Background and importance Hip fracture patients are characterised by polypharmacy and multiple care transitions within and between home, hospital, and rehabilitation institution/nursing home (ie, the patient pathway). Each care transition increases the risk of medication discrepancies. Thus, there is need to achieve a correct medication list, optimised for each patient, and ensure a seamless patient handover. Before implementing a clinical pharmacist intervention to address these issues, an evaluation of medical doctors’ perceptions of the current situation was needed. However, no appropriate questionnaire was identified.

Aim and objectives To develop a valid and feasible questionnaire to assess medical doctors’ experience with medication management of hip fracture patients in all care settings, and present an example of its applicability.

Material and methods The study took place in a region in South-Eastern Norway (approximate population: 250 000) from September 2017 to August 2018. The emerging questionnaire (MedHipPro-Q) was developed qualitatively through semi-structured interviews with stakeholders, cognitive interviews with future respondents, and a feasibility test. The novel MedHipPro-Q was thereafter distributed to hospital doctors.

Results Three questionnaire dimensions were identified: (1) Medication reconciliation and review, (2) Communication of key information and (3) Profession and setting. The MedHipPro-Q showed face and content validity through its representativeness of how stakeholders experienced medication management in all settings, and good feasibility. Almost half of the doctors in the emergency care unit responded (n = 9/20). They described medication lists missing at admission (n = 7/9), and using median 6–10 (range 3–20) min writing the medication part of the admission journal. In the orthopaedic department, 15/31 responded, and expressed that patients needed more medication reviews (n = 12/15), but wished for someone else to perform it (n = 13/15). A third of the doctors in the orthopaedic department (n = 5/15) always write the mandatory medication list at discharge.

Conclusion and relevance The MedHipPro-Q showed emerging validity and appeared feasible. It was able to identify problem areas that could be addressed by the planned clinical pharmacist intervention.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of interest No conflict of interest
Background and importance Incorrect dosing of direct oral anticoagulants (DOACs) potentially increases the risk of bleeding or thromboembolic events. For guideline-conforming dosing [1] multiple factors such as indication, age, body weight, renal function, drug interactions and risk of bleeding have to be considered. Therefore, correct dosing of DOACs represents a challenge in clinical practice.

Aim and objectives This study aimed to quantify DOAC dosing errors, identify barriers of correct dosing, assess potential reasons for errors and to investigate the acceptance rate of pharmaceutical interventions addressing dosing errors.

Material and methods During a 6-month study period (April–September 2021) all DOAC prescriptions of clinical pharmacist (CP)-reviewed patients in a 1740 bed tertiary care hospital were prospectively collected. Prescriptions were assessed for dosing errors and, if necessary, corrections were recommended to prescribers. Doses according to Summary of Product Characteristics (SPC) criteria were considered correct. A total of 813 beds on 44 different wards (including surgical and internal medicine patients) were covered by 17 CPs.

Results Dosing checks were performed in 811 patients (44.5%) women, median age 78 years, median estimated glomerular filtration rate (eGFR) Modification of Diet in Renal Disease (MDRD) 60 mL/min/1.73 m². A total of 194 incorrect doses (23.9%) were identified. The most common DOAC indication was atrial fibrillation (76.2%). The most frequently evaluated DOAC was edoxaban (31.1%). A significant relation was found between apixaban 2×2.5 mg (X²(1, N = 123) = 18.1,