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