5PSQ-115 'PATIENT EXPERIENCE' FOR IMPROVING PATIENT CLINICAL PATHWAYS IN AN ONCOLOGY DAY HOSPITAL

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Background Patient engagement is considered critical in improving quality of care provided by the healthcare system. Developed recently by our hospital, the 'Patient experience' is a programme collecting patient's journey experiential feedback with the aim of establishing a continuous improvement method. As part of a project focusing on the improvement of patient's pathways for patients receiving chemotherapy in our oncology day hospital, a 'Patient experience' was carried out.
Purpose The aim was to collect and analyse patients' feedback to improve this care pathway.
Material and methods A map describing the patient's journey was performed to identify the critical steps. An interview guide, focusing on medication management at each step and, more specifically on chemotherapy, was developed and validated with the pharmacists, the oncologist, the head nurse and the nurses. Non-recorded semistructured interviews were conducted by both a student and a pharmacist's resident or alone by a resident until data collection reached saturation point. Patients with communication difficulties, cognitive impairment or severe asthaenia were excluded. The interview's results were summarised in a 'map of emotions'. For each step of the hospital stay, the map presented a positive and negative patient's impression. A general feedback was then delivered to health professionals involved in the project.
Results In total, 20 interviews were conducted. The average age of participants was 62 years (29–82). Among them, 70% (n=14) were treated for less than 6 months. The average interview duration was 21 min (10–45). Overall, the care provided at the hospital received good feedback. The improvement's axes were: the lack of achievement and enrolment for pharmacy interview of patients who had a PICC-line or an oral chemotherapy, for explaining the treatment.
Conclusion These interviews were very informative, highlighting a good overall level of care delivered and allowing us to identify some issues to consider. This innovative method is very customer-focused, leading to the identification of patient's real needs and avoiding top-down solutions sometimes proposed by healthcare professionals, which do not take into account patient's point of view.

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5PSQ-116 ANALYSIS AND EVALUATION OF A RENAL FUNCTION-BASED DOSAGE ADJUSTMENT SYSTEM AT A UNIVERSITY HOSPITAL

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Background Renal insufficiency is relatively common among hospitalised patients, and is associated with an increase in hospitalisation-related morbidity and mortality. Drug-dosing errors are common in patients with renal impairment and can cause adverse effects and poor outcomes.
Purpose The purpose of this study was to evaluate the benefit of the Renal Function Based Dosage Adjustment System in a tertiary hospital.
Material and methods This was a single institutional, retrospective pre/post study conducted over 3 month periods within 9 years. In August 2006, the Renal Function Based Dosage Adjustment System which monitored drug prescription and generated a real-time alerting window, was implemented and has operated well in a tertiary hospital in Korea. We analysed prescription and alert data of the tertiary hospital's Healthcare Information System and compared the pre-renal dosing system versus the post-renal dosing system from April to June 2006, 2007 and 2015.
Results Among the patients whose admission and discharge periods were included during the study period, 7587 patients with an estimated glomerular filtration rate of less than 60 and who required dose adjustment according to the patient's renal function. The rate of inappropriate prescription was 8.7% in 2006, 7.4% in 2007 and 2.7% in 2015. The drug classes that most frequently generated alerts were the H2 blocker (44.2% in early clinical decision support system (CDSS) period, 52.8% in the late CDSS period) and antimicrobials (17.0% in the early CDSS period, 52.8% in the late CDSS period).
Conclusion The current system may be practically useful in the improvement of safety in renal-insufficient patients resulting in the realisation of effective pharmacotherapy. To improve the clinical acceptance of alerts, this system should strive to maximise the effectiveness of alerts/minimise over-alerting.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-117 PREVENTING MEDICATION ERRORS REGARDING HIGH-ALERT MEDICATION

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Background High-alert medications are those that, when they are not being properly used, are more likely to cause serious or even fatal harm to patients. In order to improve patient safety, it is important to focus on them and to establish practices for improving safety in all processes of their use.
Purpose To make action protocols to minimise possible errors arising from the use of high-alert medications and implementing them in a second-level hospital through the pharmacy service.

Material and methods The high-alert medication list was obtained through the Institute for the Safe Use of Medicines. We analysed the drugs included in it and we selected those that were reasons for doubt and by those who called more frequently to the hospital pharmacy service to clarify doses, routes of administration and so on: in general, those that caused failures in the process of using them. We also tried to analyse the circumstances that could motivate these doubts or errors.

These drugs were: oral anticoagulant, heparin, insulins, intravenous potassium chloride and oral methotrexate.

Results

Abstract 5PSQ-117 Table 1

High-alert medication	Error or reason of doubt	Protocol of action
Oral anticoagulants	Lack of knowledge of dose and dosage schedule.	Transcription of the haematology guideline by the pharmacy service and dispensation of the right dose for each day. Establish INR monitoring protocols.
Heparin	Confusion between doses and concentration. Possible confusion with insulins when dosed also in units.	Reduce the variety of available presentations and indicate that heparin should be separated from insulin as well as from other drugs that are prescribed in units.
Insulins	Confusion between the different types, marks and concentrations.	Prescription by trademark, decrease the number of presentations in the hospital.
Intravenous potassium chloride	Storage of the solutions concentrated in the kits.	Remove potassium vials from care units and use pre-mixed potassium prepared by industry or pharmacy service.
Oral metrotexate	Daily administration instead of weekly.	Treatments conciliation (dosage and frequency of administration) to avoid overdosing.

Conclusion The implementation of specific practices, including packaging, labelling, storage, prescription and preparation, as well as the establishment of standardised protocols of action in the hospital will help to reduce the errors of medication.

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5PSQ-118 SURVEILLANCE AND MONITORING OF PATIENT FALLS IN A HOSPITAL SETTING BY THE HOSPITAL PHARMACIST: FOCUS ON PATIENT-RELATED RISK FACTORS AND DRUG THERAPY

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Background Falls in hospitalised patients (FHPs) represent the most common adverse event in a hospital setting that can increase hospitalisation stay.

Purpose The aim of this study was to identify the risk factors related to FHPs.

Material and methods We analysed 65 falls of 61 patients that occurred in our institute from January 2013 to May 2018. There were identified patient-related risk factors (age, gender, body mass index, diseases, postoperative status, need of assistance and previous fall in the past 6 months) and therapy-related risk factors, such as the presence of fall-risk-increasing drugs (FRIDs) reported in the literature.

Results 19.7% (12/61) of the fallen patients were aged under 60 years, 45.9% (28/61) between 60 and 70 years, 31.1% (19/61) between 70 and 80 years, while 3.3% (2/61) were over 80 years. 68.9% (42/61) of the patients were males, while 31.1% (19/61) were females. 96.7% (59/61) had predisposing factors to FHPs. 55.7% (34/61) were overweight and 1.6% (1/61) were underweight. 44.3% (27/61) required total care, while 27.9% (17/61) required partial assistance. In 40% (26/65) of the FHPs, the patients were in a postoperative care, while in 31.1% (19/65) of FHPs, the patients had fallen in the previous 6 months. In 35.4% (23/65) of the FHPs, one or more diagnostic tests were necessary, for a total amount of 33 examinations. In 96.9% (63/65) of the reported falls, the patients were in polytherapy and assumed FRIDs, with an average of 7.3 FRIDs per patient: the most representative classes of FRIDs were cardiovascular drugs in 47.4% (227/479), hypoglycaemics in 12.1% (58/479), proton pump inhibitors in 11.3% (54/479), laxatives in 7.1% (34/479), opioids in 6.9% (33/47) and anxiolytics in 5% (24/479). The most frequent FRIDs were furosemide in 14.2% (68/479), omeprazole in 9.8 (47/479), insulin lispro in 5.4% (26/479) and tramadol in 5.2% (25/479).

Conclusion This analysis shows some critical points that required the implementation of preventive and safety measures, in order to reduce the incidence of FHIPs. We propose to perform: frequent fall-risk assessments of each patient through appropriate assessment scales; greater attention to drug therapy; and adequate training of healthcare professionals.

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5PSQ-119 A PRELIMINARY SURVEY ON DAILY DRUG INTAKE IN OLDER PATIENTS IN COMPLIANCE WITH EAHP POLICY STATEMENT ON AN AGEING SOCIETY

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Background The elderly are particularly at increased risk of adverse drug reactions (ADR) attributed in the main to polypharmacy, poor compliance and physiological changes affecting the pharmacokinetics and pharmacodynamics of many drugs. The tracer pharmacist (TP) can support physicians to ensure the appropriate and safe use of drugs, and stimulate patient reporting to the pharmacovigilance system.

Purpose The aim of this study was to identify the risk factors inherent in the daily drug intake, in order to prevent/reduce the incidence of ADR and to increase the reporting of them.

Material and methods A preliminary prospective observational study was performed by the TP in September 2018. Sixty elderly inpatients and outpatients were included. After acquiring informed consent, patient questionnaires were administered to evaluate the correct use of drugs and the use of Over the