5PSQ-163 MEDICATION RECONCILIATION IN AN EMERGENCY DEPARTMENT

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Background Medication errors lead to higher morbidity, mortality and expenditure. The likelihood of mistakes is higher in the Emergency Department (ED).

Purpose To determine the incidence, the type of discrepancies and reconciliation errors (RE) upon admission to an ED, and the drugs involved.

Material and methods Prospective observational study, including patients admitted to the ED pending hospitalisation, during a period of 3 weeks (9–27 April 2018). The variables collected were: sex, age, number of home medications, number of discrepancies justified by the patient's clinical evolution (DJ) and not justified requiring clarification (DNJ), type of RE detected according to the Consensus Statement of the Spanish Society of Hospital Pharmacy and drugs involved. Programme coverage indicator, quality prescription indicators and medication reconciliation process indicators were calculated. The medication reconciliation process (MRP) was carried out through a clinical interview with the patient/carer, and the data obtained from the electronic clinical history and the primary care electronic records.

Results MRP was performed in 61 of the 216 patients admitted (coverage rate of 28.24%). 55.74% were males, with an average age of 70.61 ± 14.86 years ($72.13\% > 65$ years). The median of home medications was 8 (range 1–18). Ninety-three discrepancies were detected, of which 22.58% were DJ, while the remaining 77.42% were considered DNJ. The quality indicators of the prescription were determined, obtaining the following results: 57.38% patients with RE, 42% medications with RE and 1.20 RE per patient. Regarding quality indicators of the MRP, the detected RE were 58.33%, and were classified into: 37 (88.10%) medication omissions, four (9.52%) dose errors, and one (2.38%) wrong medication. The drugs involved were: 19 (45.24%) lipid modifying agents, five (11.90%) antidepressants, four (9.52%) thyroid hormones, four (9.52%) drugs used in benign prostatic hyperplasia, two (4.76%) antipsychotics, two (4.76%) anti-glaucoma drugs and miotics, two (4.76%) insulins and analogues, one (2.38%) beta-blocking agents, one (2.38%) digitalis glycosides, one (2.38%) organic nitrates and one (2.38%) vitamin D and analogues.

Conclusion The RE affected more than half of the patients admitted to the ED. The most prevalent discrepancy was the omission of medication and the drugs most implicated were statins.

REFERENCES AND/OR ACKNOWLEDGEMENTS

No conflict of interest.

5PSQ-164 DRUG-DRUG INTERACTIONS IN PATIENTS WITH CARDIOVASCULAR DISEASES

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Background Medication reconciliation (MedRec) is the process of comparing a patient's medication orders to all of the medications that the patient has been taking. This reconciliation is done to avoid medication errors such as drug interactions. The World Health Organization has recognized MedRec as a recommended standard of quality in health assistance.

Purpose The aim of this analysis was to estimate the prevalence of patients exposed to potentially relevant drug-drug interaction (DDI) at hospital discharge.

Material and methods This was an observational retrospective study involving patients with cardiovascular diseases discharged from our hospital between December 2016 and May 2017.

A total of 1033 patients were included in this study and 8005 drug prescriptions at discharge were analysed (7.75 per patient). DDIs were classified as moderate (pharmacological effects must be controlled by individual dose adjustment or on the basis of drug plasma concentration) or severe (drug combination should be avoided in clinical practice).

Results Among 1033 patients included, 271 (26.2%) were exposed to at least one potential DDI. In particular, 173 patients were discharged with one interaction (16.7%), 54 patients with two interactions (5.2%), 23 patients with three interactions (2.2%) and 21 were exposed to four or more DDIs (2%). A total of 445 DDIs were recorded, 75.1% were classified as moderate and 24.9% as severe interactions. The median number of DDIs per patients with interactions was 1.6 (range 1–7). The most frequent severe interaction was the combination of some selective serotonin reuptake inhibitors (Paroxetine, Sertraline and Citalopram) and Furosemide ($n=46; 1\%$). This combination is known to be associated with an increased risk of cardiotoxicity (QT prolongation and cardiac arrest).

Conclusion From this first analysis, it emerged that one-third of our patients were discharged with at least one potential DDI and a remarkable portion of these combinations was severe. The next step will be to investigate whether adverse clinical events, readmission or death after discharge could be associated with a potentially severe DDI. The final target will be the involvement of a clinical pharmacist within a multidisciplinary team to highlight potential DDIs at discharge and minimise the occurrence of the related risks.

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5PSQ-165 QUALITY CONTROL OF INFUSIONS IN PATIENT-SPECIFIC PREPARATIONS FOR ONCOLOGICAL TREATMENT

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Background Patient-specific preparations have become a central therapy concept in oncological treatment. The highly potent cytostatic agents are characterised by a narrow therapeutic range. Therefore, exact dosage is important, as lower amounts reduce the effectiveness and higher doses increase the risk of severe side effects. Compound confusion can even result in