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.

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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

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