Background and importance Fall incidents are common among nursing home patients. Different tools have been developed in the prevention of fall incidents but with unsatisfactory results.

Aim and objectives To develop (part I) and validate (part II) a predictive clinical rule (CR) that can predict a fall risk in nursing home patients.

Material and methods The study was conducted in two parts. In part I, the variables which could lead to an increased fall risk of patients in part I were determined with a high sensitivity and specificity to predict the risk of falls.

Conclusion and relevance Medication data and patient characteristics were not sufficient to develop a successful clinical rule with a high sensitivity and specificity to predict the risk of falls.

REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

4CPS-189 FALL INCIDENTS IN NURSING HOME PATIENTS: DEVELOPMENT OF A PREDICTIVE CLINICAL RULE (FINDER)

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REFERENCES AND/OR ACKNOWLEDGEMENTS
No conflict of interest.

4CPS-190 EVALUATION OF A NEW CLINICAL PHARMACY SERVICE WITHIN A NEWLY LAUNCHED SURGICAL ADMISSION PROCESS

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Background and importance Clinical pharmacy services (CPS) targeting the admission of surgical patients have been shown to provide significant benefit for patient safety and care.

Aim and objectives To evaluate a CPS within a newly launched integrated admission process for elective surgery patients: (1) by defining the number and type of identified drug-related problems (DRPs) and acceptance rate of pharmacists’ suggestions for medication optimisation; and (2) by assessing the perception of the service and identifying barriers and optimisation potential.

Material and methods This was a retrospective descriptive analysis of number and type of identified DRPs, suggested interventions and their acceptance rate based on a validated classification system. We also determined the health professions’ perceptions towards the new service, measured using a piloted self-administered quantitative questionnaire.

Results Pharmacists reviewed 1877 patient files (6214 drugs) and identified 2003 DRPs, on average 1.07 DRP/patient. The most common DRPs were drug interactions (31%), drug without indication (20%), need for monitoring (14%) and untreated indication (11%).

The most common recommended interventions were drug monitoring (30%), starting a drug (13%) and stopping a drug (13%), and advisory information was provided (17%). Overall, 22% of interventions were implemented. Identified barriers were lack of awareness of the pharmacists’ e-consults, limited time resources and the surgical setting.

The questionnaire confirmed the benefits, indicating patient safety, medicine optimisation and reduced workload for medical staff. The CPS was rated as ‘good’.

Conclusion and relevance The high prevalence of identified DRPs reflected the contribution of the CPS towards improved patient safety and care. The questionnaire highlighted the value and acceptance of the CPS by other health professions and identified barriers to further adaption. The acceptance rate can be perceived as successful considering the limitations of the short-on-site stay of surgical patients and the recent implementation of the CPS in April 2018. Hence the data showed clear benefits. The role of the clinical pharmacist within the central admission process should be further established to exploit further potential for CPS in this field.
Background and importance Medication errors at hospital admission are common, increasing morbidity and mortality. The pharmacist can help to prevent the occurrence of medication-related problems through medication reconciliation.

Aim and objectives To analyse the pharmaceutical interventions performed during the implementation of a medication reconciliation programme on hospital admission to reduce medication errors (ME).

Material and methods This was an observational prospective study (October 2018–September 2019). Patients older than 65 years who received at least five drugs and had more than 24 hours of admission in the general surgery and urology units were included. Variables considered were age, sex, number of prescribed drugs and ME. The best pharmacotherapeutic history was developed, including diagnosis, medical history and complete list of chronic home medication, consulting the electronic history programme of electronic prescriptions. This information was completed with an interview with the patient/caregiver. In the event of any discrepancy, the responsible doctor was contacted.

Results Medication reconciliation was conducted for 553 patients. Median age was 75 years and 56.6% were men. The average number of medications per patient at admission was 8.2. A total of 4567 drugs were reconciled, with a total of 2404 interventions in the discrepancies found: 1586 (65.9%) were justified while 818 (34.1%) were classified as unjustified or ME (omission (90.17%), dose (2.7%), frequency, schedule or route of administration (1.69%), therapeutic duplicity (1%) and other), with a degree of acceptance of 62%, correcting the discrepancy in most cases before 24 hours had elapsed. Communication with the doctor was done by electronic messaging in 91% of cases.

Conclusion and relevance We observed that during the medication reconciliation, numerous ME were detected, the majority of which were omission of medications. The involvement of the pharmacist, integrated into a multidisciplinary team together with doctors and nurses, allowed the detection of discrepancies, obtaining a high percentage of acceptance of the interventions, thus reducing ME. The medication reconciliation programmes allow the detection and resolution of discrepancies, preventing ME in healthcare transitions.

No conflict of interest.

REFERENCES AND/OR ACKNOWLEDGEMENTS


No conflict of interest.