Material and methods A preliminary risk analysis was chosen to carry out the risk mapping. The working group included a doctor, a pharmacist, a nurse, a PT, a health framework and a manager responsible for risk management.
Results The risk mapping concerned the stages of preparation and delivery of drugs. The initial criticalities of the scenarios were distributed as follows: 46.5% unacceptable (C1), 37.2% tolerable under control (C2) and 16.3% unacceptable (C3). After the implementation of corrective actions, the residual criticalities were distributed as follows: 97.7% C1 criticality and 2.3% C2 criticality. Ten corrective actions were identified by the working group, for example, the computerisation of prescriptions and the over-labelling of non-unit drug blisters.
Conclusion and relevance The preparation step is considered more risky. For the preparation stage 76% of the scenarios were classified as very vulnerable versus 58% for the delivery stage. The realisation of the risk mapping of drug management at prison made it possible to identify the potential dangers. The weekly nominative automated preparation of drugs by the pharmacy represents a major challenge.

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Conflict of interest No conflict of interest

5PSQ-147 A SYSTEMATIC RISK ANALYSIS METHOD APPLIED TO THE MEDICAL DEVICES MANAGEMENT PROCESS IN A HOSPITAL PHARMACY

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Background and importance During the COVID-19 pandemic, the management of medical devices was foreseen by repetitive and unforeseen breaks. To optimise management a risk analysis is necessary.
Aim and objectives The present study aimed to determine risks related to the medical devices management processes in our teaching hospital according to a failure mode and effects analysis (FMEA) method.
Material and methods Skilled health care professionals were recruited to form a multidisciplinary study team (pharmacists, nurses, administrative agent, and pharmacy technician). They proceeded to draft the process cartography. They defined all related failure modes that could occur indicating causes and consequences through brainstorming meetings. These failure modes were classified considering the criticality index (CI) calculated according to the indices: severity of the potential effect, detection probability, and likelihood of occurrence. Prioritisation was carried out considering the mean and the median values of CI as limits. Corrective and preventive actions were then proposed.
Results A total of 44 failures modes were defined accumulating 4176 points of criticality. CI values ranged from 12 to 336. The step of delivery processing exhibited the highest median CI with a value of 120 (min = 63 – max = 144) followed by the ordering step with a median CI value of 80 (min = 27 – max = 144). The highest CI was related to the failure mode 'erroneous estimate of need when defining the purchasing framework' with CI value of 336. Sixteen (36%) failure modes were considered as critical, 6 (14%) as failure modes to control and 22 (50%) as acceptable. After prioritisation, three main axes to act were proposed: architectural reorganisation (by securing premises, organisation of flows, and strengthening of storage capacity), improvement of the medical device management software, and setting up a monitoring system for the conduction of the various purchasing frameworks.
Conclusion and relevance The FMEA method was a consensual tool that permits proposal actions reducing risks related to the medical devices management process. Optimising the prediction of needs, strengthening communication with user services, and securing access are essential to guarantee the availability of medical devices for the ultimate benefit of the patient.

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Conflict of interest No conflict of interest

5PSQ-149 DURVALUMAB FOR THE TREATMENT OF NON-SMALL CELL LUNG CANCER: REAL-WORLD EXPERIENCE

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Background and importance Durvalumab is indicated for the treatment of locally advanced, unresectable non-small cell lung cancer (NSCLC) in adults whose tumours express PD-L1 on ≥1% of tumour cells and whose disease has not progressed following platinum-based chemoradiation therapy (QT-RDT).
Aim and objectives To evaluate the effectiveness and safety of durvalumab in NSCLC according to the conditions of use indicated in the data sheet.
Material and methods An observational retrospective study was conducted. We identified all patients with advanced NSCLC treated with durvalumab from September 2018 to September 2021.

Patients' demographics (sex, age), clinical (diagnosis, stage, Eastern Cooperative Oncology Group (ECOG), PD-L1 expression) and therapy-related data (cycles received, duration of treatment) were analysed. Adverse effects (AE) were recorded from electronic medical records.
Results 23 patients were included (6 women, 17 men) and mean age was 66 years (38–80).

Histology was squamous in 14 patients (60.87%) and adenocarcinoma in 9 (39.13%). Mean time from the end of QT-RDT and the initiation of therapy with durvalumab was 91 (36–146) days. Mean number of cycles received was 18 (4–27).

At the time of analysis 3 patients (13.04%) continued therapy with durvalumab, 8 (34.78%) completed 12 months of therapy and 12 (52.17%) discontinued. Progression was the main reason for discontinuation, specifically in 9/12 patients (75%).

At the end of the study, with an average follow-up of 17 (4–37) months per patient, 5 patients (21.74%) died. None of these patients completed 12 months of durvalumab (1 due to intolerance and 4 due to disease progression).

Neither median progression-free survival nor median overall survival were reached at the data cut-off date.