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 Spirous 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.

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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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No acknowledgments.

No conflict of interest.

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

Authors of this presentation have the following to disclose concerning possible financial or personal relationships with commercial entities that may have a direct or indirect interest in the subject matter of this presentation:

Kyoung Suk Choi: Nothing to disclose.

Eunsook Lee: Nothing to disclose.

Sandy Jeong Rhee: Nothing to disclose.

No conflict of interest.
Abstract

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

<table>
<thead>
<tr>
<th>Table 1</th>
<th>High-alert medication</th>
<th>Error or reason of doubt</th>
<th>Protocol of action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral anticoagulants</td>
<td>Lack of knowledge of dose and dosage schedule.</td>
<td>Transcription of the haematology guideline by the pharmacy service and dispensation of the right dose for each day. Establish INR monitoring protocols.</td>
<td></td>
</tr>
<tr>
<td>Heparin</td>
<td>Confusion between doses and concentration. Possible confusion with insulins when dosed also in units.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Insulins</td>
<td>Confusion between the different types, marks and concentrations.</td>
<td>Prescription by trademark, decrease the number of presentations in the hospital.</td>
<td></td>
</tr>
<tr>
<td>Intravenous potassium chloride</td>
<td>Storage of the solutions concentrated in the kits.</td>
<td>Remove potassium vials from care units and use pre-mixed potassium prepared by industry or pharmacy service.</td>
<td></td>
</tr>
<tr>
<td>Oral methotrexate</td>
<td>Daily administration instead of weekly.</td>
<td>Treatments conciliation (dosage and frequency of administration) to avoid overdosing.</td>
<td></td>
</tr>
</tbody>
</table>

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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

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

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10.1136/ehjpharm-2019-eahpconf.552

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