QALY (one case) were also apparent. In contrast, the input parameters were quite different. Every analysis demonstrated cost-reduction and patient safety enhancement but methodological differences were present in terms of perspective, discounting, duration, inflation, sensitivity, inputs and definitions (e.g. definition of ADE).

Conclusion The different outcome data types used in studies counter the intention to prove the cost-effectiveness of CPOE systems. It is clear that no generally accepted definition is present over which system can be called CPOE. On the other hand, it will only be possible to compare different CPOEs if common agreement is developed in terms of outcomes observed by studies. Clinical pharmacists can play an important role in the unification of the upcoming studies and collection of data.

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No conflict of interest.

5PSQ-111 EVALUATION OF THE FORM'S QUALITY OF MEDICAL PRESCRIPTIONS FROM PUBLIC HOSPITALS AND PRIVATE CLINICS

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Background The medical prescription is the main document of communication between the doctor, the pharmacist and the patient. The careful writing of this document enables the reduction of many therapeutic errors.

Purpose The purpose of this work was to evaluate the quality of the form of medical prescriptions from public hospitals and private clinics.

Material and methods This was a transversal descriptive study of 210 medical orders. The quality of the form was evaluated using two parameters: the presence of the obligatory mentions and their legibility. An analysis grid with several items was used to collect the information needed to describe the form quality of the medicinal prescriptions. The pharmacist used a scale of 1 to 3 to evaluate the readability of prescriptions.

Results In our study, 210 patients were included taking a total of 588 drugs. 28.57% (60) medical prescriptions came from public hospitals, while 71.42% (150) prescriptions stemmed from private clinics. For all the medical prescriptions analysed, only 21 were computerised and came from private clinics. Only one medical prescription from a public hospital was undated. All prescriptions were written with commercial drug names. In the sample studied, 15.71% (33) prescriptions had no patient identity (first and last name) and came from public hospitals. Only six medical prescriptions contained the age and weight of the patient and came from private clinics. The

identity of the prescribing physician was absent in 14.2% (30) medical prescriptions and 38.57% (81) medical prescriptions did not contain a treatment period.

Among the medical prescriptions reviewed, 10% (21) were deemed illegible by the pharmacist, while 40% (84) were considered difficult to read.

Conclusion This study shows that prescriptions from public hospitals have serious incoherence compared to those from private clinics. This is due to the high number of patients who consult in public hospitals. This work has also demonstrated that hand-written medical orders give several non-compliance. The teaching of order-writing technique and its computerisation are required to improve the quality of medical prescribing.

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5PSQ-112 RISK ASSESSMENT OF ELEMENTAL IMPURITIES FOR MANUFACTURING THE DRUG SUBSTANCE (ICH Q3D)

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Background The new ICH Q3D guideline has been recently developed to define and provide a global policy for evaluating and limiting elemental impurities in drug products. Thus, a risk assessment and appropriate control of elemental impurities according to this guideline have become necessary.

Purpose The purpose of this study was to explain the risk assessment approach for limiting the presence of elemental impurities in the drug substance.

Material and methods According to the guideline ICH Q3D, the identification of elemental impurities of concern and their potential sources of occurrence is realised. The possible levels of elemental impurities were determined based on the published literature and provided information from suppliers. For high-risk elemental impurities, class 1 and class 2A, they were determined by the ICP-MS method. The determined level was then compared with the Permitted Daily Exposure defined in ICH Q3D. All of these assessment results were summarised into one single assessment sheet for each manufacturing step.

Results The potential sources of elemental impurities have been identified and several possible sources of class 1 and 2A elemental impurities have been identified. Based on the information in the assessment sheet, an appropriate control point in the manufacturing process and control method were determined. Additionally, the information was included in the assessment sheet to show the control strategy.

Conclusion The risk analysis approach provides a complete risk assessment of potential elemental impurities in the drug substance. All potential sources of elemental impurities of concern for the manufacturing process of the drug substance