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

Conflict of interest No conflict of interest

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

to the anaesthetist and registered into the patient's medical record. Retroactive MRs were carried out, using the same sources, after the patient's entry and after the first prescriptions.

Results Over a 6-month period, 200 MRs were performed in the vascular surgery department. 100 were proactive MRs and 100 were retroactive MRs. Concerning the populations, the average age was 66 years for proactive MRs versus 69 years for retroactive MRs, with 56% and 69% of men, respectively. The average number of home treatments was 7.4 (1–14) for proactive MRs and 8 (2–18) for retroactive MRs. As regards the UMDs found, there were 26 for the proactive MRs (ie, 0.26 UMD/patient). For retroactive MRs, there were 150 UMDs (ie, 1.55 UMD/patient).

Conclusion and relevance There are more than 5.5 times fewer UMDs when MRs are carried out proactively before the patient's entry. Carrying out MRs for PACs enables the prescription to be anticipated and the anaesthetist to obtain an exhaustive list of the patient's treatments, which also avoids forgetting to stop some of them, particularly anticoagulants. The development of prescription assistance software with a pre-prescription module would be a step forward and an added value for the reduction of medication errors.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-225 INTEGRATION OF A CLINICAL PHARMACIST IN A THERAPEUTIC EDUCATION TEAM FOR DIABETIC PATIENTS: AN INITIATIVE THAT IS WORTH GOLD!

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Background and importance Since 10 September 2020, the new instruction relating to the gradation of ambulatory care allowed multidisciplinary day hospitalisations (MDH) to be carried out with three or four healthcare workers enabling the integration of a clinical Pharmacist (CP). Therefore, it permits incorporation of therapeutic patient education (TPE) in these MDHs for the patient's benefit, who meets all the healthcare workers at the same time.

Aim and objectives The aim of this study was to assess the patient benefit and the economic gain of integrating a CP into a diabetology TPE team.

Material and methods In January 2021, implementation of the MDH in our hospital by a multidisciplinary diabetology TPE team composed of a diabetologist, a nurse, a dietitian and a CP. Realisation of a patient satisfaction survey and an economic evaluation of the MDH model of TPE over 9 months. The overall gain of three and four healthcare workers in MDH represents € 326 and € 584, respectively, for healthcare workers repaid at the base rate used by the French Social Security system. The CP examined the global medication management of the patient via an interactive game in order to ensure a good compliance and the acquisition of safety skills.

Results This survey has shown that 98% of patients (n=41) were satisfied by the establishment of a pharmaceutical time in these MDHs and by the meeting of all the TPE team on the same day. In these MDHs the fourth healthcare worker is a CP. Therefore a MDH with four healthcare workers brings an additional profit of € 258 per MDH. From January to September 2021, 41 MDH of TPE with a CP were realised for an overall gain of € 23 944 and 82 MDH without a CP for an overall gain of € 26 732. This MDH model with four healthcare workers including a CP made it possible to obtain an additional profit of € 10 578 for 41 MDHs.

Conclusion and relevance The CP has their own place in this activity. This MDH TPE model provides a significant financial gain that can be used for the implementation of other projects. These MDHs enhance clinical pharmacy activities and can be extended to other chronic pathologies.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-226 THE ROLE OF THE CLINICAL PHARMACIST IN THE SCREENING OF CANDIDATES FOR ONCO-HAEMATOLOGICAL CLINICAL TRIALS

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Background and importance Over the last decade the number of clinical trials (CTs) has increased exponentially worldwide as well as their complexity.

The identification of possible interactions of the concomitant medication with the investigational drug is a key point to avoid bias in the study result, and to ensure patient safety.

The pharmacist, as a member of the investigational team, may also be involved in screening/randomisation of the subjects.

Aim and objectives To review the concomitant medication of patients who are candidates to start a CT in order to detect possible interactions.

Material and methods Descriptive study carried out in a tertiary university hospital over a 1-year period (September 2020–August 2021). All patients who were candidates to participate in an onco-haematology clinical trial that included an oral investigational drug were included. Information on pharmacological treatment was obtained through a clinical interview conducted in the pharmaceutical care consultation or by telephone. The inclusion/exclusion criteria relating to concomitant prohibited/authorised medication described in the protocol of each trial were applied.

We retrospectively collected: sex, diagnosis, concomitant medication, pharmaceutical interventions, type of intervention, how many of these were taking alternative medicine products, and number of screening failures.

Results A total of 410 patients (53.90% women) were interviewed. According to the diagnosis, 17.32% of the patients had lung cancer, 16.83% genitourinary, 16.10% neuroendocrine tumours, 14.88% breast cancer, 8.78% haematological tumours and 26.09% others. A total of 2262 drugs were reconciled, the median of which they took per patient (range) was 5 (0–16). Interventions were performed in 155/410 (37.80%) patients. Most of these (69.03%) were for suspension of treatment not authorised by protocol. 26.10% of the