**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 December 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**

31 patients
- 68% female
- 32% male
- Median age 83 years

249 drugs (7.7/patient)
- 146 discrepancies (4.7/patient)

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%.

**CONCLUSION**

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

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