market situation. This is significant since there is currently no reliable central database in Germany which lists DS in time. The kind of DS in the hospital setting demands a rapid and focused management in order to ensure continuity of care.

**Purpose** Our aim was to develop a method to provide internal transparency over DS affecting our clinic (a 1600-bed maximum acute care facility), to cooperate with the physicians for a proper and efficient decision flow, and to adapt correspondingly to the drug-supply chain (DSC).

**Material and methods** We created a colour-coded algorithm on how to react to DS, depending on certain factors:

1. Yellow/orange: Therapeutic alternative is available. Consider brief information for the affected units.
2. Red: Therapeutic alternative is available but with relevant changes (e.g. import, internal compounding in the pharmacy), there is a very limited supply or no drug left at all. Consider interprofessional consultation.

The information was handed out by our drug information department via a drug-information sheet.

The data was recorded in an EXCEL sheet and updated upon each report from the manufacturers. Moreover, relevant changes had to be made depending on the classification of the DS (e.g. master-data-management, ward-order-system, Kanban-system, handling instructions) in order to ensure the DSC.

**Results** Between 1 January 2018 and 30 June 2018, 273 DS were recorded. Existing DS from 2016/2017 (38) were also included. One-hundred and seventy were resolved by 1 July 2018. Sixty-two were classified as red (critical or threatening to patient safety), 22 of which led to an interprofessional consultation. There was no alternative at all for five DS. Each consultation lasted 1 hour on average. Twenty-two of the recorded DS did not affect our clinic due to length and sufficient stock.

**Conclusion** The situation in everyday practice is so complex that standard procedures and interdisciplinary communication paths are necessary to manage DS in a way that does not impact the quality and continuity of patient care. Therefore, restrictions on therapeutic alternatives need to be determined and the close collaboration among pharmacists, nurses and physician is inevitable.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No references.

No conflict of interest.

## 2SPD-016 BIOSIMILARS OF INFLIXIMAB AND RITUXIMAB: DOES THE INITIAL STRATEGY OF SELECTION HELP THEIR PRESCRIPTIONS?

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**Background** The development of biological medicines (BM) was a major step in the treatment of chronic diseases and cancer. However, their high costs are a financial issue for hospitals. The arrival of biosimilar drugs (BD) improved their accessibilities by reducing their prices. Nevertheless, in France, their consumption is still low.

**Purpose** The purpose of the study was to measure and analyse the penetration rate (PR) of biosimilar Infliximab and biosimilar Rituximab in hospitals containing 300 to 700 beds in Auvergne Rhône Alpes (France).

**Material and methods** A web survey was sent to hospital pharmacists dispensing Infliximab and/or Rituximab to collect: consumption of Infliximab and Rituximab (biological reference products (BRM) and BD) in the first 6 months of 2018; initiation and switching strategy of BD; and education tools provided by pharmacists to patients and/or healthcare professionals. The PR was defined as the percentage of biosimilars of the total of BM. The web survey was online for 1 month.

**Results** Seven hospitals replied to the survey: all were consumers of Infliximab and four were consumers of Rituximab. The PR of biosimilar Infliximab was around 50% for two hospitals, around 30% for three hospitals and two hospitals did not use BD. The seven hospitals adopted the same initiation and switching strategy: biosimilar Infliximab was prescribed only for BM-naïve patients and continuous therapy could be switched with doctor's agreement.

Concerning Rituximab, the PR was 100% for two hospitals, 70% for one hospital and 40% for one hospital. All four hospitals concerned reported using the same strategy: switch from the BRM to the BD for every patient. The recent introduction of Rituximab biosimilar in the French market could explain the 2 PR lower than 100%.

Concerning education provided by pharmacists about BD, all had a different strategy (education to patient, to doctor, presentation in drug committee…).

**Conclusion** Although these hospitals adopted the same strategy of biosimilar selection, the PR were significantly different from one hospital to another. None of the education tools provided was linked to a greater biosimilar penetration. The consensus of national societies and expert recommendations should help pharmacists to convince prescribers.

**REFERENCES AND/OR ACKNOWLEDGEMENTS**

No conflict of interest.

## 2SPD-017 ECHO-ENDOSCOPY: FOR A SOURCING AS SHARP AS A NEEDLE

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**Background** In April 2018, the acquisition of two echo-endoscopes enabled the deployment of a new activity within the hospital centre. Echo-endoscopy is an act of exploration combining ultrasound with endoscopy, which allows, using specific needles, the realisation of sampling and therapeutic drainages.

**Purpose** Therefore, we compared the different market-available needles.

**Material and methods** Three providers (A, B, C), previously selected in a regional framework agreement, were solicited for new quotations and specimens. A technical sheet was designed evaluating: quality of packaging and labelling; composition of the kit; characteristics of the needles (dimensions, materials, fenestrated or not, echogenicity, penetration, graduation accuracy, grip, diameter compatibility with the working channel); and quality of the samples obtained. The scores of each supplier were calculated with a weighting of 80% for the quality and 20% for the price.

**Results** After analysing the new offers, provider B proposed separate needle references for cytological and histological diagnostic and for therapeutic drainage. Conversely, supplier A offered three sizes of the same model allowing these three functions. Finally, supplier C was not selected because of its higher quotation without any particular technical advantage. Subsequently, three specimens from A and B were evaluated on six patients.

These trials revealed four criteria differentiating needles A and B: quality of packaging, echogenicity, penetration of the needle and quality of the sample. Indeed, needle A displayed soft packaging offering a lesser protection, a lesser echogenicity and a lower sampling quality despite better penetration. The responsible gastroenterologist, aiming to use this technique mainly for diagnosis, therefore chose the needles of supplier B. The final marks were 16,56/20 for supplier B, 16,19/20 for supplier C and 16,00/20 for supplier A.

**Conclusion** The difference in the quality of the samples may be linked to needle B fenestration which allows the obtaining of a larger core at the expense of a weakening of the needle, and a decrease in the case of penetration. Thanks to a tight partnership with the medical team during these tests, pharmaceutical involvement helped to optimize the sourcing of a new product and the deployment of a new activity.


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No conflict of interest.


## 2SPD-018 AUDIT ON THE MANAGEMENT OF PERSONAL TREATMENT OF PATIENTS AT THE HOSPITAL

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**Background** The management of personal medical treatments of patients hospitalised in health facilities follows regulatory requirements. Failure to respect these requirements may result in iatrogenesis, with sometimes severe consequences for the patients. According to the High Authority of Health, not taking into consideration the personal treatment might lead to administrative mistakes which represent more than 57% of reported medication errors. In order to prevent these errors, a procedure and a technical data sheet have been designed to assist caregivers in the management of these medical treatments.

**Purpose** The objective is to evaluate the caregiver's level of knowledge of which documents in order to suggest ways of improvement.

**Material and methods** This audit has been realised in order to assess how the medical staff follow these technical data sheets. The audit has been performed by a pharmacist student during 2 months, in eight randomly chosen services. An audit grid including 15 evaluated criteria was used.

**Results** For this audit, 138 hospitalised patients were followed. At the time of their hospitalisation, 83.7% of the patients had personal treatment at home. Only 18.7% of these patients had their personal treatments prescribed in the hospital's computer software. Regarding the management of these treatments, 47% of the wards had removed the personal treatment at the hospitalisation of the patients, and 38% identified and stored the treatments in a specific and secure place as indicated in the procedure.

Seventy per cent of the patients actually took their treatment, while this fact had not been indicated in the prescription software by the responsible doctor. Regarding leaving the hospital, out of 10 outgoing patients, 54% left with a prescription including the updated personal treatment.

**Conclusion** This audit allowed us to identify several problems, the lack of knowledge of the documents and insufficient training on computer software of the medical staff. Improvements are now being developed through communication campaigns concerning the data sheet and through training on the prescription software. A future assessment will be conducted to verify that the actions taken have had a positive effect.


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No conflict of interest.


## 2SPD-019 EVALUATION OF THE INTRODUCTION OF A MEDICAL DEVICE FOR MECHANICAL INDUCTION OF LABOUR IN WOMEN WITH UNFAVOURABLE CERVIX

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**Background** Multiple pharmacological, mechanical and complementary methods are available to induce labour. and data from the literature suggest that most interventions have similar utility, differing mainly in cost. The decision to apply different techniques is linked to the availability of pharmacological treatments and medical devices at the centre. To introduce mechanical induction of labour with the cervical ripening balloon (CRB), a pilot test was conducted to locally assess the need and the feasibility of the new technology.

**Purpose** The objective is to evaluate the introduction of CRB at the centre.

**Material and methods** A clinical pilot test was conducted to compare CRB to the pharmacological method already used at the centre (slow-release vaginal PGE2 insert, Propess). The two induction methods were tested during 6 months in the delivery room (March to August 2018). Patients included were women with intact or ruptured membranes, at different gestational ages, with low (<3) Bishop score. The success of induction was defined as achievement of uncomplicated vaginal delivery. The number of vaginal deliveries within 24 hours and of caesarean sections were investigated and compared for both methods. Economic consequences for both methods were analysed.

**Results** A total of 56 patients were included in two groups, homogeneous for indications to induction and obstetric characteristics. The success of induction was comparable in the two groups. The time needed to achieve delivery by the vaginal route was on average longer with CRB (25%>24 hours) than with Propess (7%>24 hours), ($p<0.05$). Caesarean sections were comparable in the two groups (14% with CRB; 14% with Propess), however the reasons were different (one case of uterine hyperstimulation with fetal heart rate changes in the CRB group). The CRB group was associated with