vs 44% $p=0.048$) and higher erythropoietin substitution were needed for patients who had severe drug interactions ($21409 \pm 10\,991$ vs 18500 ± 11480 IU/month, $p=0.197$) compared to those patients who did not.

Conclusion Dialysis patients may experience severe potential DIs. Their anticoagulant regime should be personalised. Clinicians should be cautious when prescribing drugs to them. Involving clinical pharmacists in the primary team is advisable to prevent DIs.

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 No conflict of interest.

4CPS-021 ABSTRACT WITHDRAWN

4CPS-022 HIGH INPUT IN PATIENT SAFETY – DOCUMENTATION OF CARDIOVASCULAR SYSTEM DRUGS

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Background Cardiovascular disease (CVD), together with its main components, coronary heart disease (CHD), and cerebrovascular diseases, is the main source of morbidity and mortality in the European Union. The involvement of pharmacists demonstrated an ability to improve CVD outcomes through providing education, medicine management or a combination of both. **Purpose** To show which areas of CVD could be improved by pharmacists a retrospective analysis of data collection was conducted. Data were derived from a detailed documentation system from 2015 to 2018.

Material and methods Four times a week one pharmacist counselled two wards of a medical department with infectious diseases and tropical medicines with ~1600 admissions per year. The focus was on CVD drugs according to recent ESC guidelines. Either written recommendations or collaborative agreements with individual physicians were done.

Results One-thousand three-hundred interventions were documented by only one pharmacist. The majority (64%) of these interventions were accepted and implemented. The most common drug classes involved in interventions were CVD drugs (27%) and the most detected drug-related problems (32%) were missing indications. Thirty-one per cent of all CVD drug recommendations concerned stopping nicorandil and NO-donors for missing indication.

On the other hand, 45% of all patients who should be on a statin, did not get therapy while hospitalised, if the pharmacists would not have intervened. Fifty-four per cent of recommendations concerned change of medication due to a better side effect profile: diuretics (electrolyte imbalances), β -Blockers (selectivity) and calcium channel blocker (less flush and oedema). Time of administration for amlodipin and carvedilol was optimised in 70% of cases, and in 21% doses of ACE inhibitors and sartanes according to blood pressure was adapted.

Conclusion Through data analysis the effectiveness of clinical pharmacist interventions within a multidisciplinary team was demonstrated. These error mitigation efforts can serve as a priority in patient safety strategies in this high-risk patient group.

These improvements may also lead to an improvement in patients' quality of life, better use of healthcare resources and a reduced rate of mortality.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Link: The role of the clinical pharmacist in the care of patients with cardiovascular disease. <https://www.ncbi.nlm.nih.gov/pubmed/26541925>

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