Background and importance Clinical pharmacists involved in critical care are well described in the literature. Additionally, a computerised physician order entry (CPOE) system reduces the incidence of medication errors, especially when it allows pharmacy validation. Despite these potential benefits, integrating new members and implementing new tools in an ICU team is a complex process and it can influence overall staff satisfaction.

Aim and objectives To assess the satisfaction of ICU doctors and nurses with the new critical care pharmacist role during the last 2 years and the new CPOE 1 year after implementation.

Material and methods A cross sectional study was carried out in September 2020 in a 18 bed medical/surgical adult ICU in a second level hospital. A 5 point Likert scale based survey (5=highest level of agreement) was electronically distributed to ICU staff. The surveys contained 17 Likert questions in three sections: pharmacist integration on ICU team; pharmacist role; and CPOE. The results were expressed as a percentage of the maximum score (a value ≥4). Demographic data and sections for comments were included. Cronbach’s alpha coefficient was performed to assess reliability. Data analysis was conducted using the SPSS statistical software 20.0.

Results 31/72 nurses and 15/18 doctors completed the survey (42% vs 83.3% response rate). Regarding the pharmacist’s integration, 100% of doctors versus 22.6% of nurses knew the pharmacist by name and 100% of doctors versus 71% of nurses considered pharmacists accessible professionals. Both considered the pharmacist as an important liaison between the pharmacy and ICU (100% vs 96.8%). Doctors were satisfied with statements such as timely resolution to drug related questions (100% vs 96.7%) and CPOE presents more advantages than disadvantages (80% vs 61.3%). Cronbach’s alpha statistical analysis indicated that the survey’s reliability was high (nurses 0.77, doctors 0.89).

Conclusion and relevance Physicians appreciated the clinical pharmacist’s work and its impact on daily clinical practice. Nurses gave lower scores, but nevertheless their role as an intermediary was highly valued. The evaluation of the new CPOE was satisfactory, however it is necessary to focus on nurses’ needs to improve the pharmacist service.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest
Hospital pharmacy services had to implement a telepharmacy programme in record time, to bring drugs closer to patients.

**Aim and objectives** To measure the impact of a telepharmacy programme in terms of direct and indirect costs and benefits for patients.

**Material and methods** A retrospective observational study was conducted in a tertiary level hospital between March and September 2020. The following variables were collected: number of remote dispensings, number of patients enrolled in the telepharmacy programme, population characteristics, drugs and storage conditions, average distance, and direct and indirect costs.

**Results** 13,216 remote dispensings were made relating to 4,090 active patients within the telepharmacy programme. This represented 51.21% of the total number of our outpatients (7,986). 50.81% (2,078) of the patients were women and represented 51.21% of the total number of our outpatients (7,986). 44.59% (5,894) of the total drugs sent were thermolabile drugs. The mean distance of the shipments was 41.7 (0.2–208) km. Establishing the ratio 0.226C/km, and 1 visit every 2 months to the hospital pharmacy service, direct costs would mean an average of 113.04C per year for patients. Establishing the 1 km/2 min relationship, the annual indirect costs represent 10.5 working hours: 7.7 hours as the average travel time and 2.8 hours as the average waiting time for face-to-face dispensings.

**Conclusion and relevance** Telepharmacy has become one more tool for dispensing treatments to outpatients with savings for the patient in terms of travel and waiting times. The time of confinement due to the pandemic has accelerated the inclusion of patients in this programme, reaching more than 50% in 6 months.

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4CPS-403 CHRONIC KIDNEY DISEASE PATIENTS AND POLYPHARMACY: HOW TO OPTIMISE AND SIMPLIFY PRESCRIPTIONS

1S Masucci*, 2G Soragna, 1G Cavallero, 1B Polara, 1C Vitale, 1A Gasco. 1AO Ordine Mauriziano-Umberto I, Hospital Pharmacy, Turin, Italy; 2AO Ordine Mauriziano-Umberto I, Nephrology Unit, Turin, Italy

Background and importance Patients with chronic kidney disease (CKD) are often characterised by the comorbidity of multimorbidity, which could cause complex drug prescriptions that lead to a higher risk of incorrect administration and serious drug–drug interactions (DDIs) and potentially inappropriate medications (PIMs). According to national recommendation No17 of the national health system (NHS), these patients need appropriate attention: a multidisciplinary team (clinical pharmacists–clinician–nurse) should systematically re-evaluate pharmacological therapies to simplify/harmonise treatments and increase patient adherence.

**Aim and objectives** The aim of this study was to improve a method to analyse pharmacological therapies, identify incorrect prescriptions and simplify therapies.

**Material and methods** The chosen method requires that the clinical pharmacist in the nephrological team collaborates to analyse 231 therapies of patients, is in charge of the advanced renal disease clinic, using an already identified information and communication technology (ICT) tool.1 Drugs, classified by anatomical therapeutic chemical class (ATC), and dosage units (DU) were counted and DDIs were investigated. PIMs and dangerous drugs were identified by Beers criteria and STOPP criteria.

**Results** 2,311 drugs and 2,695 DU were counted. Each patient was receiving 10±3.1 different medicines, corresponding to 12.1±8.1 DU/day. 91% of patients were taking 5 or more DU/day and 59.3% at least 10. Stratifying drugs by ATC class identified the following: 644 prescriptions for C02-

A114