number of days from SLT assessment to pharmacy review was 0 for patients referred by SLT to pharmacy, compared with a median of 10 days for those not referred. Median percentage of medications optimally administered was 89% per patient in those referred to pharmacy versus 50% in patients not referred. This project has targeted a number of different areas to highlight and improve administration of medication to patients with dysphagia throughout a large acute hospital. The audit cycle continues with the aim of further improving patient care in this area.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-115 NEAR MISS DISPENSING ERRORS DURING WORKING HOURS IN INPATIENT DISPENSARIES AT A LARGE UK TEACHING HOSPITAL

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Background and importance Errors in medication dispensing have potential to harm patients.¹ Up to 2.7% of dispensed medications include errors, although fewer 'near miss' data exist.² Near misses are 'a dispensing error detected by the checker before the patient receives the prescription'.^{1, 2} Audits defined a local near miss rate in 2013. This UK teaching hospital has two automated (acute, specialist) and one non-robotic (paediatric) dispensaries.

Aim and objectives To determine the frequency, time, staff group and harm potential of near misses.

Material and methods A group representing all stakeholders created a data collection tool based on the UK Centre for Pharmacy Postgraduate Education.³ It recorded type, time and staff group for near misses in three dispensaries (paediatrics, adult acute and adult specialist). Data collection were piloted and then collected in September 2019 over 7 days. Two pharmacists independently rated the likelihood of harm.

Results Near misses totalled 190/8483 (2.24%) items: 1.10% (specialist), 1.41% (paediatrics) and 3.10% (acute) dispensaries (χ^2 , $p \leq 0.001$). Most near misses (51, 26.8%) occurred between 5pm and 6pm. Assistant technical officers accounted for the highest proportion of near misses (16.8%, 32) followed by pharmacists (12.1%, 23), technicians (10%, 19), checking technicians (9.5%, 18), preregistration pharmacists (6.8%, 13) and trainee technicians (5.3%, 10): 71.1% (135) of near misses were graded likely to cause patient harm.

Conclusion and relevance Previous audits observed lower near miss rates than those found in 2019. Hurrying to complete work may account for the higher error rate between 5pm and

6 pm. Loss of three senior experienced pharmacists in 2015–2018 in the adult acute dispensary may have affected supervision of newly qualified pharmacists. The specialist dispensary implemented automation of drug selection in 2009, which may account for the 3.9% reduction in near misses. Reporting dispensing near misses may be too time consuming but regular audit may inform areas for improvement.

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No conflict of interest.

5PSQ-116 SAFER HANDLING OF ORAL HAZARDOUS DRUGS IN HOSPITAL UNITS

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Background and importance After the National Institute for Occupational Safety and Health (NIOSH) classified hazardous drugs (HD), it was deemed necessary to make healthcare workers aware of the risks associated with handling HD in their daily work to mitigate these risks.

Aim and objectives To analyse oral HD handling activities to make handling recommendations based on the lowest dust inhalation risk and to ensure the safety of healthcare workers in hospital units.

Material and methods Oral HD were classified into two categories: groups 1 and 2 and group 3 according to NIOSH grouping system. Secondly, oral HD handling activities in hospital units based on their dust inhalation risk to the workers were ranked and decisions were taken accordingly: opening capsules and sachets must be avoided; marketed liquid formulations is strongly preferred; and in their absence, crushing tablets using closed systems is preferred over compounding medications due to shorter administering periods in hospital units. Finally, the above mentioned ranking was followed for every oral HD. If no marketed liquid alternatives were found, research on techniques for crushing and dissolving tablets was conducted. In the absence of crushing techniques, academic research on compounding oral HD was carried out. For the remaining oral HD, information was requested from the manufacturers.

Results A total of 59 active pharmaceutical ingredients (API) from groups 1 and 2 were analysed. Marketed liquid formulations were found for 13 API (abacavir, ciclosporin, crizotinib, phenytoin, megestrol, mycophenolate mofetil, mycophenolic acid, nevirapine, oxcarbazepine, trametinib, tofacitinib, valganciclovir, and zidovudine). Techniques on crushing and dissolving tablets were available for 21 API (abiraterone, axitinib, busulfan, dasatinib, entecavir, enzalutamide, everolimus, exemestane, flutamide, imatinib, letrozole, medroxyprogesterone, melphalan, mercaptopurine, methimazole, methotrexate, mitotane, ponatinib, rasagiline, sorafenib and tamoxifen).

For 13 API (azathioprine, capecitabine, carbamazepine, cyclophosphamide, chlorambucil, etoposide, hydroxyurea,

Abstract 5PSQ-115 Table 1

Year	Adult specialist (%)	Adult acute (%)	Paediatrics (%)	Hospital average (%)
2006	5	0.5	N/A*	0.9
2011	1.3	0.8	N/A*	1.1
2013	1.0	0.5	0.7	0.7
2019	1.1	3.1	1.4	2.2

*Not audited.