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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

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.

Results Ten studies were identified, all blind: 6/10 with children, 3/10 with adults and 1/10 with both. Children were aged 4–12 years. Participants were healthy volunteers except in one study. Fourteen drugs were tested in children and 24 in adults for a total of 27 drugs tested. Visual analogic scale with 5 point facial hedonic scales (4/10), 5 point facial scales (5/10) or 10 point analogue scales (1/10) were used as the assessment tools. The average palatability was <5 for 3/14 and 12/24 drugs in children and adults, respectively. The palatability score was lower in adults than in children, 10 times out of 11. The average difference between the scores for adults and children was 1.1 point/10.

Conclusion and relevance The majority of the most common antibiotics were covered. Differences in assessment of palatability sometimes existed for the same molecule. This may be related to the formulation tested (brand name or generic drugs). A single study allowed a direct comparison between adults and children. Further investigations are needed to determine the factors affecting the palatability of drugs. However, the available palatability assessments can help the physician to choose between several drugs with the same effectiveness and safety to improve compliance.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-206 IMPACT OF MEDICATION RECONCILIATION IN COMPLEX CHRONIC PATIENTS

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Background and importance Medication reconciliation improves continuity of patient care by reducing prescribing errors.

Aim and objectives The aim of the study was to investigate the impact of medication reconciliation on complex chronic patients (CCPs) during their hospital stay.

Material and methods A retrospective study was conducted in a tertiary hospital. CCPs admitted for general and gastrointestinal surgery, angiology and vascular surgery, urology, nephrology and rheumatology were included in the study. Any CCPs admitted between December 2017 and February 2018 (control group, before the reconciliation implementation), and between December 2018 to February 2019 (intervention group, after implementing medication reconciliation) were included in the study. Patients received medication reconciliation during their admission, discharge and once in primary care. Data were obtained through electronic health records and were analysed with STATA14.

Results The study included 116 patients in the intervention group and 199 patients in the control group. There were no significant differences in age (75.3 years, $p=0.975$) or gender between the two groups (32.7% women; $p=0.217$).

Hospitalisation stay was, on average, 9.3 days for the intervention group (95% CI 7.6–11.0) and 8.9 days for the control group (95% CI 6.9–10.9) ($p=0.789$). Patient readmission within 30 days post-discharge was greater for those who did not receive a medication reconciliation (28.4% intervention group, 32.2% group control; OR=0.8; 95% CI 0.5–1.4).

Time until readmission was 12.8 days (95% CI 10.0–15.6) and 11.5 days (95% CI 9.9–13.1) for the intervention group and control group, respectively ($p=0.395$). The study also showed fewer emergency visits for patients who received medication reconciliation (0.27 visits) in comparison with the control group (0.33 visits) (OR=0.7; 95% CI 0.4–1.2).

Conclusion and relevance This study showed that medication reconciliation has the potential to decrease the number of readmissions within 30 days post-discharge, days until the next admission and emergency visits. Overall, the results of the study showed the positive impact that medication reconciliation has on complex chronic patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

4CPS-207 TREATMENT ADEQUACY IN DOMICILIARY CARE PROGRAMME PATIENTS

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Background and importance In our area, 77.2% of patients in the domiciliary care programme (ATDOM) are polymedicated and therefore have greater morbidity.

Aim and objectives To analyse a medication plan (MP) review based on criteria of efficacy, efficiency and safety, adapting the treatments of ATDOM patients.

Material and methods This was a retrospective longitudinal study of a prospective cohort including ATDOM patients from a single health centre. Demographic variables (age and sex), type of incidents, proposals, acceptance, application or reasons for non-application, savings and polypharmacy reduction were collected. The pharmacist made proposals based on the clinical review of the MP. If the physician accepted the proposal, the patient/family member was informed for shared decision making. Applications were checked at 3 months.

Results Sample size: 122 of 142 patients were included, 84 (68.8%) women, aged ≥ 65 years. Excluded were 13 (9.1%) patients who died and 7 (4.9%) who were institutionalised.

There were 167 incidents involving 161 drugs and 79 (64.7%) patients: 70 (41.9%) related to indications, 49 (29.3%) to effectiveness–efficiency, 35 (21%) to adequacy and 13 (7.8%) to safety. Submitted proposals were 169, suggesting drug suspension in 118 (69.8%), dose change in 18 (10.6%), medication change in 14 (8.3%), therapeutic equivalent change in 12 (7.1%), monitoring in 5 (3%) and frequency change in 2 (1.2%).

For 11 (6.8%) drugs it was agreed that the change was not possible. The remaining 93.2% were accepted by the physician. A total of 76 (50.7%) changes were applied, resulting in an annual theoretical saving of 10 546€, and 74 (49.3%) were still pending, involving 49 patients. One patient's family did not accept the proposal, and 5 patients had not been visited. Drugs were reduced from 347 to 279 (19.6%) in 43 (54.4%) patients. Drugs per patient decreased