

REFERENCES AND/OR ACKNOWLEDGEMENTS

<http://dx.doi.org/10.1136/ejhpharm-2014-000591>

No conflict of interest.

4CPS-238 MEDICATION AND CONFUSION IN ACUTE HOSPITAL OLDER PATIENTS

¹V Marvin*, ¹E Ward, ²E Whiting. *Chelsea and Westminster Hospital, Pharmacy Dept, London, UK; ²Imperial College, Medical School, London, UK*

10.1136/ejhpharm-2019-eahpconf.387

Background Confusion is a significant problem in older patients. Studies have shown that up to one-third of older patients admitted to hospital have delirium and up to 40% have dementia. Various prescription medicines can cause confusion and may be inappropriate in the elderly, with the risk of harm outweighing potential benefits. Medication reviews, as part of comprehensive geriatric assessments, for example, aim to optimise an individual's medicines and reduce potentially inappropriate prescriptions.

Purpose This study aimed to determine the prevalence of confusion in older patients in an acute hospital and whether inappropriate medicines potentially contributed. We followed-up patients to find if they had a medication review while in hospital and if this led to deprescription of medicines that can contribute to confusion.

Material and methods We conducted a single-centre prospective observational cohort study. Patients aged 65 or older hospitalised with confusion were identified using their medical clerking notes. Medicines taken on admission to hospital were recorded and any that could contribute to confusion were identified. We determined whether the confused patients had a medication review during their admission and identified any changes to their medication list.

Results Three-hundred and ten patients aged 65 or older were admitted during the 1 month study period, 100/310 (32.3%) of whom were documented as having some degree of confusion. Thirty-eight per cent took at least one medicine that potentially contributed to confusion. Eighty-two per cent of confused patients had a medication review. Medication reviews did not appear to result in a decrease in prescriptions of medicines that contributed to confusion.

Conclusion Prescribing of medicines known to potentially cause confusion is common with more than one-third of those over 65 years' old and with confusion taking at least one. Further studies are needed to determine reasons for continuing or even initiating culprit medicines in this population of older patients and the impact on clinical outcomes.

REFERENCES AND/OR ACKNOWLEDGEMENTS

NIHR CLAHRC NWL, Dr Iñaki Bovill, consultant physician.

No conflict of interest.

4CPS-239 A COMPARISON OF CLINICAL PHARMACY ACTIVITY BETWEEN TWO METHODS OF CLINICAL PHARMACY SERVICE DELIVERY IN AN ACUTE PSYCHIATRIC HOSPITAL

P McGee*, G Carroll, N Doyle. *Beaumont Hospital, Pharmacy Department, Dublin, Ireland*

10.1136/ejhpharm-2019-eahpconf.388

Background Traditionally our organisation's clinical pharmacists work independently. All patient Medicine Prescription and Administration Records (MPARs) are reviewed every day. This can be time-inefficient. This service evaluation seeks to determine if it is more beneficial to work independently or to participate in weekly multidisciplinary team (MDT) meetings.

Purpose To evaluate the impact of two methods of pharmacy service delivery – working independently versus working within the MDT, by:

- Determining the number of pharmacy interventions for each service.
- Recording time taken for each service.
- Exploring severity of interventions for each service.

Material and methods This was a quantitative study undertaken by the senior psychiatry pharmacist. A specifically developed software program ('SharePoint') enabled recording of interventions. Data was recorded for MDT and non-MDT services on randomly selected weeks between January and March 2018. The 'MDT' group had MPARs clinically reviewed once weekly at MDT meetings while the 'no-MDT' group continued to have MPARs clinically reviewed daily.

Results Interventions, time taken and interventions actioned:

Abstract 4CPS-239 Table 1

	No-MDT	MDT
Total # MPARs reviewed	617	33*
Average # MPARs reviewed per day	30	4
Average # interventions recorded per day	5	4
Intervention rate per patient	0.16	0.97
Time taken per day	128 min	92 min
Interventions actioned within 24 hours per patient	31.7%	88%
Interventions actioned per patient	56.4%	100%
Average time spend per intervention	25.7 min	22.5 min

*Patients were seen once-weekly in 'MDT' group (once daily for 'no-MDT' group)

Abstract 4CPS-239 Table 2 Interaction severity between groups

	Major	Moderate	Minor
Non-MDT	9%	57%	34%
MDT	3%	78%	19%

Conclusion The higher rate of interventions per patient and reduced time spent in the 'MDT' group demonstrates that working within multidisciplinary teams is a more effective use of pharmacist's resources.

Despite increased intervention severity, the 'no-MDT' group were much less likely to have interventions acted upon promptly, if at all. Previous research similarly shows increased intervention acceptance when pharmacists work within teams.¹

Our psychiatry pharmacist resources are increasingly moving towards working within MDT teams.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. Bosma L, et al. Evaluation of pharmacist clinical interventions in a Dutch hospital setting. *Pharm World Sci* 2008; 30:31–8. <https://link.springer.com/article/10.1007%2Fs11096-007-9136-9>

No conflict of interest.