special procedures of clinical management. After two years, an independent study seeking to explore the awareness of this Recommendation and its implementation by Italian hospital pharmacists has started. It is designed in two steps that differ for methodology of enrolment: in step 1 only Directors of pharmacy departments are enrolled; in step 2 all hospital pharmacists working in Health National System hospitals will be enrolled.

Purpose To describe the results of step 1.

Materials and Methods In the period 01/08/2012–30/09/2012, 250 Directors of Italian pharmacy departments were enrolled. They received a questionnaire composed of 11 questions on the following topics: knowledge of LASA drugs and the ministerial Recommendation; any LASA drug errors and causes detected in their hospital in the period August 2010–August 2012; activation of risk management procedures to prevent LASA and implement the Recommendation in their hospital.

Results 52.5% of Pharmacists answered: 100% were familiar with LASA drugs and the ministry Recommendation. 73% had detected LASA drug errors in their hospital, caused by the following similarities: 66% packaging; 14% trade name, 6% active substance name, 6% association brand name and packaging; 8% association active substance name and packaging. 58% had publicised the Recommendation in their hospital but only 22% had adopted specific measures of risk management.

Conclusions The results could reflect little interest in preventing LASA errors by enrolled pharmacists. It is an alarming situation. If step 2 confirms this trend, it will be necessary to implement a new Ministerial Intervention against LASA drug errors in Italy.

No conflict of interest.

GRP-021 ANALYSIS OF PHARMACIST INTERVENTIONS DURING THE VALIDATION OF THE ELECTRONIC PRESCRIPTIONS IN A SPANISH HOSPITAL

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Background Computerized provider-order-entry (CPOE) system is known to improve quality, increase efficiency, and reduce medication errors.

The pharmacist, through the electronic validation, can provide improvements to the patient pharmacotherapy. However, not all hospitals follow the same method to make such proposals.

Purpose To analyse the type of interventions made in our hospital.

To validate process intervention.

Materials and Methods Pharmacists interventions were studied over a period of one year (June 2011–May 2012). Both prescription and validation are performed in the computer programme Farmatools®. The pharmacist used to write a warning on the patient treatment. Alerts were reviewed the following day and we checked if the recommendation was accepted or not by the physician. Interventions were classified according to the type of recommendation, the drug and whether it was accepted.

Results A total of 788 interventions were analysed (2.2 per day). The most frequent (27%) was dose adjustment for renal failure, followed by switching from intravenous to oral route (16%), change of dose (13%) and indication (12%). Other interventions were medication reconciliation, duplicity, therapeutic equivalent and adverse reaction.

The most frequent drugs were enoxaparin (24%), pantoprazole (12%), paracetamol (5%), insulin (5%), digoxin (4%), amoxicilin-clavulanic (4%) and levofloxacin (4%).

Only 72% of the recommendations were reviewed. From this, 54% were accepted.

Conclusions Although 788 interventions have been studied, there are many who have not been registered in the programme, so it could not be analysed. We observed that the dose adjustment for renal failure, especially enoxaparin, is recorded systematically, but this does not occur with other types of interventions.

Acceptance is lower than those reported in literature, so we can conclude that the method of communication with the clinician is inadequate and should be strengthened with verbal communication.

No conflict of interest.

GRP-022 ANALYSIS OF THE MEDICINES RECONCILIATION PROCESS IN DIFFERENT CLINICAL SERVICES

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Background Medication errors, specifically the lack of continuity of the patient's usual treatment, are a major cause of adverse effects in hospitalised patients, most of them preventable. Medicines reconciliation is the process of comparing a patient's prescriptions for medicines to all the medicines the patient has been taking.

Purpose To analyse the impact of reconciliation in different clinical services depending on discrepancies identified and severity of medicines errors (MEs).

Materials and Methods Retrospective, descriptive study conducted at a general hospital over 6 months. Daily, we identified newly-hospitalised patients aged over 75. To determine that a discrepancy existed, we compared the patient's usual medicines with the prescribed medicines and interviewed patient and/or carers. For each service, we collected: number of patients reconciled, number of drugs evaluated, kinds of discrepancies according to Documento de consenso sobre terminología, clasificación y evaluación de los programas de Conciliación de la Medicación, and severity of MEs identified according to National Coordinating Council for Medication Error Reporting and Prevention.

Results Reconciliation was conducted in 13 clinical services. 558 patients were reconciled (mean age: 83.86). 56% belonged to Internal Medicine (IM), followed by General Surgery (GS) (18%) and Traumatology (13%). 9.33 drugs were evaluated per patient, higher than average numbers of prescribed drugs being found in Ophthalmology (18), Cardiology (17.48), IM (11.62), Pneumology (11.29) and Oncology (10.38). We detected 1140 discrepancies. The services with more discrepancies requiring clarification (n = 412) were: IM (51%), GS (16%) and Traumatology (12%). The services with the highest rates of MEs were Traumatology (60%), Otolaryngology (60%), Pneumology (59%), Urology (57%) and Haematology (50%), while unresolved discrepancies were noted in Gynaecology (78%), Oncology (64%), GS (51%) and Ophthalmology (50%). Most MEs fell into category C (errors that reached patient but did not cause damage) severity but 1% were category E (error that resulted in temporary harm and required an intervention). The omission of a medicine was the most common unjustified discrepancy.

Conclusions Medicines reconciliation is important in IM, GS and Traumatology because of numerous discrepancies requiring clarification, the proportion of patients and, mainly in IM, the amount of drugs for chronic treatment. The role of reconciliation was judged essential in clinical services with more MEs (Traumatology, Otolaryngology). Unresolved discrepancies pose a potential cause of ME, so in Gynaecology and Oncology we should improve communication with clinical teams to encourage patient safety.

No conflict of interest.