

recorded. The pilot phase was started in September 2018, and ended in November 2018. Detailed information on antibiotic therapy and the 48-72-hour revision and its outcome were also documented. Pharmacist interventions and their acceptance were collated. Microsoft Excel and R-Commander were used for data management and analysis.

Results 69 patients were involved in our study, 45 men and 24 women (mean age was 57.7 years \pm 16.4 years and 71.3 years \pm 12.5 years). Overall, 84 antibiotic therapies (50 empirical and 34 targeted) were evaluated. 21 different antimicrobial agents were prescribed, the most frequent were cefuroxime (21 cases) and amoxicillin-clavulanic acid (15 cases). Based on clinical pharmacist and infectologist follow-up decisions, 44 cases (52%) of all antibiotic therapies were inappropriate. Initial antibiotic therapies weren't optimal in 29 cases (35%), mainly due to the unnecessarily wide spectrum of the chosen drug (65% of initial inappropriate therapies). Therapeutic decisions at the revision point were inappropriate in 32 cases (38%). Pharmacist interventions were offered in 50 cases, most frequently de-escalation (16 cases), and parenteral-oral conversion of the therapy (15 cases). The interventions were actioned in 60% of the cases. Higher rates of interventions were accepted when modification of the dose was advised (87%) and lower acceptance when de-escalation was suggested (31%).

Conclusion and relevance The audit gives the pharmacist an opportunity to give continuous feedback to prescribers in order to improve their compliance with the ASP guidelines. The relatively high rate of inappropriate antibiotic prescriptions shows a need for improvement in this area. Longer term, an improved synergy between clinical pharmacists and prescribers may result in an increased acceptance rate of pharmacist interventions.

ACKNOWLEDGEMENTS

<https://www.ashp.org/Products-and-Meetings-Aliases/The-Pharmacists-Guide-to-Antimicrobial-Therapy-and-Stewardship> https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/417032/Start_Smart_Then_Focus_FINAL.PDF

NP-005

IMPLEMENTING MEDICATION RECONCILIATION ON HOSPITAL ADMISSION: A MULTICENTRE PILOT STUDY IN ESTONIA AND FINLAND

¹L Randmäe*, ¹M Saar, ²L Hussar, ²K Nael, ³K Kanal, ⁴E Sepp, ⁵A Warttinen, ⁵M Rouvinen. ¹Tartu University Hospital, Tartu, Estonia; ²Pärnu Hospital, Pärnu, Estonia; ³Järvamaa Hospital, Paide, Estonia; ⁴Valga Hospital, Valga, Estonia; ⁵Päijät-Hämeen hyvinvointikuntayhtymä, Lahti, Finland

10.1136/ejhpharm-2020-eahpconf.463

Background and importance Transitions of care have been determined to be one potential source of errors, especially in relation to medications. WHO has pointed out the need to improve patient safety at transitions for many years as the probability of communication errors increases with a patient moving between facilities, sectors and staff. Almost two thirds of medication errors happen at transitions of care and these mistakes expose patients to medication-related problems and adverse drug events.

Aim and objectives To assess the effect of pharmacist-led medication reconciliation and to evaluate if a hospitalised patient's medication history is accurately recorded.

Materials and methods Medication reconciliation was performed by the pharmacist within 24 hours after the patient's

admission to the nursing, internal medicine or surgical ward using the validated data collection form in 5 hospitals.

Results A total of 101 patients were included in the pilot study with a mean age 73 years. A total of 218 medication discrepancies (MD) were revealed and 80% patients had at least one MD, a mean of 3.74 MDs per patient among those having MDs. 65% MDs were identified as unintentional MDs and they affected 54% patients with a maximum number of 10 discrepancies per patient case. 41% of MDs were considered clinically relevant by the joint decision of the pharmacist and the prescriber and the patient's medication list was modified. The most common discrepancies were drug omission (50%), relating food supplements (14%), incorrect dose (10%) and frequency (5%). Older female patient taking at least 5 medications had the highest probability of discrepancies to arise.

Conclusion and relevance The results indicate that the process of collecting medication history needs improvement by implementing medication reconciliation as in 80% of cases patients' medication list obtained by the pharmacist and nurse were not a complete match and half of the patients had at least one unintentional medication discrepancy. This finding is similar to other studies regarding medication reconciliation.

NP-006

A PAIR OF PHARMACY TECHNICIAN/NURSE TO TRAIN ON THE ANTI-RETURN VALVES

¹J Villain, ¹C Toullic, ¹M Moenaert, ²J Charles, ¹P Drancourt, ¹J Boyer. ¹Pôle Pharmacie, Service des Dispositifs Médicaux Stériles, Centre Hospitalier de Valenciennes, France; ²Service Neurologie, Centre Hospitalier de Valenciennes, France

10.1136/ejhpharm-2020-eahpconf.464

Background and importance The training of nursing staff is a major issue in hospitals. In the cardiology intensive care unit, an audit showed a lack of knowledge of the health care staff about the use of anti-return valves.

Aim and objectives The aim is to make nurses aware of the proper use of anti-return valves by a fun and practical training delivered by a pharmacy technician and a nurse of another care service.

Materials and methods Training was developed, along with a pre/post knowledge assessment (three questions) and a satisfaction questionnaire. It has two clinical cases. The first compares in real time and interactively the fluid movement of two assemblies, one of which contains an anti-return valve undergoing obstruction of the perfusion. The second one has to objective to let them mounting an infusion line by positioning the anti-return valves. After qualification by a pharmacist, the pharmacy technician/nurse pair then formed the cardiology intensive care team.

Results The duration of training for the capacitation of the pair was 2h30.

Six 30-minutes sessions were conducted to train 16 nurses (100% of the staff).

The pre-training questionnaire average was 8.7/20 and in post-training 16.2/20, which is a statistically significant improvement in knowledge (p-value<0.05). 100% of the nurses were satisfied with the training (content, pace, duration).

Regarding the pair of trainers, the completion of the training allowed the nurse to discover the practices in another department and the pharmacy technician to work in

collaboration with the nursing staff taking into consideration the difficulties they may encounter.

Conclusion and relevance This training made it possible to raise awareness of the proper use of the anti-return valves to secure them in a secure way. It has helped to foster collaboration between pharmacy preparers and the nursing staff, the nurse bringing his technical knowledge of the care and the pharmacy preparer on the equipment. A post-training audit will be organized within a few months in the cardiology intensive care unit.

On the strength of this success, we wish to continue the development of trainings dispensed by a pharmacy technician and a nurse of another care service.

NP-007

A MIXED METHODS EVALUATION OF THE CROSS-SECTOR PHARMACIST VOCATIONAL TRAINING FOUNDATION PROGRAMME: IS THE TRAINING PROGRAMME FIT FOR PURPOSE?

¹FJ McMillan, ¹A Power, ²C Bond, ²J Clelland, ²J Inch. ¹Pharmacy, NHS Education for UK; ²Aberdeen University

10.1136/ejhp2020-eahpconf.465

Background and importance Pharmacists increasingly have portfolio careers, in different settings, including hospital, community and primary care.

Aim and objectives A cross-sector Pharmacist Foundation Training programme was introduced in Scotland from September 2017¹ to develop transferable skills and competences for pharmacists working in these sectors. The aim was to assess the effectiveness of the programme.

Materials and methods The approach was underpinned by two theoretical frameworks.^{2,3} Pharmacists and tutors were invited to take part in focus groups at baseline, mid, and end-of-training, to explore their experiences. Proceedings were audio-recorded and transcribed. On-line baseline and end-of-training self-assessment questionnaires and routine assessment data were analysed.

Data was managed in nVIVO v11 and analysed thematically. Quantitative data from the questionnaires and assessments was analysed in SPSS and Excel.

Results Of the 72 registered FPs, 48 (67%) completed a baseline questionnaire. Twenty pharmacists (28%) and 16 tutors attended a focus group. Preliminary focus group themes include training/support needs, professional identity, patient safety, and training barriers/facilitators. Tutors highlighted skill gaps and noted variation in competence, training and support needs.

Questionnaire analyses suggest that pharmacists feel part of the team. They are confident communicating with patients/carers, meeting their needs, and managing pharmaceutical care issues, but have less confidence dealing with supply chain issues or applying local formularies.

Conclusions and relevance Baseline data suggests pharmacists' high self-assessed competence is not matched by reflective focus group discussions or tutor feedback. Ongoing evaluation will confirm if the programme has enabled the development of the requisite competences for future practice.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. The Pharmacist Vocational Training programme. <https://www.nes.scot.nhs.uk/education-and-training/by-discipline/pharmacy/pharmacists/pharmacy-vocational-training.aspx> Accessed August 2018
2. Miller GE. The assessment of clinical skills/competence/performance. *Academic Medicine* 1990;**65**(9). September Supplement.
3. Lave J, Wenger E. *Situated learning: legitimate peripheral participation*. Cambridge: Cambridge University Press; 1991.

NP-008

MONITORING OF PRESCRIPTIONS ON PROPHYLAXIS OF VENOUS THROMBOEMBOLISM (VTE) IN MEDICAL PATIENTS IN BEATRIZ ÂNGELO HOSPITAL

F Tátá*, P Cardoso, L Soares, R Figueiredo, T Lobo, M Capoulas, A Loba, E Marques, C Santos. Hospital Beatriz Ângelo, Loures, Portugal

10.1136/ejhp2020-eahpconf.466

Background and importance VTE is an important public health problem because of its impact in terms of morbidity, mortality, and associated costs. VTE prevention is a priority strategy to improve patient safety. More than half of all hospitalised patients are at risk for VTE. Previous studies have reported overall VTE prophylaxis rates ranging from 13% to 64%.

Aim and objective To assess the risk of VTE in patients hospitalised for medical pathology, using clinical records using the *Padua score*. Classify patients according to prescription, risk factors (RF) and contraindication (CI). To verify the use of a VTE risk assessment model. Create a computer application with the *Padua score* and integrate it into the prescription program.

Materials and methods Descriptive observational study during September in the medical patients admitted with age ≥ 18 years. Patients were classified according to the *Padua score*, LMWH prescription and contraindications in 5 populations: (a) with prescription and without RF or CI, (b) without prescription and with RF (c) with an unadjusted dose (d) with prescription and with RF, (e) without prescription and without RF or CI. Pharmaceutical intervention was performed in patients classified in (a), (b) and (c), pharmaceutical intervention, medical justification and information on the use of a VTE evaluation model were recorded.

Results Of the total number of patients (218), 66.5% had a risk of VTE of these 58.7% had no CI for pharmacological prophylaxis. Of the 58.7%, 42% do not have prescription of prophylaxis or have dose misfit. Of the population without risk of VTE 35.6% have a prescription of prophylaxis. Of the population at risk of VTE and cancer, 39% do not have prophylaxis whereas in the population at risk of VTE and without cancer, 18% have no prescription. A pharmaceutical intervention was performed in 81% of the prescriptions with an acceptance rate of 29%.

Conclusion and relevance According to the results, 42% of the patients do not have prophylactic prescription or have an unadjusted dose. In patients with score ≥ 4 and without CI, the prophylaxis percentage is lower in cancer patients. The vast majority of physicians still do not use a VTE risk assessment model. The application with *Padua score* was presented to physicians.