Background and importance

Readmission of elderly patients is an issue of concern for both healthcare professionals and health authorities. The observed rate of unscheduled 30 day readmission is up to 14% in patients aged 75 years or over. Moreover, the proportion of readmissions deemed avoidable is estimated at 23%. In elderly patients, falls are frequent and can lead to consultations in the emergency department (ED) or even hospitalisation. The proportion of people hospitalised after visiting the ED for a fall increases with age: from 25% at 65 years to almost half at 90 years. At the end of the index hospital stay, readmission of older fallers are thus challenging for the healthcare system.

Aim and objectives

To describe older patients hospitalised for falls and identify the risk of readmission in that population.

Material and methods

We conducted an observational, single centre, prospective study (from April to June 2019). Inclusion criteria were: patients aged 75 and over, admitted to the ED for falls and consenting to the study. For patients subsequently hospitalised, geriatric scores were determined (risk of readmission (ISAR) score), state of frailty, degree of autonomy (Katz score), and when appropriate, medication treatments were listed and compliance of patients was assessed (Girerd score).

Results

During this 3 month study, 154 patients were included (median age 86 years (min 75–max 103), sex ratio 0.44), of whom 73 patients were hospitalised. Among these patients, 45.2% were at risk of frailty; 72.6% were dependent. Finally, 53 of the 73 patients (72.6%) had medications in the primary care setting and presented a 71.7% non-compliance or low compliance rate. 58 patients (79.5%) had at least one drug that can cause falls (min 1–max 7).

Conclusion and relevance

Older patients presenting at hospital with a fall were often likely to become frail and the majority were dependent. More importantly, this population was at high risk of readmission. Therefore, future studies are now needed to test interventions aimed at reducing this risk.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest

No conflict of interest

Background and importance

High alert medications are those that, when they are not being used properly, are more likely to cause serious or even fatal harm to patients. Chronic patients are especially vulnerable to these possible errors because of their comorbidity and polypharmacy. The Ministry of Health, Social Services and Equality of Spain promotes the implementation of improving safe practices for these patients. In 2014, a panel of experts developed a list of high alert drugs for chronic patients to prioritise practices for improving safety in these patients. This list was named the HAMC list (high alert medications for patients with chronic illnesses) and was published by the Ministry of Health, Social Services and Equality of Spain.

Aim and objectives

To analyse the prevalence of prescribed medications included in the HAMC list in a nursing home.

Material and methods

A descriptive, transversal, retrospective study was carried out in September 2020 that included all residents with chronic illnesses in a nursing home assigned to our pharmacy service. Variables recorded were: demographic data, number of prescribed medications, and number and type of prescribed medications included in the HAMC list.

Results

81 patients were included (59 men) with a mean age of 72 (56–94) years. 721 drugs were prescribed, and 186 patients (72.6%) had medications in the primary care setting. At least 1 HAMC was prescribed for 71 patients (87%) in the HAMC list. At least 1 HAMC was prescribed for 81 patients (79.5%) in the HAMC list.

Conclusion and relevance

Older patients presenting at hospital with a fall were often likely to become frail and the majority were dependent. More importantly, this population was at high risk of readmission. Therefore, future studies are now needed to test interventions aimed at reducing this risk.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest

No conflict of interest
Abstracts

Conclusion and relevance HAMC were widely prescribed. Benzodiazepines were the therapeutic group most prescribed from the HAMC list in our population, followed by antiplatelets and antipsychotics. The HAMC list is a useful tool for a first approach in the detection of patients who may be at a higher risk of serious harms if medication errors occur. Implementation of specific safe practices for those drugs could reduce potential or real errors in these patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-227 CLINICAL TRIALS: A STANDARDISED SELF-ASSESSMENT TOOL TO REDUCE THE MULTIPLE RISKS OF THE PHARMACEUTICAL CIRCUIT

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Background and importance Despite a strict regulatory framework of clinical trials (CTs), few standardised tools are available. Our national survey conducted in 2020 demonstrated that all clinical research pharmacists (CRPs) have initiated a quality approach, which is however very heterogeneous and implemented more in university hospital centres and cancer centres, with a high activity level. New standardised tools for the investigational health products (IHPs) circuit would be of interest to 88/94 CRPs. The most useful tool was the self-assessment grid, according to 94% of CRPs. Thus we developed such a tool to manage specific risks of IHPs (complex protocols, assignment of treatment numbers, confusing packaging or labelling).

Aim and objectives The aim of this work was create a standardised self-assessment grid to manage the specific risks of IHPs.

Material and methods A pharmacy resident and two doctors of pharmacy of a regional working group defined a list of 66 evaluation criteria, mainly based on good clinical practices and on a professional guide of 2020 by the national university centre hospitals’ pharmacists commission. The criteria were divided into three main parts: general organisation and support functions; pharmaceutical management of CTs; and risk assessment and risk management. Then the grid was sent for validation to the 94 CRPs who had answered our national survey. The Delphi method was used and consensus among experts was defined by a satisfaction rate of >80% for relevance, clearness and accessibility.

Results The first round of proofreading by 16 pharmacists led to a consensus of 85% (56/66) for the criteria, which were considered relevant, clear and assessable. This led to 36 modifications, 4 deletions and 2 additions of criteria. The second round by 8 pharmacists led to a consensus of 88% (60/68) for the criteria and resulted in 18 modifications and 2 deletions. There remained only one criterion considered irrelevant, which was deleted. These results led us to validate the final version of the grid, including 62 criteria.

Conflict of interest No conflict of interest

5PSQ-228 PHARMacist MEDicines optimisation and error MITIGATION at PAEDIATRIC CRITical CARE DISCHARGE: A human solutIoN to an eLecTRONIC rISK

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Background and importance Patients are vulnerable to medication error(s) at discharge from the paediatric intensive care unit (PICU). Clinical outcomes may be compromised if medicines are inappropriately continued, omitted or prescribed incorrectly. There is an additional risk at Evelina London Children’s Hospital (ELCH) as a different prescribing system is used in ward areas (MedChart) and the PICU (eVision). Currently, critical care doctors complete the discharge summary and verbally handover patients to the ward team(s). Ward doctors are responsible for transcribing medicines from eVision to MedChart and ward pharmacists are responsible for completing the medication review. Audits have shown that prospective critical care pharmacist (CCP) step-down checks can lead to mitigation of medicine related transfer of care errors.

Aim and objectives Our aim was to assess the current PICU discharge process and review the risk of medication related errors. The objectives were to measure the time taken for medicines to be transcribed from eVision to MedChart; to measure the time taken to complete a discharge medication review; to identify the percentage of transcription errors that occur and classify errors to assess potential risk; and to identify ways to mitigate the risk associated with the current process.

Material and methods A data collection tool was designed using Microsoft Excel. Prospective data collection took place from 20 July to 7 August 2020. Patients were identified using the ‘discharge’ tool on eVision. 29 PICU discharge transcription charts were reviewed; the number of charts with errors was identified and classified by a PICU pharmacist.

Results Average time taken for a doctor to transcribe medicines from eVision to MedChart was 1 hour 50 min. Average time taken for a pharmacist to complete the transcription check on MedChart was 10 hours 54 min. 35% of transcription charts displayed one or more errors. 40% of the identified errors were classified as simple (unlikely to result in harm), and 60% were classified as serious (potential to cause reversible harm).

Conclusion and relevance To mitigate the risk associated with the current process, it is proposed that PICU doctors complete the transcription of medicines from eVision to MedChart.