the overall satisfaction of nursing staff with the use of the devices. The secondary criteria concerned the handling of materials and consumables as well as navigation in drug libraries and the duration of each scenario, timed by a project member.
Results: 77 agents (25% of the nurses concerned) were trained, 54 of whom evaluated the two ranges. The fulfilment of the medical prescription and the installation of the tubing in the pump was considered longer with the range proposed by B.Braun. No other significant difference was observed. However, 56% of nurses advised the range proposed by B.Braun which appeared safer, more ergonomic and less bulky.
Conclusion: To our knowledge, no such study has ever been published. Without observing major differences in use between the two companies, this comparison process allowed us to determine the equipment that seemed to best meet the expectations of the paramedical teams. Moreover, by involving and following the teams in the choice of their work equipment we hope to have strengthened the adherence of the teams to the change of practice induced by the use of smart pumps.
Compliance with ethics regulations: Yes in clinical research.

FC-103

Influence of clinical pharmacist presence on acceptance and delivery of pharmaceutical interventions in a pediatric resuscitation unit

HANAFIA Omar[1], HACHE Guillaume[1], BERTAULT-PERES Pierre[1], HONORE Stéphane[1], MICHEL Fabrice[1]
[1]Hopitaux Universitaires de Marseille, Marseille, France
Correspondence: Omar HANAFIA (omarhanafia@yahoo.fr)
Annals of Intensive Care 2022, **12(1):**FC-103

Rationale: Studies have shown that medication errors are common in intensive care units. The drug management of pediatric and neonatal populations is particularly at risk of iatrogenia due to the pathophysiological characteristics of these populations, the lack of suitable pharmaceutical forms and based on weak agreements. In addition, the clinical situations of these patients are serious and often require complex therapeutic strategies. Securing drug prescriptions is critical in these situations. The objective of this study was to measure the influence of the presence of the clinical pharmacist in the clinical department on the safety of drug prescriptions.
Patients and methods/Materials and methods: We conducted an observational study, before/after a pharmacist was involved in a 30-bed critical care unit. The analysis and daily pharmaceutical validation of prescriptions were performed from the pharmacy on the first part of the study (before). The issuance of Pharmaceutical Interventions (PI) was conducted by telephone and plotted on the printed prescription. For the second part (after), the pharmaceutical validation of the prescriptions was carried out in the service and the PI transmitted orally to the prescribers in person and plotted in the same way. The main criterion for evaluating the securing of prescriptions was the number of PI issued. We also characterized the nature of the PI, the consensus achieved orally, and the achievement of the prescription change suggested by the PI.
Results: We have 351 PI out of 126 days before, these PI mainly concerned overdoses (52%), route and/or inappropriate administration (17%) and non-conformities to the repository (10.8%). 179 children were affected by these IP. We found 1120 IP over 287 days, these IP mainly concerned monitoring (27.8%), overdoses (21.8%) and under dosing (10.1%). 300 children were affected by these IP.
We observed an increase in the number of IP performed per day (2.8 vs 3.9), the average number of IP per patient (2 vs 3.7). An increase in the number of IP accepted (267 vs 756; $p = 0.036$) and the number of implementations (183 vs 629; $p < 0.001$) was highlighted.
Conclusion: The presence of the pharmacist in the clinical department increased the number and relevance of PI performed. The nature of PI has evolved with a more patient-centred orientation. Acceptance and achievement rates are better, the percentage of PI achieved is higher, and these results show that PI are both better monitored and better monitored. Risk reduction is best with pharmaceutical expertise through the presence of a clinical pharmacist in the care unit.
Compliance with ethics regulations: Yes in clinical research.

FC-104

A prospective pharmacist review of drug-related problems after ICU discharge: preliminary data

ANDRÉ Sébastien[1], ROUSSEAU Anne-Françoise[2,3], COLSON Camille[2,3], MISSET Benoît[2,3], GILLET Manon[1]
[1]Hospital Pharmacy Department, University Hospital of Liège, Liège, Belgique; [2]Intensive Care Department, University Hospital of Liège, Liège, Belgique; [3]University of Liège, Liège, Belgique
Correspondence: Sébastien ANDRÉ (sebastien.andre@chuliege.be)
Annals of Intensive Care 2022, **12(1):**FC-104

Rationale: A stay in an intensive care unit (ICU) and the transitions of care are known to be at risk of drug-related problems (DRPs). These problems may contribute to readmissions and development of post-intensive care syndrome. The objective of this monocenter prospective study was to describe the prevalence of specific DRPs in patient's post-ICU drug treatments.
Patients and methods/Materials and methods: Adults with an ICU stay ≥ 7 days between 16th November 2021 and 25th January 2022 were included if they were enrolled in our post-ICU follow-up program. A pharmacist conducted a full medication review including medication reconciliation. This review was planned in general ward, during the week following ICU discharge. The pharmacist identified potential DRPs that were classified using the Pharmaceutical Care Network Europe Classification for Drug-Related Problems. Tailored interventions were also delivered to general wards clinicians based on identified DRPs.
Results: We included 29 patients (72.4% men, age 59 [33–76] years, ICU stay 19 [7–95] days). Drug treatments were reviewed 5 [2–9] days after ICU discharge. A total of 148 DRPs were identified: 27/29 patients (93.1%) experienced at least 1 DRP and a median of 5 [0–12] DRPs were observed per patient. Most DRPs referred to (potential) adverse drug events (86/148, 58.1%), (potential) non-optimal effect of drug treatment (26/148, 17.6%) and unnecessary drug-treatment (26/148, 17.6%). The main cause of DRPs was related to drug selection (80/160, 50.0%) comprising absence of indication, inappropriate drug according to guidelines and inappropriate combination of drugs. Other causes of DRPs included prolonged duration of treatment (36/160, 22.5%), inappropriate dose or dosage regimen (23/160, 14.4%) and medication reconciliation problem (7/160, 4.4%). Drugs involved in DRPs belonged mainly to the nervous system group, the alimentary tract and metabolism group, and the cardiovascular system group. The most common drugs implied were tramadol and pantoprazole. Based on identified DRPs, 147 pharmacist interventions were discussed with the clinicians. Withdrawal of a drug was the predominant intervention (75/147, 51.0%) followed by provision of information about the DRP, dosage regimen modification, dose change, initiation or resumption of a drug and drug switch. 74.2% of all interventions were accepted by the clinicians.
Conclusion: DRPs were common after ICU discharge. Drugs of the nervous system group and proton pump inhibitors probably require sustained attention. Future research should evaluate the impact of pharmaceutical interventions on mid-term outcomes of ICU survivors.
Compliance with ethics regulations: Yes in clinical research.

FC-105

Evaluation of a negative pressure aerosol protection box to prevent airborne transmission of SARS-COV-2 to healthcare providers in pediatric intensive care

CECÍLIA Rotava Buratti[1,2], JOUVET Philippe[1], BRIDIER Armelle[1], VEILLETTE Marc[3], DUCHAINE Caroline[3]
[1]Sainte Justine Research Center, University of Montreal, Montreal, Canada; [2]Postgraduate program in child and adolescent health, Universidade