cohort (p=0.273). Patients were classified into three risk categories (high, medium and low) and had the following rates of risk: 11.1% (0–6 points), 20.0% (8–13 points) and 39.5% (>13 points). Findings were similar in the validation cohort. The optimal cut-off point in the model was 9, having a sensitive of 67.09%, a specificity of 69.06%, a positive predictive value of 36.78%, and a negative predictive value of 87.61%.

Conclusion and relevance This score could be used by clinicians from the ED to identify those patients at high risk of 30 day revisits, and could be useful to design specific interventions at discharge in this group of patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-360 RISK OF MALNUTRITION IN PATIENTS WITH COVID-19 DISEASE WHO RECEIVE ORAL NUTRITIONAL SUPPLEMENTS

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Background and importance The European Society for Clinical Nutrition and Metabolism (ESPEN) guidelines recommend the optimisation of the nutritional status of patients with SARS-CoV-2 infection through dietary advice and/or oral nutritional supplements (SNO). These should provide about 400 kcal and a minimum of 30 g of protein per serving.

Aim and objectives To identify the risk of malnutrition in patients with COVID-19 who received SNO, the cause of it and the adequacy of the SNO according to ESPEN guidelines.

Material and methods A cross sectional observational study was conducted between March and April 2020. Adult patients with COVID-19 who received SNO were included. Variables collected were: age, sex, body mass index (BMI), risk of malnutrition according to GLIM criteria, phenotypic criteria (weight loss (>5% in the previous 6 months) and low BMI (≤20 kg/m^2 for those aged <70 years old and ≤22 kg/m^2 in the elderly)) and aetiologic criteria (low intake (≥ 7 days of hyporexia) and inflammation, type of SNO, energy and protein intake, adaptation of the oral diet, evaluation by the nutrition service and reason for the consultation). The SPSS programme (V.25.0) was used for data analysis.

Results 162 patients were analysed. 51.8% (85) were men with a mean age of 72.75±12.58 years. Mean BMI mean was 27.05±4.2 kg/m^2. 15.2% (25) of patients presented weight loss greater and 6.7% (11) presented low BMI. 92.1% (151) had low intake and all patients fulfilled the criteria for inflammation associated with the disease. 22.6% (37) of the patients presented with a risk of malnutrition. The SNO provided a mean of 408.4±164.06 kcal/day and all were hyperprotein, with a mean of 25.96±10.08 g of protein/day. 18.3% (30) had an adapted oral diet and 16.5% (27) of the patients underwent consultation with the nutrition service, the reasons for this being: 70% (19) marked hyporexia, 18.5% (5) dysphagia and 14.8% (3) diarrhoea.

Conclusion and relevance A quarter of the patients analysed presented with a risk of malnutrition. Hyporexia was the main symptom. In our hospital, it would be advisable to increase the caloric and protein intake of the SNO to comply with ESPEN recommendations.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-361 INTERVENTIONS OF A CLINICAL PHARMACIST IN AN INTENSIVE CARE UNIT

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Background and importance Patients in an intensive care unit (ICU) are in a critical condition and often receive complex pharmacotherapy that needs to be adjusted frequently. It has been shown that a multidisciplinary approach, including pharmacists in the ICU team, improves the pharmacologic treatment of patients and helps to provide more individualised therapy.[1]

Aim and objectives The aim of this study was to identify the most common pharmaceutical care issues (PCI) in the ICU, to assess the acceptance rate of interventions by physicians and nurses made by the clinical pharmacist (CP), and to evaluate the time spent on chart reviews.

Material and methods This was a prospective observational study conducted in a 10 bed ICU in an acute care hospital during 2019. The clinical pharmacist visited the ICU 1–2 times a week and performed chart reviews. Recommendations were verbally communicated to the nurses and physicians, and interventions documented using the Pharmaceutical Care Network Europe classification of PCI.

Results During the study period, the CP visited the ICU 65 times and identified 232 PCI. On average, during each visit, 5 (n=315) patients' charts were reviewed and 1.6 (n=147) interventions per patient were made. 80% (n=52) of the CPs' visits lasted less than 60 min and of them, 27% (n=14) less than 15 min. The most common PCI were 'wrong dosage form' (12%, n=27), 'subtherapeutic dose' (11%, n=26), 'need for additional drug' (11%, n=25) and 'inappropriate drug' (10%, n=24). 136 (59%, n=232) PCI were accepted by physicians without adjustments, 8 (3%) were accepted with adjustments, 8 (3%) were not accepted and information was missing/not possible to assess for 75 (32%) PCI.

Conclusion and relevance This study shows that there is a need for a CP in the ICU. More regular visits and better collaboration with other healthcare professionals could improve patient outcomes.

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