

or a 'medium intensity' effort. They represented 10% to 61% of items. Less than 8% of items required a 'major effort'.

Conclusion The development of this self-assessment tool shows that the lack of shared guidelines leads to inequalities in the QS between the different FFRDS pharmacies. Nevertheless, some risks are common to these pharmacies. Hence, joint actions could be of critical importance to improve these QS.

REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.

5PSQ-122 PERIPHERIC INTRAVENOUS PERFUSION IN ANAESTHESIA: SECURING MEDICAL TREATMENT IS ALSO ABOUT THE PROPER USE OF MEDICAL DEVICES

F Duwicquet*, N Avez-Platteeuro, B Luyssaert. *Groupe Hospitalier Seclin-Carvin, Pharmacy, Seclin, France*

10.1136/ejhp-2019-eahpconf.555

Background Intravenous administration is an especially risky stage of medical treatment. Securing this stage, in particular handling the proper use of medical devices (MD), is important to ensure patient safety. Anaesthesia is especially hazardous due to complex infusion installations and the frequent use of a narrow therapeutics range.

Purpose The aim of this work was to evaluate the proper use of infusion MD in anaesthesia in order to lead actions to secure intravenous administration.

Material and methods An audit was conducted during 3 months in operating rooms (OR). Infusions' installations were observed: which infusion MD were used and how.

Then, a questionnaire was distributed to nurses of the units in charge of patients after surgery, to know the becoming of infusion installations after the OR.

Results Thirty surgical interventions were observed and 37 peripheral venous access were inserted. For 36 (97.3%) of them, a one way-valve (OWV) was directly put on the catheter.

Among these 30 infusion installations, 19 (63.3%) were simple ones, which means a catheter, a OWV and an infusion set with a three-way stopcock. The others were more complicated, with additional infusion sets or an infusion reheater.

Eighteen nurses answered the questionnaire. Seventeen (94.4%) revealed that patients could leave the OR with only a catheter and a OWV on it and three (16.7%) answered that OWV could be unprotected by a cap. During the change of the infusion line, eight (4.4%) nurses disconnected the line on the OWV and 12 (66.7%) let only the catheter with a OWV in the absence of perfusion.

Conclusion OWV is not a closed system. Used as a catheter cap, there is a risk of infection and gas embolism. A working group has been formed to solve the misuse of OWV. Three specific cases have been distinguished in the OR and solutions have been proposed for each one: ambulatory patients (catheter with an obturator); patients transferred in intensive care (infusion set still connected); and patients transferred in the surgical unit (catheter with a two-way valve).

A document which reminds of the proper use of OWV has been disseminated and a training workshop concerning infusion valves has been organised.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No references.

No conflict of interest.

5PSQ-123 FAILURE MODES, EFFECTS AND CRITICALITY ANALYSIS: APPLICATION TO A HOSPITAL PHARMACY

¹MA El Wartiti*, ¹W Enneffah, ²A Cheikh, ³M Abouatia, ¹J Lamsaouri, ⁴J Taoufik, ⁵A Bennana. ¹Mohammed V Military Teaching Hospital – Faculty of Medicine and Pharmacy of Rabat, Pharmacy, Rabat, Morocco; ²Cheikh Zaid International University Hospital – Abulcasis International University of Health Sciences, Pharmacy, Rabat, Morocco; ³Rabat Children's Hospital – Faculty of Medicine and Pharmacy of Rabat, Pharmacy, Rabat, Morocco; ⁴Faculty of Medicine and Pharmacy of Rabat, Pharmacy, Rabat, Morocco; ⁵Cheikh Khalifa Ben Zayed Hospital – Faculty of Medicine and Pharmacy of Rabat, Pharmacy, Casablanca, Morocco

10.1136/ejhp-2019-eahpconf.556

Background The pharmacy is the last link in the drug chain and error, which is never an isolated fact, is still a troublesome reality. Everything must be organised to minimise risks and their severity. As such, Failure Modes, Effects and Criticality Analysis (FMECA) applied to the pharmaceutical activity helps control the risks of non-compliance that can negatively affect the quality of provided services.

Purpose The objective of this work was to apply in practice the FMECA tool (example of the procedure of medical devices' reception) at a hospital pharmacy engaged in the process of implementing a quality management system, in order to propose for each risk identified and analysed, a matrix of preventive and corrective actions.

Material and methods Our work took place in three stages:

- Identification and description of elementary processes forming the macro-process of medical devices' reception at our hospital's pharmacy pole.
- Drafting the procedure describing the main activities forming the macro-process in question.
- Application of the FMECA tool to the described activities in order to identify different risks and calculate their criticality (criticality=frequency × severity).

Results The results of this risk analysis, applied to the macro-process of medical devices' reception at our hospital's pharmacy pole, allowed us to identify 13 risks (among which three had a criticality score ≥ 8), to reconsider certain practices and to propose matrices of measurements for taking charge of most critical risks.

Conclusion This experience helped to sensitise staff to the 'risk culture'. In addition, the results specific to our hospital's pharmacy pole may constitute a model available to other hospital pharmacies seeking to improve the quality of their services, which would help to upgrade the profession of hospital pharmacists.

REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

No conflict of interest.

5PSQ-124 ABSTRACT WITHDRAWN