

an Excel© spreadsheet which logs a range of criteria, such as the patient's sociodemographic background, the drug(s) involved, the type of error, the associated pharmaceutical intervention and many others.

Results 60 errors for 1000 patient days, that is 0.5 error per stay and 90 errors per 1000 prescriptions were detected for short stays. 1393 errors of all types were detected over 5 months, which is 0.9 error per month and per bed. The errors were spread over 3 categories: errors defined by the French Clinical Pharmacy Society criteria (67.3%), errors linked to the computerised tool (14.3%) and other types of error (18.4%). 5 drug classes were heavily involved. 59% of patients were affected by an error despite a prior pharmaceutical intervention. Errors rarely have drastic consequences on the patient: 4‰ prescriptions. Weaknesses in knowledge and malpractice represent nearly 85% of the total of errors. Errors due to computer parameters represent an increasing risk (14%).

Conclusions Most prescribing errors are avoidable. Although computerised physician order entry is a way of making the medication process safer, it also generates comments and has limitations. The prescription tool determines the type and frequency of errors. All these errors justify the analysis of all the prescriptions by a pharmacist, as s/he has a rounded knowledge of the patient beyond the medical prescription. The booming certification of various software packages dedicated to helping hospital prescription writing in a way acceptable to the High Authority for Health contributes to this step of making care safer and will hopefully lead to a decrease in errors.

No conflict of interest.

GRP-043 CONCURRENT USE OF DIFFERENT BENZODIAZEPINES IN DIFFERENT HEALTHCARE LEVELS

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Background Benzodiazepines are the most commonly-used anxiolytics and hypnotics. Concern has been expressed regarding their potential over-prescription. Different benzodiazepines have fundamentally the same mechanism of action and differ from each other mainly by differences in pharmacokinetics. There is no pharmacological basis for using more than one benzodiazepine in the same patient.

Purpose The purpose of this study was to study the prevalence of concurrent use of different benzodiazepines in different healthcare levels in the same area: primary care, tertiary level hospital discharge and ambulatory mental health centre.

Materials and Methods Data were obtained from the pharmacy claims database between 1st and 31st January 2012.

Patients who had been dispensed at least one benzodiazepine during January 2012 were included (n = 1707 in primary care, n = 273 at tertiary level hospital discharge and n = 128 in an ambulatory mental health centre). The proportion of benzodiazepine users was calculated and broken down by gender and age.

Results The number of patients who were dispensed two or more different benzodiazepines simultaneously was 124 (7.3%) in primary care, 11 (4.0%) in hospital discharge and 1 (0.8%) in the ambulatory mental health centre. Most patients who were prescribed benzodiazepines were women (between 60% and 70% depending on the health care setting). Women benzodiazepines users were younger in the ambulatory mental health centre (mean age 51 years) than at hospital discharge (mean age 64 years) or in primary care (mean age 68 years).

Conclusions There was more detrimental prescribing of different benzodiazepines simultaneously in primary care than at hospital discharge or in an ambulatory mental health centre. In patients

who used benzodiazepines simultaneously, they were mainly prescribed by the same physician.

No conflict of interest.

GRP-044 CONFORMITY OF THE BATCH FILE IN PREPARATION: AN INTERNAL AUDIT

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Background Around 3000 batches of medicinal products are prepared each year in Lapeyronie Hospital.

For each batch, a batch file (BF) is created. This contains the prescription, a manufacturing and labelling sheet (MLS) and a control and batch release sheet (CBRS).

Purpose Since the publication of the French Good Manufacturing Practice in 2007, a process of quality improvement has been implemented. An internal audit of all 2011 BFs has been conducted to evaluate the non-conformity (NC) rate.

Materials and Methods An internal control questionnaire (ICQ) evaluating various criteria was written by the pharmacist and completed by students and residents for each BF. The results were compared with a previous 2010 study.

Results 42% of 2,858 BFs were not acceptable. There were 1691 non-conformities (a BF can be unacceptable on several criteria): 32% of the unacceptable BFs had a problem with the prescription, 59% had inaccuracies with the MLS and 9% with the CBRS.

Of those with prescription problems, pharmaceutical validation traceability was lacking for 49% and 31% had not been signed by the MD.

The absence of checking the sheet before preparation was the major NC factor (79%) regarding the MLS. The volume of raw materials was not checked during preparation in 8.6% of MLS.

NC regarding CBRS was due to incomplete checking of the preparation before it was released (36%).

Results in these 2 studies showed that the MLS was not checked before preparation in 28% of BFs in 2011 against 71% in 2010. The volume cheque before preparation was not performed in 41% of BF in 2011 against 85% in 2010.

Conclusions Following this audit, corrective actions were instituted: pharmacists were trained on the importance of the pharmaceutical validation of prescriptions, and the assistants were reminded of the importance of getting their work checked before and during preparation.

Nevertheless, there has been progress in the conformity rate between these two audits, pointing out the impact of corrective actions.

No conflict of interest.

GRP-045 CONTRADICTIONS IN THE INTERPRETATION OF DRUG/SUPPLEMENT INTERACTIONS AND DIFFICULTIES OF THEIR MANAGEMENT IN EVERYDAY CLINICAL PRACTISE

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Background The growing use of supplementary products (herbal remedies, food supplements, etc.) poses an unignorable and poorly explored risk to hospital patients. The results of our previous study [1] show that 85.5% of hospital patients took at least one supplementary product; and with one patient out of four we have identified potential interactions. However, several questions arise about their clinical relevance: (1) Might the interaction harm the patient?