**Purpose:**

- To evaluate the harmony between the most complete and accurate list of a patient’s current medications (PCM) and the list in the medical report at admission to and at discharge from the hospital.
- To identify/analyze the discrepancies found after the medication reconciliation (MR) realized by the pharmacist.

**Material and methods:**

**Prospective study**
(12/23/2016 - 04/23/2017)

**Target population:**
- Patients ≥65-year-old
- > 5 medications as PCM
- Admitted in Internal Medicine service (second level hospital)

**Registration of complete and accurate PCM list in the clinical history at admission and at discharge.**

**Classification of MD according to the ATC classification.**

**Analysis of medication discrepancies (MD): comparison of PCM´s list registered by the physician with the list obtained after MR.**

**MD definition:** any difference between the information obtained by the pharmacist and the registered one in the medical report.

**Classification:** omission; different dose/route/frequency/form; duplicity; wrong medicine; omission; unfinished prescription/clarification.

**Results:**

- **106 patients analyzed**
  Median age: 83.7 years old (51.9% male)

  **Admission**
  - 527 MD detected
    - Incomplete prescription: 63.6%
    - Omission: 15.7%
    - Other discrepancies: 20.7%
    - 3 patients presented no MD
      62.2% MD solved

  **Discharge**
  - 51 new MD detected
    - Incomplete prescription: 66.7%
    - Omission: 23.5%
    - Other discrepancies: 9.8%
    - 51 patients presented no MD
      17.6% MD solved

  **In 17 patients PCM was only checked at admission**
  **578 discrepancies detected:**
  5.4/patient [range: 0-14]

  **Median medicines number:**
  9.2/patient (admission and discharge)

  **Main ATC group with MD:**
  - Cardiovascular system (31.7%)
  - Nervous system (18.3%)

**Conclusion:**

- It was found harmony between PCM’s list registered at admission and the real medication list only in 2.8% of patients, which improved notably after the MR by the pharmacist; 57.3% had no medication discrepancies at discharge. It helps to a correct transmission of information in future care transitions.

- 63.1% of the discrepancies was incomplete prescriptions.

- Cardiovascular and nervous system were the main medicines groups with discrepancies.