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 inappropriately 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-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 cards 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 PPC and AEP respectively. We have measured as efficacy parameters the number of validated prescriptions before 3 pm and the percentage of the returns of