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IMPORTANCE AND IMPACT OF PHARMACEUTICAL MEDICATION RECONCILIATION AT ADMISSION IN ELDERLY POLYPHARMACOLOGIC PATIENTS

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Background and importance

Medication reconciliation is essential for improving patient safety, particularly among elderly patients exposed to polypharmacy.

Aim and objectives

To describe the implementation of a pharmacist-led medication reconciliation process at hospital admission and to identify the type and frequency of reconciliation errors in elderly polymedicated patients admitted to the Internal Medicine Department (IMD).

Material and methods

A prospective study was conducted from December 2024 to January 2025. A clinical pharmacist compared usual medications from updated electronic prescriptions and clinical histories against the hospital electronic prescribing system for all eligible patients (age >65 years; >5 prescribed medications) admitted to the IMD.

Discrepancies were classified according to the Spanish Society of Hospital Pharmacy (SEFH) Consensus on medication reconciliation terminology into: dosage discrepancies, omissions, commissions, continuation of non indicated/contraindicated medications, incomplete prescriptions, drug interactions, and duplications.

Results

153 Patients (52% female, mean age 83.5 years)

10,3 Medications per patient

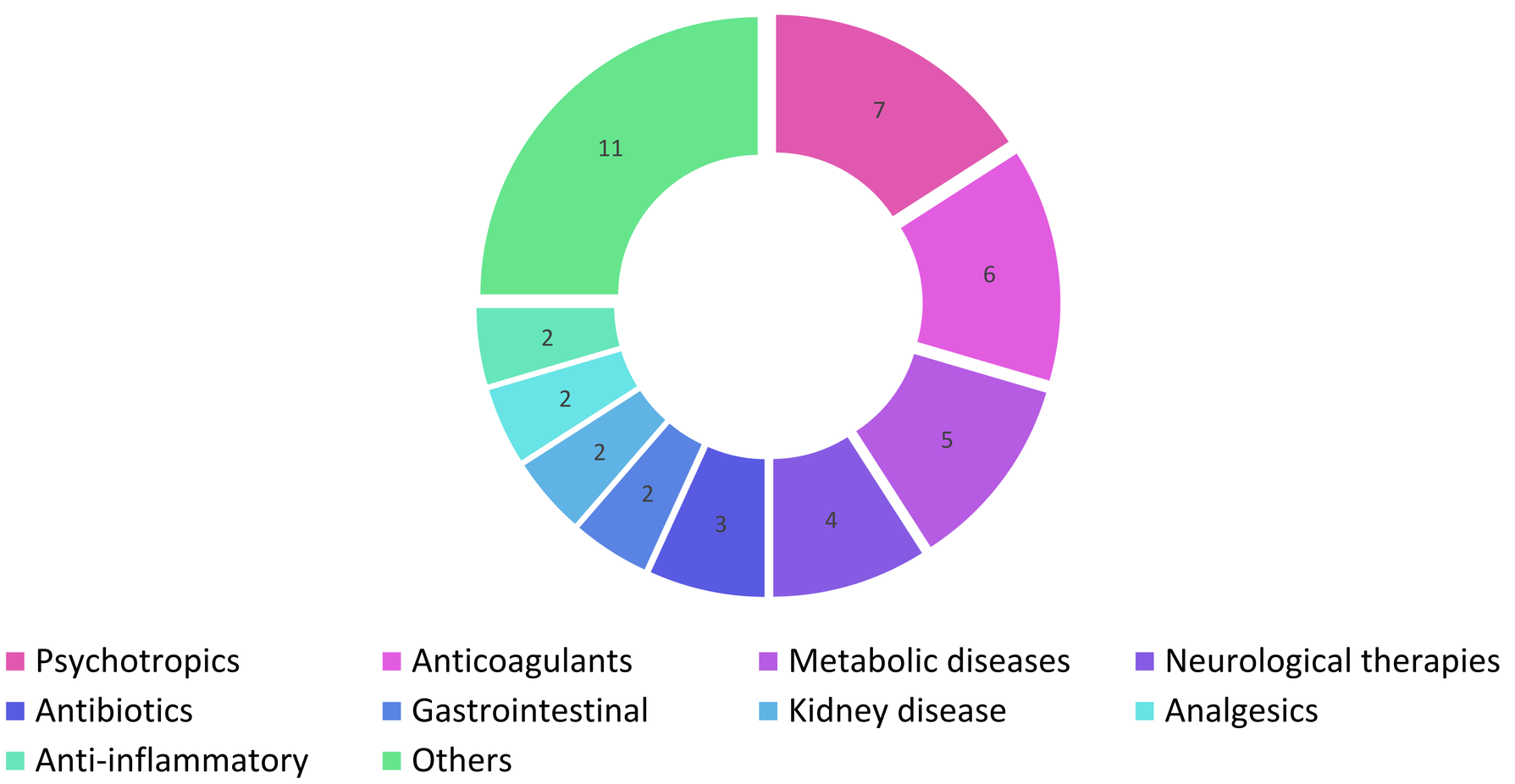
44 Discrepancies identified:

47.7% Dosage discrepancies

38,6% Omissions

43 communicated to physicians

37 accepted



Conclusion and relevance

Medication discrepancies were frequent among elderly polymedicated patients at hospital admission. The involvement of a clinical pharmacist helped identify and resolve these issues through teamwork. The study highlights the importance of structured medication reconciliation and calls for further research to assess its impact.

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