

**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  $\geq 35$  years, presence of comorbidities and pharmacotherapy with  $\geq 3$  drugs. Elaboration of Best Possible Medication History (BPMH) taking  $\geq 3$  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.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of Interest** No conflict of interest.

4CPS-225

### DEFINING INTERNATIONAL CRITICAL CARE PHARMACIST ASPIRATIONS TO THE MANAGEMENT OF SEPSIS

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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.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

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4CPS-226

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

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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

also produces weight loss, an effect considered beneficial in this type of patient. This has led to inconsistent prescribing, and it has even been used to reduce weight in obese non-diabetic patients. As a consequence of the increase in inappropriate use, in March 2023 the Spanish Agency for Medicines and Health Products issued a shortage alert.

**Aim and Objectives** Implementation of a strategy to review the suitability of semaglutide to its therapeutic indication and intervention in inappropriate prescriptions.

**Material and Methods** Prospective descriptive study including all patients on active treatment with semaglutide. An intervention strategy was implemented by reviewing all medical prescriptions, stratifying patients by hospital services, and drawing up lists of patients who did not comply with the authorised indications. In August 2023, meetings were held with the doctor in charge of each department to communicate the need for review and the suspension of treatment of patients who did not comply with the indication.

**Results** Sixty patients were reviewed, 62% male, with a median age of 54 years. Active semaglutide prescriptions by hospital services were as follows: 55% Endocrinology, 18.3% Cardiology, 16.7% Internal medicine, 3.3% Nephrology, 3.3% Mental health, 1.7% Dermatology and 1.7% Traumatology. 28.3% of patients had DMII, 46.7% did not and 25% had pre-DMII. Of the patients without DMII, 100% were obese. It was agreed to suspend treatment for all patients who did not comply with the indication.

**Conclusion and Relevance** The procedure has provided insight into the conditions under which semaglutide is being used. In the context of stock-outs, the suspension of semaglutide in patients with off-label use allowed access for poorly controlled diabetic patients. The adequacy review can be extrapolated to the abuse and/or misuse of any drug as part of the rational medicine use strategy.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

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### 4CPS-227 PHARMACEUTICAL REVIEW AND PHARMACEUTICAL INTERVENTION IN A NURSING HOME TO ENHANCE THE MEDICATION MANAGEMENT OF RESIDENTS

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**Background and Importance** Geriatrics is particularly concerned by iatrogenic medication accidents, especially in nursing homes (NH) where residents are often polypathological and can spend months without treatment reevaluation.

**Aim and Objectives** Enhance the medication management of residents in NH.

**Material and Methods** Pharmaceutical review (PR) conducted during multidisciplinary meetings, based on computerised prescriptions, biological and clinical data from the electronic patient record, and then compared to national references. Subsequently, the pharmaceutical interventions (PI) carried out are quantified and analysed.

The anticholinergic score (AS) was calculated for each resident using two assessment scales: the ACB (Anticholinergic Cognitive Burden) and CIA (Cholinergic Drug Burden) scale.

**Results** Among 71 residents, 142 PIs were carried out, with a 58.5% acceptance rate (n=83) of the physician, averaging two PIs per resident.

Most PIs (33.1%; n=47) concerned unsuitable medication for the elderly, with a 61.7% acceptance rate. Initially, 62 potentially inappropriate medications (PIMs) were identified for 38 residents, averaging 0.87 PIMs per resident. After the PR: only 33 PIMs remaining for 25 residents, averaging 0.47 PIMs per patient.

A high AS was found for 20 residents. Twenty-six PIs (18.3%) with a 42.3% acceptance rate (n=11) were performed in attempts to reduce these AS: which resulted in a decrease from five residents with a significant ACB score to three, and from 15 residents with a high CIA score to 11.

Seventy-four PIs (52.1%) were related to nervous system drugs. After a multidisciplinary discussion with geriatricians and psychiatrists, 43.2% of these PIs (n=32) were accepted. Substitution was the most recommended type of PI (n=38), resulting in a modest reduction in psychotropic drug consumption (9.7%).

**Conclusion and Relevance** This NH accommodates residents with psychotic disorders, behavioural issues, and intellectual disabilities, which explains the low acceptance rate of PIs related to psychotropic drugs and the difficulty in reducing the AS. Beyond the acceptance of PIs, the PR enables the coordinating physician to re-evaluate the overall therapeutic management of residents, and helps mitigate the underuse, overuse and misuse of medications, which are quite common in geriatrics.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

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### 4CPS-228 IMPACT AND ACCEPTANCE OF PHARMACEUTICAL INTERVENTIONS FOR EARLY MEDICATION RECONCILIATION IN THE EMERGENCY DEPARTMENT

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**Background and Importance** Emergency departments (EDs) are characterised by high care load, staff rotation and critical situations that require rapid decisions. Early conciliation in high-risk patients may improve patient safety during care transitions.

**Aim and Objectives** To establish a protocol of early medication reconciliation process in ED and re-evaluation in patients with complexity criteria (validated by Hohl et al.). Medication review by referent pharmacists in ED and their interventions were evaluated for acceptancy rate and quality.

**Material and Methods** A protocol of medication reconciliation was developed based on the 'Consensus document of RED-FASTER and SEMES-FARMA group for Medication reconciliation in ED'. Reinitiation priority of each pharmacologic group was evaluated individually, considering the benefit of their reconciliation during ED stay and defining those drugs whose reconciliation is recommended to be done in the first 12 hours.