

HPV vaccine is highly effective in prevention, but hesitancy, limited awareness, and safety concerns reduce uptake. Clinical pharmacists can help overcome these barriers through education and evidence-based guidance.

Aim: To present and evaluate the patient-centered consultations conducted by hospital pharmacists regarding the 9-valent HPV vaccine, emphasizing patient education, safety, and satisfaction.

Method: Data from the electronic hospital database regarding the consultations has been extracted and assessed to evaluate the effectiveness of direct-to-patient services provided by hospital pharmacists with clinical pharmacy specialization, focusing on the optimized patient perception of the vaccine's safety and efficacy profile.

Results: An autonomous consulting service was developed within the hospital, enabling patients to arrange consultations with hospital pharmacists. The consultations encompassed an in-depth examination of the 9-valent HPV vaccine's mechanism of action, potential adverse medication reactions, allergic responses, and requisite post-vaccination follow-up protocols. Consultations were provided at no cost, with pharmacists delivering expert advice on immunization, resolving patient inquiries, and ensuring appropriate follow-up. Patient engagement and contentment were assessed, and feedback was utilized to appraise the program's efficacy. The project generated significant interest among patients, with numerous individuals utilizing the opportunity to consult a hospital pharmacist. A reduction in vaccination-related medication mistakes was noted, resulting in safer vaccine administration. Moreover, patient satisfaction was markedly improved, with individuals indicating an elevated sense of confidence and understanding concerning the HPV vaccine. This subsequently resulted in elevated immunization rates.

Conclusion: This pharmacist-led consultation project has demonstrated efficacy in enhancing HPV vaccination rates, patient education, and overall satisfaction. The program's success indicates that analogous pharmacist-led consultations may be implemented in other vaccination initiatives, thereby improving vaccine uptake, minimizing errors, and augmenting patient care in diverse immunization settings.

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PO095: DRUG-RELATED PROBLEMS AND PHARMACIST INTERVENTIONS IN LONG-TERM CARE

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Background: Drug-related problems (DRPs) are common in long-term care facilities for older persons suffering from polypharmacy and multimorbidities. Identification and resolution of DRPs is effectively carried out through clinical pharmacist intervention.

Aim: To explore DRPs in long-term care institutions for older persons, to detect the causes of the DRPs, and discover clinical pharmacist interventions and their acceptance among prescribers. The interventions promote better medication management and active ageing.

Method: Four wards in a long-term care institution were chosen by convenience sampling. Patients over 65 years of age and being cognitively intact were included in the study. A clinical pharmacist attended the wards 2–3 times weekly for 8 weeks, carrying out medication reconciliation, medicines use review, monitoring, checking interactions and dose adjustments. DRPs were classified

according to the Pharmaceutical Care Network Europe Classification for Drug-Related Problems V9.1 [1]. Clinical pharmacist interventions for each DRP to the prescribing team and to the patient were recorded. The level of acceptance from the prescribers and the outcome of the DRP were noted.

Results: Forty patients were included in the study, 24 males and 16 females, with a mean age of 82.83 years. The average number of chronic medications per patient was 12.85. Almost half of the patients (n = 17, 42.5%) were found to have four or more DRPs. DRPs identified amounted to 126. The 'treatment effectiveness' group exhibited the highest frequency for DRPs (59.52%). Drug selection was deemed the highest cause for DRPs (n = 48, 33.57%), followed by dose selection (n = 43, 30.07%). The interventions carried out amounted to 254. From interventions at drug level, dosage changed was the highest frequency recorded (n = 35). Fifty percent of interventions were carried out prescriber level while 9.06% of interventions were aimed at the patient. Interventions accepted and fully implemented amounted to 63.49% and the interventions accepted over the three prescribers was 83.3%. DRPs were totally solved at 71.43%. Over the course of the study, 43 medications or supplements were de-prescribed, the most common medication totally or partially de-prescribed being omeprazole (n = 39).

Conclusion: The geriatric clinical pharmacist plays a role in long-term care, identifying DRPs and mitigating them as early as possible. The significance of carrying out such roles as medicines use review and monitoring frequently, is that optimal efficacy of medications is ensured. Prescribers appreciated the clinical pharmacist's input, the interventions aiding in their time-constrained schedule to give more attention to detail, ensuring accuracy in treatment and de-prescribing where appropriate.

References/Acknowledgments: 1. Pharmaceutical Care Network Europe Association (PCNE). The PCNE classification for drug-related problems V9.1 [Internet]. The Netherlands: PCNE; 2020 [cited 2025 Feb 20]. Available from: https://www.pcne.org/upload/files/417_PCNE_classification_V9-1_final.pdf

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PO096: RETROSPECTIVE ANALYSIS OF FACTORS ASSOCIATED WITH UNINTENTIONAL DISCREPANCIES TO GUIDE IMPLEMENTATION OF MEDICATION RECONCILIATION

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Background: Medication reconciliation (MR) prevents medication errors and iatrogenic risk during transitions of care. Since 2021, systematic admission and discharge MR has been implemented in a medical and rehabilitation unit. Prior evaluation demonstrated its clinical impact. Broader implementation is planned in similar units, but pharmacy resources are limited.

Aim: To identify objective patient-level criteria to guide prioritization for MR, in order to support targeted implementation in additional care units.

Method: A retrospective analysis of Unintentional Discrepancies (UDs) identified during MR was conducted in a medical and rehabilitation unit. Group comparisons were performed using the Mann-Whitney U-test ($\alpha = 0.05$, two-tailed). Therapeutic classes of drugs involved in UD were also categorized using the Anatomical Therapeutic Chemical (ATC) classification system developed by the World Health Organization.