

Material and methods An initial work consisted of making an inventory of the inhalation devices. The Zéphir guide, a video tutorial on the use of inhalers, set up by the Société de Pneumologie de Langue Française (SPLF), enabled us to acquire the right gestures. In collaboration with the pneumologists, we determined the eligibility criteria for medication reconciliation by prioritising patients with COPD or asthma. During the intake interview, the RQESR 2019 (Quebec Respiratory Health Education Network) checklist for the use of inhalation devices allowed us to evaluate the patient's control of aerosol use. Interviews were carried out by the pharmacy intern.

Results In 2.5 months, we assessed 65 patients with an average age of 65.6 years. 49.2% of the patients had more than one inhaler at home. The average length of the patient interviews was 12.4 min. The shortest interview needed for mastering device use lasted 5 min whereas the longest, when extensive training was required, lasted 25 minutes. In 85% of patients, device use was compliant. Training was therefore offered to 15% of patients using a demonstration kit which was traced in the patient file. The positive points of this new activity were the multidisciplinary nature of the work carried out by healthcare professionals to help ensure the proper use of drugs, and detection and correction of device misuse. The limitations encountered were the difficulty in obtaining the devices and time required to receive them.

Conclusion and relevance Implementation of this activity has been gradual (training, development of medication reconciliation, research into new monitoring indicators). This work has also made it possible to carry out a more in-depth reflection, within the medical and pharmaceutical teams, with a view to optimising the range of inhalers and proposing user friendly devices or those not requiring hand-lung coordination.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-347 CLINICAL TRIAL DRUGS: DISPENSING OPTIMISATION FOR OUTPATIENTS OF A CANCER CENTRE

E Mayet*, S Suzzoni, L Barty, A Rieutord, K Chetouane. *Gustave Roussy, Pharmacy Department, Villejuif, France*

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Background and importance According to national legislation, some medications are not available from the community pharmacy but only from the hospital pharmacy. Among these treatments are clinical trial drugs or investigational products. Pharmacists are expected to ascertain that patients or caregivers have gained clear and complete information. Our hospital has more than 600 beds and more than 7000 outpatients visiting a year; 70% are clinical trial outpatients.

Aim and objectives The objective of this study was to assess patient knowledge and counselling during dispensing of clinical trial products to improve clinical trial outpatient care.

Material and methods Outpatients receiving their medication from our hospital pharmacy participated in this study. An anonymous questionnaire regarding outpatient care was distributed to them. We focused in this study on clinical trial patient answers. The impact/effort matrix, a decision making tool based on the level of effort required and the potential impact

or benefits we will have, was used to determine the solutions to improve the situation. The study was conducted from February to June 2020

Results This study included 61 outpatients treated for cancer; 41 patients (68%) were treated with clinical trial drugs. 15% (9/61) were unaware of the product's status. One patient did not know about his inclusion in a clinical trial. Among the 41 clinical trial patients, 83% (34 patients) said that they never received an explanation about the clinical trial circuit and treatment dispensing. 95% (39/41) patients would like more support, such as posters, videos and more communication.

Conclusion and relevance This study showed that outpatients can be misinformed about their treatment, and that there was a lack of support for the patient. To improve this situation, firstly, we created a video to illustrate and explain what a clinical trial is and the course of the clinical trial patient. This video will be broadcast on TV in the waiting room. This solution is the easiest and fastest option to set up. An evaluation of the optimised service is planned in the near future.

The second step will be delivering clinical trial drug counselling.

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4CPS-348 THE HOSPITAL PHARMACY IN THE CREATION OF CLEAN CIRCUITS IN THE FACE OF COVID-19

R Seisdedos, I Lomares Manzano*, C García Fernández. *Hospital Universitario Puerta Del Mar, Pharmacy, Cádiz, Spain*

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Background and importance The SARS-CoV-2 health crisis unleashed in Spain in March 2020 forced hospitals to urgently reorganise and adapt in an unprecedented way. One of the strategies carried out was the establishment of 'clean' circuits and hospitals from SARS-CoV-2.

Aim and objectives To describe the organisational changes of a pharmacy service of a SARS-CoV-2 'clean' hospital and to measure their impact.

Material and methods The study was carried out in an 86 bed hospital (non-COVID-19 use) dependent on a 652 bed university hospital (with care for COVID-19 patients), located in a different location, from 11 March, when the WHO declared the pandemic, to 21 June 2020, ending the state of alarm. The activity was compared with the same period in the previous year. Outpatient pharmaceutical care unit (OPCU) patient surveys were conducted to measure impact. The staff was temporarily reinforced with a specialist in the hospital pharmacy.

Results The following implementations were carried out:

- Opening of OPCU, with 886 dispensations to 448 patients, compared with 34 dispensations to 9 patients the previous year. 60 surveys were conducted, where 60% of patients expressed that had they had to travel to their usual hospital during the pandemic, they would not have collected their medication. Furthermore, 93% of patients said they felt safe in their visit to the new OPCU. Satisfaction evaluation was excellent (average 10/10).

- Medicalisation of a 165 bed nursing home.
- Referral of day hospital patients. 570 dispensations were made to 191 patients compared with 154 dispensations to 44 patients in 2019.
- Transfer of the oncology hospital ward. Total stays increased from 3253 in the previous year to 4326 (33% increase).
- Creation of a specific respiratory emergency service, where SARS-CoV-2 positive cases were referred to the referral hospital.

Conclusion and relevance Among the new circuits, opening of the OPCU stood out because of the avoidance of a large number of trips to a 'dirty' hospital in another town, the improvement in adherence and for the great organisational effort in a very short period of time. The different measures allowed the non-COVID-19 activity to continue, minimising the risk of contagion for patients. The health crisis due to SARS-CoV-2 has been a challenge and the hospital pharmacy has shown a great capacity for adaptation.

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4CPS-349 ROLE OF HOSPITAL PHARMACISTS IN ONCOGERIATRIC CONSULTATIONS: A RETROSPECTIVE STUDY

L Ruppert*, CP Mortier, I Lelievre, B Phan. *Hopital Avranches Granville, Pharmacy, Avranches, France*

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Background and importance Population aging and the growing risk of developing cancer with age lead to an increasing number of elderly patients treated in the oncology care unit. Elderly people are fragile, poly pathological and poly medicated. To optimise their care, oncogeriatric consultations are performed by a doctor, nurse, dietician and psychologist.

Aim and objectives The aim of this study was to evaluate the benefit of including the hospital pharmacist in these consultations.

Material and methods A retrospective study was conducted on 17 patient files that had been reviewed in oncogeriatric consultations at our hospital centre from May 2019 to March 2020. We searched for information on each patient in the electronic medical record: medical background, usual treatments, considered cancer therapy, biological results, risk of falling, and the presence of balance and cognitive disorders. We then analysed drug interactions, identified potentially inappropriate prescriptions according to the STOPP and START criteria and the anticholinergic burden of the treatment.

Results Average age was 84 and the male/female ratio was 0.55. 62 pharmaceutical interventions could have been transmitted to the doctor if the pharmacist had participated in these consultations (ranging from 3 to 6 interventions per patient, average 3.65). There were 7 types: addition of treatment (21), monitoring to be programmed remotely from the consultation (10), dosage adjustments (7), treatment discontinuation (7), biological monitoring (7), adaptation of the intake plan (6) and molecule switch (4). The main interventions were: management of vitamin deficiencies (D, B9, B12), anti-pneumococcal vaccination,

discontinuation of drugs with formal contraindications or belonging to the same therapeutic class, high dose PPIs without indication, benzodiazepines dose adjustment, monitoring of nephrotoxicity and serum potassium, replacement of one benzodiazepine by another with a shorter half-life and adaptation of the intake plan to limit interactions between oral chemotherapy and antacid.

Conclusion and relevance The pharmacist has a real role to play in oncogeriatric consultations, to prevent iatrogeny and optimise patient care. The limitations of the study were the non-exhaustiveness of the treatment (self-medication and phytotherapy), ignorance of potential swallowing disorders and vaccinations carried out. However, this missing information can impact on patient care and could be collected by the hospital pharmacist.

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4CPS-350 ROLE OF THE PHARMACIST IN INTERNAL MEDICINE: ANALYSIS OF PHARMACEUTICAL INTERVENTIONS DURING A ROTATION IN AN INTERNAL MEDICINE DEPARTMENT

¹MA Meroño Saura*, ²P Pacheco-López, ²C Fernández Zamora, ²S Clavijos Bautista, ²MD Nájera Pérez. ¹*Hospital Perpetuo Socorro, Pharmacy, Murcia, Spain;* ²*Hospital General Universitario Morales Meseguer, Pharmacy, Murcia, Spain*

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Background and importance There has been a change in the performance of hospital pharmacists, aimed at increasing their participation in the pharmacotherapeutic process of patients through inclusion in the multidisciplinary team.

Aim and objectives Quantification and analysis of pharmaceutical interventions carried out by a pharmacist in an internal medicine service.

Material and methods The analysis of pharmaceutical interventions was carried out prospectively over 10 weeks. The pharmacist accompanied the doctors during their visit. The following variables were analysed: characteristics of the patients, number of interventions, type of interventions and acceptance of the interventions. Interventions that generated changes in the prescription were considered 'accepted' and those that were rejected 'not accepted'.

Results 39 patients were visited with a mean age of 81 years (39–95). The reason for admission was mainly respiratory (25.65%), followed by heart failure, kidney problems and low back pain (10%). Patients had a median of seven comorbidities, highlighting arterial hypertension (66.67%), and were poly medicated with a median of nine drugs. During the study period, 108 interventions were performed. The interventions were classified as follows:

- 38 (35.16%) adequacy of treatment
- 18 (16.66%) reconciliation of medication
- 9 (8.33%) sequential therapy
- 9 (8.33%) nutritional advice
- 6 (5.56%) substitutions by therapeutic equivalents
- 5 (4.63%) de-prescription of drugs of low therapeutic utility
- 5 (4.63%) modifications in the duration of treatment
- 4 (3.70%) detection of therapeutics duplications