

5. Notes 1396; (HR) 1368 (98%); (LR) 28 (2%)
6. Notes 603; (HR) 30 (5%); (LR) 573 (95%)
7. Notes 224; (HR) 137 (61%); (LR) 87 (39%)

From this analysis, 38% of prescriptions were modified as specifically indicated by the Pharmacist.

**Conclusion and relevance** This analysis demonstrated how the role of the pharmacist is critical in identifying potential errors that may occur at the time of prescription. This is necessary for minimising adverse effects for patients during specific therapeutic treatments.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

**Conflict of interest** No conflict of interest

### 5PSQ-216 IMPLEMENTATION OF A MEDICATION RECONCILIATION PROGRAMME AS A PATIENT SAFETY STRATEGY

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**Background and importance** Medication errors (ME) are especially frequent in hospital emergency departments (ED). To minimise these ME, medication reconciliation programmes are established, which analyse and resolve the discrepancies detected in the medication regimen of the patient.

**Aim and objectives** To evaluate implementation of the reconciliation programme in the ED of a second level general hospital.

**Material and methods** An observational retrospective study was conducted. Records from patients admitted to the observation area of the ED from 1 January 2018 to 31 March 2019 and whose chronic medication was reconciled were studied. Information related to their chronic medication was collected from the hospital medical records, the primary care prescriptions and/or through an interview with the patient. Discrepancies were classified according to the SEFH consensus document, and categorisation of the potential harm associated with these ME was based on the NCCMERP index; the pharmacotherapeutic groups involved in these ME were also analysed.

**Results** 26.7% of patients admitted to the ED during the study period were reconciled (780/2921), with a mean of 10.14 medications per patient. A mean of 1.6 discrepancies per patient were detected; 40.52% were ME, two thirds of which resulted from the omission of chronic medication and 72.15% of errors reached the patient but did not cause harm. The drugs involved in a higher proportion of ME were drugs to treat cardiovascular disorders. From the total amount of pharmaceutical interventions performed, 49.25% were accepted by physicians.

**Conclusion and relevance** Due to the high average chronic drug intake of patients attending the ED and, therefore, the potential risk of ME, collaboration between physicians and pharmacists is crucial to ensure reconciled medication of patients, as a patient safeguard strategy and a standard of quality within the health system.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

No

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### 5PSQ-217 MEDICATION RECONCILIATION PROGRAMME OF THE COMPLEX CHRONIC PATIENT IN A TRAUMATOLOGY AND ORTHOPAEDIC SURGERY SERVICE AT HOSPITAL ADMISSION

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**Background and importance** Medication errors constitute an important health problem due to their clinical and economic impact. Management of the chronic polymedicated patient during hospitalisation is a highly relevant task in clinical practice.

**Aim and objectives** To quantify and analyse discrepancies and reconciliation errors (RE) in a traumatology and orthopaedic surgery service (TOS) through a medication reconciliation programme at hospital admission.

**Material and methods** A prospective study was conducted from January to September 2020. All hospitalised patients were reconciled during the first 24 hours after admission. Demographic and clinical data were collected: diagnosis, history of interest, allergies, analytical data and treatment. The number of no discrepancies, justified discrepancies (JD), not justified discrepancies (NJD) and type of NJD were counted. Discrepancies were classified according to the criteria established in the consensus document on terminology and classification in medication reconciliation of the SEFH. Accepted NJD were recorded, thus accounting for the RE. Drugs involved in the discrepancies and their classification by ATC group were also recorded. Information sources were the electronic prescription programme, electronic medical records and interviews with the patients. Data were analysed with Excel. For quantitative variables, mean (SD) were calculated, and the qualitative variables were expressed as frequencies.

**Results** 411 patients were reconciled (age 70.43±13.1 years; 62.5% women). 3479 medications were reconciled (8.4 medications/patient) and 2106 (60.5%) had no discrepancies. 1373 (39.5%) discrepancies were detected (JD 1146 (83%); DNJ 227 (17%). The most frequent NJD types were: omission (76%), different dose, route or frequency (19%), wrong medication (2.6%) and commission (1.3%). Of the NJD, 92% were accepted by the prescriber, considering EC, and therefore CDs represented 5.9% of the total number of reconciled medications. The most frequent ATC groups implicated were: cardiovascular system (37.4%), CNS (31.2%), digestive system and metabolism (6.6%), and blood and haematopoietic organs (5.72%). The drugs that most frequently presented RE were hydrochlorothiazide, metformin, bisoprolol, lormetazepam and enalapril.

**Conclusion and relevance** Medication reconciliation within the first 24 hours of admission is a useful tool to detect errors in prescription. Identification of the most frequent ATC groups in RE allows us to identify those drugs for which it is advisable to review the prescription when validating treatment in the TOS.

## REFERENCES AND/OR ACKNOWLEDGEMENTS

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