• 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 ONCOC Geriatric 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, polypathological and polymedicated. 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 3.63). 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

Conflict of interest No conflict of interest

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 polymedicated 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
• 4 (3.70%) management of medications not included in the pharmacotherapeutic guide
• 3 (2.78%) drug detection without justification
• 3 (2.78%) dose adjustments for renal or hepatic failure
• 2 (1.85%) incomplete prescriptions
• 1 (0.93%) detection of drug interactions
• 1 (0.93%) detection of allergies.

95% of the prescriptions were accepted, and of these 95% implied changes in the medical prescription.

Conclusion and relevance The high number of interventions carried out shows that the integration of the pharmacist in the internal medicine service facilitates the detection, prevention and resolution of errors related to medications and more appropriate treatment on admission to hospital or discharge from home. Most of the interventions were accepted; a high number of interventions were related to the adequacy of the treatment.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest

4CPS-351 MEDICATION DELIVERY CONFIRMATION TO AMBULATORY PATIENTS BY INSTANT MESSAGING APP
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Background and importance Faced with the lockdown caused by COVID-19 since March 2020, we have been reorganising the external patient department to get medicines to our patients. But how do we notify them that their medication is on its way? How do they send us delivery confirmation, without wasting a lot of time and protecting their data online?

Aim and objectives To analyse the effectiveness of the use of a professional instant messaging application to confirm medication delivery to our patients or to their family members, always ensuring the protection of their data.

Material and methods A prospective study was conducted of all patients who were sent that medication. This study was done with WhatsApp Business between July and September 2020. All patients gave us prior verbal consent to participate in this study. Data collected were: number of shipments, age, sex and number of patients, number and type of sent messages with the app, number of confirmations or incident responses by patients with the app and time saved compared with phone calls.

Results A total of 190 medication shipments were made to 98 patients (60% men) with a median age of 57 (32–89) years. 354 instant messages were sent to 79 patients (80.6%), of which 177 (50%) were shipment notifications and 177 (50%) were a simple yes/no question to confirm the correct pickup. Referring to these last 177 messages, we received 122 replies from 63 patients (64.3%), of which 119 (94.3%) were correct delivery confirmations and 3 (5.7%) were incidents (which were resolved as soon as possible). The system warned us that 19 (19.4%) patients had not received the messages because neither they nor their family members had the necessary app installed on their mobile phones. Assuming an average of 3 min per phone call to confirm delivery of medication, we saved 357 min (3×119 confirmation responses) because of instant messaging.

Conclusion and relevance This method of instant messaging online was a fast, free and secure way to notify and confirm the correct delivery of medication or to detect any delivery incidents. A possible limitation is that some elderly patients do not have this app installed on their mobile phones or they do not know how to use it.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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4CPS-352 PATIENTS IN CHARGE: WHY WE SHOULD IMPLEMENT AN ONLINE PERSONAL HEALTH RECORD AS A TOOL FOR MEDICATION RECONCILIATION

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Background and importance Medication discrepancies (MDs), defined as unexplained differences among medication regimens, cause important public health problems with clinical and economic consequences. Medication reconciliation (MR) reduces the risk of MDs but is time consuming and its success relies on the quality of different information sources. Online personal health records (PHRs) may overcome these drawbacks, but the correctness of the identified MDs with a PHR compared with traditional MR is unclear.

Aim and objectives The aim of this study was to determine the level of agreement of identified MDs between traditional MR and an online PHR and the correctness of the identified MDs with an online PHR.

Material and methods Two weeks prior to a planned admission to the cardiology, neurology, internal medicine or pulmonary department, patients received an invitation from a PHR to update their medication file derived from the Nationwide Medication Record System (NMRS). At admission, MR was performed by a pharmacy technician, who created the best possible medication history (BPMH) based on the NMRS data and an interview. MDs were determined as discrepancies between the available information from the NMRS and the BPMH, and an interview. MDs were determined as discrepancies between the available information from the NMRS and the BPMH, and an interview. MDs were determined as discrepancies between the available information from the NMRS and the BPMH, and an interview. MDs were determined as discrepancies between the available information from the NMRS and the BPMH, and an interview.

Results Of 488 patients approached, 155 (31.8%) were included. The mean number of MDs identified with MR and PHR was 6.2 (SD 4.3) and 4.7 (SD 3.7), respectively. 82.1% of the drug information noted by the patient in the PHR was correct compared with the BPMH, and 98.6% had no clinically relevant differences between the lists.

Conclusion and relevance Patients who used an online PHR had the ability to correctly identify clinically relevant MDs in a manner that resembled traditional MR. Online PHRs may have the potential to replace MR in detecting MDs.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest