poor in relation to steady state and peak/trough concentrations (Clozapine (n=196) 41% samples were not troughs, and LMWH (n=193) 57% samples were not at peak levels).

A literature review has shown that there is small and sporadic research within this area. The research has shown some benefits of a pharmacist-led TDM service. Unfortunately, the studies within the literature are often limited by a small sample size and factors such as a specific population (i.e. oncology patients) or specific pharmacists (i.e. the infectious diseases pharmacist).

Purpose To review the TDM process within an outer metropolitan hospital.

Material and methods A retrospective audit was conducted on TDM undertaken between 1 January and 31 December 2016. Patients were identified using the electronic pathology database. Patients were excluded if under the age of 18, in an outpatient setting or the emergency department. Progress notes, medication charts and other relevant pathology were reviewed via the electronic pathology program and via the Electronic Clinical Record Management System. They were assessed for appropriateness of the timing of collection, compliance to recommended TDM guidelines, the appropriateness of action of the resulting pathology and the documented involvement of the pharmacist.

Results A total of 3095 tests were included in the study, covering 11 medications. Of these, 32.6% were collected at an inappropriate time, making interpretation difficult and at a pathology cost of \$23,084.86. On average, 50% of the doses administered to patients after TDM were appropriate based on results and the clinical scenario. There was documented pharmacist advice on the TDM result in only 8.6% of the time.

Conclusion TDM has a large impact on the therapy and outcome of patients. This audit showed that TDM is currently performed sub-optimally and with an unknown or ad hoc role of the pharmacist. These preliminary results show a review of the current TDM process is required and, with their drug and pharmacokinetic knowledge, a greater impact and role of the pharmacist is required.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Nil.

No conflict of interest.

4CPS-221 IMPACT OF HOSPITAL-CITY COMMUNICATION BASED ON THE MULTIPROFESSIONAL AND COLLABORATIVE DEVELOPMENT OF THE DISCHARGE LETTER ON THE CONTINUITY OF PATIENTS' MEDICATION MANAGEMENT-CITY STUDY

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Background Hospitalisation leads to changes in the patient's medication management. Currently, hospital-city communication, based mainly on the hospitalisation report, does not allow an efficient transmission of information to ensure early and optimal post-hospital care of patients. A discharge letter was imposed at the regulatory level to improve the continuity of patients' medication management after discharge from hospital. However, explanations for drug changes remain limited.

Purpose The objective of this study was to evaluate the impact of the collaborative multiprofessional implementation, integrating the clinical pharmacist, of the discharge letter explaining all drug regimen changes, and its transmission to the general practitioner by secure messaging, would improve continuity of care medication of the patient.

Material and methods A prospective randomised controlled cluster study was performed in two care units of the internal medicine department of a university hospital centre between September 2017 and February 2018. The impact of the discharge letter was evaluated based on the average number of drug changes performed in hospital and continued by general practitioners, in each group, 3 months after discharge. A sensitivity analysis was conducted on the justification of the non-continuation of drug changes by the general practitioners, based on international STOPP and START criteria. The number of re-hospitalisations was compared between the two groups and the satisfaction of general practitioners concerning this approach was evaluated by questionnaire.

Results A total of 189 patients were included in the analyses: 92 in the interventional group and 97 in the control group. The mean number of discontinued drug changes after discharge did not differ significantly between the two groups (1.5 ± 1.5 vs. 1.7 ± 1.6 , $p=0.35$). Sensitivity analysis showed similar results. A downward trend in rehospitalisations 3 months after hospitalisation was highlighted in the interventional group (22% vs. 31%, $p=0.15$). General practitioners were satisfied by this approach (91%, $n=111$).

Conclusion Transmission to the general practitioner of the discharge letter, explanation of all drug regimen changes and elaborated collaboratively and multiprofessionally, seems to be a promising tool. A large multicentre prospective study should be conducted to confirm these findings.

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4CPS-222 IMPACT OF THE ESTABLISHMENT OF ASSISTED ELECTRONIC PRESCRIPTION ON THE IMPROVEMENT OF THE UNIT-DOSE DRUG DISPENSATION SYSTEM

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Background The aim of the unit-dose drug dispensation system (UDDDS) allows us to dispense the medication required for the patient for the following 24 hours once the prescribed treatment has been validated by the pharmacist.

Purpose Evaluation of the impact on the effectiveness of UDDDS after the change from the preprinted prescription chart (PPC) to the assisted electronic prescription (AEP).

Material and methods This study was performed in a general hospital (330 beds), in which 10 units of hospitalisation were counted on UDDDS. The schedule of the delivery of the medication carts was established at 3 pm, after the daily doctor's visit. We have compared the functioning of UDDDS during the third term of 2017 and 2018, analysing in this way the dispensation with PCC and AEP respectively. We have measured as efficacy parameters the number of validated prescriptions before 3 pm and the percentage of the returns of