safety. It promotes compliance and contributes to the prevention of errors, by systematically analysing patient’s medication and detecting discrepancies. Discrepancy is defined as the difference between the patient’s usual medication and the one that is prescribed at each moment of care transition.

**Purpose** Characterisation of the medication reconciliation and pharmacotherapeutic review performed by the clinical pharmacist at the orthogeriatric unit of a central hospital over a 12 month period.

**Material and methods** Retrospective, observational study conducted from January to December 2017. Medication reconciliation and pharmaceutical review were performed at the hospitalised patient’s admission to the orthogeriatric unit. The Beers and STOPP/START criteria were used to evaluate potentially inappropriate medications in older people. Pharmaceutical intervention was performed when the discrepancies were not according to the bibliography, and their acceptance by the clinical team was evaluated. Data was recorded and treated in Excel version 15.3.3.

**Results** Thirty-one patients were included with a median age of 83 years. Of those, 68% were female. A total of 249 drugs were analysed (7.7/patient) and 146 discrepancies identified (4.7 discrepancy/patient). The most common discrepancy was ‘omission’ (n=120; 82%). The pharmacotherapeutic group with the greatest number of discrepancies was the ‘cardiovascular system’ (n=33; 30%) and the largest number of interventions (29%) was also in this group. A total of 80 interventions were performed and the most frequent was ‘drug introduction’ (59%). The pharmaceutical interventions acceptance level was 78%.

**Conclusion** Medication reconciliation and pharmacotherapeutic review in the orthogeriatric unit improved pharmaceutical and physician communication and cooperation, allowing the optimisation of this patient’s therapy.

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**REFERENCE AND/OR ACKNOWLEDGEMENTS**


No conflict of interest.

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**4CPS-205 Enoxaparin dose adjustment in the elderly – the intervention of the clinical pharmacist**

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**Background** Enoxaparin dose adjustment in the elderly is essential because its bioaccumulation may cause bleeding events. The high number of elderly protamine administrations in our hospital raised our awareness. The evidence on pharmaceutical interventions (PI) supporting dose adjustment of enoxaparin is almost nonexistent.

**Purpose** Assessing the need, acceptance and results of PI in the adjustment of enoxaparin doses prescribed to elderly inpatients.

**Material and methods** Protamine administration retrospective study (January–March 2018) followed by a 2 month prospective longitudinal study (May–June). Prospective study inclusion criteria: inpatients ≥65 years (internal medicine ward) on enoxaparin for treatment or thromboprophylaxis with acute kidney injury (AKI) or chronic kidney disease (CKD). Data were collected from electronic patient records. Patients were continuously monitored by calculating creatinine clearance (CrCl) (Cockcroft Gault formula). CrCl <30 ml/min or borderline (30–45 ml/min) led to verbal or electronic PI. Weight adjustments were also considered. The need for protamine use and the occurrence of bleeding events were monitored.

**Results** In the retrospective study, nine patients (77.9 ±11.9 years) needed protamine for partial reversal of bleeding events due to enoxaparin, eight of them had CrCl <45 ml/min. In the prospective study were included 35 patients out of 87 (40.2%) (79.9 ±8.8 years; 54.3% women; 60.0% AKI, 38% CKD, 51.4% on treatment doses, 48.6% on thromboprophylaxis). On average, pharmacists monitored CrCl during 7.4 days out of 9.2 days of treatment. There were 17 PI in 12 patients (75% CKD): seven dose adjustments by CrCl <30 ml/min; six dose adjustments to weight; and four alerts by borderline CrCl. The acceptance rate was 70.6%. The physicians took 1.1 days to electronically adjust the prescribed dose. No protamine was administered during this period. In patients whose PI were accepted, there were not any bleeding events. Major haematomas were observed in two patients whose PI were not accepted. Patients with borderline CrCl presented minor haematomas. Although guidelines indicated dose adjustments only for CrCl <30 ml/min, there is a growing concern about the unadjusted doses’ safety in patients with CrCl 30–50 ml/min.

**Conclusion** PI were relevant in avoiding bleeding events in a growing geriatric population. Collaboration between the clinical pharmacist and medical staff brings improvements in elderly pharmacotherapy.

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No conflict of interest.