PHARMACEUTICAL CARE IN PATIENTS DIAGNOSED WITH MULTIPLE MYELOMA TREATED WITH LENALIDOMIDE

Purpose
CPC-100
Bermejo, MP Bachiller Cacho.
We set up a weekly PI meeting with all pharmacists in June 2012. PI is recorded in the patient record and can be accepted or rejected by physicians. PIs are marked critical, medium or low by the pharmacist. Acceptance is dependent on patient comment, discrepancy on out of formulary discharge proposal, and pre-existing formulary discharge proposal discrepancies about cardiology. Sensitivity analysis concluded 3% critical, 18% ‘medium’ and 3% ‘critical’ interventions. The main pharmaceutical problem was out of the formulary discharge proposal which represented 54% of PIs (796/1483). Dosage adaptation was recommended in 12% of cases; 9% of PIs were for stopping the treatment and other interventions were about the choice of route of administration. Adding a treatment, therapeutic monitoring and optimization of administration. In total, 58% of PIs were accepted, the physician was not informed of 23% and 19% were not accepted; but 11% of the PIs accepted were not implemented.

135 PIs were discussed in pharmaceutical meetings. Among the subjects that arose, 3 were particularly highlighted: re-evaluation of renal failure and metformin, interaction between beta blockers and flecainide and recommendations on allergies. We have studied out of the formulary discharge proposal discrepancies about cardiology medicines (angiotensin converting enzyme inhibitors and angiotensin receptor antagonists).

Conclusions
Feedback on PIs is a key element to improve their relevance. Finally, a weekly pharmaceutical meeting can highlight recurrent prescription problems in order to propose and implement corrective measures. It is moreover a working base for our hospital to improve the quality of medical care.

No conflict of interest.

PHARMACEUTICAL INTERVENTION IN THE PATIENT RECORD: TOWARDS HARMONISATION OF OUR PRACTISE

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Background
Clinical pharmacy and clinical trials

In our hospital, patient records and all medical prescriptions are computerised in 11 departments. These prescriptions are analysed daily by a pharmacist. Each pharmaceutical intervention (PI) is recorded in the patient record and can be accepted or rejected by physicians. PIs are marked critical, medium or low by the pharmacist. We set up a weekly PI meeting with all pharmacists in June 2012.

Purpose
To standardise, analyse and promote our interventions.

Materials and Methods
For each PI, the pharmacy student fills in an Excel table with medical ward, drug, problem identified, type of intervention, pharmacist rating and clinical impact of the intervention. During the meeting, all PIs marked critical or that had a physician comment, discrepancy on out of formulary discharge proposal, or any PIs considered relevant by the pharmacist were considered and discussed.

Results
Analysis of medical prescriptions generated 1,483 PIs over 3.5 months. The most frequent rating was ‘low’ (70%). There were 18% ‘medium’ and 3% ‘critical’ interventions. The main pharmaceutical problem was out of the formulary discharge proposal which represented 54% of PIs (796/1483). Dosage adaptation was recommended in 12% of cases; 9% of PIs were for stopping the treatment and other interventions were about the choice of route of administration. Adding a treatment, therapeutic monitoring and optimization of administration. In total, 58% of PIs were accepted, the physician was not informed of 23% and 19% were not accepted; but 11% of the PIs accepted were not implemented.

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No conflict of interest.

PHARMACIST-DRIVEN INTERVENTIONS IMPROVE THROMBOPROPHYLAXIS IN ACUTELY ILL MEDICAL PATIENTS OVER TIME – RESULTS AFTER SIX MONTHS

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Background
Forty to 50% of hospitalised patients with an acute medical illness have risk factors for venous thromboembolism (VTE) and it has been shown that thromboprophylaxis reduces the incidence of VTE events in these patients [1]. However, a large multinational survey, the ENDORSE study, showed that only 37% of medical patients with VTE risk factors currently received thromboprophylaxis [2].

Purpose
To evaluate the impact over time of pharmacist-driven interventions aiming at increasing the appropriate use of thromboprophylaxis in acutely ill medical patients hospitalised in an urban academic tertiary care hospital.

Materials and Methods
First, medical and nurse reports of hospitalised medical patients were reviewed to evaluate the proportion of patients who were on prophylaxis according to clinical practise guidelines. Second, interventions were conducted and included unit-specific physician and nurse education, dissemination of educational tools summarising VTE prophylaxis guidelines, and reminders. Third, the effect of the interventions on the proportion of patients receiving appropriate thromboprophylaxis was evaluated after three and six months.

Results
The baseline evaluation showed that 36% (26/72) of the patients at risk of VTE received appropriate thromboprophylaxis. Three and six months after the interventions, 68% (55/81), and 72% (68/81) of the patients at risk of VTE received appropriate thromboprophylaxis.

Of the patients not at risk of VTE, 15% (21/141), 8% (24/290), and 8% (27/330) respectively at baseline evaluation, three and six months after the interventions, received thromboprophylaxis.

Conclusions
Pharmacist-driven interventions improved the proportion of acutely ill medical patients receiving appropriate thromboprophylaxis and the benefit of the interventions was maintained after six months.

References

No conflict of interest.