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 sensitivity 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-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) charts were reviewed. Recommendations were accepted by physicians without 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.

REFERENCES AND/OR ACKNOWLEDGEMENTS


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