47% of their defects were discovered before they were used in patients, 13% presented a risk of incident and 40% caused an incident in patients.

The process of marketing a medical device, ensuring its quality and safety, must satisfy several cheques regarding the design, manufacture, import, sale purchase and use, before Ministry of Health certification can be obtained.

Conclusions Claims concerned several categories of medical devices. Abnormalities detected compromise the quality and the safety of our patient care. Checks must take place at all levels of the distribution chain to avoid these risks.

Abstract GRP-112 Table 1

Medical devices	Types of claim
Catheters	• *urinary catheters*: too flexible or too rigid, balloon hernia; • *haemodialysis catheters*: thrombogenic, insufficient blood flow; • *infusors tubes*: tube bending.
Surgical drapes	low impermeability, a blue tint was released in the operating field.
Gloves	• *clean gloves*: poorly talc-powdered, low impermeability, break easily; • *sterile gloves*: poor resistance, difficult unpacking in sterile conditions.
Others	• *trocars*: mandrel hard to remove, difficult screwing and unscrewing; • *needles*: difficult handling, nonconformity of the tip; • *sticking plaster*: poor adhesion.

No conflict of interest.

GRP-113 MEDICINES HISTORY IN THE CARE PROCESS OF PLANNED SURGERY: A KEY STEP

doi:10.1136/ejhpharm-2013-000276.113

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Background Since January 2011, pharmacists have been taking medication histories (MHs) both in abdominal and orthopaedic surgery wards. Out of 1400 annual MHs, 40% are for patients whose intervention is planned. During the pre-anaesthesia consultation, the anaesthetics form (AF) is filled out and currently used as reference for post-operative prescriptions.

Purpose The objective was to assess the concordance between the MH and the AF data in order to find ways of improvement.

Materials and Methods A five-week prospective study was conducted by two experienced pharmacy students (>100 MHs done by each one). During the medicines reconciliation, the discrepancies were split into two groups: medicines (inappropriate drug, missing or additional medicine, incorrect or omitted dosage) and administration plan (omitted, incorrect or incomplete).

Results 70 patients, involving 272 medicines according to the MH and 223 according to the AF, were included in the survey. Discrepancies were found in 73% of patients. These patients were significantly older and were taking more medicines than the ones without any discordance (60.5 years versus 47.5; 5.3 medicines/patient versus 1.7). Among the discordances, 44.9% (n = 122) were due to 'medicines errors' with the following breakdown: missing medicine 45% of cases, omitted dosage 38%, medication discontinued 13%, incorrect dose 2%, wrong drug 2%. Regarding the discordances linked to the 'administration plan', the plan was omitted, incomplete or incorrect in 47%, 40%, or 13% of cases, respectively.

Conclusions This demonstrates that the pharmaceutical consultation including MH is mandatory and when done prior to admission can greatly improve the post-operative prescription process. The final step to be done with other healthcare professionals involved (anaesthetists, surgeons, nurses, pharmacy technicians, pharmacists), is to identify the best time to schedule MHs in the whole process.

No conflict of interest.

GRP-114 MEDICINES RECONCILIATION BY THE PHARMACIST AT THE EMERGENCY DEPARTMENT

doi:10.1136/ejhpharm-2013-000276.114

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Background Medicines reconciliation is done to avoid errors in patient treatment such as omissions, duplications, dosing errors, drugs not included in the hospital formulary or drug interactions. Admission to hospital is one of the best times to reconcile medicines for patients with multiple comorbidities.

Purpose To analyse the pharmacist's intervention in the medicines reconciliation process in the Emergency Department of a General Hospital.

Materials and Methods Prospective observational study in the Emergency Department (ED) of a General Hospital in October 2011 to September 2012. We included all patients admitted to the ED of our hospital whose medical orders (MOs) contained a conflict of medicines. When medical or nursing staff detected a conflict they sent the prescriptions to the unit dose drugs distribution system (UDDDS) and the pharmacist checked the drugs taken by the patient upon admission. All pharmaceutical interventions were recorded at the Pharmacy Department.

Results During the study period 969 MOs were received at the UDDDS and the pharmacist interventions were: 344 (35.5%) exchanged medicines not included in the hospital formulary for other alternatives, 219 (22.6%) exchanged to therapeutic equivalents, 167 (17.2%) exchanged to a brand of the same drug stocked in the hospital, 174 (18%) no alternative dosage forms, 24 (2.5%) interventions for errors in dosing regimen, 17 (1.8%) checked the parenteral or oral route, 7 (0.7%) prevented duplication of treatment and 17 (1.8%) other interventions.

Conclusions The role of the pharmacist in medicines reconciliation at patient admission increases coordination between different health care providers and maybe improves the global quality of care.

No conflict of interest.

GRP-115 MEDICINES RECONCILIATION PROCESS AT ADMISSION IN PATIENTS OVER 75 YEARS OF AGE

doi:10.1136/ejhpharm-2013-000276.115

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Background Elderly patients are likely to be served by different health professionals with the consequent appearance of polypharmacy, increased risk of adverse drug reactions and increased hospital admissions. Therefore, we consider this population candidates for a medicines reconciliation process.

Purpose To identify the type, frequency and severity of discrepancies between the medicines prescribed during admission and their chronic medicines and to investigate medicines involved in reconciliation errors.

Materials and Methods Retrospective and descriptive study conducted in a general hospital from November to December 2011. A pharmacist reviewed the treatments 24 hours after hospitalisation, comparing the prescription for medicines sent to the pharmacy with the clinical history and patient interview. Discrepancies were classified according to the consensus document on terminology, classification and assessment of the reconciliation programmes, and severity according to the NCCMERP index.

Results 192 patients were analysed, the median age of patients was 84.3 years (SD: 5.7) of whom 56.3% were women. 98.4% took