

- 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.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of interest** No conflict of interest

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

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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.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

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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

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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