

IMPORTANCE AND IMPACT OF PHARMACEUTICAL RECONCILIATION AT DISCHARGE IN THE ELDERLY PATIENT WITH POLYMEDICATION

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OBJECTIVES:

The aim of the study is to assess the **impact of reconciliation** and to identify and **prevent reconciliation errors (RE)** in **polymedicated elderly**.

MATERIALS AND METHODS:

A prospective study consisting in a medication reconciliation project at discharge, with a pharmacist in charge.

Patients **over 65 years** of age and **polymedicated** were included.

The pharmacist in charge recorded, evaluated and classified the "reconciliation errors", according to the SEFH Consensus Document on terminology and classification in medication reconciliation.

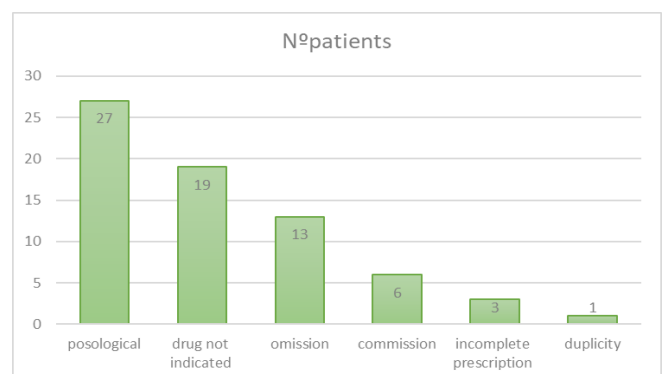
We classified the REs into seven: dosage discrepancy, omission in the prescription, commission, prescription of a drug not indicated or contraindicated due to the patient's clinical situation, incomplete prescription and duplicity.

The pharmacist was personally in charge of keeping the discharge report and an information sheet with the updated discharge medication, providing pharmaceutical care.

RESULTS:

- Discharge reconciliation in 113 patients 51% women
- Mean age **82.4 years** (62-100)
- Number of drugs** prescribed/ patient **11** (5-22)

Classification of discrepancies



CONCLUSIONS:

- Pharmacotherapeutic reconciliation resulted in a **significant reduction in the incidence of RE** and its impact, constituting a **strategy to improve safety** in **polymedicated elderly** patients.
- The presence of a pharmacist on the hospital ward is very useful to carry out this task, improving communication between professionals and contributing to a more effective reconciliation.