

The total error rate (including near-misses) per patient prescribed in a CMI with certified quality management was 1.26.

The total error rate (including near-misses) per patient prescribed in a CMI without the provision of treatment orders was 6.74.

Conclusion The percentage of suitable beds was very low and compliance of pre-filled solutions was much lower than NHS. CMIs with an accredited quality management system where staff had been trained in prevention of medication errors had better concentrated pharmacy storage conditions and had a slightly higher use of pre-filled pharmacy solutions than non-accredited CMIs.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Source: for Safe Medication Practices

No conflict of interest.

PS-055 THE INCIDENCE OF DRUG ALLERGIES IN HOSPITALISED PATIENTS

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Background The literature reveals that approximately 20% of healthcare professionals fail to document drug allergies (DA) in the electronic records. Shortcomings in the documentation of allergies can lead to medication errors (MEs).

Purpose The aims of this study were to measure patient DA profiles documented in the electronic records and to determine MEs associated with DA.

Material and methods Retrospective observational study including all adult patients admitted in our hospital on February 24, 2014. Discharge prescriptions and patient DA profiles entered into the different (non-integrated) electronic records were reviewed.

Results 158 patients were included in the study. In all patients, a history of an allergic reaction to drugs or not was reported in at least one electronic record. 1.9% in the patient's admission prescriptions, 20% in the nursing assessment form and 46.8% in the electronic prescription system. Nevertheless, only in 3% of the cases was it reported in all of the records. In 13.3% of the cases, there were discrepancies between different electronic records. DA were recorded in 60 patients. The drugs most frequently recorded were penicillins (30%) and metanalsols (25%). 11 MEs were identified in which a drug was prescribed for a patient with a documented DA. In 6 cases the medicine didn't reach the patient and was prevented by a pharmacist in four cases. In the other 5, the medicine reached the patients. Fortunately, there was no evidence of any reactions following the administration of the drugs.

Conclusion The existence of different non-integrated electronic records hinders independently recorded DA, discrepancies and MEs related to DA. Pharmacists can play an active role in getting adequate DA recording systems into hospitals and improving inpatient safety.

REFERENCES AND/OR ACKNOWLEDGEMENTS

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No conflict of interest.

PS-056 IMPROVING THE CULTURE OF SAFETY THROUGH AN ONLINE INCIDENT REPORTING SYSTEM: A NATIONAL PROJECT

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Background The project involved the Hospital Pharmacists Association network in collecting incident reports/near misses related to drugs and medical devices. There is evidence that by reporting errors and analysing error patterns there could be a reduction in medication errors (MEs).

Purpose To improve the safety culture through the development of an online national incident reporting system (IRS) in order to reduce potential MEs and increase patient safety.

Material and methods We performed a literature review of IRSs. We created our national IRS, which is available online on our Hospital Pharmacists Association national website. It is composed of three sections (context; details; causes and consequences). Submission of MEs is anonymous to guarantee confidentiality. Periodically a ME report is published on the website to educate readers in potential MEs. MEs reported between October 2011 and September 2014 were collected and analysed. We evaluated the severity of the errors reported using the American National Coordinating Council for Medication Error Reporting and Prevention Index (NCCMERPI), which classifies errors in 9 categories according to the severity of harm caused (with increasing severity from A to I).

Results From quantitative data analysis it emerged that all reports (69 valid out of 84) referred to drugs and the majority of MEs were prevented by pharmacists (50.7%). The riskiest phases turn out to be administration (52.2%), followed by prescription (29%) and distribution (8.7%). From NCCMERPI analysis it emerged that the majority of MEs reported were classified in the C category (39.1%).

Conclusion Incident reports collected suggest increasing checks (double check) throughout the medication process and developing specific checklists. We mostly need to sensitise healthcare professionals to improve incident reporting. We need to take specific initiatives on potential errors with medical devices because of the lack of reporting in this important category.

REFERENCES AND/OR ACKNOWLEDGEMENTS

American National Coordinating Council for Medication Error Reporting and Prevention Index

No conflict of interest.

PS-057 CISPLATIN-INDUCED HYPOMAGNESEMIA

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Background Hypomagnesaemia is a well-known side effect of cisplatin, induced by the drug's renal toxicity. Although hypomagnesaemia refers to any magnesium level below 1.2 mg/dL, it does not lead to clinical symptoms until levels < 1.2 mg/dL. Life-threatening consequences have been reported only when levels < 0.7 mg/dL.

Purpose To evaluate the incidence and severity of cisplatin-related hypomagnesaemia.