Background and importance Medication errors at hospital admission are common, increasing morbidity and mortality. The pharmacist can help to prevent the occurrence of medication related problems through medication reconciliation.

Aim and objectives To analyse the pharmaceutical interventions performed during the implementation of a medication reconciliation programme on hospital admission to reduce medication errors (ME).

Material and methods This was an observational prospective study (October 2018–September 2019). Patients older than 65 years who received at least five drugs and had more than 24 hours of admission in the general surgery and urology units were included. Variables considered were age, sex, number of prescribed drugs and ME. The best pharmacotherapeutic history was developed, including diagnosis, medical history and complete list of chronic home medication, consulting the electronic history programme of electronic prescriptions. This information was completed with an interview with the patient/caregiver. In the event of any discrepancy, the responsible doctor was contacted.

Results Medication reconciliation was conducted for 553 patients. Median age was 75 years and 56.6% were men. The average number of medications per patient at admission was 8.2. A total of 4567 drugs were reconciled, with a total of 2404 interventions in the discrepancies found: 1586 (65.9%) were justified while 818 (34.1%) were classified as unjustified or ME (omission (90.17%), dose (2.7%), frequency, schedule or route of administration (1.69%), therapeutic duplicity (1%) and other), with a degree of acceptance of 62%, correcting the discrepancy in most cases before 24 hours had elapsed. Communication with the doctor was done by electronic messaging in 91% of cases.

Conclusion and relevance We observed that during the medication reconciliation, numerous ME were detected, the majority of which were omission of medications. The involvement of the pharmacist, integrated into a multidisciplinary team together with doctors and nurses, allowed the detection of discrepancies, obtaining a high percentage of acceptance of the interventions, thus reducing ME. The medication reconciliation programmes allow the detection and resolution of discrepancies, preventing ME in healthcare transitions.

REFERENCES AND/OR ACKNOWLEDGEMENTS
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