

patients who collected medicines from the pharmacy. This included adult male and female patients above 12 years. Their responses were recorded and tallied in the register book. This study was carried out between October 2017 and December 2017.

Results Eleven factors were established. Out of 5235 patients who received pharmaceutical services, 1641 patients were interviewed. The dispensing design factor represented 23.45%, while the least was the language factor with 0.24%.

Abstract 4CPS-257 Table 1 Factors that influence the patients from getting clear medication instructions

Factor (s)	Number of patients	%
1. Design of dispensing bench	384	23.45
2. Overcrowding at the dispensing window	312	19.01
3. Lack of concentration	172	10.48
4. Distractions i.e noise	156	9.50
5. Interruption by phone	143	8.71
6. Dispenser's attitude	90	5.48
7. Polypharmacy	23	1.40
8. Patient's state of mind	19	1.15
9. Dispensed want was not expected	11	0.67
10. Not feeling well	9	0.54
11. Language	4	0.24
12. Others	318	19.37

Conclusion Health professionals have a duty to ensure that instructions are given to the patients with clear understanding in whatever situations they are operating from, in order to achieve a complete healthcare delivery system.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. Design for Patient Safety: a guide to the design of dispensing environment, 1st Edition 2007.
2. Management Sciences for Health; Managing Drug Supply, 2nd Edition, revised and expanded, 1981.
3. Kampamba Martin, Evelyn Hone College, Pharmacy Section, Dispensing Manual, 2006.

No conflict of interest.

4CPS-258 IMPACT OF A TEAM OF CLINICAL PHARMACISTS IN A PAEDIATRIC SURGERY UNIT: RESULTS AFTER 6 MONTHS

AS Remoué Fanuel*, C Louet, D Navas, JF Huon, J Mocquard, E Corbineau. *CHU Nantes, Pharmacy, Nantes, France*

10.1136/ejhp-2019-eahpconf.407

Background In the paediatric surgery unit (38 beds), due to the multiplicity of prescribers (anaesthetists and surgeons) and to the parents' presence who are accustomed to looking after their child's medications, the management of patients' home medications is a critical point. The two main specialties of the unit are orthopaedic and visceral surgeries. A clinical pharmacy team has been deployed in the unit in April 2018 to improve medication safety.

Purpose To assess the impact of the pharmaceutical team in the unit.

Material and methods The pharmaceutical team undertook three main missions:

- Medication reconciliation (MR) for patients undergoing treatment: before admission for planned patients and after admission for non-planned patients. These patients were identified thanks to the anaesthetist consultation or the electronic record.
- MR on transfer to the rehabilitation centre, if necessary.
- Medication review during hospitalisation.

Since April, every pharmaceutical intervention (PI) has been registered and categorised according to the French Society of Clinical Pharmacy classification.

Results Over the past 6 months, the team realised 321 MRs on admission; 60 MRs on transfer to the rehabilitation centre; and all the prescriptions were reviewed daily from Monday to Friday.

Thirty-seven per cent of planned patients and 11% of non-planned patients had an undergoing treatment before their admission.

The team realised 163 PIs concerning 120 patients, throughout medication review or MR. These PIs mainly concerned omitted medication (46%), incorrect posology (33%) and inadequate use (13%). A PI has been recorded for 20% of patients for whom the medications were reconciled.

According to the Anatomic, Therapeutic and Chemical classification, the most represented classes were A: alimentary tract and metabolism (29%); N: nervous system (26%); R: respiratory system (13%); and J: anti-infectives for systemic use (11%).

Conclusion This analysis highlights that about one-quarter of children have a current medication on admission. It is important to focus on those patients to be effective. Considering the number of PIs, the work of the pharmaceutical team, together with the medical team, is essential in securing patients' healthcare and achieve continuity in medication management.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. Mocquard J, et al. A regional resource center to promote and develop medication reconciliation: missions and helping tools. *J Pharma Clin* https://www.jle.com/en/revues/jpc/e-docs/creation_dun_centre_de_ressources_en_conciliation_medicamenteuse_presentation_dune_initiative_regionale_pour_le_deploiement_de_lacti-vite_312336/article.phtml

No conflict of interest.

4CPS-259 EVALUATION OF PATIENTS', DOCTORS' AND COMMUNITY PHARMACISTS' SATISFACTION CONCERNING PHARMACEUTICAL CONSULTATIONS FOR PATIENTS RECEIVING ORAL ANTI-CANCER DRUGS

C Renard*, G Dozias, B Rey-Rubio, G Larhantec, N Mugnier, M Perennes. *CHRU Brest, Pharmacy, Brest, France*

10.1136/ejhp-2019-eahpconf.408

Background The development and expansion of oral anti-cancer agents provide multiple benefits, including improvement in patients' quality of life but also create numerous challenges such as side-effect management or medication adherence. In January 2018, we implemented pharmaceutical consultations, as part of a multidisciplinary consultation programme for patients receiving oral chemotherapy agents.

Purpose The aim of this study was to evaluate patients', community pharmacists' and oncologists' satisfaction with the pharmaceutical consultations.

Material and methods A paper-based questionnaire (10 questions) was distributed to patients receiving oral anti-cancer drugs at the end of the pharmaceutical consultation.

The overall community pharmacists' and oncologists' satisfaction was measured using an online survey tool. The surveys consisted of 14 questions divided into five sections.

The survey design was based on a 4-point scale, with answers ranging from strongly agree to strongly disagree, and also included yes/no and short answer questions.

All the answers to the questionnaires were collected in an anonymous way.

Results Between 1 January 2018 and 20 July 2018 a total of 20 patients, nine oncologists and 15 community pharmacists completed the survey. The response rates were respectively 49%, 53% and 35%.

Overall, pharmacists, doctors and patients were highly satisfied with the services of the oral anti-cancer therapy programme (100%).

Most patients (90%) felt that the majority of their questions and concerns were answered during the consultation. They found the written information useful (85%) and expressed that they had gained new and clarifying information about their medication (70%).

Community pharmacists were satisfied to have been informed of the oral cancer drug initiation (93%), most of the time it allowed them to order the treatment before the patient's arrival (80%).

Oncologists felt that pharmaceutical consultations were always (56%) or sometimes (44%) useful for the patients. Most of them (89%) considered there would be sometimes an interest in conducting consultations together with the pharmacist.

Conclusion This study showed that all participants highly appreciated the pharmaceutical consultations. These results are consistent with previous studies showing the key role of the clinical pharmacist in multidisciplinary programmes established for patients taking oral anti-cancer treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS

- Ma C. Role of pharmacists in optimizing the use of anticancer drugs in the clinical setting. *Integr Pharm Res Pract* 2014.

No conflict of interest.

4CPS-260 PRE-ANAESTHESIA BEST POSSIBLE MEDICATION HISTORY FOR ORTHOPAEDIC SURGERY-PROGRAMMED PATIENTS

A Renaudin*, V Delannoy, M Knight, C Roux, JM Kinowski, H Richard. *University Hospital of Nimes, Clinical Pharmacy Department, Nimes, France*

10.1136/ejhpharm-2019-eahpconf.409

Background In the orthopaedic surgery department, anaesthetists prescribe medicines to programmed patients during the pre-surgery anaesthesia consultation. Nevertheless, a 3 month (2016) study on medication reconciliation (MR) at admission, performed by a clinical pharmacist on 215 patients, shows that despite this process, there is at least one unintended medication discrepancy (UMD) for 53% of them. A pre-anaesthesia best possible medication history (PA-BPMH) has been implemented.

Purpose This study's main objective was to test the impact of this PA-BPMH on the number of UMD.

Material and methods This was a monocentric prospective study carried out during 3 months (from February to April 2018) in an orthopaedic surgery department. Included in this study were programmed patients for three different surgeries (hip bone, knee bone and spine). The PA-BPMH was obtained before the anaesthesia consultation from data given by the patient's usual pharmacy. If necessary, the pharmacist contacted the patient. The PA-BPMH recorded into the prescription software on pre-admission was at the anaesthetists' request during the consultation. Finally, a MR was performed at admission.

Results In total, 106 patients were included, with an average age of 68 years. The PA-BPMH was possible in 83% (n=88) of them. The PA-BPMH was not obtained because of the absence of the pharmacy's contacts (7.8%; n=8) and the lack of pre-admissions (6.6%; n=7). Anaesthetists used the PA-BPMH in 89% of cases (n=78). Among patients with PA-BPMH, 76% (n=67) had a MR at admission. At least one UMD was observed in 21% (n=14) of patients at admission and this number could have been reduced to 16% if 100% of the PA-BPMH had been used.

Conclusion This test phase allowed the evaluation of the PA-BPMH's feasibility. Obtaining a BPMH before the anaesthesia consultation has reduced the number of unintended medication discrepancies at admission (53% vs 16%). The difficulty of exhaustivity led us to create a pre-anaesthesia pharmacist consultation in the patients' presence in order to improve efficiency.

REFERENCES AND/OR ACKNOWLEDGEMENTS

- Kwan, *et al.* Pharmacist medication assessments in a surgical preadmission clinic. *Arch Intern Med* 2007.
- Van den Bemt, *et al.* Medication reconciliation performed by pharmacy technicians at the time of preoperative screening. *Ann Pharmacother* 2009.

No conflict of interest.

4CPS-261 ANALYSIS OF THE METHODOLOGY TO COMMUNICATE POTENTIALLY INAPPROPRIATE PRESCRIPTIONS IN INPATIENTS TO AN INTERNAL MEDICINE SERVICE OF A THIRD-LEVEL HOSPITAL

¹M Fernandez, ²E Carmona, ¹J Cordero, ¹L Rendón de Lope*, ²MA Colmenero, ¹L Alvarez, ¹MA Calleja. ¹Hospital Universitario Virgen Macarena, Pharmacy, Sevilla, Spain; ²Hospital Universitario Virgen Macarena, Internal Medicine, Sevilla, Spain

10.1136/ejhpharm-2019-eahpconf.410

Background For decades, advances in medicine have led to an increase in life expectancy. In Spain, life expectancy is 81 years in men and 85.6 years in woman. This fact has led a high percentage of inpatients over 65 years' old. These patients have often multiple pathologies and the are polymedicated. In these patients it is common to find potentially inappropriate prescriptions (PIP). According to current publications between 25%–30% of patients admitted to the hospital present one or more PIPs. The adequate medication control in these patients makes detection of PIPs crucial in providing adequate healthcare.

Purpose Clinical pharmacists have shown a great capacity in decreasing these PIPs through pharmacist-physician interventions.

Our objective is to analyse the possible pharmacist-physician communication channels through which to notify the detected PIPs