MEDICINES RECONCILIATION IN THE INTENSIVE CARE UNIT

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BACKGROUND
Medicines reconciliation is known to minimise medication errors and reduce morbidity in hospitalized patients.

PURPOSE
To analyse the number, type, and importance of pharmacist contributions in the ICU of a tertiary level hospital.

METHODS
Prospective study conducted in July 2014 to assess the accuracy of in-patient prescription charts.
Exclusion criteria: in-patient stay below 24 hours.
Drug history and medicines reconciliation were undertaken within the first 24 hours by a specialist pharmacist.
Discrepancies between the patient’s regular medicines and prescribed medicines were conveyed to the medical team.
Discrepancies were considered medication errors when they required further intervention by the responsible doctor.

RESULTS
48 patients included, mean age= 62±14.04 years-old, %female= 39.6%. Average number of regular medicines per patient: 5.41±3.5. Discrepancies were found in 62.5% of patients, of which 79.9% required pharmacy intervention (the rest of them were obviated due to the patient’s clinical condition -mostly swallowing inability-).

CONCLUSIONS
Medication errors in the ICU have a similar incidence to other non-acute clinical settings. This study is in line with previous publications, suggesting that the ICU might benefit from the regular input from a pharmacist, which in turn would result in a reduction of medication errors.