

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

RE types

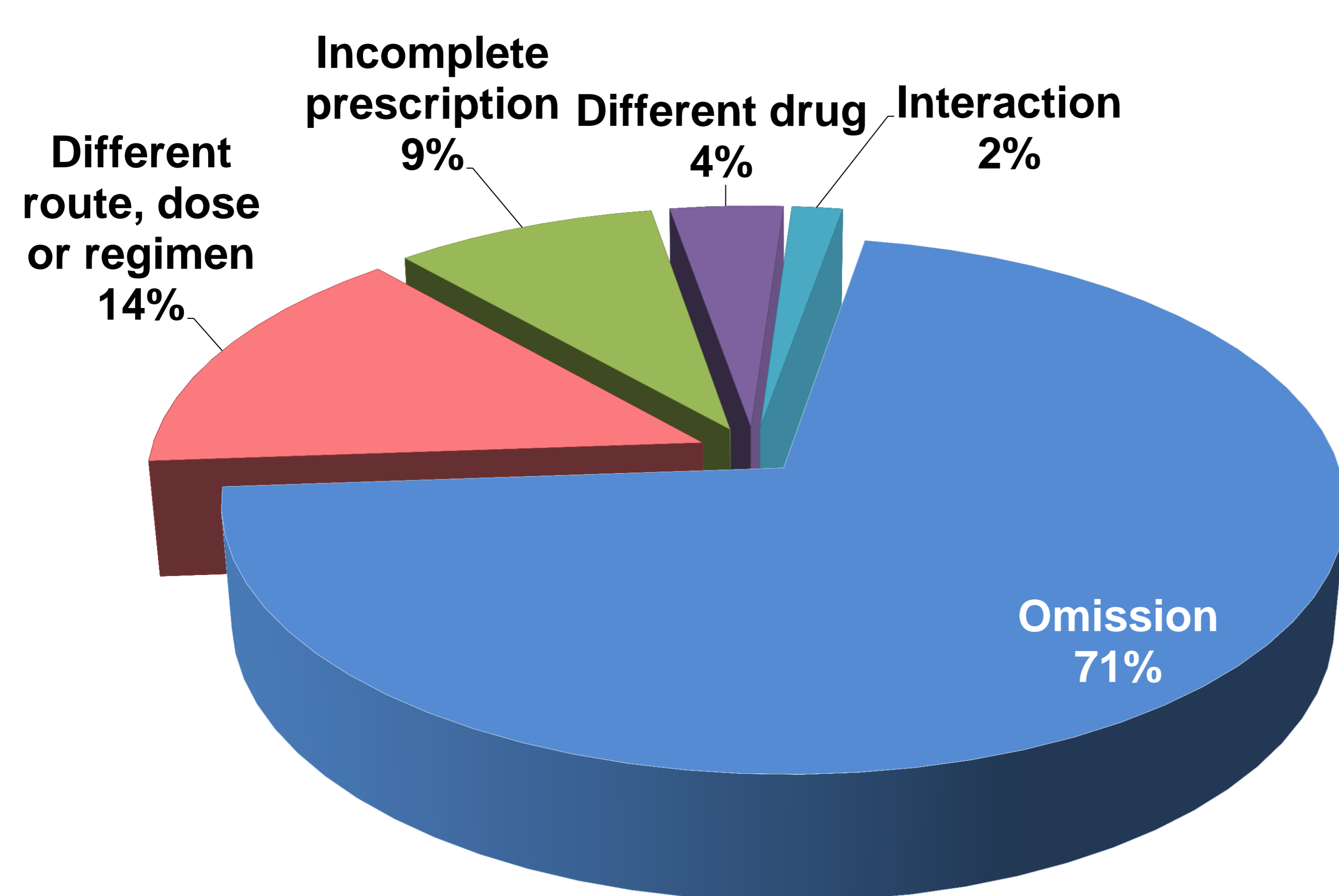
- According to the Consensus Statement of the Spanish Society of Hospital Pharmacy (SEFH)

RE severity

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

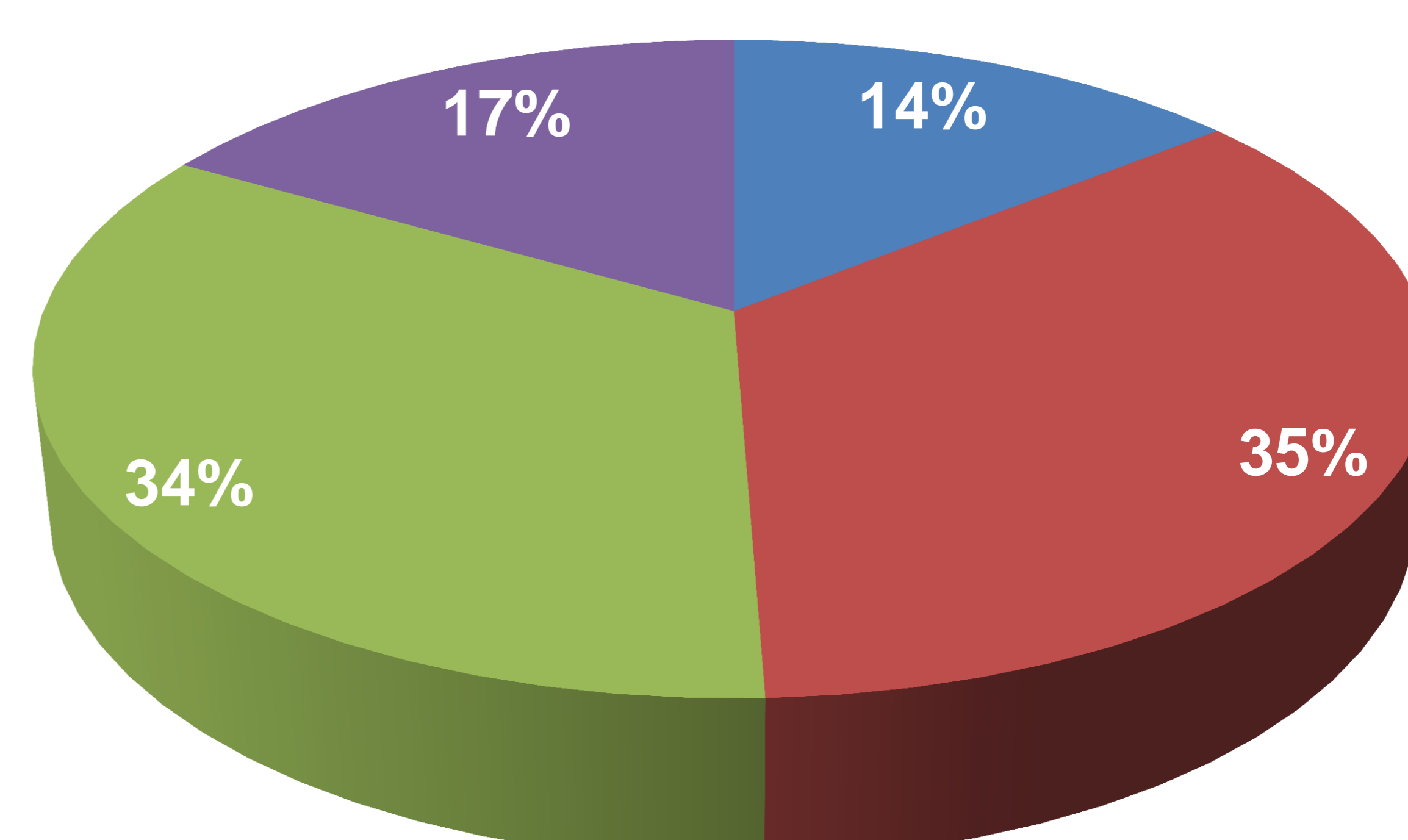
RESULTS

- 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

- C: reached the patient without causing harm
- D: reached the patient and require intervention/monitoring
- E: would cause temporary harm
- F: harm that would have prolonged hospitalization



RE severity

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