

facilitate patient care. This algorithm is the subject of a parallel work.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-222 THE REAL-LIFE OF BENZODIAZEPINES IN GERIATRIC DEPARTMENTS: CAN THE PHARMACIST HAVE AN IMPACT?

¹C Tan*, ¹P Carlier, ¹R Devaux, ¹M Pottier, ²A Nare, ¹L Real. ¹Centre Hospitalier D'arras, Pharmacy, Arras, France; ²Centre Hospitalier D'arras, Geriatric, Arras, France

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Background and Importance Benzodiazepines and derivatives (BZD) are anti-anxiety or hypnotic drugs. They are frequently prescribed over a long period of time and are rarely re-evaluated. However, they can cause side effects, especially among the elderly. It is then necessary to reassess the treatment. Through his activities, the pharmacist may participate at a re-evaluation of treatment (pharmaceutical validation, medication reconciliation process).

Aim and Objectives This study assesses the impact of the pharmacist in the re-evaluation of benzodiazepines treatments.

Material and Methods An extraction of prescriptions containing at least one BZD in a geriatric ward was conducted for 4 months. A pharmaceutical analysis of the prescription is carried out, then pharmaceutical interventions are made by message to the prescribers via our prescription software in order to propose substitutions, dosage reductions or stoppage of treatments by BZD.

At the patient's discharge, a comparison of the exit prescription and the prescription during the hospitalisation allows us to know if the pharmaceutical interventions were accepted. Some patients have had a medication reconciliation process during which the same proposals are made to the doctor.

Results A total of 202 BZD were prescribed to the geriatric unit over 4 months, representing 169 patients. Of these, 34.2% were initiated during hospitalisation and 65.8% were home treatments.

A pharmaceutical intervention was performed in 71% of cases: a substitution was proposed in 40%, a dosage decrease in 13.3%, a re-evaluation of exit treatment in 15% and a discontinuation in 31.7%.

A total of 55% of pharmaceutical interventions were accepted at the discharge of patient.

Among the 169 patients, 12.4% received a medication reconciliation process during which pharmaceutical interventions were done: a substitution was proposed in 28.6% of cases, a dosage decrease in 19% and a discontinuation in 52.4%. In 100% of cases, they were accepted.

Conclusion and Relevance Through this study, we analyse that the pharmacist has a positive impact on the re-evaluation of treatments, especially during the medication reconciliation process where a review of BZD drug relevance is carried out with the geriatrician. It would be interesting to analyse if the presence of a pharmacist on the ward may improve the acceptance of pharmaceutical interventions and allow more medication reconciliation processing.

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4CPS-223 A STUDY ON THE PERCEPTION OF ELDERLY PATIENTS ON THE EXPIRATION DATE AND STORAGE OF PRESCRIBED MEDICATION: A QUESTIONNAIRE STUDY

E Byun*, S Hong, N Kim, S Baek, K Yeon. VHS Medical Centre, Pharmacy Department, Seoul, South Korea

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Background and Importance Due to the increase in the elderly population in Korea, the number of powdered medicines and long-term repackaging of prescriptions has increased. As a result, the safety of medicines is becoming vulnerable.

Aim and Objectives This study aims to find out how elderly patients perceive the expiration date and storage of prescription drugs and to consider appropriate patient education for the safe use of drugs.

Material and Methods A cross-sectional study was conducted among 221 elderly outpatients from 14 December 2022 to 21 April 2023 at Veterans Health Service (VHS) medical centre in Seoul, South Korea. The questionnaire was divided into five parts. We used a Chi-squared test and Fisher's exact test to compare each group and $p < 0.05$ was considered statistically.

Results A survey of 213 people was analysed, excluding eight who dropped out. When asked about the expiration date of the prescribed medicines, the most people responded '3 months'. The main storage place for medicines was the 'living room/bedroom drawer' at 30.52%. The main storage places for powdered medicines were 28.64% for 'refrigerator/kimchi refrigerator' and 26.29% for 'living room/bedroom drawer.' There were 136 people (63.85%) who responded that they would grind 3 months' worth of powdered medicine at once, and the most common reason given by 66 people (30.99%) was 'difficulty in grinding'. Seventy-seven people (36.15%) said they would crush the pill every time they took it, and the most common reason was 'risk of deterioration' at 37 people (17.37%). There was no statistically significant difference when analysing the perception of expiration date and storage of medicines according to drug managers and perception of powdered medicine according to whether or not to prescribe powdered medicine.

Conclusion and Relevance Elderly patients recognised the expiration date of oral medicines was shorter than recommended by the Korean Pharmaceutical Association. There was also a lack of awareness of how to properly store medicines. Therefore, in consideration of drug safety, long-term prescriptions, repackaged prescriptions, and powdered preparations should be avoided if possible. If medical institutions conduct patient education for the safe use of medicines, they will be able to provide proper pharmacist services that consider the safety of medicines.

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4CPS-224 MEDICATION RECONCILIATION IN A SURGERY DEPARTMENT: 6-MONTHS' EXPERIENCE

A Leal*, T Cunha, P Barbeita, A Mendes, P Rocha. Centro Hospitalar Universitário De Santo António, Pharmaceutical Services, Porto, Portugal

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Background and Importance Medication Reconciliation (MR) allows us to reduce medication errors that are very likely to occur in care transitions like admission, transfer and clinical discharge. In our country, a few hospital institutions have MR, although the effectiveness of this method and Pharmaceutical Interventions (PI) in preventing adverse reactions, drug interactions and prescription errors. is known.

Aim and Objectives Establishing MR for patients at a vascular surgery department, in a tertiary care university hospital, to evaluate its impact in prescription error prevention and to characterise PI and its acceptance in our centre.

Material and Methods MR applied in the first 48 hours of patient admissions between April 2023 and September 2023. Inclusion criteria: age ≥ 35 years, presence of comorbidities and pharmacotherapy with ≥ 3 drugs. Elaboration of Best Possible Medication History (BPMH) taking ≥ 3 sources of information into account, comparison with medical prescription for identification and classification of discrepancies. Discussion of PI with prescribers, data recording and analysis using Microsoft Excel.

Results Of 210 patients (77.4% male), 16 were excluded for intervention rescheduling, sudden clinical discharge or transfer between departments. Medium age was 70.7 years [range 35; 92] and we found a medium of 4.7 comorbidities per patient as hypertension, dyslipidaemia and diabetes were the most prevalent. For BPMH gathering, medical records (28.8%), patient interview (25.0%) and drug packaging (20.2%) were the most used sources of information. In 202 MR, 3,010 prescription lines were analysed and 77.5% of them contained discrepancies. Of those, 31.5% were unintentional with potential to cause harm to patients. A total of 761 PI were made with 89.1% acceptance by prescribers, mostly for drugs with cardiovascular (32.5%), central nervous system (18.8%) and endocrine (13.9%) action. Drug omission was the most frequent medication error (62.8%), followed by erroneous dose (16.9%) and erroneous drug (6.1%). It was detected 348 pharmacological interactions and 37 adverse events with independent PI, whenever patient harm was considered.

Conclusion and Relevance MR allowed us to reduce and prevent a major number of medication errors, as almost 90% of PI were accepted by physicians. This method should be implemented in most susceptible hospital departments, as a clinical pharmacist presence benefits all of the healthcare team, the patient and medication safety.

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4CPS-225

DEFINING INTERNATIONAL CRITICAL CARE PHARMACIST ASPIRATIONS TO THE MANAGEMENT OF SEPSIS

¹R Oakley, ²S Guntschnig*, ¹S Al-Mahdi, ¹H Trinh, ³M Custodio, ¹S Khorshid, ⁴D Lonsdale, ⁵A Gous. ¹ST. George's University Hospitals NHS Foundation Trust, Pharmacy, London, UK; ²Tauernklinikum GmbH, Clinical Pharmacy, Zell Am See, Austria; ³Chesapeake Regional Medical Center, Pharmacy, Chesapeake, USA; ⁴ST. George's University Of London, Clinical Pharmacology, London, UK; ⁵Sefako Makgatho Health Science University, Pharmacy, Garankuwa, South Africa

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Background and Importance Clinical pharmacist input in intensive care unit (ICU) patient care varies greatly among different countries and settings.

Aim and Objectives To identify areas of desired professional contribution and development, whilst exploring variability. This is envisaged to support leadership activities to enhance the clinical pharmacist workforce based on evolving ICU infrastructures.

Material and Methods Clinical pharmacists involved in the management of sepsis in the ICU setting were surveyed using semi-structured interview methods. Institutional ethical approval for the study was obtained, which included a data protection impact assessment. Recruitment via non-probability convenience and snowball sampling of registered pharmacists proficient in the English language occurred between 31 May 2013 and 13 July 2023. Data saturation determined the sample size. Remote interviews were conducted via Zoom. Interviews were transcribed, coded and thematically analysed in line with Braun and Clarke's six-stage process. As this was an exploratory study, no theoretical assumptions were addressed.

Results Twenty participants from 14 countries participated. Reported aspirations varied between pharmacists working in dedicated ICU roles based at the bedside and non-dedicated ICU roles with little/no bedside component. Overcoming multifaceted professional barriers associated with physical, social, financial and training/education themes relative to local/national contexts were consistently reported. As were research aspirations. Physical and social themes were associated with scope of practice and ICU/patient record access. This included sepsis identification, initiating antimicrobials, individualising/altering antimicrobial dosing and ownership of therapeutic drug monitoring (TDM) activities. Improving multidisciplinary team integration, stakeholder perceptions, digital infrastructures and legislation were identified as key vehicles. Improved financial incentives were interlinked with stakeholder perceptions and metric capture associated with pharmacist contributions. Whereas education/training was desired for workforce standardisation, increasing scope of practice and improving research outputs. Including increased/improved TDM practices supplemented by pharmacokinetic/pharmacodynamic expertise, enhanced by point-of-care devices and metagenomics.

Conclusion and Relevance The content and variation in ICU clinical pharmacist aspirations worldwide reflects a broader disparity in ICU clinical pharmacist adoption/contribution worldwide, particularly in Europe. Leadership and research addressing study identified themes is required to enable pharmacists to maximise their impact on the care of septic patients. This must demonstrate the value of ICU clinical pharmacists to different stakeholders to promote adoption, capability enhancement and research outputs.

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4CPS-226

PHARMACEUTICAL INTERVENTION ON THE ADEQUACY OF THE INDICATION OF SEMAGLUTIDE IN DIABETES MELLITUS 2

CM Dominguez Santana, ME Blanco Rivas, V Vazquez Vela, EJ Alegre Del Rey, JM Borrero Rubio*. Hospital Universitario Puerto Real, Hospital Pharmacy, Puerto Real, Spain

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Background and Importance Semaglutide is a GLP-1 analogue approved for the treatment of adults with poorly controlled type 2 diabetes mellitus (DMII). It has been shown to reduce blood glucose levels and the risk of health complications. It