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.

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**Abstract GRP-093 Table 1**

<table>
<thead>
<tr>
<th>Date</th>
<th>Median%</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2007</td>
<td>60%</td>
</tr>
<tr>
<td>July-Dec 2007</td>
<td>56%</td>
</tr>
<tr>
<td>Jan-Jun 2008</td>
<td>67%</td>
</tr>
<tr>
<td>Jul-Dec 2008</td>
<td>73%</td>
</tr>
<tr>
<td>Jan-Jun 2009</td>
<td>77%</td>
</tr>
<tr>
<td>Jul-Dec 2009</td>
<td>77%</td>
</tr>
<tr>
<td>Jan-Jun 2010</td>
<td>85%</td>
</tr>
<tr>
<td>Jul-Dec 2010</td>
<td>92%</td>
</tr>
<tr>
<td>Jan-Jun 2011</td>
<td>96%</td>
</tr>
<tr>
<td>Jul-Dec 2011</td>
<td>95%</td>
</tr>
<tr>
<td>Jan-Jun 2012</td>
<td>95%</td>
</tr>
<tr>
<td>Sep 2012</td>
<td>98%</td>
</tr>
</tbody>
</table>

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**References**

2. Quality, Innovation, Productivity and Prevention (QIPP) including Medicines Optimisation and Transfer of Care

No conflict of interest.

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

doi:10.1136/ejhpharm-2013-000276.094

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**GRP-095 IMPROVING MEDICATION SAFETY: THE DANAPAROID STOREY**

doi:10.1136/ejhpharm-2013-000276.095

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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...