4CPS-393 IMPACT OF MULTIDISCIPLINARY TEAM INTERVENTION IN MEDICATION RECONCILIATION FOR GERIATRIC PATIENTS

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Background and importance Records of prescribed medication in the primary care setting have a high level of discrepancies regarding the medication that geriatric patients are really taking, when they are consulted at the hospital level.

Aim and objectives To review the rate of discrepancies between medication prescribed at the primary care level and medication that patients really need to take, in the geriatric population consulted with a multidisciplinary team in the hospital setting.

Material and methods An ambispective study was carried out by a multidisciplinary team (nurse, geriatrician, pharmacist) in all patients at a geriatric specialised outpatient office attended by a doctor in the hospital level setting, during the first fortnight of January 2020. An interview with every patient was carried out by a nurse, who was responsible for documenting in the medication records what every patient was really taking in that moment. Afterwards, a geriatrician made an evaluation of the clinical situation and adjusted treatment accordingly in every patient who attended. The pharmacist was then responsible for reconciliation of the medication. Demographic data, number of drugs prescribed, types of discrepancies and rate of acceptance by the physician were collected.

Results 34 patients, median age 85.5 years, were reviewed (8 men, 26 women), with a median of 10 (IQR 8.25–14) drugs prescribed. 61 discrepancies were detected with a mean of 1.8/patient (IQR 0–4). These discrepancies were: 47 (77.05%) inappropriate dosage, 8 (13.11%) drug omission, 2 (3.28%) drug duplication, 2 drug interaction and 2 commission. 46 discrepancies were reconciled with Turriano (tool for prescribing drugs in the primary care setting by general practitioners): 9 (19.56%) interventions adding drugs to the prescription, 15 (32.60%) referrals for drug discontinuing and 22 (47.82%) proposals to change the dosage. The remaining 15 were not accepted: 8 were unfunded drugs, 4 posology was conditioned to the clinical situation (intentional discrepancies), 2 due to ignorance of the prescription and 1 due to a computer problem. Only 4 patients (11.76%) did not present any discrepancy.

Conclusion and relevance The high percentage of patients with discrepancies in Turriano represents a significant safety problem for patients. In this study, a large number of discrepancies were found and corrected, leading to an improvement in quality of treatment and patient safety. These interventions are essential in elderly, multipathological and polymedicated patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-394 EVALUATION OF THE DEGREE OF THERAPEUTIC KNOWLEDGE IN LUNG TRANSPLANT RECIPIENTS

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Background and importance Lung transplant (LT) recipients require intensive and continuous care due to the complexity and relevance of pharmacological treatments in the clinical course after transplantation. Acute rejection, infections and side effects of immunosuppressants are common, especially during the first year after transplantation. Patients must acquire knowledge and skills that allow them to actively participate in the control of their 'new disease'.

Aim and objectives To analyse the degree of LT recipient knowledge about their treatment in the immediate post-transplant period and to identify weaknesses and characteristics of the patients.

Material and methods A prospective observational study was conducted from June to December 2019, corresponding to the pilot phase of an e-learning programme in LT recipients (e-duca). We designed a 25 multiple answer question test which was completed by the patients before post-transplant discharge. Variables studied were: age, gender, LT indication, educational level, number of drugs prescribed at discharge, test score (TS) and answers correctly with more or less frequency. We considered a high degree of knowledge as a TS $\geq$20, moderate 13–20 and deficient <13.

Results 16 patients were included with a mean age of 61.4 years (48–68) and 81.3% (13) were men. The LT indication was COPD in 56.3% (9), idiopathic pulmonary fibrosis in 37.5% (6) and bronchiectasis in 6.2% (1). Educational levels were university (3), secondary (4) and basic (9). The average number of drugs prescribed at discharge was 14.31 (9–20). Mean TS was 14.56 (6–22), equivalent to 58.2% of correct answers. 31.3% (5) of patients demonstrated a poor degree of knowledge, 62.5% (10) moderate and 6.2% (1) high. The most frequently correct answers were related to how to take tacrolimus and mycophenolate (87.5%) and the function and duration of immunosuppressive treatment (93.8%). On the other hand, the least frequently correct answers were related to the role of adjuvant therapy: only to prevent infections (93.8%), to identify prednisone as immunosuppressant (56.3%) and acting correctly when vomiting after taking immunosuppressants (56.3%).

Conclusion and relevance This type of test allows us to know the patients' skills about their treatment and to identify which points need to be reinforced by the pharmacist as part of the healthcare team that attends to the patient. It also allows early detection of possible medication errors.

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