less than 10 days. 8.8% needed critical care and stayed in the ICU for a median of 10.5 days (IR 6–16). The following drugs were prescribed as COVID-19 treatment during hospitalisation: lopinavir/ritonavir (86.8%), hydroxychloroquine (86.8%), corticosteroids (63.2%), ceftriaxone (58.8%), azithromycin (50%), tocilizumab (14.7%), remdesivir (4.4%) and anakinra (2.9%). One patient died and the rest were discharged to home.

Conclusion and relevance Patients who needed hospitalisation due to clinical worsening after being discharged from the ED were mostly middle age men with hypertension. About 80% were admitted for presenting with dyspnoea and rapid radiological progression. Less than 10% needed intensive care, and only one died. Most showed clinical improvement in less than 10 days and were discharged home. Drugs most commonly prescribed for COVID-19 were hydroxychloroquine, azithromycin and lopinavir/ritonavir.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-214 'UNIT DOSE': CLINICAL RISK MANAGEMENT OF COVID-19 PATIENTS TREATED WITH HYDROXYCHLOROQUINE

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Background and importance The use of unit dose (UD) has been proved to be a critical tool in supporting the phases of prescription, preparation and administration of therapies, and most importantly in the management of the COVID-19 emergency. All drugs managed in the UD are screened and validated by the pharmacist; during this stage, if any prescription presents a potential risk of adverse events for a patient, the pharmacist is required to insert notes requesting modification of the prescription. These notes provide information about the risk of potential errors such as therapy duration, dosage, administration frequency, interactions, therapeutic indications, dilution, type of formulation and double prescriptions.

Aim and objectives The aim of this work was to demonstrate the key role that pharmacists play in patient safety and clinical risk management, particularly in the prescription of hydroxychloroquine (HCQ) for COVID-19 patients.

Material and methods We analysed therapies from all patients managed with UD in the period 1 March 2020 to 31 July 2020, and reviewed the notes entered by the pharmacists. These notes were further divided based on the potential risk of event/error, latent/active and high and low risk (HR, LW), where high risk refers to potentially harmful events for the patient.

Results During the observed period, hospitalised patients receiving the UD regimen were 4649 patients, 413 resulting from COVID-19, including 231 men and 182 women, with a median age of 70 (20–99) years and average number of hospitalisation days of 19 (SD±17). In 334 (81%) prescriptions for these patients, one or more notes were reported from the pharmacist, including 283 HR and 51 LR. The total number of notes entered were 445, with 322 (72%) related to HCQ

interactions as follows: (1) 67% medicines that prolong the QT interval which can induce heart rhythm disorders (class IA and III antiarrhythmics, tricyclic antidepressants, antipsychotics, macrolides and quinolones); (2) 3% digoxin; (3) 20% antidiabetics; and (4) 10% antiepileptics.

Conclusion and relevance This study showed that in 72% of notes reported in advance by the pharmacist in the prescription, there was a HR of potential adverse events resulting from the interaction with HCQ. This led to interruption in the use of this drug, as subsequently confirmed by the decision of the EMA (29 May 2020) to recommend its use only in clinical trials.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-215 CLINICAL RISK MANAGEMENT THROUGH THE 'UNIT DOSE' SYSTEM

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Background and importance In clinical practice, the unit dose (UD) system allows minimisation of potential errors during prescription, preparation and therapy administration phases. In this context, the intervention of a pharmacist in clinical choices may optimise this process by assessing the appropriateness of prescriptions. At the time of UD therapy validation, the pharmacist takes part in the evaluation of the most appropriate therapeutic options through the inclusion of annotations on each individual prescription for each patient.

Aim and objectives The aim of this work was to demonstrate how the intervention of pharmacists in this process is essential for patient safety and improving clinical risk management.

Material and methods Therapies of all patients receiving the UD system in the period 1 March 2019 to 28 February 2020 were analysed, and all of the annotations included by the pharmacist were reviewed. The annotations were classified into seven subgroups, based on the type of potential errors identified regards: (1) duration of therapy; (2) dosage/frequency of administration; (3) interactions; (4) therapeutic indications; (5) method of reconstitution/dilution; (6) type of formulation; and (7) double prescriptions. These subgroups were further divided based on the potential risk of event/error, latent/active, and high and low risk (HR, LR) where high risk refers to potentially dangerous effects for patients.

Results In the observed period, 11 881 patients were admitted to the UD regimen, of whom 5414 carried one or more annotations by the pharmacist, requesting specific changes to the prescriptions. In particular, based on the indicated subgroups, 10 537 notes were inserted and divided as follows:

1. Notes 1235; (HR) 531 (43%); (LR) 704 (57%)
2. Notes 4558; (HR) 1595 (35%); (LR) 2963 (65%)
3. Notes 2329; (HR) 2073 (89%); (LR) 256 (11%)
4. Notes 192; (HR) 192 (100%); (LR) 0 (0%)

5. Notes 1396; (HR) 1368 (98%); (LR) 28 (2%)
6. Notes 603; (HR) 30 (5%); (LR) 573 (95%)
7. Notes 224; (HR) 137 (61%); (LR) 87 (39%)

From this analysis, 38% of prescriptions were modified as specifically indicated by the Pharmacist.

Conclusion and relevance This analysis demonstrated how the role of the pharmacist is critical in identifying potential errors that may occur at the time of prescription. This is necessary for minimising adverse effects for patients during specific therapeutic treatments.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-216 IMPLEMENTATION OF A MEDICATION RECONCILIATION PROGRAMME AS A PATIENT SAFETY STRATEGY

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Background and importance Medication errors (ME) are especially frequent in hospital emergency departments (ED). To minimise these ME, medication reconciliation programmes are established, which analyse and resolve the discrepancies detected in the medication regimen of the patient.

Aim and objectives To evaluate implementation of the reconciliation programme in the ED of a second level general hospital.

Material and methods An observational retrospective study was conducted. Records from patients admitted to the observation area of the ED from 1 January 2018 to 31 March 2019 and whose chronic medication was reconciled were studied. Information related to their chronic medication was collected from the hospital medical records, the primary care prescriptions and/or through an interview with the patient. Discrepancies were classified according to the SEFH consensus document, and categorisation of the potential harm associated with these ME was based on the NCCMERP index; the pharmacotherapeutic groups involved in these ME were also analysed.

Results 26.7% of patients admitted to the ED during the study period were reconciled (780/2921), with a mean of 10.14 medications per patient. A mean of 1.6 discrepancies per patient were detected; 40.52% were ME, two thirds of which resulted from the omission of chronic medication and 72.15% of errors reached the patient but did not cause harm. The drugs involved in a higher proportion of ME were drugs to treat cardiovascular disorders. From the total amount of pharmaceutical interventions performed, 49.25% were accepted by physicians.

Conclusion and relevance Due to the high average chronic drug intake of patients attending the ED and, therefore, the potential risk of ME, collaboration between physicians and pharmacists is crucial to ensure reconciled medication of patients, as a patient safeguard strategy and a standard of quality within the health system.

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No

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5PSQ-217 MEDICATION RECONCILIATION PROGRAMME OF THE COMPLEX CHRONIC PATIENT IN A TRAUMATOLOGY AND ORTHOPAEDIC SURGERY SERVICE AT HOSPITAL ADMISSION

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Background and importance Medication errors constitute an important health problem due to their clinical and economic impact. Management of the chronic polymedicated patient during hospitalisation is a highly relevant task in clinical practice.

Aim and objectives To quantify and analyse discrepancies and reconciliation errors (RE) in a traumatology and orthopaedic surgery service (TOS) through a medication reconciliation programme at hospital admission.

Material and methods A prospective study was conducted from January to September 2020. All hospitalised patients were reconciled during the first 24 hours after admission. Demographic and clinical data were collected: diagnosis, history of interest, allergies, analytical data and treatment. The number of no discrepancies, justified discrepancies (JD), not justified discrepancies (NJD) and type of NJD were counted. Discrepancies were classified according to the criteria established in the consensus document on terminology and classification in medication reconciliation of the SEFH. Accepted NJD were recorded, thus accounting for the RE. Drugs involved in the discrepancies and their classification by ATC group were also recorded. Information sources were the electronic prescription programme, electronic medical records and interviews with the patients. Data were analysed with Excel. For quantitative variables, mean (SD) were calculated, and the qualitative variables were expressed as frequencies.

Results 411 patients were reconciled (age 70.43±13.1 years; 62.5% women). 3479 medications were reconciled (8.4 medications/patient) and 2106 (60.5%) had no discrepancies. 1373 (39.5%) discrepancies were detected (JD 1146 (83%); DNJ 227 (17%). The most frequent NJD types were: omission (76%), different dose, route or frequency (19%), wrong medication (2.6%) and commission (1.3%). Of the NJD, 92% were accepted by the prescriber, considering EC, and therefore CDs represented 5.9% of the total number of reconciled medications. The most frequent ATC groups implicated were: cardiovascular system (37.4%), CNS (31.2%), digestive system and metabolism (6.6%), and blood and haematopoietic organs (5.72%). The drugs that most frequently presented RE were hydrochlorothiazide, metformin, bisoprolol, lormetazepam and enalapril.

Conclusion and relevance Medication reconciliation within the first 24 hours of admission is a useful tool to detect errors in prescription. Identification of the most frequent ATC groups in RE allows us to identify those drugs for which it is advisable to review the prescription when validating treatment in the TOS.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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