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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

<https://www.ncbi.nlm.nih.gov/pubmed/30197399>

https://www.legifrance.gouv.fr/eli/decret/2016/3/25/2016-360/jo/article_59

No conflict of interest.

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

C Bons*, H Roux, MP Ponrouch, N Deshormiere, C Breuker, A Jalabert. *CHU Montpellier, Pharmacy Center, Montpellier, France*

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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.

REFERENCE AND/OR ACKNOWLEDGEMENTS

Patients personal treatment management in hospital: practices analysis and improvement opportunities. *J Pharm Clin* 2015;34.

No conflict of interest.

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

¹SE Campbell Davies*, ²S Nobili, ²P Richelmi, ²V Curci, ²M Medaglia. ¹ASST Fatebenefratelli Sacco, Hospital Pharmacy, Milano, Italy; ²Fatebenefratelli e Oftalmico Hospital – ASST Fatebenefratelli Sacco, Hospital Pharmacy, Milano, Italy

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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