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

[1]G Mc Namara*, [2]L Gleeson, [1]A Harnett. *[1]University Hospital Limerick, Pharmacy Department, Limerick, Republic of Ireland; [2]University College Cork, School of Pharmacy, Cork, Republic of Ireland*

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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.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Conflict of interest No conflict of interest

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

F Nagele*, E Tudela-Lopez, M Hana, M Holbik, S Zotter, M Amtmann, B Datterl, P Pölzleitner, K Jadrna, G Stemer, M Anditsch. *University Hospital Vienna, Pharmacy Department, Vienna, Austria*

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

p<0.001) as well as dabigatran 2×150 mg (X^2(1, N = 40) = 5.95, p = 0.015) and incorrect dosing. A risk factor significantly related with incorrect dosing was age above 80 years (X^2(1, N = 351) = 7.0, p = 0.008). 45.9% of dosing errors were corrected following a pharmaceutical intervention. A common reason given for incorrect dosing was 'unstable renal function'.

Conclusion and relevance This study showed that DOAC dosing errors are frequent and pharmaceutical interventions can contribute to a reduction of these errors. Special caution is needed in elderly patients. Measures to increase acceptance rate need to be further investigated.

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5PSQ-011 INTRAVENOUS POTASSIUM CHLORIDE: HOSPITAL-WIDE EVALUATION AND BENEFITS OF A VIDEO COURSE

L Roux*, E Lazzaro, D Regnault, T Poinsat, L Merian-Brosse, AC Lagrave. *Hopital de Poissy, Yvelines, Poissy, France*

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Background and importance Never-events are a main point in the making secure the medication circuit. As they are preventable events we wanted to set up a support that fitted with the knowledge of our health professionals (HP). We decided to focus on one of them, namely intravenous potassium chloride (KCl).

Aim and objectives We aimed to assess the knowledge of HP about intravenous KCl to produce a relevant and suitable support.

Material and methods Two pharmacy residents created a Google Forms survey on various aspects of intravenous KCl: prescription, storage, preparation, adverse effects, recognition, and administration. For each topic there were four or five items which were true or false. All HP of our hospital could answer online or on a paper form. An item was 'known' if the rate of correct answers was ≥80%.

We then made a video according to the lack of knowledge found through the survey.

Finally a new Google Forms survey was created to assess the video content and the satisfaction of HP.

Results We registered 144 answers. 78 were from nurses and caregivers (60%). The rate of correct answers varied from 67% for midwives to 83% for pharmacists (mean 75%). The units of prescription for children (44%), the warning labelling (42%) and the adverse effects (22%) were the lesser known items.

The video lasted about 4 min and covered all the topics from the first survey. It was available on the hospital's document management system.

The second survey registered 34 answers. Nearly 27% were from pharmacy technicians. The average rating of the content of the video was 9.5/10. The mean score for knowledge improvement was 8.4/10. HP declared an improvement in their knowledge about adverse effects (50%) and prescription (42%).

Conclusion and relevance The first evaluation showed an overall good knowledge about intravenous KCl. The video format was well received and will be complemented with a poster for care units. The improvement in prescription and adverse effects knowledge fits with the results of the first survey. It will be a useful tool for further courses for HP. The positive feedback will encourage us to develop the same approach for the other never-events.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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5PSQ-012 ARE 12 MONTHS OF TREATMENT WITH MONOCLONAL ANTIBODIES SUFFICIENT FOR MIGRAINE ATTACK PREVENTION?

[1]D Fresan, [1]E Lacalle, [1]M Calvo, [1]D Tejada, [2]A Albalat Torres*, [1]I Ortega, [1]A Pino, [1]S Erdozain, [1]B Larrayoz, [1]M Sarobe. *[1]Complejo Hospitalario de Navarra, Pharmacy Service, Pamplona, Spain; [2]Hospital del Mar, Pharmacy, Barcelona, Spain*

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Background and importance Monoclonal antibodies (MAB) galcanezumab, erenumab and fremanezumab have been recently incorporated into the treatments for migraine attack prevention. All have proven to be safe and effective at reducing the number of migraine days (MD) versus placebo in short-duration clinical trials. However, some uncertainties remain unsolved, such as the optimal therapy duration. Clinical practice guidelines recommend treatment maintainance for 12 months.

Aim and objectives To analyse patients' clinical situation after the year of treatment.

Material and methods Prospective and observational study conducted in a tertiary hospital between December 2019 and August 2021.

After 12 months, neurologists decide whether the patient should continue with chronic treatment or, as recommended, stop and ask for re-evaluation if migraine worsens. All patients are reviewed 3 months after discontinuation.

Pharmacists' tasks range from validating and dispensing all treatments to medication counselling and follow-up.

Results 97 patients completed the first 12-month treatment course. 15.5% (15) were maintained chronically (8 as they had a strong likelihood of worsening if discontinued; 3 because MD diminished although they still had >15 days monthly; 2 since an effect was demonstrated during the last 3 months of treatment and 2 due to previous failure of dose reduction attempts).

32% (31) of patients required treatment reintroduction: 8 in less than 3 months (mean 1.57 (0–2) months) and 24 in ≥3 months (mean 4.08 (3–6) months). 21 of them have reached the second course 3 months' evaluation and all continue with effectiveness.

6.2% (6) changed to another preventative therapy (*botulinum toxin*, mainly) when their condition worsened and 2.1% (2) to another MAB. 8.2% (8) switched directly to another MAB due to poor response to the first one. 36% (35) remain in a clinically stable condition without a preventive therapy (20 after ≥3 months and 15 in the first 3 months).

Conclusion and relevance Effect of treatment remains for at least 3 months after discontinuation in 45% (44) of patients.

24% (23) of patients are either maintained chronically or need an early re-start.