options when oral bioavailability is decreased. Further research is needed to fill the gap of ivermectin administration in patients with compromised enteral absorption.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-188 AN AUDIT OF PRESCRIBING, ADMINISTRATION AND STORAGE OF CONCENTRATED ELECTROLYTES

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Background and importance Concentrated electrolytes can be fatal if administered inappropriately. Local hospital policies and protocols exist to ensure appropriate concentrated electrolyte treatment for patients, while reducing the risk of inappropriate or incorrect administration. Patient safety is optimised by using ready mixed bags where possible and ensuring correct storage of intravenous (IV) electrolytes, both concentrated electrolyte ampoules and non-concentrated ready mixed bags, at ward level to reduce the risk of mis-selection and drug error. Local incident reports indicated poor compliance with hospital concentrated electrolyte policies and protocols and so an audit was undertaken to assess this.

Aim and objectives This study aimed to audit the prescribing, administration and storage of concentrated electrolytes in a large teaching hospital.

Material and methods Adherence to hospital concentrated electrolyte protocols and guidelines was determined by a point prevalence audit undertaken in February 2019. Data were collected by clinical pharmacists on a single day and included review of prescriptions from the preceding 7 days.

Results

- There were 133 prescriptions for IV electrolytes on 14 wards.
- Prescribing and administration was appropriate in 32% (n=43) of cases.
- Appropriate storage of concentrated electrolyte ampoules was noted on 95% of the wards. Segregated storage of ready mixed electrolyte bags was found on 30% of the wards.
- Of the 94 potassium chloride prescriptions, ampoules were administered in 78% (n=73) of cases and ready mixed bags were administered in 21% (n=20) of cases. No inappropriate use was identified; however, in 43% (n=31) of cases, no diluent or volume was specified and therefore it was unclear if use of ampoules was clinically indicated. These instances were due to 'as required' prescribing of concentrated electrolytes in the cardiothoracic patient cohort, which requires follow-up.

The Drug Safety Service analysed and circulated the audit results to pharmacy, nursing and medical staff to highlight the main findings and recommendations.

Conclusion and relevance A number of improvement areas were identified:

- Complete concentrated electrolyte prescriptions in accordance with hospital protocols, avoiding 'as required' incomplete prescriptions.
- Define parameters for IV electrolyte replacement postoperatively in cardiothoracic patients.

- More clearly define 'segregated storage' of ready mixed potassium chloride bags.
- Re-audit; undertaken in July 2020, the results of which are currently being analysed.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-189 NEAR MISS LOOKALIKE AND SOUNDALIKE INTRAVENOUS MEDICATION ERROR: A 12 MONTH RETROSPECTIVE STUDY

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Background and importance There is little quantitative evidence in the current literature on the incidence of incorrect medication administration of intravenous medications by clinicians. Analysis of infusion pump medication library alert-logs for user initiated corrections of erroneous medication selections adds quantitative data to the investigation of the incidence of lookalike-soundalike intravenous medication administration errors.

Aim and objectives To establish baseline data from infusion pump medication library alert-logs on near miss and user correction lookalike-soundalike medication selection errors during intravenous medication administration.

Material and methods A 12 month facility wide retrospective review of infusion pump medication library alert-logs was conducted to obtain metrics on the set-up phase of intravenous medication administration. Cancelled infusions and user initiated resolutions of incorrect medication selections were analysed. Decision times of clinicians were calculated from the time-date stamps of the pumps' alert-logs.

Results Incorrect medication selection represented 3.45% (10 017/290 807) of all medication library alerts and 22.40% (10 017/44 721) of all cancelled infusions. Average selection error recognition to cancellation and correction time was 27.00 s (SD 22.25). Medications with longer names were more prevalent among the initial selection errors. Users were more likely to make selection errors with the first part of the medication names (6991/10 017, 69.79%) while the middle part of the medication names were the next most likely to be misidentified (2144/10 017, 21.40%), with name ending confusion being responsible for 8.80% of errors (882/10 017).

Conclusion and relevance The study provides a quantitative appraisal of an area that has been resistant to measurement, and identified a high number of near miss lookalike-soundalike errors. This phenomenon, while largely centred on initial misreading of the beginning of the medication name, also ran through the middle and end portions of medication nomenclature. The value of an infusion pump showing the entire medication name complete with TALLman lettering on the user interface, so that the selection fully matches that of the medication's pharmacy label, is supported by these findings. FMEA type infusion pump strategies that use multiple distinct user confirmation steps (eg, medication selection followed by therapy selection, and user confirmation of clinical advisories) may reduce the risk of incorrect medication selection, as

medications which require the user to pass through such selection and confirmation steps were far less prevalent in the near miss lookalike-soundalike error group.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

5PSQ-190 EXPERIENCE AND SATISFACTION OF OUTPATIENTS IN THE DEVELOPMENT OF A PROGRAMME FOR HOME MEDICATION DELIVERY

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Background and importance Faced with the lockdown caused by COVID-19 since March 2020, we have been reorganising the external patients department to get medicines to our patients. To avoid the displacement of patients to the hospital during the state of alarm, we developed a drug delivery system.

Aim and objectives To analyse the opinion of patients about the new home delivery programme of their medication during the COVID-19 pandemic.

Material and methods Retrospective surveys were conducted with our patients between April and July (they had received their medication between 15 March and 30 June) with the following questions: sex and age, distance from their home to our hospital, employment situation, score for status of the medication at the time of delivery, punctuality of delivery, willingness to pay for transportation for new shipments and general satisfaction.

Results 1123 medication deliveries to 751 patients took place, of which 123 surveys were conducted with our patients (63% men, with the following age ranges: 18–40 years (23.6%), 41–64 years (49.6%) and >65 years (20.8%). Most patients (69.1%) lived between 10 and 50 km away from our hospital. A high percentage of patients did not have a job: students, pensioners or unemployed (49.6%). Our patients scored an average of 9.87 out of 10 for the status of the medication (correct temperature, correct expiration date and correct packaging) given to them. Regarding punctuality, the patients scored an average of 9.86 out of 10 for punctuality of delivery. We also asked our patients if they would be willing to pay the transportation costs for shipping their medication. The result was that 74% of patients strongly or fairly agreed to cover these costs. Finally, regarding the general satisfaction of our patients in this new system, the result was that 91% were totally satisfied and 9% were quite satisfied. No survey was returned with the result quite dissatisfied or not at all satisfied.

Conclusion and relevance Based on the results, our new outpatient drug delivery programme obtained very good scores in these surveys and it could be an alternative for patients with mobility problems who live far away. Also, many patients would be willing to pay for transportation.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-191 NEW GENERAL DRUG CHART, POST-IMPLEMENTATION CLINICAL AUDIT

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Background and importance A new general drug chart was introduced in May 2019. The chart was developed in response to medication incidents and in line with national medication record templates. The new drug chart has a new configuration and format for prescribing. Changes include dedicated sections for anticoagulants and antimicrobials and a venous thromboembolism and bleeding risk assessment (VTE-RA) tool, which was previously available on the hospital intranet.

Aim and objectives To assess the implementation of this change in prescribing practice.

Material and methods A data collection form was designed using the hospital's 'prescribing and drug administration standards'. This document describes how prescribers and nursing staff are to use the drug chart. Guidelines include where to prescribe specific medication, use of abbreviations and general best practice guidelines. Data were collected by nurse and pharmacist volunteers in September 2019. A target sample size of approximately 275 patients was chosen as this equates to half of the inpatients. A convenience sample was collected. Data collectors were assigned to collect data on specific wards until the target sample number was reached. Anonymised data were analysed by pharmacy staff using Microsoft Excel. Descriptive statistics were calculated.

Results

- 273 drug charts were reviewed. An average of 16 medicines were prescribed per patient (range 1–41).
- 75% (n=204) of patients were prescribed an anticoagulant, however, only 3% (n=8) of patients had the VTE-RA tool completed by the medical team.
- The majority of anticoagulant (99.5%) and antimicrobial (95%) prescriptions were written in the correct section.
- The surgical antimicrobial prophylaxis (SAP) section was used in 42% (n=11) of applicable cases.
- For patients prescribed an antimicrobial requiring therapeutic drug monitoring (TDM), the correct section was always used. Completion of target and attained levels was documented for 38% and 35% of patients on TDM antimicrobials, respectively.
- Documentation of 'proposed duration' and 'clinical indication' for antimicrobials was 25% and 50%, respectively.

Conclusion and relevance The new general drug chart is being used in line with hospital standards in most instances. Topics that could be targeted for improvement include the use of the SAP section, documentation of target/attained levels of TDM antimicrobials and specifying 'proposed duration' and 'clinical indication' for antimicrobials. Research on the appropriate completion of the VTE-RA tool is currently underway.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest