

# Clinical pharmacy

**Clinical Pharmacy is a  
patient-focused discipline**

Pharmaceutical care is a co-operative, patient-centred system for achieving specific and positive patient outcomes from the responsible provision of medicines. The practice of clinical pharmacy is an essential component in the delivery of pharmaceutical care

## **Pharmaceutical care**

## **Health History**

It is an organized summary of all known patient information.

- To provide a thorough and detailed picture of the patient at the time of the presentation.
- To summarize important information
- To provide all the information required to understand the patient case without wasting time in duplication, trivial or irrelevant information

## **Components of the health history**

**Patient Demographics:** Patient demographics include the patient's name, address, phone number, birthdate, sex, race, and marital status. Other items that may be included are the patient's birth-place and occupation

**Chief/Main Complaint (CC):** The chief complaint is a brief statement of why the patient is seeking care

**History of Present Illness (HPI):** The history of present illness

Specific characteristics should be obtained

Timing: onset, duration, and frequency of symptoms.

Location: precise area of symptoms.

Quality or character: specific descriptive terms of symptoms (e.g.. sharp pain, black tarry stools).

Quantity or severity: mild, moderate, or severe.

Setting: what the patient was doing when the symptoms occurred.

Aggravating and relieving factors: things that cause or make the symptoms worse and that relieve or make the symptoms better.

Associated symptoms: other symptoms that occur with the primary symptoms

**Past Medical History (PMH):** it includes a brief description of the patient's past medical problems, which may or may not relate to the patient's current medical condition

**Family History (FH):** It is a brief summary of presence or absence of illnesses in the patient's first degree relatives (parents, siblings and children). These data typically includes status (dead or alive), causes of death, age at death, current health problems of living members. There are some common abbreviations used to document the FH (e.g., M= mother, F= father, B= brother, S= sister, (↑) = alive, (↓) = dead.

**Social History (SH):** the patient's lifestyle is documented in the SH, which contains the use of alcohol (type, amount, pattern and duration), illicit drugs (amount, pattern, duration of use, start and stop dates, reason for stopping), tobacco (pack/day and pack-year, start and stop dates, reason for stopping), as well as nutrition and exercise

Information regarding the patient's education, employment, marital status, and living conditions is important as well, because these factors can influence the patient's health and medication use

## **Medication History**

### **Current Prescription Medications**

Name, Dosage (strength), Dosing schedule, Duration of the therapy, Reasons the patients is taking the medication, Outcomes of the therapy

### **Current Nonprescription Medications**

### **Past Prescription Medication**

### **Past Nonprescription Medication**

### **Medication Allergies**

### **Adverse Drug Reactions**

# Pharmaceutical Care Plan

A good method for processing the patient's information, assessing his case, generating drug-related problems list, designing a care plan, and tracking progress is through the use of **SOAP** or **FARM** notes.

## SOAP Notes Format

# SOAP

Subjective

Objective

Assessment

Plan

# SOAP Notes Format

## Subjective

Data include patient symptoms, things that may be observed about the patient, or information obtained about the patient.

- Chief Complaint (CC)/ History of Presenting Complain (HPC).
- Past Medical History (PMH)
- Allergies
- Family History (FH)
- Social history
- Nonprescription medication use (including complementary and alternative medication)
- Open/ closed question
- These are considered **non-reproducible data**

# SOAP Notes Format

## O bjective

Information include physical examination, laboratory values, serum drug concentrations (along with the target therapeutic range for each level), and the results of other diagnostic tests (e.g., ECG, x-rays, culture and sensitivity tests), and risk factors.

Objective data are **measurable** and **reproducible**.

# SOAP Notes Format

## A ssessment

Outlines what the practitioner thinks the patient's problem is, based on **S** and **O**. It often takes the form of a diagnosis or differential diagnosis

# SOAP Notes Format

## P lan

A detailed description of recommended or intended further workup. may include

- ordering additional diagnostic tests or initiating, revising.
- treatment ( changes in medications, the drug, dose, dosage form, schedule, route of administration, and duration of therapy, diet).
- patient education (self-care, goals of therapy, medication use)
- monitoring, and follow-up relative to the above assessment.

## FARM Notes Format

# FARM

Findings

Assessment

Resolutions

(Recommendations)

Monitoring



Subjective & Objective



Plan

# FARM Notes Format

Each problem in the FARM note should be addressed separately and assigned a sequential number.

Eight types of medication-related problems have been identified:

1. Untreated indications
2. Improper drug selection
3. Subtherapeutic dosage
4. Failure to receive drugs
5. Overdosage
6. Adverse drug events
7. Drug interactions
8. Drug use without indication

A 55 year-old woman was admitted to the hospital following the onset of chest pain approximately a few hours earlier while she was working in her house garden.

She mentioned that it is not the first time, and she has been taking paracetamol 500mg bid for pain without any relief of symptoms, her father had died of a heart attack at age of 50.

After initial assessment she was referred to the cardiology team who documented that she had obvious symptoms of stable angina.

Other available data:

Weight 79 kg, height 165 cm, troponin (-), ECG showed no changes in ST segment.

## Clinical case 2