

5PSQ-135 SAFETY RELATED TO PSYCHOGERIATRIC PATIENTS.  
ONE-YEAR PROSPECTIVE STUDY

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**Background** Patient safety is the most important concern for healthcare professionals, patients and healthcare systems. Adverse drug events (ADEs) are a common cause of hospitalisation and occur with increasing frequency in hospital as patients age.

**Purpose** Determine the ADEs at admission and during the stay in a psychogeriatric unit.

**Material and methods** One-year prospective cross-sectional study (July 2015–2016), in a psychogeriatric ward (21 beds). Included patients with dementia, admitted presenting neuropsychiatric/behavioural and psychological symptoms in dementia (BPSD). Excluded patients with previous psychiatric illness or palliative conditions.

Prescription information: Aegerus and Catalonia clinical record HC3. Variables: demographics, diagnoses, Global Deterioration Scale (GDS-R), functional assessment (Barthel Index), fall risk (Downton JH and Tinetti). Anticholinergic risk level (Drug Burden Index (DBI). ADE assessment: causality by Naranjo algorithm, severity by classification system of the Institute for Healthcare Improvement and preventability by the Schumock–Thornton algorithm. Drugs classification by the Anatomical Therapeutic Chemical Code (ATC).

**Results** Sixty patients (60% females), age: 84.8 years (68–96). Dementia: unidentified (43%), Alzheimer's (31%), Lewy bodies (8%), vascular (8%), mixed (5%) and others (6%). GDS-R 4.5 ( $\pm 1.2$ ), moderate cognitive impairment. Barthel Index 43.8 ( $\pm 23.9$ ), moderate dependence. Patients comorbidities 4.8 ( $\pm 1.6$ ). Drugs/patient 9.03 ( $\pm 3.12$ ). DBI high risk in 69% of the patients. High risk of falls, Tinetti (15.5 $\pm 8$ ) and Downton test (4.5 $\pm 1.3$ ).

Sixty-eight ADEs (53 patients, 81.5%, 22.6% more than one). 73.5% not related to falls. From this 80% were related to the ATC nervous system (46% (23 ADE) psycholeptics). Naranjo algorithm one definite (2%), probable 45 (90%) and possible four (8%). Severity Category E: temporary harm to the patient and required intervention in 34 (68%) and F: temporary harm to the patient and required initial or prolonged hospitalisation in 16 (32%). Schumock–Thornton test 58% (29) of the ADE were preventable, possibly preventable 6% (three) and unavoidable 36% (18). Main ADE drowsiness/somnolence 27.7%, 12.8% weakness and hypoactivity and 10.7% hypotension. DBI significant differences related to fall as ADE result (fall group 1.288 $\pm 0.79$ , non-fall group 0.95 $\pm 0.71$  p=0.05).

**Conclusion** The balance between effective treatments and safety is complex in these patients. Mostly ADE are related to the pharmacological treatment of this BPSD.

Anticholinergic load is a determinant for a specific ADE and were related to falls, the worst consequence in this patient, clinical and economic impact.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-136 A PHARMACEUTICAL CARE PROGRAMME IN PATIENTS UNDERGOING CARDIAC SURGERY

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**Background** The preoperative setting is an area with high risk for medication errors with potentially severe consequences. Strategies to reduce the incidence of medication errors are needed to guarantee the safety of these patients.

**Purpose** To describe the implementation of a pharmaceutical care programme (PCP) in patients undergoing cardiac surgery and its results in preventing medication errors.

**Material and methods** The comprehensive PCP was implemented in July 2018. Telephonic pharmacists' clinical interviews took place the week prior to cardiac surgery. Patients' complete medication list including over the counter and herbal products was compiled during the interview and medical instructions for adequate preoperative drug management were reinforced. Patients were admitted to the hospital at least 36 hours before the surgery, where medication management was supervised by ward personnel. At the time of admission, the ward pharmacist performed the medication reconciliation and suggested any further adjustments deemed necessary.

Observational prospective study. Time of study: July 2018 to September 2018. Pharmacists' interventions classified according to Overhage classification and the severity of medication errors according to NCC MERP were analysed.

**Results** Fifty-one patients were included, mean age 67.7 years, 60.8% males. Patients received an average of 7.1 (SD 3.1) chronic drugs. Forty patients (78.4%) were taking drugs that needed to be discontinued before surgery. Nineteen patients (37.3%) were on anticoagulants and 19 were taking antiplatelet drugs. Pre-operative drug management was correct in all cases.

Thirty-eight pharmacist interventions were made at the time of admission, classified as: wrong dose (47.4%), drug omission (31.6%), wrong frequency of administration (10.5%), wrong drug (7.9%) and wrong dosage form (2.6%). Overall acceptance of pharmacy interventions was 89.5%.

According to the severity of medication errors, 30 (78.9%) errors were serious (E/F), and eight (21.1%) classified as error without harm (C/D).

Regarding health outcomes, no surgeries had to be postponed due to wrong perioperative medication management. The mean length of hospital stay was 16 days (2–60). The readmission rate at 30 days was 3.9% (n=2).

**Conclusion** The PCP in patients undergoing cardiac surgery was successfully implemented, ensuring a correct preoperative drug management. We intercepted 0.8 medication errors per patient included in the programme. The errors were mostly serious.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.