In addition, no increased risk of serious adverse events was observed. Further follow-up is needed to confirm long-term safety.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest.

5PSQ-039 IMPACT OF TAILORED SCREENING INTERVALS ON THE BURDEN OF DRUG-DRUG INTERACTION ALERTS: AN INTERRUPTED TIME SERIES ANALYSIS

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10.1136/ejhpharm-2024-eahp.373

Background and Importance Using fixed as well as broad screening intervals for drug-drug interaction (DDI) alerts leads to an excess of false positive alerts, contributing to alert fatigue among prescribers.
Aim and Objectives We aimed to investigate the effect of tailored screening intervals on the occurrence of DDI alerts.
Material and Methods An interrupted time series analysis was performed to evaluate the effect of a pragmatic intervention on the daily percentage of DDI alerts. The study period consisted of 100 randomly selected days between April 2021 and December 2022. A fixed screening interval of 7 days before and after prescribing a drug had been used to screen for DDIs, until implementation of the intervention. The intervention comprised embedding tailored screening intervals for 27 selected DDIs into the hospital information system. The daily percentage of DDI alerts was defined as the ratio of the number of DDI alerts to the number of new prescriptions per day.
Results During the study period, a mean of 5731 (±2909) daily new prescriptions was created. Daily DDI alerts decreased from an average of 8.6% (±2.2) in the pre-intervention period to 6.6% (±1.4) in the post-intervention period. A significant immediate absolute reduction of 4.5% (95% CI: -6.2; -2.8%, $p<0.0001$) in the number of prescriptions with a DDI alert was observed, which translated to approximately 258 (0.045*5731) false positive DDI alerts avoided per day.
Conclusion and relevance Defining and implementing tailored screening intervals was feasible and effective in reducing the burden of DDI alerts.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest.

5PSQ-040 VOLUNTARY MEDICATION ERRORS REPORTING SYSTEM IN AN ORTHOPAEDIC SURGERY AND TRAUMATOLOGY UNIT

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10.1136/ejhpharm-2024-eahp.374

Background and Importance Medication errors (ME) are incidents that can occur at any stage of medication use in patient's care process. Voluntary incident reporting has proven to be a useful tool to identify contributing factors and establish improvement actions. Surgical patients have one of the highest rates of MEs because of their vulnerable profile and their multiple care transitions.
Aim and Objectives To analyse the voluntary ME notifications made in the Orthopedic surgery and Traumatology unit of a tertiary level hospital with electronic prescription, validation and administration system, to identify the most important contributing factors and to describe improvement actions.
Material and Methods ME reported in the Orthopedic surgery and Traumatology unit were analysed monthly by Hospital Safe Medication Use Committee from February 2022 to June 2023. Notifications were classified according to three factors: causality (prescription, administration, reconciliation, monitoring, transfers, labeling, dispensing, similarity of packaging and/or name), severity (potential circumstance to produce ME, incident that does not reach the patient, incident without harm and adverse events) and notifying personnel (physicians, nurses or pharmacists). Contributing factors were also identified and improvement actions were proposed.
Results A total of 83 ME voluntary reports were analysed. 74.6% of them were prescription errors, 6% were related to administration and 4.8% were related to reconciliation and monitoring. In terms of severity, 47.8% were harmless incidents, 26.5% were potential ME-causing circumstances, 19.3% were incidents that did not reach the patient and 7.2% were adverse events that did cause harm. The reporting personnel were mostly nurses (58%) and pharmacists (25%). The main contributing factors identified were daily review electronic prescriptions failure, lack of reconciliation of the patient's regular medication and variability in paediatric patient prescriptions. Improvement actions implemented were a specific protocol for the management of paediatric trauma patients, a multidisciplinary study of prescription errors and an informative session in the Orthopaedic surgery and traumatology unit where we explain the reported ME and specific recommendations were given to avoid them.
Conclusion and Relevance The analysis of the reported ME has allowed us to identify the contributing factors and to establish recommendations to modify them. Further studies of prescription errors will allow us to monitor the impact of the implemented actions.

REFERENCES AND/OR ACKNOWLEDGEMENTS
Conflict of Interest No conflict of interest.

5PSQ-041 IMPACT OF INTRODUCING PREFILLED ATROPINE SYRINGES IN OCULAR SURGERY: PROACTIVE ASSESSMENT OF DRUG COSTS AND MEDICATION SAFETY

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10.1136/ejhpharm-2024-eahp.375

Background and Importance Intravenous atropine injection is used to treat acute bradycardia during ocular surgery. It has been observed that a significant amount of ampoule-drawn atropine injections were unused and wasted yearly in a large ocular surgery unit. Some potential medication safety risks have also been recognised. Although ready-to-use prefilled atropine syringes are recommended to improve medication

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