

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 metotrexate	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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

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 FHPs. 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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

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 poly-pharmacy, 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