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.

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No conflict of interest.

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

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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.

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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

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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

Material and methods A 3 month prospective study (February 2018 to April 2018) to analyse the effectiveness of pharmacist-physician communication channels.

Effectivity was determined by the% acceptance of the interventions.

Channels chosen were: Through direct communication with the physician.

Electronic communication using the Farmatools program.

Interventions were performed following inadequate prescription, dosage, omissions and duplicates of STOPP/START and Beers criteria.

The target population on which the study was conducted were polymedicated patients in an internal medicine service.

Results The medications found in the prescriptions were mainly: nonsteroidal anti-inflammatory drugs (22.1%) antibiotics (22.1%), insulins (19.5%), proton pump inhibitors (10.1%), low-molecular weight heparin (9.4%), digoxin (8.7%) and others (8.1%).

Through direct communication with the doctor, the prescriptions of 125 patients over 65 years of age were studied, and pharmacist-physician verbal intervention was performed in 35 of them (28%). 74.3% (n=26) of them were accepted by the physician.

Through electronic communication, interventions were performed in 221 patients. Analysing the record of the electronic interventions carried out, only 28.8% (n=62) were accepted.

Conclusion Pharmacist-physician interventions carried out by clinical pharmacists are fundamental for a reduction of PIPs.

Direct pharmacist-physician communication provides a greater degree of interventions acceptance rather than electronic intervention.

Adding clinical pharmacists to clinical services could help to reduce PIPs.

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4CPS-262

PLACE OF CLINICAL PHARMACIST IN THE MANAGEMENT OF PATIENTS UNDERGOING BARIATRIC SURGERY

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Background Obesity is a major national public health concern, with a prevalence of 15%. Among these patients, bariatric surgery procedures can be proposed, by sleeve gastrectomy or gastric bypass. Considering potential comorbidities of obesity (diabetes, arterial hypertension) many specialists are involved.

Purpose Our pharmacy department decided: to develop a pharmaceutical healthcare pathway in bariatric surgery for inpatients and outpatients; and to evaluate the relevance of medication reconciliation in this specific surgery.

Material and methods During the 3 month study period, the pharmacy department organised medication reconciliation in collaboration with the digestive surgery ward, and highlighted endpoints (including short-term stay at hospital) in the healthcare pathway of bariatric surgery where the pharmacist could be helpful.

All patients undergoing bariatric surgery could be included for medication reconciliation. The number and

type of discrepancies between admission medication and reconciled updated medication were reported, considering the particulars of medication management in surgery wards (such as switching oral by the IV route, usual peri- and post-operative management of anticoagulant, antihypertensive drugs).

Results The clinical pharmacist was integrated in initial information meetings for patients (including the organiser nurse, dietitians and a psychologist), which allowed him/her to answer questions from patients, collect their prescriptions and contact specialists, general practitioners and community pharmacists. The pharmacist received the surgical programme and planned admission reconciliation on day -1 before surgery. Forty-eight or 72 hours following surgery, the pharmacist explained the post-operative treatment and instructions with the patient (vitamin supplementation for life, crushing tablets during 45 days, contraindication for non-steroidal anti-inflammatory drugs and effervescent tablets). The community pharmacist received an informative leaflet and a mail was sent to the general practitioner and specialists detailing discharge medication reconciliation and proposing medication alternatives for non-crushing tablets.

Concerning the relevance of medication reconciliation: 51 patients had reconciled medication, 33% showing at least one discrepancy (17/51). 32/47 total discrepancies were unintended with 21/32 of omitted medication and 10/32 dosage error.

Conclusion Integrating clinical pharmacy in the healthcare pathway of bariatric surgery is relevant, with a gain in care management both for inpatients and outpatients. This activity fits with national/regional indicators referring to the healthcare pathway for obesity.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-263

ANALYSIS OF CLINICAL PHARMACIST INTERVENTIONS CARRIED OUT IN AN INTENSIVE CARE UNIT

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Background The clinical instability of patients in intensive care units (ICU), makes them subject to drug-related problems (DRP) that may have an impact on the efficacy and safety of treatments.

Purpose To analyse clinical pharmacist interventions (PIs) carried out over DRP registered in an ICU.

Material and methods This prospective and descriptive study was carried out in 1 month (15 t May to 15 June) in an ICU of 18 beds in a tertiary hospital. PIs were detected by a resident pharmacist in his ICU period during the validation of physician orders. The variables of this study were: demographic data (sex, age); type of medical intervention; degree of response (accepted if they changed the physician order or rejected if the change was not accepted); and the drugs used.