Demographic, clinical and pharmacological data were retrospectively collected from residents with confirmed SARS-CoV-2 infection: comorbidities, signs and symptoms, outcome (recovery or death), therapy received for COVID-19 and concomitant antibiotic.

**Results** Of the 231 residents who lived in the LTCF when the first resident with confirmed COVID-19 was tested, 29.4% tested positive for SARS-CoV-2 during the study period, of whom 23.5% died. All cause mortality increased by 228.7% compared with the previous 3 years. Median Charlson comorbidity index, age adjusted was 6 (IQR 4.5–7). A few confirmed cases were hospitalised (26.5%) and most of these residents died in the local hospital (68.7%). Median duration of hospitalisation was 12.5 days (IQR 3.5–19). Most of the cases (72.1%) had symptoms, often typical symptoms (fever, cough or breathlessness). More than half received any experimental treatment for COVID-19 (58.8%). Antibiotics were prescribed in 52.9%, with an increase of 47.2% in consumption compared with the same period in 2019.

**Conclusion and relevance** We detected considerable mortality associated with COVID-19, highlighting the challenges of the implementation of a coordinated programme to control SARS-CoV2 outbreaks in LCTFs reducing hospital referral rates.

### REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of interest** No conflict of interest

## 4CPS-358 POINT PREVALENCE REVIEW OF MEDICINES RECONCILIATION FOLLOW-UP BY MEDICAL TEAMS

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**Background and importance** Medicines reconciliation (MR) is identified as a patient safety priority by the World Health Organization (WHO). The pharmacist led medicines reconciliation service at our institution undertakes MR in the WHO priority patient cohort; patients 65 years and over admitted through the emergency department (ED). Completed MR is documented in the general drug chart. On completion of MR, the pharmacist documents in the medical notes that MR has been undertaken. Discrepancies identified through MR are reviewed and actioned, as required, by the medical team.

**Aim and objectives** To determine if MR completed by pharmacists was being reviewed and actioned by medical teams and to determine any trends in discrepancies not being followed-up.

**Material and methods** A 1 day hospital wide point prevalence review of MR follow-up by medical teams was undertaken. The review was completed by clinical pharmacists in February 2020. All patients who had an MR completed by a pharmacist in the current general drug chart were reviewed. Data were collected on the number of discrepancies, if the discrepancies were followed-up and the drugs involved.

**Results** A completed MR in the in-use general drug chart was identified for 88 (21%) inpatients. A total of 226 discrepancies were recorded. 76 patients (86%) had at least one discrepancy requiring medical review. Review and actioning of MR discrepancies was as follows (n=76):

- Followed–up in full for 67% of patients
- Partly followed–up for 18% of patients
- Not followed–up for 15% of patients.

These discrepancies related to 27 individual drugs. Frequently occurring drugs included hydroxocobalamin, folic acid, cholecalciferol, denosumab, inhalers and eye drops. High risk drugs accounted for n=2 of the discrepancies not actioned. In all cases this involved a sedative drug.

**Conclusion and relevance** In most instances, MR undertaken by pharmacists was being reviewed and actioned by the medical teams. However, there is room for improvement. There is no international published data to benchmark this figure against. The low incidence of incomplete follow-up of high risk drugs is reassuring. A large body of literature demonstrates the benefit of MR to the patient; however, this benefit can only be realised if MR is followed-up. Identification of inhouse initiatives to ascertain barriers to follow-up is recommended.

### REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of interest** No conflict of interest

## 4CPS-359 DEVELOPMENT AND VALIDATION OF A 30 DAY REVISIT RISK PREDICTION MODEL IN PATIENTS ADMITTED TO THE EMERGENCY DEPARTMENT DUE TO DRUG RELATED PROBLEMS

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**Background and importance** Drug related problems (DRPs) are an important cause of admission to the emergency department (ED), and one of the most frequently implicated drugs are those used for cardiovascular diseases. However, information regarding the risk factors associated with ED revisits is this group of patients is scarce.

**Aim and objectives** The aim of this study was to develop a predictive model of 30 day revisits to the ED in patients with a first visit for an episode of DRP.

**Material and methods** A retrospective cohort study was carried out including patients who attended an ED in 2019 due to DRPs caused by drugs classified in the ATC classification system as A, B and C. A 30 day prediction model was created in a derivation cohort using backward logistic regression. Those variables significant at $p<0.100$ in a multivariate analysis were assigned an integer score proportional to the regression coefficient. The model was then internally validated by k-fold cross validation and in the validation cohort.

**Results** 580 patients were included (mean age 80.0 (12.6) years) and 133 (22.9%) patients revisited the ED at day 30. Five independent risk factors (moderate to severe chronic kidney disease (5 points), previous ED visit within 3 months (6), high anticholinergic burden (8), DRPs related to heparin use (12) and safety DRPs (8)) were identified in the derivation cohort and were combined into an overall score. The model achieved an area under the curve–receiver operating curve of 0.71 (95% CI 0.66 to 0.75) in the derivation cohort and 0.70 (95% CI 0.65 to 0.74) in the validation