

REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest

CP-047 EVALUATION OF THE CLINICAL PHARMACIST IMPACT ON TOTAL PARENTERAL NUTRITION PRESCRIPTION ORDER REVIEW AND PREPARATION IN THE NEONATAL INTENSIVE CARE UNIT

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Background Clinical pharmacist (CP) services to hospitalised patients are highly recommended, especially in vulnerable populations such as neonates. Neonates are in need of prompt nutrition support but total parenteral nutrition (TPN) practices remain unsatisfactory due to a lack of knowledge of neonatal nutritional needs. The CP plays a crucial role in all steps of TPN: prescribing review, compounding and administering instructions. However, there is insufficient evidence related to the role of the CP in the neonatal intensive care unit (NICU) setting, and most of the literature is either outdated or focuses on lack of standardisation of practices, and the role of CP as prescriber in the NICU. Few (and none in our country) have focused on the role of the CP in all TPN related processes and the impact on decreasing the potential errors and fatal events.

Purpose To evaluate the impact of involving the CP in TPN order review and preparation in the NICU on the potential errors related to 2 in 1 (dextrose/amino acids) and lipid prescription orders.

Material and methods A 6 month prospective analysis was conducted in NICU where TPN order set forms that were elaborated by the CP were filled by neonatologists and sent on a daily basis to the CP for review, calculations, issuing of labels and instructions for compounding and administration. Any noted error or discrepancy in the order was communicated to the neonatologist for prompt amendment.

Results 209 2 in 1 and 149 lipid prescription orders were analysed. 57.5% of 2 in 1 and 11.5% of lipid prescriptions contained errors in dosing, infusion rate and volume, missing components, wrong venous access or high risk of precipitation. The most common 2 in 1 order errors prevented by the CP involved: amino acid dose (14.6%), followed by total infusion volume (13.2%), rate of infusion (13.2%), heparin dose (13.2%), missing component (12.5%), precipitation of calcium and phosphorus risk (12.1%), dextrose dose (9.2%), venous access not mentioned (8.4%), venous access (central vs peripheral) (1.8%), trace element dose (1.1%) and electrolytes dose (0.7%). The most common lipid order errors prevented by the CP involved: rate of infusion (44.5%), followed by total infusion volume (37%), lipid dose (11.1%), lipid soluble vitamin dose (3.7%) and missing component (3.7%).

Conclusion This study shows the impact of including the CP in TPN processes by highlighting the potential errors of prescription/preparation and fatal events that he/she can prevent, thus achieving optimal neonatal nutritional needs and contributing to patient safety. Further studies could be conducted to assess the financial impact of CP driven TPN error prevention

as well as other roles of the CP in the NICU setting, which remains a neglected area.

No conflict of interest

CP-048 EARLY RECOVERY AFTER CAESAREAN SECTION AND EVALUATION OF CARBETOCIN

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Background Early recovery is a concept involving the entire medical team following caesarean section. Carbetocin (Pabal) is currently indicated for prevention of uterine atony after delivery by caesarean section. Administration of carbetocin requires a single dose after caesarean section; this allows the removal of an intravenous drip on exit from the operating room and contributes to the early recovery of patient's autonomy.

Purpose The objective of this study was to evaluate the use of carbetocin in caesarean section.

Material and methods We compared the medical records from January 2015 where oxytocin (Syntocinon) was used for the prevention of uterine atony until March 2016 after the introduction of carbetocin in April 2015. Simultaneously with this comparison, a satisfaction questionnaire was distributed to patients who received carbetocin.

Results 71 women gave birth by caesarean section: 33 in January 2015 and 38 in March 2016. Average length of post-caesarean recovery was 7.6 days for January and 6.7 days for March (a difference of 0.9 days). The French costs for hospital stays according to the diagnosis related group (DRG) for uncomplicated caesarean section and the national length of stay for this DRG allowed us to assess the cost of a hospital day for an uncomplicated caesarean section as € 667.17. The reduction of 0.9 days per stay allows a saving of € 609 per stay. The average costs of administration are € 25.27/per stay for carbetocin and € 5.41/per stay for oxytocin, a difference of € 19.86. 50% of patients were very satisfied with their recovery of autonomy, 27% somewhat satisfied and 23% dissatisfied because of pain. Of the 26 patients, 7 had a previous caesarean delivery without an early recovery protocol and 86% gave preference to the new protocol.

Conclusion Early recovery after caesarean section has enabled savings in the cost of stay of € 609.45. However, these savings cannot be exclusively attributed to the use of carbetocin. Indeed, many other parameters influence the decrease in length of stay. Carbetocin is more expensive than oxytocin but its use allows a clear improvement in patients' comfort.

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Laboratory data <http://www.atih.sante.fr>

No conflict of interest

CP-049 EFFECTIVENESS OF CINACALCET VIA PERCUTANEOUS ENDOSCOPIC GASTROSTOMY CATHETER: A CASE REPORT

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