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.

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**Abstracts**

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

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**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 χ² 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**

No conflict of interest.

**5PSQ-162 ABSTRACT WITHDRAWN**