

identified: intentional with notification, intentional without notification and unintentional (UD). For each patient included, a prioritisation score was calculated based on age, number of drugs, comorbidities and different therapeutic class prescribed. A threshold of this score was searched to target the patients with high risk of UD. A Chi² test was used to find an association between the score and the presence of UD.

Results During this period, 2720 patients were hospitalised in the VSD, with a mean number of patients admitted per day of 12 (min=1; max=22). Among these patients, 233 patients (9%) benefited from MR. Among these patients, 34% had at least one UD. For these patients, the mean number of medications on admission was nine. Among the 145 UD identified, the main reason for UD was omission (30%) and the most frequent medication was antihypertensive (10%). The median prioritisation score of patients with UD and without UD were, respectively, 11 and 9. There was a significant association between the score ≥ 11 and UD presence ($p < 0.01$).

Conclusion MR could identify UD in 34% of patients included. A threshold score has been identified. Currently, MR has been performed to VSD, mainly to patients with score ≥ 11 . For a better optimisation of MR time, it will be interesting to include other characteristics, such as the number of patients admitted per day.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Vascular surgery department staff.

No conflict of interest.

5PSQ-159 KEY POINTS IN IMPROVING THE RECONCILIATION PROCESS IN AN EMERGENCY DEPARTMENT

R Tamayo Bermejo*, JC Del Río Valencia, M Conesa Muñoz, MI Muñoz Castillo. *Hospital Regional Universitario de Málaga, Pharmacy Department, Málaga, Spain*

10.1136/ejhp-2019-eahpconf.592

Background Medication errors commonly occur at transition points in patient care, particularly on admission to hospital.

Medicines reconciliation is the process of identifying the most accurate list of a patient's current medicines and it should be done before the first 24 hour after admission.

The participation of pharmacists in obtaining an accurate medication history for hospitalised patients is a key point in improving the process of reconciliation.

Purpose Evaluate the benefits of the introduction of a pharmacist into the Emergency Department (ED) to improve the reconciliation process.

Material and methods A prospective intervention study (2016–2017). The medication was reconciled at two different times and places: in admission to the geriatric ward (2016) and the admission to the ED (2017).

Patients older than 65 years and six or more drugs admitted to the ward were included. A target was set that ideally 100% of patients admitted would have their medications reconciled within 24 hour of admission.

To calculate the percentage of patients reconciled within 24 hour, the total number of patients who met the inclusion criteria for conciliation were collected. We did not collect data on Saturdays or Sundays. For the inferential statistics, the Chi-square test was used.

Results A total of 394 patients was reconciled, 106 patients in the ward for the first time and 288 patients in the ED for a second time.

The percentage of patients with their medicines reconciled by a pharmacist within 24 hour of admission increased from 38% in the ward to 83% in the ED, and was significant ($p < 0.001$).

The lack of weekend cover resulted in not meeting the target of 100% of patients having medication reconciliation complete within 24 hour of admission.

For those patients in the ED who had been admitted medically but awaited a bed on a ward for a number of hours, the opportunity for their medicines to be reconciled within 24 hour was greatly reduced in the absence of an ED pharmacist.

Conclusion The presence of an ED pharmacist improves the number of patients who have their medicines reconciled within 24 hour of admission.

Since this initial project, we must continue working to expand the role of the clinical pharmacist further and to provide an extended pharmacy service to both hospital staff and patients.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-160 MEDICATION RECONCILIATION IN THE EMERGENCY DEPARTMENT IN ELDERLY PATIENTS

R Tamayo Bermejo*, JC Del Río Valencia, M Conesa Muñoz, MI Muñoz Castillo. *Hospital Regional Universitario de Málaga, Pharmacy, Málaga, Spain*

10.1136/ejhp-2019-eahpconf.593

Background Medication reconciliation is a process to identify and solve unintended medicine discrepancies, defined as differences between the home treatment prescription and the first hospital prescription.

A large number of studies show that the reconciliation process minimises reconciliation errors (RE).

Purpose To determine the incidence of RE in polymedicated elderly patients admitted to an Emergency Department (ED) and to analyse the type of RE, drug group involved and severity of the RE.

Material and methods A prospective, 2 year intervention study, starting in February 2016.

The medication was reconciled in the first 24 hour after admission to the ED. Patients older than 65 years and six or more drugs were included.

The reconciliation was done by interviewing patients or carers in the ED and by consulting clinical and prescribing records.

A chronic medication list was collected. This list was compared with prescriptions performed during hospitalisation. In cases where a discrepancy that required clarification was found, it was discussed with the doctor. To classify a discrepancy as an RE, the prescriber had to accept it.

Variables collected were: age, sex, drugs prescribed, unjustified discrepancies, potentially inappropriate drugs, interactions and medication-related problems, RE and severity of RE.

Results Reconciliation in the admission to the ED was done with 553 patients, mean age 86 years (65–99), 68% females and 6027 drugs were reconciled (mean 10.9). There were 1050 unjustified discrepancies at admission, 326 potentially inappropriate drugs, 192 interactions and 118 medication-related problems, and 72 RE (average of 0.13 RE per patient).

The most common RE was omission of drugs (81%) followed by different dose, regimen or route (14%). According to the Anatomical Therapeutic Chemical Classification, the main groups involved in the RE were benzodiazepines with 36% of the RE, HMG Co-A reductase inhibitors (11%), cardioselective beta blockers (7%), proton pump inhibitors (4%), antidepressants selective serotonin reuptake inhibitors (3%), and insulins and analogues (3%). Regarding the severity of errors, 100% reached the patient without damage (severity C). **Conclusion** Medication reconciliation by a pharmacist in the ED is an effective procedure to identify and resolve medication errors.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-161 SECURING STORAGE OF HIGH-RISK MEDICINES IN A CARE UNIT: WHERE ARE WE NOW?

S Stenuit, G Tchuente Modjo*, A Pardo. *Marie Curie Civil Hospital – Chu Charleroi, Pharmacy, 6042 Lodolinsart, Belgium*

10.1136/ejhp-harm-2019-eahpconf.594

Background In our country, a Platform for Continuous Improvement of Quality of Care and Patient Safety has set the following target for hospitals: by the end of 2018, 100% of high-risk medicines (HRMs) will be correctly identified and stored in a pilot unit according to the established procedure.

Purpose To evaluate, through a monthly audit, the compliance with the tidying procedure of HRMs established in the pilot unit.

Material and methods The internal medicine ward was the pilot unit chosen for this work. The tidying procedure of HRMs implemented in this unit includes: the withdrawal from the unit of all concentrated electrolytes; the storage of each HRM in a labelling area on which appears an HRM symbol in addition to the usual drug information; the HRM storage in a zone marked 'HRM', except insulins, narcotics and infusions which are respectively stored in the refrigerator, the narcotic chest and the infusion cabinet; and the remoteness of HRMs 'Look Alike – Sound Alike' from each other. One week after the HRMs tidying of the unit by the pharmacist, monthly audits were started and were carried out once a month, on Wednesdays, from June 2018 to October 2018. In addition, awareness information was posted every 2 months on the medicine cabinet of the unit. Compliance results were analysed using χ^2 and *t* tests for, respectively, all HRMs and HRMs classes.

Results The compliance for all 44 HRMs stored in the unit (64%–73%) was not significantly different between the different audits ($p > 0.05$). No statistically significant differences ($p > 0.05$) between the five audits were observed for insulin (43%–50% compliant), narcotics (100% compliant) and infusions (0% compliant): for the HRMs stored in the marked zone (67%–89% compliant), the difference between the months was not significant either, except between July (89% compliant) and August (67% compliant), where a significant decrease in compliance was observed ($p < 0.05$). This decrease was associated with a lack of awareness action between these 2 months.

Conclusion This work highlighted the improperly stored HRMs and showed that more awareness-raising actions need to be carried out to improve their tidying in a care unit.

REFERENCES AND/OR ACKNOWLEDGEMENTS

Eur J Clin Pharmacol 2014;70:637–45.

No conflict of interest.

5PSQ-162 ABSTRACT WITHDRAWN