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

Thanks to the Health Framework.

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 ≥2 chronic non-AIDS pathologies were considered pluripathologic and polymedicated if they were prescribed ≥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

with a median of three (2–4) comorbidities and 26.7% polymedicated with a median of seven (6–9) drugs per patient. The most common chronic diseases were: anxiety/depression (45.8%), dyslipidaemia (32.5%), hypertension (20.8%) and psychiatric disorders (19.2%). Benzodiazepines (32.5%), vitamin D (31.7%), proton-pump inhibitors (22.5%), statins (20%), antidepressants (18.3%) and antipsychotics (15%) were the most common drugs prescribed.

A total of 55 CSDIs were identified in 41 patients (34.2% of patients), of which 78.18% involved ARV drugs. Classes of drugs most involved in CSDIs were: pharmacokinetic enhancers (40%), protease inhibitors (38.18%), statins (25.45%), antipsychotics (25.45%) and antidepressants (14.54%). The risk of DRPs was high in 46.7% of patients. In statistical analysis (Mann–Whitney *U* test), the relationship between the number of comorbidities and the risk of DRPs and CSDIs was statistically significant ($p<0.005$) in both cases.

Conclusion The results of the study demonstrate the aging of the HIV +population and the consequences that this entails: an increased risk of presenting DRPs as well as the risk of CSDIs. Due to this, a meticulous and multidisciplinary approach is necessary in this population in order to identify the most susceptible patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-129 BALANCE AND CLASSIFICATION OF PHARMACEUTICAL INTERVENTIONS IN A GENERAL HOSPITAL OF SPECIALTIES: THE PERSONALISED HOSPITAL PHARMACY

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Background Pharmaceutical care (PC) is the 'supply of medicines with the purpose of achieving concrete results that improve the quality of life of the patient', being related to the global process of prescription through pharmaceutical intervention (PI).

Purpose Analyse the registration data of the PIs carried out in a tertiary hospital to avoid adverse effects and health hazards.

Material and methods Retrospective study of the PIs registered between January and August 2018. The PIs were structured in three blocks: Block 1: qualitative (method of comunication of PIs); Block 2: quantitative (active principle, schedules, drugs included/not included in the Pharmacotherapeutic Guide (PTG) and dose adjustment in paediatric presentations); and Block 3: communicative (computer or telephone/personal), dose adjustment according to renal and hepatic functions and acceptance degree.

Results There were 573 PIs over 12 024 admissions, 72.6% in adults and 27.4% in paediatrics. The main method of communication was the computer on 408 occasions and telephone/personal in 165, depending on the urgency. The most frequent error was schedule (43%), not adjusting for nursing shifts, altering the administration of the medication. Those of active principle (26%) were due to drugs not included in the PTG and of those doses (18%) that were related to paediatric presentations. The inadequate form of administration was also registered in 6%, being related to the prescription of medications not included in the PTG, requiring a complete description sensitive to faults in the prescription or transcription. Those of low posology (4%) were due to dose adjustment according to renal and hepatic functions, and those of high (3%) to shortening of the therapeutic interval. The 'pharmaceutical performance' included 63 PIs of therapeutic exchange and modified dosages in 29 cases. Acceptance was 97.5%, performing 98.6% immediately and 1.4% in a range of 8 hours. All these problems related to the medication were detected and corrected by pharmacists as the intermediate step between the medical prescription and the nursing administration.

Conclusion It has been shown that the review and validation of treatments significantly improves therapeutic safety, minimising the risk to the patient. These results provide quantifiable data to measure the activity of the clinical pharmacist, in addition to providing data on pharmacotherapeutic quality indicators.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Database Pharmacy Unit.

No conflict of interest.

5PSQ-130 ANALYSIS OF RITUXIMAB OFF-LABEL USE

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Background Rituximab is a monoclonal antibody indicated in Spain in adults with non-Hodgkin's lymphoma, chronic lymphatic leukaemia, rheumatoid arthritis and granulomatosis with polyangiitis and microscopic polyangiitis.

Purpose To evaluate the use of rituximab in a district hospital in off-label conditions which did not respond to corticosteroids or immunosuppressants treatment.

Material and methods We carried out a retrospective observational study of the use of rituximab off-label from its inclusion in the pharmacotherapeutic guide of the hospital in 2009 until July 2018.

Data collected: number of patients, sex, age, diagnosis, previous treatment with rituximab, concomitant treatment with rituximab, treatment schemes and adverse effects 6 months after the start of treatment. Digital clinical history and external consultations application were used. Statistical analysis was performed with SPSS version 24.

Results Number of patients: 21. Sex: 11 (52.4%) males. Mean Age: 53.3 (21–80). Diagnostic groups: six patients (28.6%) developed glomerulonephritis, five (23.8%) lupus, five (23.8%) vasculitis for cryoglobulins and ANCA positive, three (14.3%) myositis and two (9.5%) pemphigus. Treatment prior to rituximab: all patients were treated with prednisone, 11 (52.4%) with mycophenolate mofetil, 10 (47.6%) with azathioprine, 10 (47.6%) with cyclosporine A, six (28.6%) with hydroxychloroquine, three (14.3%) methotrexate, two (9.5%) with tacrolimus, one (4.8%) with immunoglobulins and one (4.8%) with monoclonal antibodies. Concomitant treatment with rituximab: all patients had been treated with prednisone, five (23.8%) with hydroxychloroquine, five (23.8%) with azathioprine, four (19%) with mycophenolate