

Aim and objectives We started this retrospective prospective study about ophthalmic treatments to verify any non-refunds or incorrect prescriptions and to guarantee a better allocation of available resources and prescriptive appropriateness.

Material and methods We created an Excel file to compare data extracted from AIFA's registers and medical records, and to verify the correct request for reimbursement of prescribed treatments.

Results 400 prescriptions were paper based (not web based as should be the case) with no AIFA registration. Use of paper based AIFA requests: failure to register the new therapy in patients already signed in for other diseases or drugs, failure to transfer four patients from other centres. Of 179 patients treated, 175 dispensations were identified and registered ex novo, involving: 43 requests for reimbursement (obtained from paper based requests), registration of four patients and inclusion of six previously unsolicited treatments. During meetings, incorrect data from a few patients emerged (personal data or treated eye) with consequent correction in six medical records and registers. All folders were registered on the AIFA platform with consequent request of 43 refunds as payment by result, equal to 26 337 586€ (1 531 255€ derived from 25 dispensing requests not previously made and emerged because of the retrospective control carried out in November 2019).

In the Official Gazette No 45 (23 February 2017), a capping agreement was introduced, for each eye, of a refund of the drug's cost following the seventh treatment in naïve patients. The team agreed to continue monitoring prescriptions and this resulted in a saving of about 40 500€ from the request for 90 refunds as a bonus. On 8 October 2019, the AIFA introduced a simplified multi-drug monitoring register so the pharmacist does not have to dispense drugs and there are no refunds.

Conclusion and relevance Collaboration between clinicians and pharmacists is ongoing, monitoring the correct transfer of patients from the old to the new register. It can be concluded that a figure dedicated to the management of drugs can guarantee clinical and economic drug administration, ensuring greater appropriateness and better allocation of resources.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

11SG-027 CARBON FOOTPRINT OF A STERILISATION UNIT

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Background and importance Preparation of the Greenhouse Gas Emission Balance (GGEB) has become mandatory in hospitals but is not yet carried out in healthcare services.

Aim and objectives The objectives were to carry out the GGEB of a sterilisation unit, to calculate the carbon cost of a central sterile services department (CSSD) and to propose improvements to limit these emissions.

Material and methods Three aspects were selected from a document carried out on one of the establishments of our hospital group (GH): environment, staff and equipment. The data relating to the carbon cost of staff transport, waste produced, consumables used, equipment maintenance and energy consumption, as well as the water consumed by the unit

were calculated or measured and related to 1 year of activity. They were then associated with the carbon emission factor created to produce the GH GGEB. The carbon balance obtained was applied to the CSSD national production indicators (S point).

Results The GGEB unit was 88 tons of CO₂ produced per year. Energy (electricity, steam from the Parisian District Heating Company (PDHC) network) and water consumption accounted for 75% of emissions and equipment maintenance for 18%. Waste and staff transport generated 3.5% and 3.0% of the carbon footprint, respectively. The carbon cost related to consumables could not be defined due to a lack of information from the main suppliers. In 2019, the unit treated 7 565 710 S points, so the treatment of 1 S point released 12 g of CO₂.

Conclusion and relevance Energy and water constituted the first emitting item in this balance sheet, which remained underestimated due to a lack of data. The methodology remains to be validated and the emission factors used to be confirmed, in the absence of a bibliography on this subject. Nevertheless, this work can serve as a basis for calculating the carbon cost of any surgical operation. Finally, to limit these emissions, the use of the PDHC network and the installation of a chilled water system on the autoclaves have been implemented in the unit. This work initiates a reflection on the carbon footprint of this activity and the development of actions to reduce these emissions.

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11SG-028 BECOMING A GRADUATE HOSPITAL PHARMACIST: A FRENCH NATIONAL SURVEY

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Background and importance Currently, in France, pharmacy students undergo 5 years of pharmacy studies at the university. To be able to work in a hospital pharmacy, they must complete 4 additional years of specialisation 'residency'. In Europe, the Common Training Framework (CTF), drawn up by the European Association of Hospital Pharmacy (EAHP), recommends this specialisation to improve the quality of pharmacy education and thus comply with the European Statements of hospital pharmacy.

Aim and objectives The objectives of our study were: (1) to assess the areas of activities of pharmacists in French hospitals and (2) to describe their training during the residency.

Material and methods A 52 question survey was written by the French National Federation of Hospital Pharmacy Residents (FNSIP-BM). It was sent to 297 graduate pharmacists from March 2019 to June 2019. The questions concerned their type of internship completed during the 4 years of specialisation, their training and also their first job.

Results Over the study period, 154 (51%) graduate pharmacists responded to the survey. Among them, 137 (89%) were hospital pharmacists and 17 (11%) worked in pharmaceutical industries or health agencies. For their first job, pharmacists worked mainly in various departments as clinical pharmacists