CLINICAL RELEVANCE OF RECONCILIATION ERRORS AT ADMISSION FROM EMERGENCY DEPARTMENT AVOIDED BY THE CLINICAL PHARMACIST


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BACKGROUND
Medication reconciliation in emergency department (ED) is essential to optimizing the safe and effective use of medication.

OBJECTIVES
To analyze reconciliation errors (RE) avoided by the ED pharmacist and to assess the severity and clinical relevance.

MATERIAL AND METHODS
• The study was conducted between November 2013 and June 2014 in a general hospital of 330 beds.

- Role of clinical pharmacist:
  - Attended daily to the ED meeting, selecting patients at higher risk of medication error.
  - Developed the home medication history with primary care electronic records and interview with the patient/caregiver, and compared it with the prescription in the ED.
  - Medication reconciliation was carried out with the emergency physician, considering reconciliation error (RE) any unjustified discrepancy.

RESULTS
- 132 patients. Mean age: 75.8 ± 9.4 years. Average number of drugs per patient: 11.4 ± 4.2.
- 239 RE were found affecting 89 patients (67.4%). Average error per patient: 1.8 ± 2.

RE types
- According to the Consensus Statement of the Spanish Society of Hospital Pharmacy (SEFH).

RE severity
- Using the categorization of The National Coordinating Council for Medication Error Reporting and Prevention's.

85.9% of interventions on clinically relevant RE (category E-F) were accepted, thus avoiding a potential harm to 61.8% of patients with RE.

CONCLUSION
• The high proportion of patients in which ED pharmacist intervention prevented a potential harm highlights the importance of his role in the reconciliation process.