Results 200 patients (54% males and 46% females) admitted to HED were evaluated by the pharmacy team. Mean age was 75 (31–99) years.

66 interventions were proposed in 54 patients (27%). 55% were accepted and 22% rejected. The remaining 23% could not be appraised as patients had been discharged prior to the medical team evaluation of the suggestions.

Drug-related problems found were: 45% related to reconciliation (overdosing, underdosing, posology disparities, absence or no longer taking medicine prescription); 13% overdosing according to renal function or indication; 10% excessive anticholinergic burden that may have contributed to the current clinical problem; 9% underdosing for the indication; 8% lack of indication; 6% lack of prescription of a highly likely needed drug; 4% duplicities; 3% not optimal drug for the indication and 2% allergy-related problems.

Proposed actions were: dosing adjustments (50%), prescription (20%), discontinuation (20%), posology modification (7%) and alternative drug selection (3%).

Affected drug families were: antibiotics (22%), antidepressants, antipsychotics and anxiolytics (15%), antithrombotics (14%), blood pressure lowering agents (9%), vitamin and electrolytes supplements (9%), antiepileptics (7%), immunosupressors (4%) and others below 3% of incidence (painkillers, statins, antiretrovirals, antiarrhythmics, anti-gouts, thyroid hormones and eye-drops).

Conclusion and relevance Multidisciplinary teams are beneficial to patients' care. Incorporating a pharmacist in a HED reduces the incidence of medication errors and can positively contribute to the management of patients. Medicines reconciliation, dosing and indication checking and pharmacotherapy optimisation are actions in which the pharmacy team is capable of actively contributing for patients' best outcomes.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-221 POTENTIALLY INAPPROPRIATE MEDICINES IN OLDER PATIENTS

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Background and importance Chronic diseases, physiological changes associated with aging, and altered drug pharmacodynamics and pharmacokinetics as consequences of aging place elderly patients at high risk of prescribing potentially inappropriate medication (PIMs). Screening Tool of the Older Person's potentially inappropriate Prescriptions (STOPP) criteria refers to drugs classified according to the systems of the organs in which they operate.

Aim and objectives To determine the prevalence rate of PIMs in older patients (≥65 years) by using STOPP criteria on admission to the university hospital.

Material and methods A cross-sectional study including 250 patients ≥65 years, who had two or more drugs prescribed. Data collection lasted for 2 months and was conducted by a pharmacist. Approval for the study was granted by the ethics committee of the hospital. Informed consent was obtained from all participants.

The inadequacy of prescribed drugs was assessed on the basis of STOPP criteria, using a shortened version with 30 indicators. Statistical analyis was performed using the software PASW Statistics (PASW Inc., Chicago, IL, USA) version 22 and Microsoft Excel 2010.

Results The mean age in the group was 74.23±6.92 years. The majority were male patients (62.1%). 218 (87.90%) patients had hypertension. Mean of prescribed drugs was 5.25±2.70. We identified a total of 62 PIMs prescribed for 57 (22.98%) patients. Pantoprazole (46.77%) was the most prescribed, followed by diazepam (16.13%) and omeprazole (14.52%). The higher prevalence of PIMs related to proton pump inhibitors (PPIs) (42 of a total of 62 PIMs or 67.74%). Only 4 (13.33%) criteria were shown to be relevant for identifying PIMs (long-term use of PPIs, long-acting benzodiazepines, presence of therapeutic duplications, and use of thiazide diuretics in patients with gout). Correlation between the number of drug prescribed and the number of PIMs was significant (ρ=0.297; p<0.01).

Conclusion and relevance The STOPP criteria should be used when prescribing drugs to older patients with multimorbidity and polypharmacy in order to avoid the prescribing of innapropriate ones.

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Conflict of interest No conflict of interest

4CPS-222 ADHERENCE IN POLYMEDICATED ELDERLY PATIENTS ADMITTED TO A TRAUMA WARD

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Background and importance Polymedication is one of the most important problems facing healthcare professionals in Europe today.

Aim and objectives To analyse adherence in polymedicated elderly patients and its relationship with the number of drugs prescribed.

Material and methods Cross-sectional observational study, carried out between February and May 2021 in the Traumatology area of a tertiary hospital. Patients >75 years old, multipathological (≥2 chronic pathologies) and polymedicated (≥5 chronic medications) were included. We excluded those with whom we were unable to communicate, due to their physical/mental condition and absence of a companion.

The clinical history was reviewed, collecting anthropometric variables, pathologies and home medication, confirmed by a personal interview.

Adherence to treatment was measured using the Morisky–Green questionnaire, which consists of four dichotomous yes/no questions to obtain information on patient compliance. Adherence was related to the number of drugs prescribed.

The Shapiro–Wilk normality test and the non-parametric Mann–Whitney U test were used for statistical analysis. Results with p values <0.05 were considered significant.

Results 48 patients were selected, 76.2% female; mean age was 83.8±5.4 years.

The mean number of pathologies/patient was 6±2.6. 61.9% of patients had five or more diseases. The most frequent health problems were hypertension (66.7%), hypercholesterolaemia (42.8%), diabetes mellitus (33.3%) and depression (33.3%). The mean number of medications/patient was 9±3.4. 35.7% of patients were highly polymedicated (≥10 medications).

The Morisky–Green test showed that 82.5% were adherent to treatment. 22.5% of patients were not taking ≥2 prescribed and necessary medications. In addition, 36.6% were found to self-medicate.

No statistically significant relationship was found between the number of medications and adherence (p=0.8).

Conclusion and relevance Contrary to other recently published studies, adherence was good in our sample and was not related to the number of medications. The first finding may be related to the fact that many patients had caregivers who took care of their medication.

This study shows that a significant proportion of the population is self-medicating. This calls for closer monitoring by community pharmacists, with patient education and collaboration with hospital pharmacists, whose easy access to medical records can help to conduct studies on the prevalence of polymedicated patients and the appropriateness of their prescriptions.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-223 ADHERENCE TO ABIRATERONE AND CORTICOID IN PATIENTS WITH PROSTATE CANCER

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Background and importance The concomitant administration of abiraterone with corticoids is necessary to manage adverse events related to mineralocorticoid effect. A proper adherence to both therapies is needed to reach effectiveness in metastatic prostate cancer (mPC).

Aim and objectives To measure and compare adherence to abiraterone and concomitant corticoids in patients with mPC.

Material and methods Retrospective observational study, which included patients under treatment with abiraterone, and corticosteroid (prednisone/dexamethasone) that attended the Outpatient Pharmaceutical Care Unit (OPCU) between March 2020 and February 2021. Abiraterone is dispensed in the hospital pharmacy and concomitant treatment with corticoid is dispensed in the community pharmacy.

Full treatment adherence was measured by combining two indirect methods: dispensing registration and the Morisky–Green (MG) test. Patients with a dispensing record greater than 95% and a score in the MG questionnaire of 4 were considered adherent.

To obtain data, the Ambulatory Information System (AIS) was used, which includes electronic prescriptions, and reports of dispensations in the community pharmacy as well as the dispensing registration system of the hospital pharmacy.

Statistical analysis: qualitative variables were expressed percentagewise and compared using the Chi-square test.

Results Thirty patients were included, with an average age of 74 (SD 10.8) years. Of them 50% were aged over 80 years. The average number of drugs per patient was 9.9 (SD 3.7) so 85% were polymedicated patients (drugs >6). Of the 30 patients treated with abiraterone, 2 died and 2 abandoned the treatment.

Of those aged over 80 years, 69.2% were abiraterone adherents whereas under 80 the figure was 84.6% (p<0.352). In those over 80, 46.2% were corticoid adherents

Polymedicated patients were 72% abiraterone-adherent, while non-polymedicated patients were 100% adherent (p<0.234). Polymedicated patients were 40.9% corticoid-adherent.

By dispensation recounts 84% abiraterone and 46% corticosteroid were adherent patients; while according to the MG test, 85% abiraterone and 81% corticosteroid were adherent patients.

Combining both methods, adherence data were observed to be higher in patients treated with abiraterone compared with corticoids (77% vs 42%), with no significant statistically difference (p=0.147)

Conclusion and relevance Abiraterone combined adherence is higher than corticoid adherence, but not statically significant in this small study group. Good adherence must be concomitant in both drugs in order to avoid side effects. This assessment helps identify patients with adherence problems and prioritise pharmaceutical care actions.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-224 IMPACT OF PROACTIVE MEDICATION RECONCILIATION PRIOR TO PRE-ANAESTHESIC CONSULTATION

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Background and importance Continuity of medication management in hospitals is a major issue today, and the clinical pharmacist has a key role to play in it. Surgical departments are particularly at risk, with a higher rate of unintended medication discrepancies (UMDs) found during medication reconciliation (MR) than in medical departments. An MR process prior to the pre-anaesthetic consultation (PAC) has been set up to improve the continuity of care for patients hospitalised in our vascular surgery department.

Aim and objectives The aim of our study was to assess the impact of carrying out proactive MR by a clinical pharmacist prior to the PAC versus retroactive MR.

Material and methods Proactive MRs were performed by a pharmacy intern and a pharmacy student, approximately 1 week before PACs. A telephone interview with the patient was carried out and then the retail pharmacy and/or primary care physician were contacted to collect the patient's prescriptions. The best possible medication history (BPMH) form was given