

4CPS-155 APPROPRIATENESS OF PHARMACOTHERAPY IN NURSING HOMES: PHARMACY AND GERIATRICS SERVICES COORDINATION PROJECT

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Background and importance Potentially inappropriate prescriptions (PIPs) in elderly persons lead to increased morbidity and mortality, greater number of hospital admissions and use of healthcare resources. The periodic clinical review of the prescriptions is necessary to adapt the pharmacotherapy to the current situation of the patient, and the incorporation of the pharmacist in the multidisciplinary team is therefore essential.

Aim and objectives Appropriateness of pharmacotherapy (AP) and analysis of the interventions carried out in elderly patients from nursing homes (NHs) with polypharmacy.

Material and methods Prospective study carried out from October 2020 of a programme of AP in polymedicated patients of NHs, through the implementation of a project for the coordination of Geriatrics, Pharmacy and NHs from a university hospital. The pharmacist carried out a pharmacotherapeutic review of the active prescriptions of the patients, and subsequently prepared an individualised report with proposals for therapeutic optimisation and sent it to the geriatrician for evaluation. PIPs were identified by explicit/implicit criteria (STOPP/START, BEERS, LESS-CHRON, MAI) and CheckTheMeds software, and were classified according to the Third Granada Consensus on Medication-Related-Problems (MRPs). The economic impact was calculated from the direct costs of the discontinued drugs.

Results 102 patients (74.5% women) were revised with feedback from 10 NHs. Median age 88 (IQR 84–93) years. Average of pathologies per patient: 8. Median of prescribed drugs: 13 (IQR 11–15).

495 prescriptions with possible MRPs were detected, the main ones being: unfavourable risk–benefit balance according to the functional situation (29.3%), probability of adverse events (17.6%), inadequate duration of therapy (18.4%), inadequate dose/regimen (16.4%) and duplication (5%). 41% corresponded to PIPs according to STOPP/BEERS or LESS-CHRON criteria. According to the therapeutic group, MRPs have been detected mainly in drugs from group A: 30%, N: 24.2%, C: 18.4% and M: 14%.

81% of the detected MRPs were intervened, with a degree of acceptance of 73%. The main interventions were: suspension or deprescription of drugs (67%) and dose reduction or change of frequency of administration (24%).

23% reduction in the number of drugs prescribed/patient, with an economic saving of € 2550/month and € 15 700/6 months.

Conclusion and relevance Deprescription strategy in our NHs has been efficient, since a high number of interventions with a high degree of acceptance have been detected. AP supposes great support to clinicians, promoting the rational use of the drugs.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

4CPS-156 ANTIMICROBIAL STEWARDSHIP PROGRAMME IN A GENERAL SURGERY SERVICE: ROLE OF THE PHARMACIST

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Background and importance The aim of antimicrobial stewardship programmes (AMS) is to improve clinical outcomes, minimise associated adverse events and avoid the potential emergence of resistance. The General Surgery Service (GSS), given its complexity, heterogeneity and need to treat varied and complex infections, is a service potentially benefitting from these interventions.

Aim and objectives Our objective was to analyse the recommendations issued by the pharmacist and evaluate the degree of acceptance by surgeons.

Material and methods A prospective study was carried out between February and April 2021. Patients with antimicrobial treatment for ≥ 4 days were included. Recommendations were: duration of treatment, dosage optimisation, early sequential therapy (EST) (at 72 hours if clinical stability criteria, availability of oral route and existence of antimicrobial for oral administration). Recommendations were made after reviewing the clinical course and microbiological data. They were considered accepted if the prescription was modified after 24 hours. The variables were: gender, age, previous intensive care unit (ICU) stay and initiation of treatment, isolated microorganism, empirical versus targeted treatment, drug, recommendation category and their acceptance, mean of days from discontinuation of treatment to discharge and need to restart antimicrobial therapy at 7 days.

Results 75 recommendations were made. 58 patients were included with a mean age of 69 (SD 15.8) years and 58.7% men. 36% were admitted from the ICU where antimicrobial treatment was started in 66.8%. The most frequent microorganisms were *Escherichia coli* (13.4%), *Enterobacter cloacae* (10.4%) and *Enterococcus faecium* (8.9%). Treatment was empirical in 68%. Recommendations were: duration of treatment (84%), EST (9.3%), dosage optimisation (6.7%). 66.6% of them were accepted. Most drugs prescribed were: piperacilin/tazobactam (34.7%), amoxicillin/clavulanic acid (16.0%), meropenem (13.3%). Mean of 5 days from discontinuation of treatment to discharge. Need to restart antimicrobial therapy at 7 days (4%).

Conclusion and relevance The duration of antimicrobial therapy was one of the main reasons for inappropriate use in the GSS. A third of patients came from the ICU. All of these make the participation of the pharmacist as a cornerstone of ASP essential. Recommendations were well accepted; however, periodic communication between pharmacists and physicians could be a strategy to optimise treatment, improving efficiency and security.

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