Data on antimicrobial prescribing in PC were obtained from a public database with anonymised data on the total number of items of each drug prescribed. Hospital data were obtained from the clinical unit of pharmacy.

Results Between March 2020 and February 2021 antimicrobial consumption decreased –36.0% (7.3 vs 11.4 DID) in PC and increased +37.5 (16.5 vs 12.0 DID) in HC, both compared to the same period of the previous year.

The most prescribed antimicrobials in PC before the COVID-19 pandemic were amoxicillin, amoxicillin/clavulanate, doxycycline, azithromycin, ciprofloxacin, and between March 2020 and February 2021 these were amoxicillin/clavulanate, amoxicillin, doxycycline, ciprofloxacin and azithromycin.

The most prescribed antimicrobial used in HC before the COVID-19 pandemic were amoxicillin/clavulanate, levofloxacin, piperacillin/tazobactam, ceftriaxone and ciprofloxacin, and between March 2020 and February 2021 these were amoxicillin/clavulanate, ceftriaxone, azithromycin, piperacillin/tazobactam and meropenem.

Comparing the COVID period with the previous year, in PC the antimicrobial that most decreased in consumption was phenoxymethylpenicillin (–66.59%). Amoxicillin decreased by –52.13%, clarithromycin (–50.60%), moxifloxacin (–45.98%), levofloxacin (–44.42%), amoxicillin/clavulanate (–35.55%) and azithromycin (–29.05%). For HC the antimicrobial that most increased in consumption was azithromycin (+721.42%), followed by amoxicillin (+602.0%), ceftriaxone (+184.34%), vancomycin (+116.9%) and amikacin (+88.79%). Meropenem DID increased by +52.94%.

Conclusion and relevance The COVID-19 pandemic has impacted on the increase in antimicrobial use in HC along with a proportional decrease in PC.

Antimicrobial prescription patterns in PC remain stable. The increase in amoxicillin/clavulanate over amoxicillin may be related to non-contact patient care (telemedicine).

In HC, antimicrobial stewardship strategies can help return the consumption of broad-spectrum antibiotics to acceptable levels.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-148 TANDEM PROJECT: TRANSITIONS OF CARE AND MEDICATION RECONCILIATION IN HIGH-RISK PATIENTS

C Ortega Navarro*, A de Lorenzo Pinto, R García Sánchez, B Torroba Sanz, A Herranz Alonso, M Sanjurjo Sáez. *HGU Gregorio Marañón, Pharmacy, Madrid, Spain*

10.1136/ejhpharm-2022-eahp.427

Background and importance The implementation of medication reconciliation programmes is a quality standard in health centres according to the recommendations of national and international patient safety organisations to reduce medication errors during transitions of care.

Aim and objectives Main objective was to implement a medication reconciliation programme in high-risk patients admitted to a tertiary hospital. Secondary objective was to promote patient safety by detecting medication errors that occur during transitions of care.

Material and methods Selection of high-risk patients by two clinical pharmacists physically present in the Emergency Department.

At admission, pharmacists make an advanced medication review and interview the patient or carers to obtain a complete and accurate home medication list. When a potential prescribing error is detected, the pharmacist makes a pharmacotherapy recommendation (PR) to the physician.

At discharge, pharmacists review the medication list on the discharge plan and interview patients via telephone within 72 hours post-discharge to confirm that they have understood the new treatment plan. If the pharmacist detects an error, he/she makes a PR directly to the patient.

The impact was measured with the number of PR and the severity of the detected prescribing errors according to the National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) severity index at admission and discharge.

Results Between February 2018 and September 2021, a total of 789 patients were included in the programme (53.3% women, mean age 81.3 years (SD 9.65)). Mean number of home medications at admission was 11.2 (SD 4.30). Pharmacists made a total of 1140 PR to physicians (1,5 per patient). Main types of prescribing errors were: omission of a drug (37.3%), wrong drug (23.6%), wrong dose (21.0%) and wrong frequency (11.2%). A total of 707 (62.0%) prescribing errors could have caused harm to the patient (NCC MERP severity index, Category $\geq$ E). Physician acceptance rate was 92.5%.

At discharge, 277 patients were interviewed by a pharmacist via telephone; 46.9% did not understand at least one aspect of the discharge medication list. Pharmacists made 336 PR to patients and 64.6% of the detected errors could have caused harm.

Conclusion and relevance We have succesfully implemented a medication reconciliation program in high-risk patients that allows us to detect medication errors at admission and discharge.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-150 IMPLEMENTATION OF A PROGRAM FOR OPTIMISING THE USE OF ANTIBIOTICS (PROA) IN THE PAEDIATRICS EMERGENCY CARE UNIT OF A THIRD-LEVEL HOSPITAL

[1]I Garcia Del Valle*, [1]G Morla Clavero, [1]P Marcos Pacua, [2]N Joaqui Lopez, [1]M Garcia Pelaez, [1]G Baronet Jordana, [1]M Sanmartin Suñer, [1]L Val Prat. *[1]Hospital Universitario General de Cataluña, Pharmacy, Sant Cugat del Valles, Spain*; *[2]Hospital Universitario General de Cataluña, Pediatrics, Sant Cugat del Valles, Spain*

10.1136/ejhpharm-2022-eahp.428

Background and importance P*rograms for optimising the use of antibiotics (PROA)* have been demonstrated to be useful tools to guarantee the rational use and adequacy of antibiotics, while decreasing the risk of developing treatment resistances.

Given the extensive use of antibiotics and, in order to expand the program, we decided to study the possibility of including the paediatric emergency care unit as part of the PROA.

Aim and objectives The main objectives of the study were:

To identify the need for a PROA in the paediatrics emergency care unit of a third-level hosptital by analysing the current situation.

To analyse the adequacy of the antibiotics prescribed (indication and duration) according to the local guide of the centre.