4CPS-214 ASSESSMENT OF THE MEDICATION ERROR RATE PRE-PRESCRIPTION DURING THE MEDICATION RECONCILIATION PROCESS

¹V Chevalet*, ¹O Gleizes, ¹L Hammi, ¹A Rieutord, ²R Sterpu, ²G Bussone, ²R Fior, ¹N Curatolo. ¹Hôpital Antoine Bécère, Service Pharmacie, Clamart, France; ²Hôpital Antoine Bécère, Service Médecine Aigue Polyvalente, Clamart, France

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Background Medication reconciliation has been carried out since 2015 in the internal medicine ward. However, prescription errors at admission still occur, mainly linked to the transcription in the CPOE system by the physician of the medication history (MH) collected by the pharmacy. In order to improve the quality of prescription at admission, we studied the implementation of a pharmacist pre-prescription (PpP) process.

Purpose To evaluate the impact of the PpP on the number of unintentional medication discrepancies (UMD) at admission.

Material and methods

- Interventional prospective study before/after in a 24-bed internal medicine unit.
- Eligibility criteria: age >65 years and/or >three chronic treatments at admission.
- Pre-intervention phase (2 months): MH provided by the pharmacist and used by the physician to write the admission prescription.
- Intervention phase (2 months): MH entered by the pharmacist in the CPOE system as a PpP and then used by the physician to electronically generate an admission prescription without any transcription.
- Data collected: age, sex, number of UMD on the admission prescription, potential of harm for the patient (minor, moderate or severe) evaluated by the prescriber and the pharmacist, prescriber satisfaction (survey).

Results Eighty patients (29 males, 51 females; age 68.4 ± 18.6 ; medications at admission: 8.8 ± 4.0) were included in the pre-intervention phase. 36.2% of patients had at least one UMD

(0.53 ± 0.80 UMD/patient). 40.4% of UMDs had a moderate or severe potential of harm for the patient. The main UMDs were dosage errors (38.0%) and omissions (33.3%). In the intervention phase, 47 patients (28 males, 19 females; age 66.3 ± 18.7 ; medications at admission: 8.0 ± 4.5) were included and PpP was used for 83% of them. Patients with at least one UMD decreased to 8.5% ($p = 4.2 \times 10^{-5}$). Among the 39 patients for whom PpP was used, no UMDs were observed. The four physicians of the ward were satisfied with this new process as it allowed a reduction in medication errors and their time spent on admission prescription.

Conclusion This study shows that pre-prescription by pharmacists decreases the number of UMD at admission. The main challenge for the future will consist in integrating PpP as part of the clinical pharmacist's routine.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-215 ACCESS TO 'FONDO AIFA 5%' AS AN INSTRUMENT SUPPORTING THE SUSTAINABILITY IN A SHARED CLINICAL MANAGEMENT OF RARE AND DIFFICULT-TO-TREAT DISEASES

G Valinotti, M Scaldaferrì, M Tonelli, P Crosasso*, MR Chiappetta, F Cattel. Città Della Salute e Della Scienza di Torino, Pharmacy, Torino, Italy

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Background AIFA 5% Fund is a national fund intended to cover costs related to the treatment of rare diseases and other pathologies with orphan drugs or off-label drugs, through a patient-named system of evaluation.

Purpose The aim was to demonstrate how the interdisciplinary activity of the pharmacist can lead to a potential cost-saving.

Material and methods The identification of patients that could access the Fund, took place through direct reporting by the doctor or through evaluation of the pharmacist during the discussion of cases during the interdisciplinary rounds or following the reporting of off-label drugs.

The pharmacy had drawn up a special official procedure that provided the key elements for:

- Requesting the AIFA authorisation.
- Management of orders and reimbursement by the pharmacy.

All these data were collected in a hospital database that is updated for each new request.

Results From July 2017 to September 2018, 52 clinical cases were identified as eligible for the access request: at the moment, 46 cases have been authorised. Cases related to rare diseases reported on 18 March 2017¹ are 13 (membranoproliferative glomerulonephritis, autoimmune hypoparathyroidism, peripheral T-cell lymphoma, giantocellular arteritis, neuroblastoma, systemic sclerosis). Twenty-two requests came from the nephrology area (eculizumab – membranoproliferative glomerulonephritis, tocilizumab/antibody-mediated chronic rejection), while 12 cases belonged to the haematological area (belinostat – PTCL-U, ibrutinib and ruxolitinib – GVHD, venetoclax – mantellar cell lymphoma, venetoclax +5 azacitidine – leukaemia acute myeloid (LAM), sorafenib – LAM FLT3 +, peg-interferon – essential thrombocythaemia, pembrolizumab – mediastinal lymphoma, bortezomib – post-transplant maintenance in multiple high-risk myeloma). The remaining cases are