

# IMPACT OF MEDICATION RECONCILIATION AT HOSPITAL ADMISSION AND DISCHARGE IN ELDERLY POLYMEDICATED PATIENTS

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## BACKGROUND AND IMPORTANCE

Elderly patients frequently present multimorbidity and polypharmacy, increasing the risk of medication errors and adverse drug events. Care transitions, such as hospital admission and discharge, are critical points for medication discrepancies. Medication reconciliation performed by a clinical pharmacist improves therapeutic continuity and patient safety.

## AIM AND OBJETIVES

To analyse pharmaceutical interventions during medication reconciliation in elderly patients and to identify medication discrepancies. The aim is to improve prescription accuracy according to the patient's clinical profile, thereby reducing medication-related risks and improving patient safety.

## MATERIAL AND METHODS

Retrospective observational study

Patients aged  $\geq 75$  years with  $\geq 8$  chronic treatments

### Variables collected

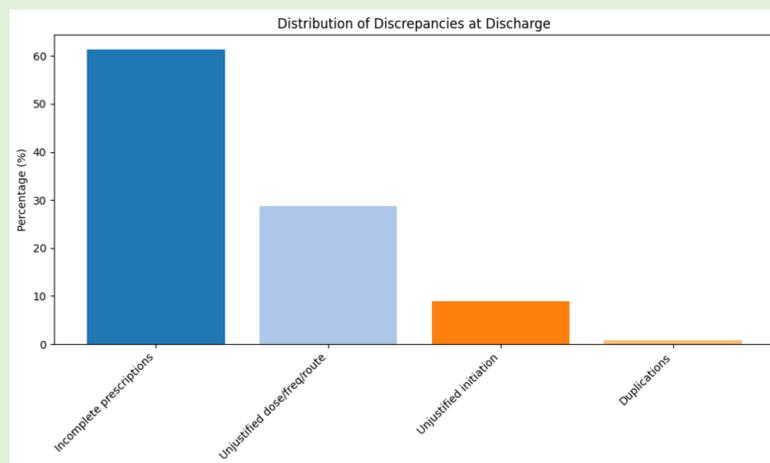
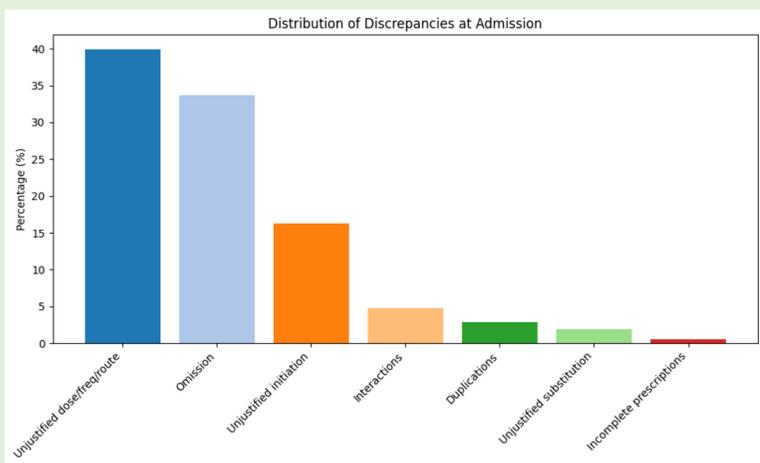
- Age and sex
- Number of chronic treatments
- Medication discrepancies at admission and discharge
- Type of discrepancy
- Physician acceptance of interventions

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Farmatools® software application

## RESULTS

n=188 patients 71.3% women Age:  $83 \pm 8.4$  years  
 $10.8 \pm 3.4$  chronic treatments



Physician acceptance was 96.4%.

## CONCLUSION AND RELEVANCE

- ✓ Medication reconciliation identified a high number of discrepancies at both admission and discharge, highlighting the pharmacotherapeutic vulnerability of elderly polymedicated patients.
- ✓ The high level of physician acceptance reflects the clinical relevance of pharmacist interventions.
- ✓ Most discrepancies required clarification or adjustment, underscoring the need for structured reconciliation processes during care transitions.
- ✓ Multidisciplinary collaboration is essential to optimise pharmacotherapy and reduce medication-related risks in this vulnerable population

