pharmaceutical guideline for giving QT advice was adjusted in collaboration with cardiologists.

Aim and objectives To compare the feasibility and clinical relevance of QT advice guided by the original and adapted QT guideline.

Material and methods QT advice provided by the pharmacist was analysed. This retrospective analysis included: number of times QT advice was given according to the original (April 2018 to January 2019) and the adapted guideline (May 2019 to October 2019), number of QT drugs (defined as drugs on the CredibleMeds list KR) per prescription and QTc interval >500 ms (if known). For 1 month (15 May to 14 June 2019), the acceptance rate of the pharmaceutical advice, including the QT advice was registered.

Results Differences between the original and adapted guideline are: (1) threshold for advising an ECG (original: ≥ 2 prescribed QT drugs or 1 QT drug in combination with a drug that inhibits the metabolism of a QT drug; adapted: ≥ 1 prescribed QT drug) and (2) definition of a recent ECG (original: maximum 1 year old; adapted: during hospitalisation). If no recent ECG is available or the QTc interval is >500 ms, advice is given to the physician.

The number of times advice was given using the original and adapted guideline were 78 (8 advices/month) and 243 (41 advices/month), respectively. On average, using the adapted guideline, advice related to QTc interval ≥ 500 ms was given 5 times per month compared with once using the original guideline. The acceptance rate of QT advice was 40% with an overall acceptance rate of 79% for all pharmaceutical advices.

Conclusion and relevance Adapting the QT flow resulted in a fivefold increase in the number of times advice was given in relation to QT. The rather low acceptance rate may be explained by the fact that the pharmacist only selected patients on QT drug prescriptions. To enhance the number of times clinically relevant advice is given, patient related risk factors (hypokalaemia, age, gender, cardiovascular comedications) should be included. It is therefore necessary that personalised risk assessment systems help the pharmacist to identify patients at greatest risk for QT prolongation.

REFERENCES AND/OR ACKNOWLEDGEMENTS

1. Arizona Center for Education and Research on Therapeutics. <https://www.credible-meds.org/>

Conflict of interest No conflict of interest

4CPS-365 INTEGRATION OF THE HOSPITAL PHARMACIST INTO A MULTIDISCIPLINARY COMPLEX CHRONIC PATIENT CARE TEAM

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Background and importance The integration of the hospital pharmacist into a multidisciplinary team is needed due to the increase in hospital admissions of complex chronic patients.

Aim and objectives To describe discrepancies and potentially inappropriate prescriptions (PIPs) of medications detected by the pharmacist, integrated into multidisciplinary team, in complex chronic patients (CCP) hospitalised in the chronic patient unit (CPU).

Material and methods This was a descriptive and prospective 5 month analysis (June to November 2019). We developed a protocol to standardise the pharmacotherapeutic plan review of all patients admitted to the CPU. We also developed a registry model of pharmaceutical interventions (PI). Anthropometric and demographic patient data were analysed (sex, age and number of chronic medications). A patient/care giver interview was conducted at hospital admission and the following PI were registered:

- Reconciliation: detection of unjustified discrepancies when comparing outpatient drug with hospital therapy.
- Adequacy: detection of PIPs using explicit/implicit criteria with CheckTheMeds software.

Individualised strategies based on the prescription's evidence of adequacy were communicated verbally and also by means of the electronic medical records.

Results 138 hospitalised CCP were included in the study, 58.7% men, with a mean age of 82.25 ± 9.4 years. The average number of drugs administered per patient was 10.83 ± 5.5 . For all prescribed drugs (1490), discrepancies were found for 623 (40.81%), meaning that 127 patients presented with discrepancies from which 56.02% were justified. The average reconciliation errors were 4.5 ± 2.9 per patient and these were: omission (50%), different route of administration, different dose or frequency (36.9%), contraindicated drug (9.9%), duplicity (2.6%) and different drug (0.7%).

100% of patients had at least one PIP and the total number of PIPs was 481 (3.5/patient). The most common PIPs were related to drugs that increased the risk of falls (154 (32%)) and CNS related drugs (140 (29%)). PIPs related to greater duration than that indicated in the technical data sheet in the benzodiazepine group (83 patients) and duplicity (67 patients) were also detected.

Conclusion and relevance Pharmacist inclusion on the equipment allows an exhaustive review of pharmacological therapy, an important role in patient safety (polypharmacy, patient complexity, etc). The next step is to measure the results of the PI performed to measure the magnitude of the effect of the intervention.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-366 COMPARING THE MEDICATION PROCESS ACROSS COUNTRIES USING THE FUNCTIONAL RESONANCE ANALYSIS METHOD

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Background and importance The medication process in hospitals that comprises prescribing, dispensing, administration and monitoring is an interprofessional collaboration. This includes hospital pharmacists (HPs) in one or more stages, which improves patient safety and reduces costs. However, the use of HPs varies greatly between countries and so do the results of studies evaluating the benefit of HPs. The differences between the HP's role across countries has not yet been described on a tangible level.