

In 1992, 19 ADRs were notified, a value that progressively increased over the years, reaching its highest in 2003 (84 ADRs). In 2004 it decreased to 46, remained constant (mean 35.7 ± 9.7) and then declined to 31 in the last year.

Conclusion and relevance More than one-third of ADRs were serious, but most patients recovered without sequelae. Most notifications to the RPC come from the MDS-H, but a significant number were detected by health staff and HP. In recent years, reported ADRs has decreased, so the HP could be an essential element to develop the pharmacovigilance programme, which is key to improving the safety of medicines by promoting relevant modifications in the technical data sheets and issuing alerts from the Spanish Agency for Medicines and Health Products.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-105 PREVENTING FALLS IN ORTHOGERIATRIC PATIENTS BY MANAGING THEIR THERAPEUTIC PROFILES

¹R Oliveira*, ¹T Lobo, ²L Marques, ³A Pereira, ¹C Santos. ¹Beatriz Ângelo Hospital, Pharmacy Department, Loures, Portugal; ²Beatriz Ângelo Hospital, Medicine Department, Loures, Portugal; ³Beatriz Ângelo Hospital, Orthopaedic Department, Loures, Portugal

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Background and importance Elderly people are polymedicated due to their multiple comorbidities. The risks of polypharmacy can be higher than the benefits. Some medicines, labelled 'increasing risk of fall drugs', such as benzodiazepines, antidepressants and antipsychotics, are among the major causes of falls. Thus in order to prevent unnecessary falls and their consequences, there is an urgent need to review patients' therapeutic profiles and to adapt to the real needs of each patient. The orthogeriatric hospital unit was created to provide multidisciplinary care to patients aged >65 years with a hip fracture admitted to hospital.

Aim and objectives To review and optimise the therapeutic profile of patients admitted to the orthogeriatric unit, during hospital admission and follow-up appointments, to prevent the recurrence of falls and fractures.

Material and methods An observational, retrospective, cohort study was conducted in patients aged >65 years admitted to the emergency service with a hip fracture, between the 1 January 2019 and 30 June 2019. These patients were admitted to the orthogeriatric unit during hospitalisation and scheduled for follow-up appointments. Their medication profile was obtained via the digital medical record and the national platform of healthcare. Descriptive statistics was used to summarise the data.

Results A total of 162 patients met the criteria, 75% were women (n=121) and median age was 84 years. The average length of stay was 12.4 days. In 30% (n=48), inappropriate medicines were considered the most likely cause of the fall. During hospitalisation, 316 drugs were suspended and 516 were initiated. Of the 162 patients, 80 already attended follow-up appointments with the general practitioner. From these, 19% (n=15) restarted the inappropriate drugs that were suspended.

Conclusion and relevance It is possible to conclude that the majority of patients had inappropriate drugs in their

therapeutic profile. Although only 30% of the patients had medicines as a precipitant factor for the fall, almost every patient had one or more 'increasing risk of fall drugs'. Therefore, these drugs were discontinued to prevent new falls.

A considerable percentage of patients restarted the suspended drugs. Consequently, there is a need to find a better strategy to prevent this occurrence.

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5PSQ-106 ANALYSIS OF HANDLING OF HAZARDOUS DRUGS IN A NURSING HOME

A Peláez Bejarano*, R Sánchez Del Moral, O Montero Pérez, IM Carrión Madroñal. Hospital Universitario Juan Ramón Jiménez, Farmacia Hospitalaria, Huelva, Spain

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Background and importance Hazardous drugs (HD) are those that exhibit one or more of the following six characteristics in humans or animals: carcinogenicity, teratogenicity or other developmental toxicity, reproductive toxicity, organ toxicity at low doses, genotoxicity, and structure and toxicity profiles of new drugs that mimic existing drugs, determined hazardous by the above criteria. Exposure to HD in the workplace could lead to serious health risks, which increase with exposure frequency. Therefore, it is crucial to limit exposure with appropriate equipment.

Aim and objectives To identify HD used in a nursing home and to analyse the use of appropriate self-protection measures by nursing staff.

Material and methods A prospective, observational study was performed in a nursing home over a 1 month period. Direct observation was carried out about how nursing staff handled HD. These drugs were identified through the medication sent to the nursing home and were categorised according to reference documentation (NIOSH and INSST (group 1, 2 or 3)). Data collected were, for the nursing staff, age, sex, staff at reproductive risk and use of personal protective equipment (PPE) during HD handling. Use or not of hazardous drug waste containment was also collected.

Results A total of 152 drugs were sent weekly to the nursing home, of which 11 were HD: acenocoumarol, bicalutamide, carbamazepine, clonazepam, spironolactone, lamivudine, paroxetine, risperidone, tacrolimus, topiramate and valproic acid (18% group 1, 36% group 2 and 46% group 3). Nursing staff comprised 24 workers, 14 women (58.3%) and 10 men (41.7%), with a median age 41 years. Personnel at reproductive risk were 10 (66.7%): 7 women and 3 men. All staff used PPE insufficiently: they did not wear double gloves when handling HD or goggles with side shields when splashing was a possibility. Waste disposal was inadequate in 100% because of containers used were incorrect.

Conclusion and relevance Mishandling of HD was widespread: nursing staff did not use PPE as recommended by the administration guidelines for HD. There was no awareness of suitable waste disposal. Pharmaceutical interventions could decrease the potential risk of occupational exposure.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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