Background and importance Surgical patients are at risk of medication-related adverse events, with some of these patients having comorbidities requiring long-term medications prior to surgery. Published data suggest pharmacist interventions can reduce adverse drug reactions (ADRs) and medication errors and reduce hospital length of stay.

The effect of implementing a pharmacist into the HpB surgical ward round (WR) was unknown; this would also support ongoing service development projects in liver pharmacy on patient pathways.

Aim and objectives To establish the range and clinical impact of interventions made by the specialist pharmacist when attending HpB post-surgical WR as part of ongoing pharmacy engagement and service development.

1. To measure the number of interventions being made by the specialist pharmacist on WR.
2. To determine the common themes of pharmacist interventions.
3. To determine the proportion of 'on the spot' pharmaceutical advice given to healthcare professionals and patients as part of this process.

Material and methods A prospective study of 1 month, with attendance at two WR per week. Review of all postsurgical HpB on an inpatient ward. All interventions were collated and categorised based on commonality.

Results Over the course of data collection, the pharmacist reviewed 140 patients and made 477 interventions as part of the WR. This included 45 history medications restarted, identification of 32 ADRs to current treatment, 16 instances of vancomycin dose adjustments, confirmation of anticoagulation for 17 patients and addition of 101 antibiotic stop dates contributing to better antimicrobial stewardship. There were also 70 instances of a nurse/doctor/patient requiring additional information on medication treatments.

Conclusion and relevance This study has highlighted the scale of interventions a pharmacist can make on a WR, emphasising not only adjustment of medications but also the need for medication-related information by healthcare professionals and patients alike.

Moving forward a pharmacist will attend at least two WR per week, with potential scope for support in pre-assessment and postoperative clinics to review weaning of analgesia and long-term management of pancreatic replacement, for example.

With the recent announcement regarding new standards for the initial education and training of pharmacists in the UK, it would be valuable to assess the impact of a prescribing pharmacist on these WR.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-274 EVALUATION OF PHARMACEUTICAL INTERVENTIONS DOCUMENTED BY A PHARMACY TECHNICIAN: WHERE DO PHARMACY TECHNICIANS HAVE THE BIGGEST IMPACT TO AVOID DRUG-RELATED PROBLEMS?

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Background and importance In the field of clinical pharmacy services there are activities that are suitable for pharmacy technicians under the supervision of a pharmacist. At the university hospital in Dresden one full-time pharmacist and one half-time pharmacy technician (4 hours/day) are looking after 80 beds in the department of urology. The main tasks of the pharmacy technician are medication reconciliation as well as clinical prioritisation by using guidelines to identify patients who are at high risk of drug-related problems.

Aim and objectives The aim of this study was to identify the clinical pharmacy services where the integration of pharmacy technicians has the biggest impact on avoiding drug-related problems.

Material and methods Since 2019 the pharmacy technician has recorded their interventions in a categorical Excel worksheet, and there are two documentation weeks per quarter. The categories are drug name, short description of the drug-related problem, intervention, classification (dose-related problems, consultation of general practitioner, consultation of patient, electronic prescription, other drug-related problems after discussion with the pharmacist, drug substitution).

Results During 22 documentation weeks from January 2019 to September 2020 the pharmacy technician documented 468 interventions. The main interventions were drug substitution on admission considering local guidelines (n=181; 39%), consultation with the general practitioner because of identified discrepancies on the medicine lists (n=138; 29%) and consultation with patients because of identified discrepancies (n=78; 17%). Dose-related interventions and other drug-related problems were detected by the pharmacy technician and discussed with doctors under the supervision of the pharmacist (n=49; 10%).

Conclusion and relevance Especially in the field of medication reconciliation, trained pharmacy technicians can be suitable to prevent medication errors. Consultations with general practitioners and patients because of identified discrepancies on the medication lists are time-intensive and probably would not happen in the same way without integration of the pharmacy technician. Drug substitution in consideration of local guidelines and the preparation of the electronic prescription led to fewer queries from nurses or doctors.

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Conflict of interest No conflict of interest

Section 5: Patient safety and quality assurance

5PSQ-003 DEVELOPMENT AND APPLICABILITY OF THE MEDHIPPRO-Q: A QUESTIONNAIRE ASSESSING MEDICAL DOCTORS' EXPERIENCE WITH MEDICATION MANAGEMENT IN THE HIP FRACTURE PATIENT PATHWAY

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Background and importance Hip fracture patients are characterised by polypharmacy and multiple care transitions within and between home, hospital, and rehabilitation institution/nursing home (ie, the patient pathway). Each care transition increases the risk of medication discrepancies. Thus, there is need to achieve a correct medication list, optimised for each patient, and ensure a seamless patient handover. Before implementing a clinical pharmacist intervention to address these issues, an evaluation of medical doctors' perceptions of the current situation was needed. However, no appropriate questionnaire was identified.
Aim and objectives To develop a valid and feasible questionnaire to assess medical doctors' experience with medication management of hip fracture patients in all care settings, and present an example of its applicability.
Material and methods The study took place in a region in South-Eastern Norway (approximate population: 250 000) from September 2017 to August 2018. The emerging questionnaire (MedHipPro-Q) was developed qualitatively through semi-structured interviews with stakeholders, cognitive interviews with future respondents, and a feasibility test. The novel MedHipPro-Q was thereafter distributed to hospital doctors.
Results Three questionnaire dimensions were identified: (1) Medication reconciliation and review, (2) Communication of key information and (3) Profession and setting. The MedHipPro-Q showed face and content validity through its representativeness of how stakeholders experienced medication management in all settings, and good feasibility. Almost half of the doctors in the emergency care unit responded (n = 9/20). They described medication lists missing at admission (n = 7/9), and using median 6–10 (range 3–20) min writing the medication part of the admission journal. In the orthopaedic department, 15/31 responded, and expressed that patients needed more medication reviews (n = 12/15), but wished for someone else to perform it (n = 13/15). A third of the doctors in the orthopaedic department (n = 5/15) always write the mandatory medication list at discharge.
Conclusion and relevance The MedHipPro-Q showed emerging validity and appeared feasible. It was able to identify problem areas that could be addressed by the planned clinical pharmacist intervention.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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5PSQ-006 DOSING LOW MOLECULAR WEIGHT HEPARINS IN RENAL IMPAIRMENT: A NATIONWIDE SURVEY

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Background and importance International guidelines vary in their advice whether or not to reduce the therapeutic dose of low molecular weight heparins (LMWHs) in renal impairment. The use of anti-Xa monitoring as a basis of dose adjustments is also a matter of debate.
Aim and objectives To study the nationwide treatment policies of therapeutically dosed LMWHs in renal impairment in hospitals.
Material and methods An 11-item survey was distributed to clinical pharmacists nationwide between June 2020 and March 2021. Primary outcome was the hospital dosing regimen for therapeutically dosed LMWHs in renally impaired patients. Secondary outcomes were the proportion of hospitals that used anti-Xa monitoring and the anti-Xa target range used. Descriptive statistics were used to analyse the data.
Results The survey was completed by 56 of the 69 (81%) hospital organisations nationwide. Of the included hospitals, 91% applied a fixed-dose reduction at the start of the LMWH treatment in renally impaired patients (71% reduced if estimated glomerular filtration rate (eGFR) <50 mL/min and 20% if eGFR <30 mL/min). The majority (64%) of hospitals applied a dose reduction of 25% if eGFR is 30–50 mL/min and of 50% if eGFR is <30 mL/min. Anti-Xa levels were not routinely monitored in renally impaired patients in 43% of hospitals, while 20% of hospitals monitored anti-Xa if eGFR <50 mL/min, 25% if eGFR <30 mL/min and 12% with other eGFR cut-off values. Target ranges of 1.0–2.0 IU/mL (once-daily dosing) and 0.5/0.6–1.0 IU/mL (twice-daily dosing) were used in 69% of hospitals that monitored anti-Xa.

The most commonly applied treatment regimen was dose reduction if eGFR <50 mL/min without anti-Xa monitoring, regardless of the type of LMWH.
Conclusion and relevance This study demonstrates substantial nationwide diversity in the treatment policies of therapeutically dosed LMWHs in renally impaired patients in hospitals. The most commonly used treatment regimen in hospitals is to apply a fixed dose reduction if eGFR is <50 mL/min, without anti-Xa monitoring. This treatment regimen is not yet described in LMWH treatment guidelines in renally impaired patients and should be explored in future research.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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5PSQ-008 ASSESSMENT OF PATIENT-CONTROLLED ANALGESIA (PCA) PRACTICES IN A PUBLIC HOSPITAL

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Background and importance PCA pumps help patients manage their pain by guaranteeing them autonomy, while lightening nursing workload. In this context, the prescriptions must contain the information necessary for secure programming (background dose, bolus, inter-dose, *etc*.) leaving no possibility for interpretation. This project was founded in response to repeated adverse event reports concerning patient-controlled analgesia (PCA) (8 reports between 2017 and 2020 with a majority of overdoses requiring care).
Aim and objectives An assessment of the prescription and monitoring of PCA is carried out with the aim of having a database in order to standardise the method of prescription using a multidisciplinary working group.
Material and methods Information is collected through an interview of the health executive of each department using a