admission. This process involves discussion with patients/carers/using primary care records.

Medicines errors cause harm to patients, lead to increased morbidity/mortality/inflated healthcare costs [1, 2]

NBT has invested in many safety initiatives including: the Safer Patients Initiative (SPI2) and the Southwest Quality and Patient Safety Improvement Programme (SWQPSI).

Purpose To implement and improve Medicines Reconciliation. The objectives were to: Ensure more than 95% of patients admitted receive Medicines Reconciliation within 24 hours; Improve the quality of Medicines Reconciliation and reduce medicines errors on admission.

Materials and Methods Using improvement methodology, tests of change were trialled and spread, involving:

- **Phase 1: 2007–2008: (1–8 wards)**
  - Introduced a Medicines Admissions Proforma
  - Developed an e-audit tool
- **Phase 2: 2008–2009: (8–11 wards)**
  - Training DVD was designed
  - Analysed admissions data to spread towards where admissions were >2% of the total number of admissions
  - Collected randomised data electronically as a run chart
  - Improved communication (Patients/Ambulance/GP's)
- **Phase 3: 2009–now: (11–30 wards)**
  - 2010: tests of change on accuracy of Medicines Reconciliation, spreading to 42 wards
  - 2012: Surgical Pharmacist funding agreed following a Pre-admissions clinic trial.

Results The medians in the table show improvements 2007–2012. In 2011 we achieved and maintained our target. Accuracy data showed only 55% of admissions drug histories taken by doctors alone are accurate.

Conclusions From February 2011 we achieved and maintained our 95% target on 30 wards. We improved the quality of medicines reconciliation and reduced medicines errors on admission.

The Institute for Healthcare Improvement congratulated us and QIPP's national programme benchmarking teaching hospitals also highlights our remarkable results.

Abstract GRP-093 Table 1

Date	Median%
May 2007	60%
July-Dec 2007	56%
Jan-Jun 2008	67%
Jul-Dec 2008	73%
Jan-Jun 2009	77%
Jul-Dec 2009	77%
Jan-Jun 2010	85%
Jul-Dec 2010	92%
Jan-Jun 2011	96%
Jul-Dec 2011	95%
Jan-Jun 2012	95%
Sep 2012	98%

References

1. National Institute for Health and Clinical Excellence/National Patient Safety Agency: Medicines Reconciliation guidance
2. Quality, Innovation, Productivity and Prevention (QIPP) including Medicines Optimisation and Transfer of Care

No conflict of interest.

GRP-094 IMPROVEMENT OF THE CLINICALLY RELEVANT SAFETY OF CHEMOTHERAPY BY THE INVOLVEMENT OF A CLINICAL PHARMACIST

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Background To avoid medical errors and thus to improve the safety and quality of cancer treatment in our institution, all chemotherapy prescriptions are critically checked by a clinical pharmacist. Prescription errors are communicated immediately to the attending physician and corrected prior to the preparation and administration of the drugs.

Purpose To compile error statistics and to assess the potential severity of errors in chemotherapy prescriptions, we retrospectively analysed and evaluated prescription errors in order to improve the safety of treatment.

Materials and Methods 42624 paper written (no CPOE) chemotherapy prescriptions (containing 86101 prescriptions for medicines) from 19 departments of the University Hospital of RWTH Aachen between 2004 and 2009 were analysed retrospectively by the hospital pharmacy. The most important criteria for analysis were wrong patient, wrong drug, missing drug, wrong dose, wrong application day and wrong protocol. The clinical relevance of the medical errors detected was assessed independently by four oncologists and two clinical pharmacists using the criteria of Small *et al*, [1].

Results In total, 696 medicines errors were detected in 373 prescriptions during the routine verification by the pharmacist. By far the most abundant errors (92.4% of the total) were related to the dose. Of the 373 prescriptions the team reviewed 20% of the errors as minor, 50% as significant, 25% as severe and 5% as potentially fatal. Potentially fatal errors were detected in regard to overdoses and once to the prescription of the wrong drug.

Conclusions Our results clearly show the relevance of clinical pharmacists being part of the therapeutic team to reduce medicines errors and to prevent any patient harm.

Reference

1. Small MD, Barrett A, Price GM. The impact of computerized prescribing on error rate in a department of Oncology/Hematology. *J Oncol Pharm Pract* 2008;14:181–7.

No conflict of interest.

GRP-095 IMPROVING MEDICATION SAFETY: THE DANAPAROID STOREY

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Background During rounds a clinical pharmacist identified and corrected subtherapeutic doses of danaparoid. This error was caused by misleading information in the German Summary of Product Characteristics (SPC).

Purpose To improve medication safety an in-house standard operation procedure for the use of danaparoid sodium was implemented and changes in the SPC were requested.

Materials and Methods The error frequency when using danaparoid was determined over a period of 4 months. The medicines information centre intensified the routine cheque of prescriptions for danaparoid as well as the counselling on dose adjustment. Medication errors were reported to the manufacturer and the Federal Institute for Drugs and Medical Devices (BfArM). At the same time an interdisciplinary working group developed in-house dosing recommendations. Suggestions for modifications of the SPC were submitted to the BfArM.

Results From April to July 2011 subtherapeutic doses were detected in 7 of 21 patients treated with danaparoid at the university hospital Klinikum rechts der Isar: because of misleading information in the SPC, prophylactic doses were administered despite indications for therapeutic anticoagulation. In July 2011 the results