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

Conflict of Interest No conflict of interest.

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

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10.1136/ejhpharm-2024-eahp.331

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 revaluation.

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

Conflict of Interest No conflict of interest.

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

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10.1136/ejhpharm-2024-eahp.332

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.

This protocol was implemented in a third-level hospital with 330 average daily ED assistance and five daily hours of presential pharmaceutical activity.

ED pharmacists made individual recommendations: early reconciliation was performed in all patients reviewed, and remaining conciliation interventions were performed in patients with stays longer than 12 hours and complexity criteria.

Results The chronic medication of 1,645 patients was reviewed over a 2-month period: 475 recommendations of early reconciliations were given in 337 patients and physicians accepted 248 (52.32%). Demographic data: 73 (13,64) average age, 196 (58,16%) men. Mean time of recommendations from arrival to ED was 6.73 hours. Time average of reintroduction by physicians was 10,38h. Within the first 12 hours, 179 drugs (72.18%) were introduced.

Forty pharmacological groups were recommended to be reintroduced: insulin and analogues (A10A) and beta blockers (C07A) were the most recommended (N=236), following others: antithrombotic (B01A) (N=37), Calcium channel blockers (C08C) (N=34), immunosuppressant (L04A) (N=37), antiepileptic (N03A) (N=33), nitrates (C01DA) (N=18).

A total of 402 patients with stays longer than 12 hours and complexity criteria were reviewed, leading to 171 recommendations.

Pharmaceutical interventions were analysed over a period of 2 months comparing before and after protocol application: variety of intervention were similar, but quantity increased after protocol implementation (531 vs 1043 interventions).

Conclusion and relevance Early conciliation led to early reintroduction of priority drugs, ensuring safety and quality across care transitions and with a high rate acceptance among physicians.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of Interest No conflict of interest.

4CPS-229 SUSTAINABILITY: A PERSON-CENTRED, WHOLE SYSTEMS APPROACH TO MEDICINES OPTIMISATION

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10.1136/ejhpharm-2024-eahp.333

Background and Importance Suboptimal medicines use is a challenge for health systems globally, contributing to suboptimal outcomes, inefficiencies and sustainability issues, including waste.

Aim and Objectives The aim was to utilise the Clinical Pharmacy Team to drive medicines optimisation and sustainability in a Health and Social Care Trust through the safe, effective and economic use of medicines.

Material and Methods In 2001, a person-centred, whole systems approach to medicines optimisation was implemented in a Health and Social Care Trust. Central to the model was a ward-based Clinical Pharmacy team delivering a comprehensive clinical pharmacy service including medicines reconciliation, medicine review, patient education, interface communication and extended roles for the Clinical Pharmacy team. Evaluation included length of stay, readmission, medicines appropriateness using the Medicines Appropriateness Index and clinical significance of pharmacist interventions using the Eadon grading tool. The model was further developed and evaluated over two decades to include pharmacist prescribing, post-discharge telephone follow-up and person-centred structured medicine review and was extended to include nursing and intermediate care settings.

Results Initial evaluation demonstrated significantly improved medicines appropriateness, reduced length of stay (2 days) and readmission (number needed to treat =12). Further benefits were achieved through post-discharge telephone follow-up (10% reduction in readmission) and structured medicine reviews (94.7% interventions deemed clinically significant and 92% of medicines stopped remained stopped 1year post-review).

Conclusion and Relevance This work has demonstrated improved medicines optimisation and sustainability and has been scaled and spread to other European countries including Austria and Poland. It has been identified as an example of best practice to inform Clinical Pharmacy Services in Central and Eastern Europe[1] and work is ongoing to innovate and further develop the model.

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Conflict of Interest No conflict of interest.

4CPS-230 IDENTIFICATION OF RARE DPYD VARIANTS ASSOCIATED WITH TOXICITY TO FLUOROPYRIMIDINES IN A CLINICAL PHARMACOGENOMICS PROGRAMME

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10.1136/ejhpharm-2024-eahp.334

Background and Importance Dihydropyrimidine dehydrogenase (DPYD) is a key enzyme in the metabolism of fluoropyrimidines. Patients with deficiency in DPYD are at great risk of severe adverse events when treated with fluoropyrimidines (5-fluorouracil, capecitabine). It is recommended that patients are screened for the most common variants in this gene before initiating chemotherapy. However, some patients still develop early serious toxicities.

Aim and Objectives We report the result of a clinical pharmacogenomics programme targeted to patients who developed toxicity with fluoropyrimidines. The aim was to identify rare variants in the DPYD gene associated with severe toxicity, and to provide patients and clinicians with pharmacogenomic counselling.

Material and Methods Patients who suffered severe toxicities (grade≥3) during their first three cycles of treatment with fluoropyrimidines were identified by their oncologist or oncology pharmacist. They were all negative for the four recommended variants (DPYD*2A, c.2846A>T, c.1679T>G, and c.1236G>A). A methodology for sequencing the 23 exons of DPYD was developed by the Pharmacogenomics Unit, integrated in the Hospital Pharmacy Department. The study was approved by the local Ethics Committee. Patients were informed and gave consent to participate in the programme.

Results Since 2017, 91 patients have been included in the programme and 32 variants in DPYD were identified. Nine of