

satisfaction of caregivers on this presence because few data are available on this issue. However, it seems important to better understand the expectations of staff and to target pharmaceutical activities to help improve the management of patients admitted to the emergency department.

Aim and objectives Our objectives were to collect caregivers' opinions on the role of the pharmacy intern as well as on the clinical pharmacy, regarding reorganisation of the pharmacies in international non-proprietary name (INN).

Material and methods A questionnaire was submitted to the 52 day nurses during a 10 day period in April 2018. The questionnaire had two parts: one concerning the activities of the pharmacy resident and their relevance to the improvement in patient care and another about the new pharmacy organisation and the role of the pharmaceutical team in helping caregivers to use it.

Results A total of 71% of day nurses answered the questionnaire: 92% were strongly satisfied with the pharmaceutical team's availability for answering their questions or helping them with treatments; 86% were strongly satisfied with the information given about the new organisation in INN and the equivalence table developed; 80% agreed that storing drugs based on INN was better even if it was harder; 100% strongly agreed that clinical pharmacy activities (medication reconciliation, pharmaceutical analysis) improve patient safety; and 96% thought strongly or very strongly that the pharmaceutical presence allowed better continuity of treatment.

Regarding transmission of information from the pharmacy (medicine shortages, new references) only 46% were very satisfied, and 8% were unsatisfied. Opinions were more divided for reporting side effects related to care or drugs: only 35% were strongly satisfied, 8% not enough and 19% did not have an opinion.

Conclusion and relevance The satisfaction of caregivers on the relevance of the presence of a pharmacy resident on the emergency ward was good overall. However, they considered that the transmission of information from the central pharmacy and the reporting of iatrogenic events were insufficient. The next step is to work on this to keep improving nurses' satisfaction.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-204 MEDICINE RECONCILIATION AT HOSPITAL DISCHARGE

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Background and importance It has been proven that an updated pharmacotherapeutic report means improvements in patient safety and system efficiency.

Aim and objectives To describe and analyse medicine reconciliation errors (MRE) and to determine awareness of prescribers of keeping the treatment report updated at medical discharge.

Material and methods This was a prospective study over a period of 17 weeks, involving all inpatients from the internal medicine ward (IM), cardiology ward (CAR) and oncology ward (ONC), for 8 weeks, 6 weeks and 3 weeks, respectively. Variables collected were age, sex, number of new medications, number of discrepancies not justified requiring clarification,

type of MRE, communicated MRE and number of acceptances, and number of patients that received pharmaceutical care at discharge. On admission, data were collected by the pharmacist from an interview with the patient. All detected discrepancies were communicated to the physician to modify and update the treatment before discharge. The pharmacist conducted a final interview, where all modifications and new drugs were explained. Updated treatment and discharge reports were given after resolving patient doubts.

Results A total of 151 patients were analysed with a mean age of 75±13 and 46.3% were women. The number of not justified discrepancies identified were 116, corresponding to IM 58.6% (68), CAR 27.6% (32) and ONC 13.8% (16). Classification of the discrepancies: dosage error 30.2% (35); not indicated or contraindicated for current clinical situation 24.1% (28); omission error 22.4% (26); commission error 16.4% (19); mistaken drug 1.7% (2); incomplete prescription 1.7% (2); and duplicity 3.4% (4). A total of 104 discrepancies were communicated and discussed with the physicians: 49% (51) of the discrepancies were accepted and 31.1% (47) of the discharge reports were incomplete, which means the dosage or duration of treatment and changes established were not included. New drugs were started in 74.8% of inpatients and pharmaceutical care was offered to 80.5% (91) before discharge.

Conclusion and relevance The pharmacist integration has facilitated the acceptance of pharmaceutical interventions and has prevented MRE on discharge, where the most prevalent one was dosage discrepancy. This has raised awareness among all professionals about the importance of updating the medical history. All concerns about discharge medication were resolved in almost 80% of discharges.

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4CPS-205 ASSESSMENT OF THE PALATABILITY OF ANTIBIOTIC ORAL SUSPENSIONS: A LITERATURE REVIEW

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Background and importance Non-adherence to a full course of antibiotic occurs in approximately 25% of paediatric patients. The child's refusal to take the drug is the second most common reason for non-adherence. Palatability is the third most important antibiotic feature for parents after effectiveness and safety.

Aim and objectives To review the literature for assessments of the palatability of antibiotic oral suspensions to inform physicians in their daily practice and consequently improve adherence.

Material and methods A systematic literature search was conducted in August 2019 in the Pubmed database. A study was eligible for inclusion if it reported an assessment of the palatability of one or more antibiotic suspensions with any assessment scale among adults and/or children. The lowest score was for poor palatability and the highest for excellent palatability. Study characteristics, population demographics and palatability assessments were extracted. For comparison purposes, all results are expressed on a 10 point scale. Averages were calculated for paediatric and adult populations.