Results 13 patients were included, 76.9% men, mean age 60.4 $\pm$ 8.8 years. Among the four patients with tumour samples that were evaluated for PD-L1 expression, 75% had a score $\geq$ 1. Three patients were treated with at least one previous line. Previous treatments were: sunitinib (n=3) cabozantinib (n=1) or nivolumab (n=1). IMDC risk classification: 7.7% favourable, 53.8% intermediate and 38.5% poor risk. Presence of metastases: lung (7/13), bone (5/13), liver (3/13), ganglionic (2/13), cerebral (1/13) and unknown (2/13). All patients were treated with pembrolizumab 200 mg every 3 weeks and axitinib 5 mg twice daily until progression, unacceptable toxicity or death. Mean duration of treatment was 28.7 weeks. 46% are continuing with active treatment. Discontinuation causes included: death (n=3), adverse effects (n=3) and progression (n=1). Toxicities included: asthenia grade (G)1–3 (n=11), anorexia G1–2 (n=6), diarrhoea G1–4 (n=5), liver profile alterations G1–3 (n=3), hyperthyroidism G1–3 (n=3), abdominal pain G1–2 (n=3), palmar-plantar erythrodysesthesia G2–3 (n=2), pruritus G1 (n=1), dizziness and paraesthesia G1 (n=1), vomiting G1 (n=1), thrombopenia G2 (n=1) and arthralgias G1 (n=1). Best TAC responses obtained were: 50% stable disease, 25% partial response and 12.5% progressive disease. In five patients the response rate was not evaluated.

Conclusion and relevance Effectiveness in our patients resulted in a higher objective response rate than that in the KEY-NOTE-426 trial. The combination treatment was well tolerated. To rationalise the use of novel medicines and optimise efficiency, measuring health results is crucial.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-225 ELDER FALLERS: A GROUP AT RISK OF READMISSION?

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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, 63% presented a high risk of readmission; 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.

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Conflict of interest No conflict of interest

5PSQ-226 ANALYSIS OF HIGH ALERT MEDICATION PRESCRIPTIONS IN A NURSING HOME

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Background and importance High alert medications are those that, when they are not being properly used, 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 those 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 medicaments, and number and type of prescribed medicaments 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 were included in the HAMC list. At least 1 HAMC was prescribed in 86% of patients, with a mean of 3 HAMC per patient (1–7). The therapeutic groups of the drugs on the HAMC that were prescribed were: benzodiazepines (63% of patients), inhibitors of platelet aggregation (36%), antipsychotics (26%), beta-adrenergic blockers (26%), oral hypoglycaemics agents (26%), loop diuretics (19%), oral anticoagulants (11%), antiepileptics (9%), opioids (9%), including minor and major opioids, insulin (7%), eplerenone/spironolactone (7%), immunosuppressants (1%) and non-steroidal anti-inflammatory drugs (1%).

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.

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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.

Conclusion and relevance This interactive tool will be disseminated in a free public online 'CTs' toolbox. It will provide a conformity score per process, allowing specific risks to be identified across the circuit of IHPs, by pharmacies in any healthcare facility, whatever the level of activity.

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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