self-administered their own medication. In the control group, medication was dispensed by nurses in the ward.

The proportion of ward level dispensing errors was collected through disguised observation of patients in the patient room and nurses in the medicine room.

A dispensing error was defined as a deviation between the prescription and the dispensed medication (eg, incorrect dose). Opportunity for errors (OEs) was defined as any medication dispensed and any medication prescribed but not dispensed. Dispensing error proportion = (dispensing errors/OEs) × 100%.

Results A total of 250 patients were recruited; 11 were withdrawn as they were discharged prior to observation. The proportion of men was 66% and mean age was 64.2 years (SD 12.2). Total cost per patient in the intervention group was 49.9€ (95% CI 46.7; 53.1€) compared with 52.6€ (95% CI 47.1; 58.1€) in the control group ($p=0.09$). Sensitivity analysis consistently showed total costs favouring the intervention. The dispensing error proportion was 9.7% (95% CI 7.9 to 11.6%) (100 errors/1033 OEs) in the intervention group compared with 12.8% (95% CI 10.9 to 15.6) (132 errors/1028 OEs) in the control group ($p=0.02$).

Conclusion and relevance SAM seem to cost less but the results were not statistically significant. As SAM patients made fewer dispensing errors compared with nurse-led medication dispensing, the results are suggested to be cost effective.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

11SG-015 EVALUATION OF BISPECTRAL INDEX MONITORING IN GENERAL ANAESTHESIA THROUGH A HEALTH TECHNOLOGY ASSESSMENT METHOD: A POSSIBLE INTRODUCTION IN CLINICAL PRACTICE IN AN ITALIAN HOSPITAL?

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Background and importance International guidelines suggest evaluation of clinical signs to guide the dosages of anaesthetic agents in order to achieve the basic goals of anaesthetic management. The use of the bispectral index (BIS) as standard practice might be useful for anaesthesia management by reducing the risk of intraoperative awareness (0.1–0.2% of the surgical population), consumption of anaesthetic agents, recovery time and total cost of anaesthesia.

Aim and objectives The objective of the study was to assess the efficacy of BIS guided anaesthesia monitoring for its potential introduction as standard practice.

Material and methods The study was conducted from January 2008 to July 2019, using the following databases: PubMed, Cochrane Library, ECRI and NICE. The articles included meta-analyses, randomised control trials, health technology assessment (HTA) reports and guidelines for BIS guided monitoring versus clinical signs as standard practice during general anaesthesia in adult patients. The evaluation was conducted according to the scheme reported in the sub annex G of Lombardy region Resolution XI/1046 which describes methods for the systematic research and critical analysis of the literature sources and the drawing up of an HTA report.

Results We reviewed 18 articles to analyse the benefits in terms of more reliable statistical evidence and cost

effectiveness. BIS reduced the risk of intraoperative awareness in high risk patients by 80% (OR=0.24, 95% CI 0.12, 0.48). Furthermore, BIS reduced discharge time from postanaesthesia care units by about 23 mins (95% CI -31.01, -13.69; $I^2=20\%$), postoperative nausea and vomiting by 12%, risk of postoperative cognitive disorders at 3 months after extubation by 3% (95% CI -0.05, -0.00; $I^2=52\%$) and risk of postoperative delirium by 6% (95% CI -0.10, -0.03; $I^2=11\%$).

Conclusion and relevance BIS guided monitoring reduced the risk of intraoperative awareness in high risk patients under intravenous general anaesthesia. Furthermore, BIS was effective in reducing consumption of anaesthetic agents, time to discharge from postanaesthesia care units and postoperative adverse events. It remains to be clarified whether BIS technology is cost effective, considering the low prevalence of intraoperative awareness, and whether it represents a real benefit in perioperative and postoperative preventable adverse events. The costs of preventable adverse events should be evaluated at a single healthcare facility, considering the long term benefits.

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No conflict of interest.

11SG-016 ENVISIONING SUSTAINABILITY IN PERSONALISED MEDICINE: FONDO AIFA 5% AND THE ITALIAN EXAMPLE

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Background and importance Sustainability in the era of personalised medicine represents one the major problems because of the possible limited access to innovative therapies. Since 2003, the Agenzia Italiana del Farmaco (AIFA), along with pharma industries, has established an innovative and unique programme, 'Fondo 5%',¹ to deliver innovative and highly expensive therapies to patients with rare diseases after their approval by the EMA but before AIFA authorisation and reimbursement for the specific indication. A joint evaluation by physicians and clinical pharmacists, based on the scientific literature, clinical reports, treatment plan and cost estimate analysis, produces a patient specific request for a peculiar drug not otherwise available through conventional channels. AIFA is responsible for the scientific evaluation, and final authorisation or rejection. Once the treatment plan has received AIFA official approval, the clinician is authorised to administer the therapy whose cost will be subsequently refunded by the AIFA.²

Aim and objectives To describe the Italian method in order to improve the availability of the best innovative therapies, considering sustainability of the national health system.

Material and methods Collection and processing of drug requests for Fondo 5% and analysis of the clinical and economic impact.

Results From August 2018 to September 2019, 24 treatments were authorised by AIFA: 20 (83%) in the adult and paediatric haematological area (venetoclax for acute myeloid leukaemia/mantle cell lymphoma, eltrombopag for pure red cell