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

M. Vara Urruchua, C. Vila Gallego, M. Inclan Conde, B. Belio Aguera, N. Gomez Echevarria, Z. Perez España, N.M. Pardo Santos, A.V. Aguirrezabala Arredondo (Spain)

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)

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.