5PSQ-125 QUALITY AND RISK MANAGEMENT IN HOSPITALS: EVALUATION OF IMPLANTABLE MEDICAL DEVICES' TRACEABILITY PROCESS

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Background Medical devices may be at the origin of incidents or risks of incidents due to several deficiencies in their circuit, from their design to their use, passing through their manufacturing and marketing. For implantable medical device (IMD's), risks are greater, and a quality management system based on rigorous traceability is essential to their management to ensure their quality and the safety of implanted patients.

Purpose To assess overall conformity of the IMD's traceability process in the operating rooms as part of quality and risk management at our hospital.

Material and methods This was a prospective study of the IMD's traceability process conformity for all patients admitted for a surgical procedure using IMD's in gynaecology, urology, thoracic surgery and visceral surgery, over a period of 6 months.

Information was extracted from the individual IMD's traceability records and from the IMD's traceability register.

Results During the study period, 365 IMD's were implanted in 297 patients. The most used IMD's were parietal reinforcement plates (50%) and implantable staples (28%). The most IMD's consuming services were visceral surgery (73%) and urology (18%). Traceability anomalies (lack of information about patients and/or IMD's) were present in 22% of cases, and the service responsible for the majority of discrepancies was the urology service (58%). A total lack of traceability was noted in less than 1% of cases.

Conclusion The traceability procedure remains imperfectly applied, in particular concerning the completeness of recorded information. Efforts must be pursued in terms of observance of this procedure, and continuously evaluated to improve the quality, and to master the risk level, at our establishment.

REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.

5PSQ-126 MEDICATIONS AND FALLS IN THE ELDERLY: AN EPIDEMIOLOGICAL STUDY IN A FRENCH HOSPITAL

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Background Falls in the elderly is a major public health problem. One-third of people over 65 fall at least once a year. Polypharmacy, which is defined as taking more than four drugs a day, is a major risk factor for falls in the elderly.

Purpose The aim of this study was to determine the frequency of use of drugs that increase the risk of falls and the impact of changes in these treatments in the occurrence of falls in the hospital.

Material and methods This study was a retrospective chart review of patients who sustained falls in the hospital. The list of fallers was obtained from the fall reporting data. In the first part, the clinical characteristics of patients and environmental falls were analysed.

In the second part, the pharmaceutical data of patients with a recent modification of their treatments were sought (number of medications per day, hypotensive and inducing drowsiness treatments and type of recent modifications of these treatments).

Results Seventy-three per cent of patients were falling in their rooms. Patients during the fall were mostly calm and wandering. In the majority of cases, the falls were of no clinical consequence (69%).

Fifteen per cent of patients had a change in their treatment before falling. The average number of drugs per patient was nine per day. In these patients, the rate of prescription of drugs at risk of falling was high (87% for hypotensive treatments and 91% for inducing drowsiness treatments). A very high consumption of diuretics (40%) and benzodiazepines (60%) was observed. The combination of benzodiazepines was found in 16% of patients. Respectively, 24% and 65% of patients had a modification in their hypotensive and inducing drowsiness treatments.

Conclusion The use of drugs that increased the risk of falling was common in our hospital. The recent change in inducing drowsiness treatments seemed to increase the risk of falling.

Pharmaceutical interventions with prescribers on good prescribing practices in the elderly should be strengthened to minimise the use of drugs at risk of falling.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

5PSQ-127 DISPENSATION OF FINITE MEDICATION AT DISCHARGE IN THE COMPLEX CHRONIC PATIENT

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Background Within the programmes of continuous care of the complex chronic patient (CCP), there are initiatives to improve adherence and continuity of care. Most frequent is dispensing medication upon discharge.

A discharge finite medication (FM) programme for complex chronic diseases (DMCDP) was implemented in the continuity care unit of internal medicine (UCA) in our hospital.

Purpose Evaluate the DMCDP from our hospital.

Material and methods FM is defined as drugs that the patient doesn't have and whose estimated duration of treatment is less than 30 days.

A prospective observational study was designed with all patients classified as CCP admitted to the UCA during the first 6 months of 2018, to compare cost and number of doses dispensed (DD) between the community pharmacy (CP) system vs the DMCDP programme.

An Excel database was created. Variables: age, sex, medication dispensed, therapeutic group, indication, duration and days until end of treatment, units dispensed and saved vs CP more adjusted to treatment presentation, estimated cost in CP according to Remedios, cost of hospital dispensation and opportunity cost. All data were analysed with XLS Stat for descriptive statistics.

Tools: history of primary care, electronic prescription, medication bag, informative interview on admission and discharge, medication sheet at discharge, hourly chart, FM in unit doses with posology until the end of treatment and in daily kits dated for medications with variable posology such as descending corticoid patterns. Remedios data base.

Results Sixty-six patients were studied. Age 83 (44–98) years.

All patients had at least seven medical prescriptions: 100% of admissions were reconciled and interviewed on admission and discharge.

Thirty-four (47.2%) patients required FM according to discharge medical prescription to finish initiated hospital treatments for anticoagulation (78%), respiratory infection (ABR) (14%), urinary infection (3%), other infections (4%) and hepatic encephalopathy (1%).

Medication DD avoided were: systemic corticosteroids (59.3%), antibacterial (34.7%) and antithrombotic antihaemorragic (4.7%).

Cost savings in medication for the national health system (88.27%). Pathologies' greatest savings were AC (78%) and ABR(14%).

The biggest problem on admission and discharge was lack of time.

Conclusion A discharge medication programme led by a hospital pharmacist, reinforces understanding and compliance for each patient, decreases the risk failure due to lack of adherence, knowledge or accessibility problems. In addition, it promotes rational use, since dispensing of the exact units reduces the possibility of future self-medication at home.

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No conflict of interest.

5PSQ-128 PHARMACOTHERAPEUTIC PROFILE AND RISK OF DRUG-RELATED PROBLEMS AND DRUG INTERACTIONS IN HIV+ PATIENTS OF A HEALTH AREA

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Background The expected lifespan of HIV +patients has increased dramatically as a result of improved antiretroviral therapy (ART), with the consequent increase in comorbidities and polypharmacy.

Purpose To analyse the profile of comorbidities and polypharmacy in HIV +patients of a Health Area and determine their influence on the risk of presenting drug-related problems (DRPs) and potential clinically significant drug interactions (CSDIs).

Material and methods Retrospective observational study conducted in a Reference Hospital Area that treated 457 HIV +patients with ART. We included all HIV +patients who collected ART in our pharmacy service during a randomly chosen week of March 2018. Variables included in the analysis were: demographics (age, sex) and clinical (viral load (VL), comorbidities) from computerised medical records and pharmacotherapeutic (ART scheme, dispensing data and concomitant treatment) from a management programme (Savac) and application AGORA PLUS®. Patients with $\geq$2 chronic non-AIDS pathologies were considered pluripathologic and polymedicated if they were prescribed $\geq$5 non-ART drugs. The risk of DRPs was obtained from the PREDICTOR tool of the Spanish Society of Hospital Pharmacy and CSDIs from the Lexicomp database. Statistical analysis was performed using SPSS v23.0.

Results We included 120 patients (76.7% males), with a mean age of 51.15±9.61 years (59.17%>50 years' old). 94.17% had undetectable VL. 54.2% patients were pluripathologic