Purpose To describe and analyse the discrepancies in HIV chronic treatments prescribed by hospital practitioners at admission to hospital.

Materials and Methods From June to October 2012, data of patients admitted with antiretroviral medicines were collected. HIV patients admitted to the Infectious Diseases Service or treated chronically in other hospitals were excluded. The pharmacist compared the computerised prescriptions at admission with the current HIV treatment recorded in the pharmacy chronic prescriptions dispensed programme (Farhos). In the event of discrepancies the pharmacist informed the physician/nurse and corrected the order. Non-justified discrepancies were notified and classified as reconciliation errors.

Results 68 patients’ treatments were analysed (Average age: 46 years. 44 men, 24 women). 49 patients were admitted to the emergency ward (E) and 19 to other wards (O). The average HIV drugs per patient were 2.2. In 17 patients (25%) the treatment was not correct (22.5% of E and 31.5% of O).

23 discrepancies were found in 150 medicines (0.33 per patient). 12 of these were associated with darunavir (41.6% of darunavir treatments were wrong). Classified by reconciliation errors: dose/frequency incorrect (16), omission (5), wrong drug (2).

Conclusions Incorrect prescriptions at admission of chronic hospital medicines such as HIV treatments cause a great number of reconciliation errors. Complex regimes, such as those including darunavir, facilitate prescription errors. Until HIV medicines are recorded in patients’ primary care records or recording is complete in hospital medical histories, the pharmacy data and pharmacist interventions are needed to guarantee the correct treatment. Due to the results, HIV stock drugs were removed from the Emergency Service.

No conflict of interest.

Background The reconciliation process detects medicines errors and is a key point for improving patient safety.

Purpose To analyse the incidence, type and severity of reconciliation errors at Cardiology Unit admission.

Materials and Methods Descriptive prospective observational study from October-November 2011 in patients admitted to the Cardiology Unit in a tertiary hospital. Demographic data studied: sex and age.

The patient’s usual chronic treatment, obtained by comprehensive interview of the patient and by reviewing the clinical history, was compared with the medicines prescribed on admission in order to identify: no discrepancies (ND), intentional discrepancies (ID)

(Formulary substitutions/modifications in response to a patient’s clinical status) and apparently unexplained discrepancies requiring clarification with the physician (DRCs). After clarification, Reconciliation Errors (REs) (discrepancies resulting in physician order changes) were classified by type and severity.

Results 113 patients were included. The median age was 71.2 ± 10.4 years. 56.2% were male. Only 50 patients were reconciled due to logistical reasons.

528 medicines investigated: 159 ND (30.11%), 256 ID (48.49%) and 113 DRCs (21.40%).

After clarification, 47 (41.59%) DRCs were REs, while 5 discrepancies (4.42%) (2 patients) could not be resolved. 9.91% of prescriptions (47/528) were REs.

REs affected 22 (45.83%) of the 48 real study patients. The average number of REs per patient was 2.14 ± 1.21.

Types of RE were: omissions (n = 31), different dose/route/frequency (n = 7), unnecessary medicines (n = 5), wrong medicine (n = 5) and incomplete prescription (n = 1).

In terms of severity, REs were distributed as follows: No error, but possible (n = 10), error that does not reach the patient (n = 25), error reaching but not harmful (n = 11) and error requiring monitoring (n = 1).

Conclusions The process of taking a pharmacotherapeutic history at hospital admission is inadequate since almost half of the patients showed REs, mostly omissions.

Although most REs caused no harm, if perpetuated at discharge, they might have worse consequences and/or affect the effectiveness of treatment.

The pharmacist’s work in hospitalisation units is vital to reduce errors in care transitions and represents an opportunity to develop integral pharmaceutical attention in order to increase patient safety.

No conflict of interest.
Phase 3: May 2011–September 2011:
A Training package was introduced/spread and Ward Posters and Handover sheet were developed.

Phase 4: October 2011–August 2012:
Monthly run charts of results were shared with senior managers. Pink order slips and orange leaflets were introduced.

Results We achieved our target for 2010/11. The 1.95% target for 2011/2012 was more difficult but was achieved as shown in the table.

Conclusions In achieving our targets we improved communication and changed the culture from staff not unduly concerned with missed doses to staff taking action to reduce missed doses and improve patient care.

Abstract GRP-157 Table 1

<table>
<thead>
<tr>
<th>Date</th>
<th>% Missed Doses (Target 1.95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov 2011</td>
<td>2.37%</td>
</tr>
<tr>
<td>Jan 2012</td>
<td>1.88%</td>
</tr>
<tr>
<td>Feb 2012</td>
<td>1.42%</td>
</tr>
<tr>
<td>Mar 2012</td>
<td>1.05%</td>
</tr>
</tbody>
</table>

No conflict of interest.

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**GRP-158** REPORTING AND ANALYSIS OF ERRORS IN CANCER TREATMENT IN THE ANTIBLASTIC DRUGS LABORATORY OF THE EUROPEAN INSTITUTE OF ONCOLOGY
doi:10.1136/ehjpharm-2013-000276.158

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**Background** The lack of management software for patients undergoing chemotherapy suggested to us that we should investigate errors that have occurred at all stages of the process: prescription, transcription, preparation, distribution and administration of treatment.

**Purpose** To encourage reports and classify the errors, in order to develop a computerised system of internal management of chemotherapy which can reduce the risk of error at all stages.

**Materials and Methods** Two reporting channels were established: one for major errors, such as prescriptions or preparations containing incorrect drugs or dosages, improper units of measurement, diluents incompatible with the active ingredient, improper administration. These errors are shared in corporate software with the Risk Management Office.

The second concerns minor errors, prescriptions containing compilation errors, incomplete compilation of the treatment regimen, incomplete administration of treatment; these errors are reported in an internal Excel file.

**Results** From January to September 2012, 73 major errors were reported from a total of 30406 preparations. Some of these were: prescription of paclitaxel instead of docetaxel, vinorelbine written as vinblastine; preparation of a 5-fluorouracil weekly dose in a two-day infuser, administration of paclitaxel bag to the wrong patient. In 85% of these cases the intervention of pharmacist avoided the error. 468 minor errors were reported, including 447 prescription errors, 3 transcription errors, 8 for lack of a cheque of the output treatment and 10 for incomplete delivery of the treatment.

**Conclusions** This analysis allowed us to draw a picture of the most frequent types of error. Most of them concerned the prescription stage, which we hope to minimize with the implementation of a computerised prescribing system. This will also cut down the transcription and administration errors by reading the barcode of the preparation with a patient wristband. The reduced number of preparation errors can be attributed to the use of an automated system for chemotherapy preparation.

No conflict of interest.