

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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

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) 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 ($X^2(1, N = 123) = 18.1$,