RESULTS

- 154 medication reconciliation interviews were conducted. The frequencies of the information sources used are illustrated in Figure 1.

- 136 (88.31%) patients had at least 1 medication error. In total there were 498 errors (mean of 3.23 errors/patient). The most frequent type was drug omission (n=252, 50.60%).

- The therapeutic group with the highest number of errors was the alimentary tract and metabolism (n=132, 26.51%).

- With regards to severity, 208 (41.77%) of the medication errors were rated as potentially requiring monitoring or intervention to prevent harm while 33 (6.63%) had the potential to cause harm (Figure 2).

- Medication errors were found to be correlated with the number of drugs at admission and total number of information sources used (p < 0.05).

CONCLUSION

A clinical pharmacist-led medication reconciliation was an effective procedure to identify and resolve medication errors. Results obtained formed the basis for the development of such a service to optimise patient care and safety. This study showed that using various sources of information helped to produce an accurate list of all the drugs a patient was taking. Patients who benefited the most were those consuming the highest number of drugs.

REFERENCES
