomes-oriented drug therapy plan. The plan may have various components which address each of the patient's diseases or conditions. In designing the plan, the pharmacist must carefully consider the psychosocial aspects of the disease as well as the potential relationship between the cost and/or complexity of therapy and patient adherence.

In addition, the patient must be apprised of (1) various pros and cons (i.e. cost, side effects, different monitoring aspects, etc.) of the options relative to drug therapy and (2) instances where one option may be more beneficial based on the pharmacist's professional judgment. The essential elements of the plan, including the patient's responsibilities, must be carefully and completely explained to the patient. Information should be provided to the patient at a level the patient will

Tips for Taking Medication History

- Use a systematic approach.
- Engage patients.
- Avoid yes/no questions.
- Consider all sources to obtain medication history and/or to clarify conflicting information.
- For each medication name, strength, dose, route, frequency, and last dose taken should be recorded.

How to Take an Accurate and Detailed Medication History

Obtaining an accurate medication history is the first step of the medicine reconciliation process. Such histories usually consist of a list of all medicines (prescribed and purchased) that a patient was taking prior to their admission to hospital. In addition to this, details of allergies or sensitivities to medicines (or excipients), recently stopped medicines (e.g. in the past month), and recent short courses of antimicrobials or corticosteroids should also be included. For some medical conditions, a list of previously tried medicines should also be included to help direct future prescribing (e.g. disease-modifying antirheumatic drugs [DMARDs] for rheumatoid arthritis). Traditionally, obtaining a medication history has been undertaken solely by doctors, but pharmacists and suitably trained pharmacy technicians now play a vital role in this process.

Use of herbal medicines and supplements should also be noted, as these may also cause ADRs or interact with medicines commenced on admission. Obtaining an accurate medication history in a preoperative clinic will allow appropriate suspension of certain medicines (e.g. anticoagulants and antiplatelets) prior to surgery, preventing complications following surgery or the procedure being cancelled (if this information is identified on the day of surgery).

Without an accurate medication history, prescribers may inadvertently make incorrect decisions about a patient's treatment, causing harm if previously discontinued medicines are restarted, or if current medicines are omitted or prescribed at the wrong dose for the patient.

algorithms. Some of the important algorithms (causality assessment scales) used for assessing the causality relationship include Naranjo's scale, WHO, European ABO system, Kramer, Bayesian, Karch and Lasagna's French imputation method. Every suspected ADR should be assessed for its causality and documented in the patient's medical record. This serves as a useful reference for alerting clinicians by the clinical pharmacist about the possibility of a particular drug causing a suspected reaction. The Clinical pharmacist's involvement in the ADR reporting system has had a positive impact. They are useful assets to the clinicians as they can assist physicians in better management of suspected reactions.

Role of Clinical Pharmacist in the Management of ADR

Pharmacist plays a pivotal role in the identification, detection, prevention, and management of drug-drug interactions, drug-food interactions and ADRs. Pharmacist can carry out such activities in inpatient setting, while taking part in viewing charts during ward rounds, and during medication management while dealing with prescriptions. Since pharmacists have a vast knowledge on drugs and therapeutics, their ability to discover and deal with ADRs is quite important.

The intervention of pharmacists by organizing lectures and group discussions thus providing information about the importance, seriousness, preventability and necessity of reporting shows heightened improvement of knowledge, attitude and perception about ADRs. All health professionals play their respective roles in balancing between benefits and risks of medication when it is introduced in the market. However, the expertise of a pharmacist about a drug, especially if newly marketed, play a more important role in ADRs reporting to the authorities which helps in either withdrawing the product from the market or cause labelling changes.

Pharmacists working in community pharmacy have an added advantage of detecting and reporting ADRs while dealing with on the counter prescriptions and herbal products. In a community pharmacy, a pharmacist may not have direct and definite patient list but the patients coming to the same