

Rita Branco(1,2,3), Sofia Duque (1,3,4,7), Rosana Andrade (1,2,3), Erica Viegas (1,2,7), Guimarães Consciência (1,3,5), Luís Campos (1,3,4), Fátima Falcão (1,2,7)

1 - Centro Hospitalar de Lisboa Ocidental, Lisbon, Portugal; 2 - Hospital Pharmacy; 3 - Orthogeriatric Unit; 4 - Internal Medicin; 5 - Orthopedics; 6 - Lisbon University faculty of Medicin, Lisbon, Portugal; 7 - Lisbon University faculty of Pharmacy, Lisbon, Portugal .

Poster Nº
4CPS-204

BACKGROUND

Medication reconciliation and pharmacotherapeutic review reduces drug related problems and improves patient safety. It promotes compliance and contributes to the prevention of errors by systematically analyzing patient's medication and detecting discrepancies. Discrepancy is defined as the difference between the patient's usual medication and the one that is prescribed at each moment of care transition.

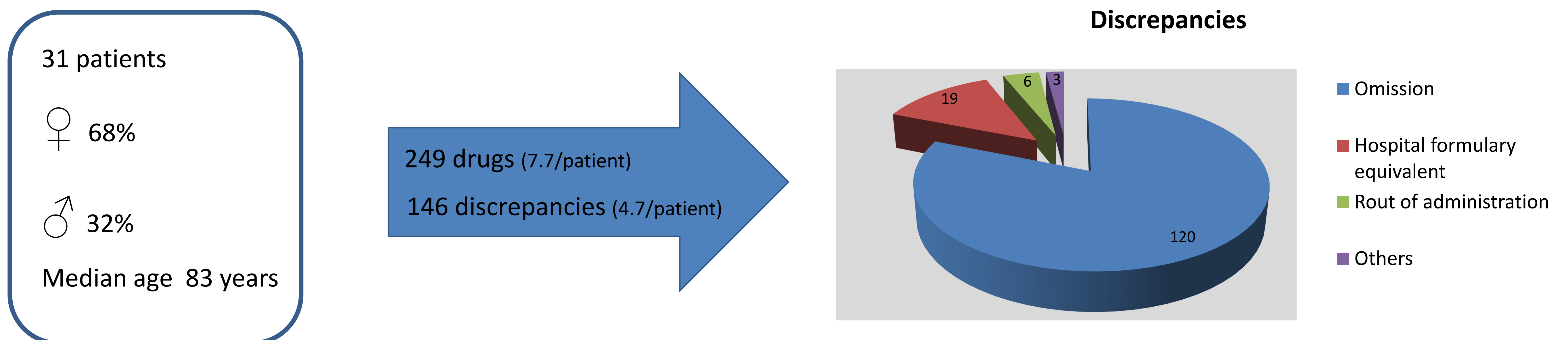
OBJECTIVE

Characterization of the medication reconciliation and pharmacotherapeutic review performed by the clinical pharmacist at the orthogeriatric unit of a central hospital in a 12-month period.

METHODS AND STUDY DESIGN

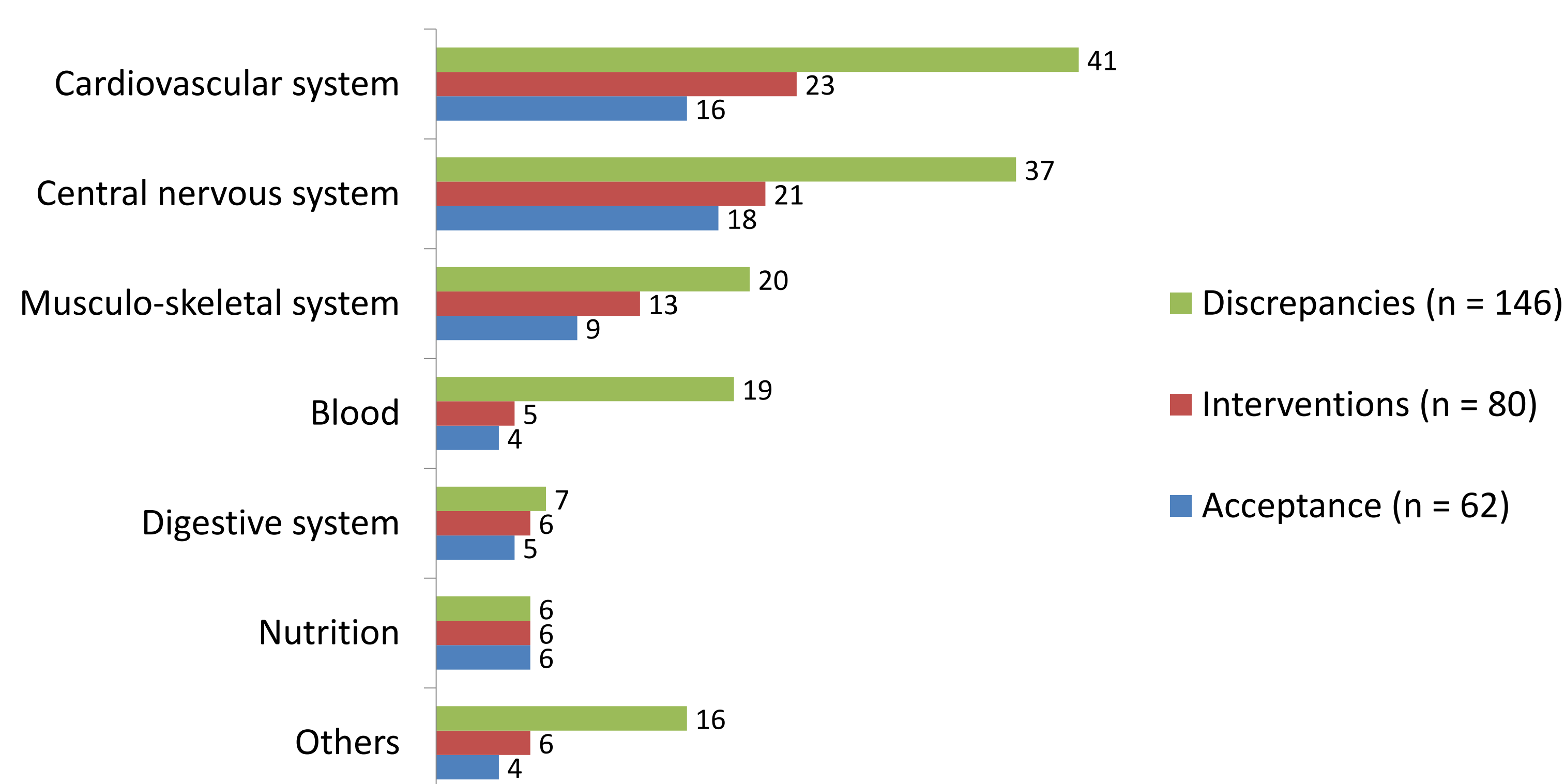
Retrospective, observational study conducted from January to Decembre 2017. Medication reconciliation and pharmaceutical review were performed at the hospitalized patient's admission in the orthogeriatric unit. The Beers and STOPP / START criteria were used to evaluate potentially inappropriate medications in older people. Pharmaceutical intervention was performed when the discrepancies were not according to the bibliography and their acceptance by the clinical team was evaluated. Data was recorded and treated in Excel version 15.3.3.

RESULTS

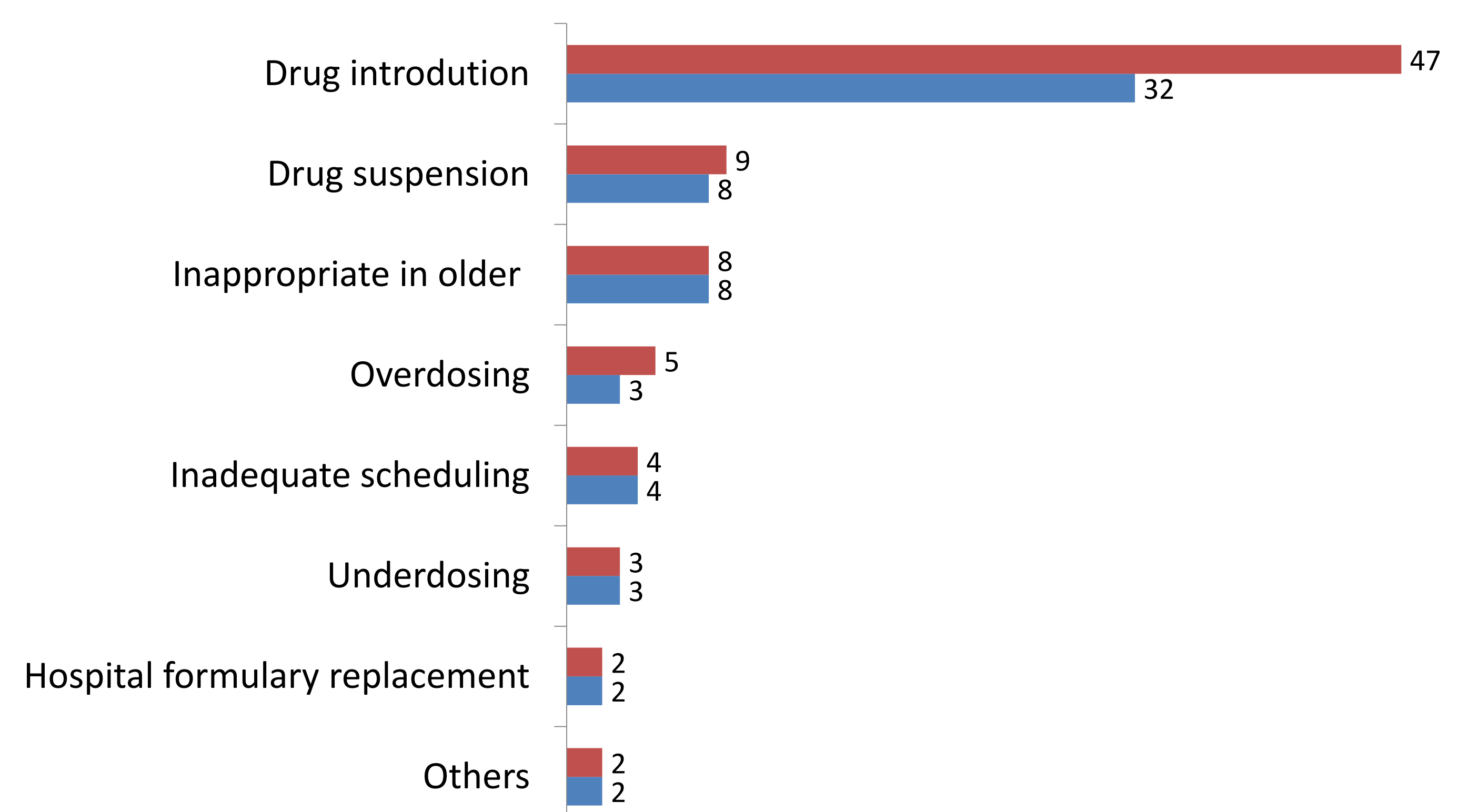


The most common discrepancy was "omission" (n=120; 82%). The pharmacotherapeutic group with the greatest number of discrepancies was the "cardiovascular system" (n=35; 30%) and the largest number of interventions (n=23; 29%) was also in this group. A total of 80 interventions were performed and the most frequent was "drug introduction" (59%). Pharmaceutical interventions acceptance level was 78%.

Pharmacotherapeutic group



Interventions



CONCLUSION

Medication reconciliation and pharmacotherapeutic review in orthogeriatric unit improved pharmacist and physician communication and cooperation allowing the optimization of this patients therapy.

ACKNOWLEDGMENTS

Elizabeth A. Janne K. et al Medication reconciliation of patients with hip fracture by clinical pharmacists
<http://dx.doi.org/10.1136/ejhpharm-2015-000741>

