

PIs were carried out in relation to DRP in the Third Consensus of Granada and the prescribing physician was orally informed of all of them.

Results A total of 31 interventions were registered, 71% of which were males and 29% females, with an average age of 74 years (41–92). PIs were classified in this way: 15.2% drug dose adjustment; 9.2% start of medication; 8.2% pharmacokinetics monitoring; 6.2% routes of administration of drugs; 4.2% interruption of treatment; 4.2% mistakes in the transcription of physician orders; 4.2% drug interaction prevention; and 4.2% allergic reaction prevention. 93.3 per cent of PIs were accepted.

The group of drugs J (systemic anti-infectious) was the most involved, with 35.5% of PIs, followed by group C (cardiovascular system) with 19.4% and group B (blood and haematopoietic organs) with 12.1%, among others. Regarding DRP, 51.7% were related to safety, 25.7% to the efficacy of the treatment and 22.6% to the indication.

Conclusion The high level of acceptance of the proposed interventions and its clinical relevance demonstrates the significance of clinical pharmacists that prevent, detect and solve DRP in the prescription process before they affect the patient. According to the published literature, the presence of a clinical pharmacist in critical patient care multidisciplinary teams provides improvements in terms of safety, efficacy and cost of treatments.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

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ANALYSIS OF THE DISCREPANCIES FOUND IN THE RECONCILIATION OF CONCOMITANT MEDICATION IN A COHORT OF ELDERLY PATIENTS INFECTED WITH HIV

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Background The increase of life expectancy in HIV patients leads to the appearance of comorbidities and therefore the increase in concomitant medication.

Purpose To determine the prevalence of discrepancies in the reconciliation of concomitant medication in elderly HIV patients. To describe the most frequent discrepancies as well as the medications involved.

Material and methods Prospective observational study conducted in HIV-infected patients treated at the pharmacy service (1 January 2014–31 December 2014) of a regional university hospital.

Collected variables: age, sex, concomitant medications, discrepancies found in the clinical history of specialised care (CH) and primary care (PC) and plasma viral load (VL). The discrepancies were classified as: omission, different dose/frequency/route, erroneous medication and therapeutic duplication.

In the conciliation the CH was reviewed, the pharmacotherapeutic history of PC and the patient was interviewed.

The inclusion criteria were: HIV infection, age ≥ 50 years and antiretroviral treatment for at least 6 months.

The statistical analyses were performed using the statistical package SPSS 15.0.

Results We analysed 327 patients of which 132 (40,37%) were elderly patients.

In the study population (n=132), the median age was 53 years (RI: 50–88), with 61.4% (n=81) being polymedicated patients. 73.5% (n=97) of the population was male.

A total of 790 active ingredients were analysed, 439 being concomitant active ingredients. The median of active ingredients/patient was 5 (RI: 1–21). One-hundred and thirty-one active substances with HC discrepancy and 154 active ingredients in PC were registered and 81 patients were affected (61.4%). 81.5% of them (n=66) were polymedicated patients.

In CH there were: 109 omissions, 22 erroneous medications and two medications with erroneous doses. In the PC: 132 drug omissions were collected, 21 wrong medications and one medication with the wrong dose. The active ingredients mostly involved belonged to: vitamins (16.17%), psycholeptics (11.0%) and antacids (10.1%).

VL was less than 50 copies/ml in 81 patients (61.4%) and less than 200 copies/ml in 119 patients (90.15%).

Conclusion Seropositive patients have a high number of discrepancies affecting patients' polymedicated majority. The most frequent discrepancy in both primary and specialised care is the omission of medications. The group of drugs mostly involved are vitamins. It would be interesting to analyse in the future if patients with more discrepancies in medication have more interactions or worse immuno-virological control.

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EFFECT OF DEDICATED PHARMACIST INTERVENTION IN NEUROCRITICAL CARE UNIT: BEFORE AND AFTER PARTICIPATING IN MULTIDISCIPLINARY ROUNDS

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Background Few studies have assessed the activities of a designated neurocritical care pharmacist (NCP) by reducing preventable adverse drug events and medication errors.

Purpose This study evaluated the effect on the pharmaceutical service by a dedicated NCP.

Material and methods A retrospective study was conducted to compare a pre-designated NCP period (from 1 May 2016 to 31 December 2016) and post-designated NCP (from 1 May 2017 to 31 December 2017). Intensive care unit (ICU) length of stay, ICU mortality, a total number of interventions, intervention rates per prescription and acceptance rate of NCP interventions were compared between the two groups. The types of interventions and relevant medications were investigated.

Results The total number of patients was 676 during the pre-NCP period and 769 during the post-NCP period. The presence of NCP pharmacists decreased ICU length of stay (B = -0.077 (-0.148–0.006), p = 0.033), increased the clinically significant interventions (OR, 2.2 (1.5–3.1), p < 0.001) and showed a tendency to reduce ICU mortality (OR, 0.7 (0.3–1.7), p = 0.436). The number of interventions per