

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

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**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

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**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  $\geq 8$ ), 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

from their design to their use, passing through their manufacturing and marketing. For implantable medical device (IMD's), risks are greater, and a quality management system based on rigorous traceability is essential to their management to ensure their quality and the safety of implanted patients.

**Purpose** To assess overall conformity of the IMD's traceability process in the operating rooms as part of quality and risk management at our hospital.

**Material and methods** This was a prospective study of the IMD's traceability process conformity for all patients admitted for a surgical procedure using IMD's in gynaecology, urology, thoracic surgery and visceral surgery, over a period of 6 months.

Information was extracted from the individual IMD's traceability records and from the IMD's traceability register.

**Results** During the study period, 365 IMD's were implanted in 297 patients. The most used IMD's were parietal reinforcement plates (50%) and implantable staples (28%). The most IMD's consuming services were visceral surgery (73%) and urology (18%). Traceability anomalies (lack of information about patients and/or IMD's) were present in 22% of cases, and the service responsible for the majority of discrepancies was the urology service (58%). A total lack of traceability was noted in less than 1% of cases.

**Conclusion** The traceability procedure remains imperfectly applied, in particular concerning the completeness of recorded information. Efforts must be pursued in terms of observance of this procedure, and continuously evaluated to improve the quality, and to master the risk level, at our establishment.

#### REFERENCES AND/OR ACKNOWLEDGEMENTS

None.

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#### 5PSQ-126 MEDICATIONS AND FALLS IN THE ELDERLY: AN EPIDEMIOLOGICAL STUDY IN A FRENCH HOSPITAL

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**Background** Falls in the elderly is a major public health problem. One-third of people over 65 fall at least once a year. Polypharmacy, which is defined as taking more than four drugs a day, is a major risk factor for falls in the elderly.

**Purpose** The aim of this study was to determine the frequency of use of drugs that increase the risk of falls and the impact of changes in these treatments in the occurrence of falls in the hospital.

**Material and methods** This study was a retrospective chart review of patients who sustained falls in the hospital. The list of fallers was obtained from the fall reporting data. In the first part, the clinical characteristics of patients and environmental falls were analysed.

In the second part, the pharmaceutical data of patients with a recent modification of their treatments were sought (number of medications per day, hypotensive and inducing drowsiness treatments and type of recent modifications of these treatments).

**Results** Seventy-three per cent of patients were falling in their rooms. Patients during the fall were mostly calm and wandering. In the majority of cases, the falls were of no clinical consequence (69%).

#### 5PSQ-125 QUALITY AND RISK MANAGEMENT IN HOSPITALS: EVALUATION OF IMPLANTABLE MEDICAL DEVICES' TRACEABILITY PROCESS

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**Background** Medical devices may be at the origin of incidents or risks of incidents due to several deficiencies in their circuit,