240 mg q.wk (2), brodalumab 210 mg q.wk (3), tocilizumab 8 mg/kg q.4.wk (1), guselkumab 100 mg q.4.wk (2), and ustekinumab 90 mg q.8.wk (1). Median previous lines in H3 patients were 1 (IQR 1-3), and five of H3 patients does not show a satisfactory improvement with current treatment. Only 3 patients showed an adherence <80% to treatment based on recorded dispensations.

Conclusion and Relevance Most patients with moderate to severe HS do not respond at approved dose of adalimumab, forcing to use higher doses or switching to other biological treatments, which are also used at higher doses than indicated in the Summaty Product Characteristics. Unfortunately, these treatments are not always effective, and there is no consensus about how to manage it. It is necessary to keep a close follow up of these patients, looking for adverse events and lack of adherence.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest

4CPS-067 A CROSS-SECTORAL PHARMACIST INTERVENTION FOR PATIENTS IN TRANSITION BETWEEN HOSPITAL AND GENERAL PRACTICE: A PILOT STUDY

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Background and Importance Drug-related problems (DRPs) in cross-sectoral transitions are often seen, primarily due to inconsistent information about patients' medicines at transfer.

Aim and Objectives To test a cross-sectoral pharmacist intervention for patients in healthcare transitions.

Material and Methods The study was performed in one hospital and four General Practices (GPs). The pharmacists had shared employment between the Hospital Pharmacy and the GPs.

Intervention

Transition GP to Hospital

Medication history, medication reconciliation, updating the Shared Medication Record (SMR).

Transition Hospital to GP

Medication review, overview of medication changes, follow-up telephone calls, communication with GP on DRPs.

The intervention was tested in one GP and evaluated descriptively.

Afterwards, the intervention was tested in four GPs with differing characteristics and evaluated qualitatively (semi-structured interviews).

Results Test in one GP:

Transition GP to Hospital (n=14)

The GP updated the SMR in 86% of patients. The medication history revealed discrepancies between SMR-prescriptions and actual medication intake in 64% of these patients; 91% of discrepancies were easily solved by correcting the SMR.

Transition Hospital to GP (n=30)

Hospital medication changes occurred in 79% of patients; 71% were communicated to the GP and 42% to homecare nurses.

Medication reviews revealed 55 DRPs in 67% of patients, mostly related to medication reconciliation, dose or interactions.

Follow-up telephone calls on 23 patients revealed DRPs in 30% of these.

Test in four GPs:

Seven interviews were performed – one per GP, three with the pharmacists involved (mean 71 minutes).

Clinical staff had positive attitudes towards the intervention and saw the advantages of a pharmacist with a shared employment. Economics were identified as a barrier for future implementation.

Pharmacists in smaller GP clinics had easier access to clinicians and felt a more integrated member of the team.

The larger clinics were more structured and used to interdisciplinary collaboration, allowing the pharmacist more freedom to work independently.

Conclusion and Relevance GPs had little focus on updating the SMR prior to admission. Medication changes and follow-up plans were not always communicated to the patient, GP or homecare at discharge.

Shared employment with unique access to health records in both sectors was the most important tool in identification and resolution of DRPs.

The intervention was transferable to other GPs and was considered acceptable and relevant by all.

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Conflict of Interest No conflict of interest

4CPS-068 CONDUCTION OF AN AUDIT TO REDUCE THE ECONOMIC LOSS DUE TO UNUTILISED ONCOLOGICAL DRUG PREPARATIONS

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Background and Importance The costs related to unutilised oncological drugs preparations have the greatest impact on the expense of a hospital. In order to reduce wastes, it is possible to act on procedure that leads to failure to administer an already compounded oncological drug. This represents an economic loss for hospital.

Aim and Objectives The aim of the study is to identify the reasons that led to the failure to administer the compounded oncological drugs, in order to reduce errors and, wastes and economic loss.

Material and Methods The analysis was conducted between January-August 2022. Data were collected through an array including protocol, dosage, ward and reason for non-administration. It also included whether the drug had been reused (totally or partially) or thrown away and the economic loss. To conduct the analysis an audit was carried out between doctors, pharmacists and nurses aimed at identifying both the reasons that causes the economic loss and possible improvements.

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