MEDICINE RECONCILIATION AT HOSPITAL DISCHARGE
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BACKGROUND AND IMPORTANCE
It has been proven that an updated pharmacotherapeutic report means improvements in patient safety and system efficiency.

AIM AND OBJECTIVES
To describe and to analyze the medicine reconciliation errors (MRE). To awareness prescribers of keeping the treatment report updated at medical discharge.

MATERIALS AND METHODS
• A prospective study during a period of 17 weeks,
• involving all inpatients at:
  • Internal Medicine (IM) → 8 weeks
  • Cardiology ward (CAR) → 6 weeks
  • Oncology ward (ONC) → 3 weeks

Data collected from an interview → Communicated to physician to modify and update the treatment before the discharge → Pharmacist conducted a final encounter, where all modifications and new drugs were explained → Updated treatment and discharge reports were given after resolving patient doubts.

RESULTS
151 patients were analyzed:
Mean age 75 +/- 13
46.3% female
116 MRE

WARD CLASSIFICATION (n=116)

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<thead>
<tr>
<th>WARD</th>
<th>Number</th>
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<tbody>
<tr>
<td>IM</td>
<td>68</td>
</tr>
<tr>
<td>CAR</td>
<td>32</td>
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<td>ONC</td>
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IM 58.6% CAR 27.6% ONC 13.8%

CONCLUSION AND RELEVANCE
The pharmacist integration has facilitated the acceptance of pharmaceutical interventions and it has prevented MRE upon discharge, where the most prevalent one was dosage discrepancy. This has raised awareness among all professional about the importance of updating the medical history

104 discrepancies were communicated → 49% (51) were accepted
• 31.1% of the discharge reports were IMCOMPLETE
  • New drugs started in 74.8%
• Pharmaceutical care was given to 80.5% (91) of the inpatients before discharge

Variables:
Age, sex, number of new medication, number of discrepancies not justified requiring clarification, type of MRE, communicated MRE and number of acceptances, number of patients that received pharmaceutical care at discharge.

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