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BACKGROUND

Medicines reconciliation at the time of admission is considered by the World Health Organization (WHO) as a **strong process of prevention and interception of some medicines errors**, called **unintended discrepancies**.

These unintended discrepancies are particularly worthy of attention because not detected by the computerized physician order entry system.

As part of the WHO's High 5s project, the **Standard Operating Protocol « Medication Reconciliation »** has been implemented in our hospital center since 2010.



PURPOSE

- ▶ Describe the **type** of the unintended discrepancies
- ▶ Analyze their **potential seriousness** if not intercepted by reconciliation
- ▶ Determine **the most involved groups** from the Anatomical Therapeutic Chemical (ATC) classification system
- ▶ Identify the **causes** of the loss of information

MATERIAL AND METHODS

Prospective observational and interventional study
From July to September 2014

- ▶ Eligible patients :
 - Older than 65 years
 - And hospitalized in short stay units after admission through the Emergency Department
- ▶ Medicines reconciliation is done **within 48 hours of admission** by the pharmacist staff :
 1. The regularly medicines taken by the patient are searched.
 2. The complete and accurate list is compared with the admission prescription in the computerized physician order entry system Pharma®.
 3. The discrepancies are identified and discussed with the physician.
 4. The potential seriousness of every unintended discrepancy is assessed according to the cotation's method described in the « **Med'Rec Kappa** » project. This is based on the REMED 2013 method of the Société Française de Pharmacie Clinique (SFPC).
 5. Every corrected wrong prescription's line is recorded in an Excel file.

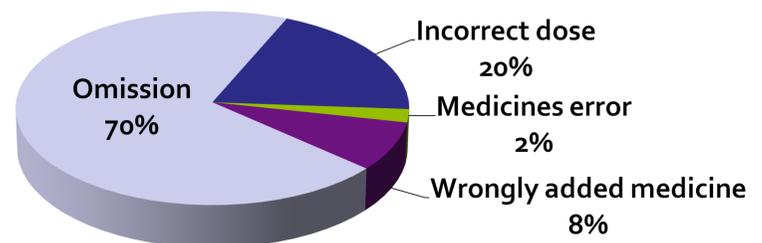
CONCLUSION

- ▶ Most medicines errors are **omissions**, and the information is most frequently lost due to **inattention** ; these kinds of errors are **easily corrected by reconciliation**.
- ▶ Without reconciliation, almost a half of medicines errors might have **significant consequences for patients if they were perpetuated at discharge**.
- ▶ Working within a multidisciplinary team in hospitalization units, the pharmacist contributes to **increasing patient safety**.
- ▶ Medicines reconciliation is a **time-consuming activity**. To keep it steady in our hospital center after the end of the WHO's project and to be exhaustive, we need **more pharmacist time**. Otherwise we must specify the current eligible criteria by **identifying which patients are the most relevant to be reconciled**.

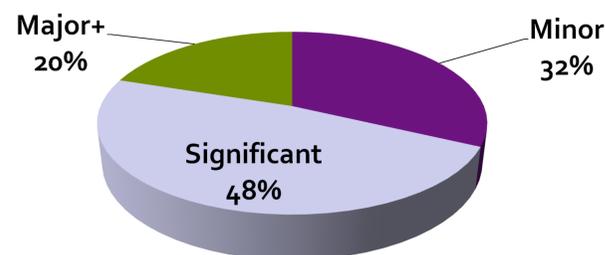
RESULTS

- ▶ During the three-month study :
 - **508 patients** were included. These represent 30% from the eligible patients.
 - On average, **30 minutes** were necessary to reconcile one patient.
 - Among these 508 reconciled patients, **191 lines of unintended discrepancies** were identified.

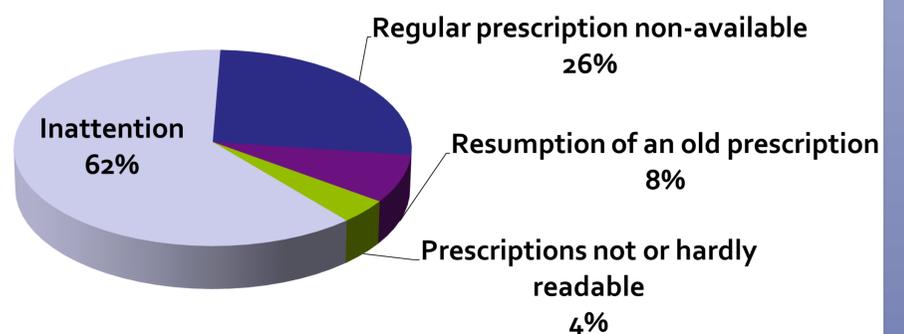
Types Of Medicines Errors



Potential Seriousness Of Medicines Errors



Identified Causes Of Medicines Errors



Most involved ATC groups

- ▶ The most frequent errors concern medicines of the **ATC group C : "Cardiovascular system" (35%)**.
- ▶ Among this group C, most medicines belong to the subgroup Cog "Agents acting on the renin-angiotensin system" (30%). The most identified cause in this subgroup is an inattention error in the choice of the equivalence, particularly when the medicine is an association of several molecules in which several dosages are possible.