

**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

C Rodríguez Bernuz\*, A Morales Triadó, L Vilaró Jaques, A Martín Val, RA Fernández Fernández, A Vilaríño Seijas, S Cervero Corbella, C Oliveras Simón, C Quiñones Ribas. *Hospital Universitari Germans Trias I Pujol, Pharmacy, Badalona, Spain*

10.1136/ejhpharm-2020-eahpconf.307

**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

<sup>1</sup>C Salom\*, <sup>1</sup>C Campabadal, <sup>2</sup>I Muiño, <sup>3</sup>C Carrillo, <sup>1</sup>F Bejarano, <sup>1</sup>N Marco, <sup>4</sup>J Del Estal, <sup>5</sup>MP Muniain, <sup>4</sup>MÁ Roch, <sup>5</sup>L Palacios, <sup>5</sup>L Canadell. <sup>1</sup>Dap Camp De Tarragona-Ics, Pharmacy, Tarragona, Spain; <sup>2</sup>Ap Camp De Tarragona-Ics, Eap Salou, Tarragona, Spain; <sup>3</sup>Dap Camp De Tarragona-Ics, Computing, Tarragona, Spain; <sup>4</sup>Hospital Joan XXiii, Pharmacy, Tarragona, Spain; <sup>5</sup>Dap Camp De Tarragona-Ics, Management, Tarragona, Spain

10.1136/ejhpharm-2020-eahpconf.308

**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  $\geq 65$  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

from 8.1±3.2 to 6.5±3.2, which is a reduction of 1.6 drugs/patient.

**Conclusion and relevance** Physician acceptance of the proposals was high, but almost one half were not carried out despite having been visited. Most pending proposals could be due to organisation or registration mistakes. Suggestions for improvement: (1) to stratify patients according to clinical characteristics that allow prioritisation; (2) to add in situ review of the drug's kit at home, thus allowing a thorough check, including adherence, isoappearance, conservation and administration.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

#### 4CPS-208 NUTRITIONAL SUPPORT IN ONCOLOGY: A CROSS SECTIONAL STUDY AMONG CANCER PATIENTS

<sup>1</sup>Y Samouh\*, <sup>2</sup>A Benider, <sup>3</sup>S Derfoufi. <sup>1</sup>Faculty of Medicine and Pharmacy-Hassan II University-Casablanca-Morocco, Laboratory of Drug Science-Biomedical Research and Biotechnology-Faculty of Medicine and Pharmacy-Hassan II University-Casablanca-Morocco, Casablanca, Morocco; <sup>2</sup>Faculty of Medicine and Pharmacy-Hassan II University-Casablanca-Morocco, Mohammed VI Centre for the Treatment of Cancers-Ibnrochd University Hospital Centre-Casablanca-Morocco, Casablanca, Morocco; <sup>3</sup>Faculty of Medicine and Pharmacy-Hassan II University-Casablanca-Morocco, Pharmacy Unit of Ibn Rochd University Hospital Centre-Casablanca-Morocco, Casablanca, Morocco

10.1136/ejhp-pharm-2020-eahpconf.309

**Background and importance** Malnutrition is a high risk health complication that occurs with cancer. Deterioration of nutritional status in cancer patients increases morbidity and mortality, decreases the efficacy and tolerance of oncology treatments and decreases quality of life. Patient information and knowledge of their illness, treatment and nutrition allows them to participate in their own care, manage undesirable effects and prevent malnutrition.

**Aim and objectives** To evaluate the prevalence of malnutrition, and to assess nutritional knowledge and eating habits in cancer patients.

**Material and methods** This was an observational descriptive study based on a questionnaire, conducted in the unit of oncology at a university hospital centre. Malnutrition was defined as a body mass index (BMI) <18.5 in patients aged <75 years old or <21 in patients aged ≥75 years old.

**Results** A total of 216 questionnaires were analysed. The extremes of age ranged between 28 and 79 years with an average age of 44 years. Objective evaluation of nutritional status showed that 48% of patients were malnourished. Our population of patients had poor knowledge of the nutritional problems caused by cancer, with a rate of 78%, and 88% did not benefit from nutritional monitoring by a dietitian. The most common causes of the decline in food intake were loss of appetite (84%), taste loss (45%), nausea and swallowing disorders (26%), loss of smell (19%), vomiting (18%) and abdominal pain (15%).

**Conclusion and relevance** The prevalence of malnutrition was high in patients with cancer, and nutritional care seemed insufficient. An improvement in the information tools on nutrition and cancer available to patients is required.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

#### 4CPS-209 AN EXPLORATION INTO A PHARMACIST-LED MEDICINES RECONCILIATION SERVICE IN AN ACUTE HOSPITAL SETTING

<sup>1</sup>C Shine\*, <sup>2</sup>M Kieran, <sup>3</sup>C Meegan. <sup>1</sup>Mater Misericordiae University Hospital, Pharmacy Department, Dublin 7, Ireland; <sup>2</sup>MMUH, Pharmacy, Dublin, Ireland; <sup>3</sup>Mater Misericordiae University Hospital, Pharmacy, Dublin, Ireland

10.1136/ejhp-pharm-2020-eahpconf.310

**Background and importance** Accurate medication records are essential in preventing errors, avoiding harm, aiding diagnosis and treatment planning. Prescribing errors are more prevalent on hospital admission.<sup>1</sup> Medicines reconciliation (MR), 'the formal process in which healthcare professionals partner with patients to ensure accurate and complete medication information transfer at interfaces of care', ensures accurate medication record generation.<sup>3</sup> MR is undertaken to varying degrees in many institutions, by a variety of healthcare professionals, each with their own focus, priorities and methods.<sup>4</sup> MR is a WHO patient safety priority outlined in the High 5s Project.<sup>3</sup> **Aim and objectives** To determine views and opinions of doctors towards a pharmacist-led MR service in an acute hospital and to ascertain what doctors identify as MR barriers and facilitators.

**Material and methods** A self-completion questionnaire using mixed methodology was conducted. This involved analysing data both qualitatively and quantitatively. Data were collected simultaneously. Inclusion criteria: all doctors working at the Mater Misericordiae University Hospital (MMUH). Exclusion criteria: none. Data were analysed on site using a password protected spreadsheet on Microsoft Excel. Detailed content and thematic analysis were performed to identify common concepts. A 10% proportion of the data was checked by an independent reviewer

**Results** The positive impact on patient care and safety demonstrated by MR was acknowledged by 98% (n=50): 94% (n=49) agreed MR saved them time while 92% (n=48) recognised MR decreased their workload, 90% (n=46) of participants were satisfied with the MMUH MR service and 94% (n=49) agreed MR was accurate. Participants called for dedication of pharmacy resources to MR (88%, n=46), and service expansion to include all patients on admission, care transition and discharge was advocated by participants (79%, n=41; 86%, n=44; and 79%, n=41, respectively). The most important facilitator was verbal communication of MR discrepancies. The most important barrier was current service limitations. Thematic analysis identified four themes: patient safety (n=33), workload implications (n=9), MR usefulness (n=52) and service development (n=56).

**Conclusion and relevance** Prescribers viewed the pharmacist-led MR service as a positive useful initiative, saving prescribers time, and increasing patient care and safety hospital wide.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

1. Porcelli PJ, Waitman LR, Brown SH. A review of medication reconciliation issues and experiences with clinical staff and information systems. *Appl Clin Informatics* 2010;**1**:442-461.
2. FitzGerald RJ. Medication errors: the importance of an accurate drug history. *Br J Clin Pharmacol* 2009;**67**:671-675.
3. World Health Organization. *Standard operating protocol assuring medication accuracy at transitions in care*, 2014.
4. Barnsteiner JH. Medication reconciliation. In: Hughes RG, editor. *Patient safety and quality an evidence-based handbook for nurses* 2008;**38**:2-459.

No conflict of interest.