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

5PSQ-006 DOSING LOW MOLECULAR WEIGHT HEPARINS IN RENAL IMPAIRMENT: A NATIONWIDE SURVEY

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Background and importance International guidelines vary in their advice whether or not to reduce the therapeutic dose of low molecular weight heparins (LMWHs) in renal impairment. The use of anti-Xa monitoring as a basis of dose adjustments is also a matter of debate.
Aim and objectives To study the nationwide treatment policies of therapeutically dosed LMWHs in renal impairment in hospitals.
Material and methods An 11-item survey was distributed to clinical pharmacists nationwide between June 2020 and March 2021. Primary outcome was the hospital dosing regimen for therapeutically dosed LMWHs in renally impaired patients. Secondary outcomes were the proportion of hospitals that used anti-Xa monitoring and the anti-Xa target range used. Descriptive statistics were used to analyse the data.
Results The survey was completed by 56 of the 69 (81%) hospital organisations nationwide. Of the included hospitals, 91% applied a fixed-dose reduction at the start of the LMWH treatment in renally impaired patients (71% reduced if estimated glomerular filtration rate (eGFR) <50 mL/min and 20% if eGFR <30 mL/min). The majority (64%) of hospitals applied a dose reduction of 25% if eGFR is 30–50 mL/min and of 50% if eGFR is <30 mL/min. Anti-Xa levels were not routinely monitored in renally impaired patients in 43% of hospitals, while 20% of hospitals monitored anti-Xa if eGFR <50 mL/min, 25% if eGFR <30 mL/min and 12% with other eGFR cut-off values. Target ranges of 1.0–2.0 IU/mL (once-daily dosing) and 0.5/0.6–1.0 IU/mL (twice-daily dosing) were used in 69% of hospitals that monitored anti-Xa.

The most commonly applied treatment regimen was dose reduction if eGFR <50 mL/min without anti-Xa monitoring, regardless of the type of LMWH.
Conclusion and relevance This study demonstrates substantial nationwide diversity in the treatment policies of therapeutically dosed LMWHs in renally impaired patients in hospitals. The most commonly used treatment regimen in hospitals is to apply a fixed dose reduction if eGFR is <50 mL/min, without anti-Xa monitoring. This treatment regimen is not yet described in LMWH treatment guidelines in renally impaired patients and should be explored in future research.

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5PSQ-008 ASSESSMENT OF PATIENT-CONTROLLED ANALGESIA (PCA) PRACTICES IN A PUBLIC HOSPITAL

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Background and importance PCA pumps help patients manage their pain by guaranteeing them autonomy, while lightening nursing workload. In this context, the prescriptions must contain the information necessary for secure programming (background dose, bolus, inter-dose, *etc*.) leaving no possibility for interpretation. This project was founded in response to repeated adverse event reports concerning patient-controlled analgesia (PCA) (8 reports between 2017 and 2020 with a majority of overdoses requiring care).
Aim and objectives An assessment of the prescription and monitoring of PCA is carried out with the aim of having a database in order to standardise the method of prescription using a multidisciplinary working group.
Material and methods Information is collected through an interview of the health executive of each department using a

seven-item questionnaire: prescription, monitoring, pump use, clarity of prescription, nurse skills and presence of a pain-referent (specialised nurse). The information was collected in the care unit using PCA between June and September 2021.

Results Seven department health executives were interviewed. Concerning the prescription: five departments use a computerised prescription, none include dilution information, and programming details are added by the prescriber because there is no prepared protocol. Two services use a paper prescription that is also the follow-up paper: they contain dilution information but not the background dose. Five services carry out the follow-up with a paper follow-up sheet, which differs according to the service, and two services use written computer transmissions. Concerning the other items: there is a lack of training sessions about the PCA pump use, only one service had a recent course by the company.

Conclusion and relevance The assessment showed a disparity in the method of prescription and monitoring. It appears that essential data are missing, data which are necessary to have a complete prescription. It would be interesting to work on a computer protocol making it possible to simplify the prescription (basic dose, bolus, inter-dose, etc.), as well as to propose a single paper prescription for non-computerised services. A working group comprising representatives of the pharmacy department, prescribers from the care units concerned, health executives and pain-adviser nurses has been set up to work on this issue with the objective of improving patient care.

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5PSQ-009 PATIENT SAFETY AND MEDICATION SAFETY CULTURE IN A HOSPITAL PHARMACY DEPARTMENT: A MIXED-METHODS STUDY

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Background and importance Pharmacists play an essential role in patient safety culture and medication safety, coordinating and implementing patient safety initiatives and preventing medication errors; however, there is limited literature on safety culture in pharmacy departments specifically. While patient safety culture surveys are a widely accepted measurement tool to measure patient safety culture, there is no widely used tool to measure attitudes towards medication safety. Measuring patient and medication safety culture could identify important areas for improvement.

Aim and objectives To assess the perceptions, opinions and attitudes of pharmacy staff to the patient and medication safety culture in a hospital pharmacy department.

Material and methods A mixed-methods cross-sectional survey study was conducted in a hospital pharmacy department over a 2-week period in June 2021. The quantitative phase involved a patient safety culture assessment, using an adapted version of the Safety Attitudes Questionnaire (SAQ) and a medication safety culture assessment with 12 Likert-scaled questions developed by the research team. Statistical analysis was performed on the quantitative data. Qualitative data from two open-ended questions on recommendations to improve patient and medication safety were subjected to thematic analysis.

Results Forty-four staff members completed the questionnaire (30 pharmacists and 14 pharmacy technicians) resulting in a 75.9% response rate. The pharmacy department scored below the SAQ international benchmark in four domains, with particularly low scores in the 'Perception of Management' and 'Working Conditions' domains. Medication safety culture scores were positive with a mean score of 61.8. Seven themes emerged from the qualitative data: (1) Communication, (2) Staffing Issues, (3) Training and Education, (4) Digital and Technological Advances, (5) Environment, (6) Collaboration and (7) Medication Safety Initiatives.

Conclusion and relevance Survey respondents identified many barriers to improving safety in the hospital including staffing issues, communication, lack of training and education and work environment. Pharmacy staff recommended the use of more technological advances, collaboration with multidisciplinary teams and more medication safety initiatives. These are important recommendations which should be discussed with hospital management and introduced to improve the safety culture in the hospital.

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5PSQ-010 IDENTIFICATION OF INCORRECT DOSING OF DIRECT ORAL ANTICOAGULANTS: AN IMPORTANT INTERVENTION TO IMPROVE PATIENT SAFETY

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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) Modificaiton of Diet in Renal Disease (MDRD) 60 mL/min/1.73 m^2). 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 ($X^2(1, N = 123) = 18.1$,