

Conclusion and relevance During the first wave of the SARS-CoV-2 pandemic, activity related to the validation of inpatients treatments increased significantly in our centre. The acceptance rate of interventions was not collected but it should be considered for future studies. The therapeutic groups involved in the pharmaceutical interventions differed between the P and pre-P periods. In the P period, those related to antiparasitic drugs (which includes hydroxychloroquine) increased significantly. Types of interventions were also different between both periods. In the P period, the interventions related to drug interactions and excessive durations of treatments were the most frequent. Both types were interventions related to the safety of treatments during the pandemic.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-373 PHARMACEUTICAL CARE IN HOSPITALISATION UNITS: ANALYSIS OF INTERVENTIONS

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Background and importance The roles of hospital pharmacists have been expanded from dispensing to patient care. Establishing interprofessional collaboration between pharmacists and other specialists significantly improves the quality of patient care.

Aim and objectives To analyse pharmaceutical interventions (PIs) carried out in a preliminary phase of a pharmaceutical care programme targeting hospitalised patients.

Material and methods A retrospective descriptive study of PIs was carried out in a tertiary referral hospital (529 beds) over a 1 year period, from January to December 2019. The pharmaceutical care programme was conducted by five pharmacists involving 14 hospitalisation units. Data were obtained from the electronic medical record. Variables included were: number of patients susceptible of monitoring, number of PIs, PIs per patient, type of PI, PIs per hospitalisation unit and acceptance rate. PIs included resolution of issues raised by specialists and proactive recommendations and were performed in the electronic prescription programme (Farmatools). The PIs were registered and classified into eight groups: pharmacokinetic monitoring, dose adjustment in renal failures, clinically relevant interaction, medical reconciliation error, prescribing error, information to prescriber, adverse drug reaction and other.

Results 1102 PIs were performed in 868 patients during the study period (1.3 PI per patient): 19.7% (216) were related to pharmacokinetic monitoring, 19.1% (210) to dose adjustment in renal failure, 14.1% (155) to clinically relevant interactions (categories D and X of Lexicomp), 11.2% (123) to medical reconciliation errors, 10.4% (115) to prescribing errors, 10.3% (114) to information to prescribers, 7.6% (84) to adverse drug reactions and 7.7% (85) other. Regarding PIs per hospitalisation unit: 12.4% were related to pneumology, 11.9% to internal medicine, 9.2% to neurology, 9.1% to general surgery, 8.4% to urology, 8% to traumatology, 7.7% to digestive, 7.3% to vascular surgery, 7% to cardiology, 5.4% to

neurosurgery, 5.1% to oncology, 4% to heart surgery, 3% to psychiatry and 1.5% to intensive care unit. The acceptance rate was 78.6% (866).

Conclusion and relevance The acceptance rate was high, which indicated considerable concern by the majority of hospitalisation units. The clinical pharmacist's integration into hospitalisation units improved the quality of patient care, especially through pharmacokinetic monitoring and dose adjustment in renal failure.

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4CPS-374 A SCREENING MODEL TO IDENTIFY ELDERLY POLYPHARMACY PATIENTS THAT MAY BENEFIT FROM PHARMACIST LED MEDICATION REVIEW DURING HOSPITAL ADMISSION

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Background and importance The National Health Authority calls for initiatives ensuring that relevant elderly polypharmacy patients receive medication reviews during hospital admission to reduce the risk of adverse events. Potentially inappropriate medications (PIMs) are one of the most frequent causes of adverse events in older people. Pharmacist led systematic medication reviews are time consuming, and while hospital length of stay has progressively reduced to an average of a few days, the effort has to be aimed at PIM interventions that are best suited to being carried out by a hospital physician.

Aim and objectives The purpose of the study was to develop a screening model to identify patients who may benefit from a pharmacist led medication review in hospital.

Material and methods A screening model was developed using PIMs described in the international literature and the workflow of pharmaconomists and clinical pharmacists in local hospitals. The screening model was applied to all elderly polypharmacy patients admitted to bed wards having pharmaconomist medicine management in five hospitals. Patients fitting the model were identified by pharmaconomists and referred to a pharmacist led medication review. The pharmacist led medication review was performed centrally with the aim of reducing the number of drugs, number of PIMs and complexity of the medication regimen. The primary outcome was the number of PIMs at discharge compared with the number of PIMs at admission to hospital.

Results The screening tool in the model comprised 10 medication focus points and demonstrated a specificity of 78% and sensitivity of 80% in detecting the relevant patients when applied to a cohort of elderly polypharmacy patients. From April to June 2018, 17 631 patients were screened using the tool. The pharmaconomists referred 396 patients to the pharmacists (average age 78 years, 52% women). Of these, 229 received a pharmacist led medication review (average of 2.78 interventions/patient). For the 115 patients with a possible follow-up, the average number of PIMs/patient was significantly reduced ($p < 0.001$) from 2.02 PIMs at admission to 1.57 PIMs at the end of hospital admission.

Conclusion and relevance The screening model developed detected relevant elderly polypharmacy patients for a