patients were taking alternative therapy at the time of screening. Finally, 20.49% were screening failures.

Conclusion and relevance The results of our study show that approximately 4 in 10 patients require at least one change in their usual treatment.

The involvement of the pharmacist in the assessment of interactions may play a central role in the research process, which can directly influence the inclusion of a patient in a clinical trial.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-227 FEEDBACK FROM A REGION ON THE USE OF E-THERAPEUTIC PATIENT EDUCATION DURING THE HEALTH CRISIS: HIGH-SPEED INTERVIEWS!

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Background and importance The coronarovirus disease-19 (COVID-19) pandemic has strongly impacted organiation of care. Some patients with chronic diseases did not get their regular follow-ups. New digital health care techniques, such as e-therapeutic patient education (e-TPE), allowed maintenance of the continuity of these patients' care.

Aim and objectives Objectives of this study were to assess in a French region how TPE programmes have adapted during the lockdown due to the COVID-19 pandemic and to evaluate the establishment of e-TPE.

Material and methods A survey was conducted in February 2021 based on an online questionnaire containing 21 questions submitted to 180 TPE programme coordinators in a region. This questionnaire was composed by three parts: the first one is about TPE programmes that have been achieved, the second one concerns the adaptation of the sessions during the first lockdown, and the last one refers to the implementation of e-TPE.

Results A total of 62 questionnaires were collected corresponding to 80 TPE programmes in the region. The majority of health professionals (79%, n = 49) completely stopped their programmes during the first lockdown and 21% (n = 13) kept it either with reduced activity or with continued TPE sessions. Among the second group, the majority of their programmes have been adapted to the context: development of teleconsultation and e-TPE sessions. The e-TPE sessions were set up by 13 coordinators using different tools: internet platforms such as 'app'e-sante' or 'Mydiabby' and videoconferences. The advantages stated by healthcare professionals were: easy access to sessions and limited travel (n = 7), maintenance of the link with the patient (n = 5) and adaptability to the patient's organisational issues (n = 4). Drawbacks were also highlighted, in particular the lack of interaction between healthcare professionals and the patient (n = 8) but also some internet connection issues in certain residential areas (n = 5).

Conclusion and relevance The development of e-TPE allowed the decompartmentalisation of the ambulatory patients' care. The patients and healthcare professionals who participated in the digital sessions declared themselves to be fully satisfied. The e-TPE is a digital tool at the service of the clinical pharmacist to achieve their mission of health promotion.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-229 IMPLEMENTATION OF AN INTERPROFESSIONAL PREOPERATIVE MEDICATION MANAGEMENT PROGRAMME IN CARDIAC SURGERY: A PRE–POST QUALITY IMPROVEMENT STUDY

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Background and importance In order to ensure the efficacy and safety of a prescribed drug regimen during cardiac surgery, a standardised preoperative management strategy is needed in routine care. However, data are lacking on how many drugs need preoperative management and which strategies are effective in routine care.

Aim and objectives To investigate the overall need of preoperative medication management in cardiac surgery patients and to determine the efficacy of an interprofessional preoperative medication management bundle in routine care.

Material and methods An interprofessional cooperation of cardiac surgeons and hospital pharmacists developed an evidence-based preoperative medication management standard for the most common drugs (eg, oral anticoagulants, antidiabetics, etc.) which was subsequently implemented in clinical routine. Briefly, the standard was included in the admission letter for the primary care physician, sent to the referring hospitals, distributed as a pocket card to the physicians, and an interprofessional hotline for inquiries was made available. Before and after implementation, the timepoints of the last preoperative drug intake were assessed by pharmacists and cardiac surgeons according to the determined standard in two samples of consecutively admitted patients (except emergencies). The study was approved by the local ethics committee.

Results Before implementation, 222 of 273 included patients (78.7%) were admitted to surgery with at least one drug that needed active preoperative management according to the defined standard. Management was deemed correct for 30.0% of direct oral anticoagulants (DOAC) (n=52), 28.2% of metformin (n=39), 15.5% of sodium-glucose transporter II (SLGT-2) inhibitors (n=19) and 78.9% of prophylactic platelet inhibitors (n=142). Six months after implementation, 249 of 290 patients (85.9%) had at least one drug that needed to be perioperatively addressed. The number of correctly managed drugs increased for DOAC to 68.4% (n=57) and to 96.4% for platelet inhibitors in prophylaxis (n=167), but only slightly for metformin (n= 36) to 44.4% and to 24.0% for SLGT-2 inhibitors (n= 25).

Conclusion and relevance The standardised preoperative management bundle effectively improved perioperative drug therapy; however, the results indicate that there is potential for

further improvement, especially in patients referred from other hospitals.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-231 ARE WE SUSTAINABLE? A BASELINE QUESTIONNAIRE REGARDING THE ENVIRONMENTAL IMPACT OF PHARMACY PRACTICE ACROSS THE COUNTRY

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Background and importance We are on course for a global temperature rise which will see millions of people displaced, injured or dying through rising sea levels, starvation and disease by the end of this century. The health costs are projected to be extraordinary. The use of medicines and medicinal products create waste and pollution. The COVID pandemic and the relentless consumption of personal protective equipment (PPE) has escalated this issue. We must strive towards reducing waste, and ultimately pollution, in order to increase sustainability both for our patients, and for global health.

Aim and objectives To determine the awareness of qualified pharmacists across the UK with regard to the health risks of a climate crisis, as well as the impact of pharmacy on the environment.

Material and methods In July 2021, we invited all of our members (n=4788) to complete a short survey to gauge their understanding of the role of pharmacy in the promotion of a sustainable approach to healthcare via an emailed link to a 10-item survey in Webropol. The results were analysed using descriptive statistics and thematic analysis. No completion incentives were offered. Ethical approval was not required for this study.

Results One hundred and seven pharmacists responded to the survey (2.23% response rate). Ninety-four percent of respondents believed that there were aspects of pharmacy practice. Themes to improve sustainability included; sustainable prescribing and deprescribing, raising awareness and penalties for poor practice. Sixty-five percent of respondents provided suggestions on how the proposed changes could be measured, such as measuring the carbon footprint of your organisation, creating energy and waste logs as well as encouraging working from home. Ninety-four percent of respondents believed that aspects of practice were wasteful, and only 37% felt empowered to make change in their organisation. Ninety percent of respondents believed that an increased focus on climate change was required at an organisational level and that leadership was required at all levels of practice.

Conclusion and relevance Survey respondents believe that aspects of pharmacy practice are not sustainable; however, most do not feel empowered to make change. There is a need for national guidance to support changes in practice, and for local champions and leadership at all levels.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-232 PHARMACIST-LED MEDICATION REVIEW UNVEILED MORE MEDICATION-RELATED PROBLEMS IN POSSIBLY MEDICATION-RELATED HOSPITALISATIONS THAN IN UNLIKELY MEDICATION-RELATED HOSPITALISATIONS IN ELDERLY PATIENTS

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Background and importance Elderly patients are prone to unsafe and/or ineffective pharmacotherapy. Medication-related admissions are common in older people and over half of these hospitalisations are preventable.

Aim and objectives The aim of this study was to identify medication-related problems associated with medication-related admissions in hospital in older people.

Material and methods We performed a retrospective study by analysing the folders of patients over 75 years old, undergoing pharmacist-led medication review as part of the multidisciplinary geriatric mobile team, between March and October 2021. We performed the assessment tool for identifying hospital admissions related to medicine (AT-HARM10) to assess hospital admissions as being either possibly or unlikely medication-related (MRH). First, we compared demographic- and therapeutic-related variables between possibly and unlikely MRH. Therapeutic-related variables were number of treatments upon admission, potentially inappropriate medication as measured by both START/STOPP and PIMcheck, number of drug interactions, drug burden index (DBI), and number of medication errors during medication reconciliation at admission. Secondly, we performed univariate logistic regression by calculating odds ratios with 95% confidence intervals to identify mediation-related problems associated with MRH.

Results We included 67 patients, 32 possibly MRH and 35 unlikely MRH. Most demographics were comparable between the two groups except a higher proportion of women (81.3% *vs* 54.3%; $p<0.05$) and less under nutrition (16.7% *vs* 54.5%; $p<0.05$) in possibly MRH. In possibly MRH, we found higher numbers of (i) START/STOPP items (4.8 ± 2.7 *vs* 2.3 ± 2.0; $p<0.05$), (ii) PIMcheck overuses (2.0 ± 1.7 *vs* 1.3 ± 1.4; $p<0.05$), (iii) drug interactions (8.7 ± 8.9 *vs* 4.6 ± 4.9; $p<0.05$) and a higher DBI score (0.9 ± 0.8 *vs* 0.3 ± 0.5; $p<0.05$). Interestingly, we unveiled more medication errors during medication reconciliation at admission in possibly MRH (4.3 ± 3.3 *vs* 2.7 ± 2.3; $p<0.05$).

START/STOPP items (OR 1.54; 95% CI 1.21 to 1.96), PIMcheck overuses (OR 1.5; 95% CI 1.05 to 2.13), drug interactions (OR 1.13; 95% CI 1.02 to 1.24) were identified as medication-related problems associated with MRH. DBI (OR 5.8; 95% CI 2.05 to 16.42) was also significantly associated with MRH.

Conclusion and relevance Our results illustrate a balanced proportion of MRA in patients treated by the multidisciplinary geriatric mobile team. We unveiled more medication-related problems in patients possibly MRH than in unlikely MRH, suggesting that AT-HARM10 may be used to identify patients requiring priority on pharmacist-led medication review.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest