

service as having been dispensed in the last year. The following variables were collected: sex, age, daily number of tablets (T), dose regimen (once daily OD, twice daily TD), ART combination with Nucleoside Reverse Transcriptase Inhibitors (NRTI), Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI) and Protease Inhibitors (PI/r), adherence and viral load (VL). A patient was considered to be adherent when adherence was $\geq 90\%$. The ART was considered effective when VL was ≤ 50 copies/mL.

Results N = 835, 566 men (67.9%), 268 women (32.1%) Mean age = 46.7 ± 8 years Mean Adherence = $92.2 \pm 11.3\%$ (* units dispensed/units that should have been dispensed) Adherent patients = 76.3% (No. adherent patients/No. patients) $\times 100$ Mean tablets/day, adherent patients = 3.2 (* no. tablets/day taken by adherent patients/No. adherent patients) non-adherents = 3.7 (This means that non-adherent patients take more tablets/day than adherent patients) Efficacy of ART: 89.5% of adherent patients, 70.1% of non-adherent patients Adherents (%) according to: • Sex: men = 79.3%, women = 69.8% • Daily number of tablets: 1T = 81.1%, 2T = 82.4%, 3T = 81.9%, 4T = 74.5%, 5T = 6.9% 6T = 72.2% and $>7T = 76.3\%$ • Dose Regimen: OD = 80.2% and TD = 72.2% • ART combinations: § 2NRTI+NNRTI = 80.7% § 2NRTI + PI/r = 64.8% § PI/r = 89.4%.

Conclusions The success of the ART is considerably higher in adherent patients (89.5%) than in non-adherents patients (70.1%). Simplifying the ART (OD, fewer tablets) is a strategy able to increase the number of adherent patients. Monotherapy with PI/r improves the adherence to ART.

No conflict of interest.

CPC-016 ANALYSIS OF PHARMACISTS' INTERVENTIONS ON INPATIENT PRESCRIPTIONS AND A CONSIDERATION OF THE ROLE OF HOSPITAL PHARMACISTS

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Background The hospital pharmacist's role has changed steadily and is turning away from dispensing functions toward active involvement in pharmaceutical care. Intensifying verification of the prescriptions by dispensing pharmacists can contribute to improving the drug treatment of many more patients. Therefore, the system of inpatient prescription review by dispensing pharmacists was developed. Collaborative clinical pharmacist services in inpatient care have generally resulted in improved care and interaction with the health care team on patient rounds, patient interviews, medicines reconciliation, patient discharge counselling and follow-up. All these have resulted in improved outcomes.

Purpose The purpose of this study was to examine the record of interventions by pharmacists who didn't use a prescription review programme, the record of interventions by pharmacists who did use this programme, and the record of interventions by clinical pharmacists who participated in rounds. Thereafter, the purpose was to discuss the necessity for a change of role of hospital pharmacists.

Materials and Methods A retrospective study, analysis of intervention records by prescription error, type of pharmacist intervention, the significance of error, chi-square test SPSS v19, $p < 0.05$. Significance was classified as B2: could have resulted in significant morbidity or mortality if not prevented; B3: low potential for negative patient outcome.

Results The rates of pharmacist intervention in the three groups were 0.3%, 0.4% and 0.7%. Considerably different results were shown in the three groups of records on the types of prescription

error, the type of pharmacist intervention and the significance of the error. The percentages of significance B2 in three groups were 28%, 37%, 80%, and those of B3 were 72%, 63%, 20%.

Conclusions In view of the results so far achieved especially in the significance of error, the role of clinical pharmacists participating in rounds has had a much more significant therapeutic effect on inpatients. The addition of clinical pharmacist services collaboratively in the care of inpatients generally resulted in improved care. Interacting with the health care team on patient rounds, interviewing patients, medicines reconciliation, and providing patient discharge counselling and follow-up have all resulted in improved outcomes. So, continuing efforts on effectiveness of all kinds of hospital pharmacists' work, such as automation of dispensing, are necessary.

Abstract CPC-016 Table 1

Analysis group	Group 1	Group 2	Group 3
Total prescriptions (n)	406,527	421,505	109,628
Prescriptions to be reviewed (n)	310,947	328,481	93,063
Intervention by pharmacist (n)	928	1,247	681
Rate (%) (intervention/prescriptions to be reviewed/month)	928/310,947 = 0.3	1,247/328,481 = 0.4	681/93,063 = 0.7

No conflict of interest.

CPC-017 ANALYSIS OF SURVIVAL IN PATIENTS WITH ADVANCED NON-SMALL CELL LUNG CANCER

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Background Non-small cell lung cancer (NSCLC) accounts for most cases of lung cancer. Approximately 40% of patients with NSCLC present with advanced-stage disease at the time of diagnosis.

Purpose To analyse the median overall survival in patients with NSCLC stage IIIB or IV.

Materials and Methods Retrospective observational study. Patients with NSCLC stage IIIB or IV who started treatment between 01/01/2011 and 30/06/2011. Data source: Patient medical records, oncology programme (Oncowin) and outpatient dispensing record programme (SAVAC and Farmatools). Data recorded: age, gender, age at diagnosis, stage, histology, chemotherapy, number of chemotherapy cycles and number of prior chemotherapy regimens.

Results Thirty patients were included with a median age at diagnosis of 63 years (IC95% 60–66). 73.3% were male. The stage at time of diagnosis was IV in 80% of patients. The most common histology was adenocarcinoma (50%), 30% squamous cell carcinoma, 10% large cell and another 10% other histological type. Platinum-based chemotherapy was the first line treatment in 66.7% of the patients and for the remaining 23.3% it was vinorelbine alone or in combination. Six patients received maintenance treatment, three with erlotinib, two with pemetrexed and one with bevacizumab. The median progression-free survival time was 4 months (IC95% 2.9–5.1) in patients receiving maintenance treatment and 3 months (IC95% 0.8–5.2) in patients who were not given maintenance treatment. The median overall survival time was 6 months (IC95% 1.2–10.8) for patients with maintenance treatment and also 6 months (IC95% 3.1–8.8) in patients without maintenance treatment.

Conclusions Platinum-based chemotherapy remains the standard treatment.