MEDICATION RECONCILIATION

PROCEDURE ©

DOCUMENT SUMMARY/KEY POINTS

- Medication reconciliation is the responsibility of all medical, nursing and pharmacy staff. SCHN recognises the importance of a best possible medication history (BPMH), medication reconciliation and a comprehensive medication management plan as contributors to improved patient care.
- Medication reconciliation involves matching the medications the patient should be prescribed to those that are actually currently prescribed to identify accidental errors.
- Medication reconciliation should be performed at admission using the BPMH, at transfer of care and finally at discharge.
- Australian Commission on Safety and Quality in Health Care (ACSQHC) National Quality and Safety in Health Care Standards and NSW Health Medication Management Policy Directive (PD2013_043) require all health care facilities have formal processes for obtaining, verifying and documenting Best Possible Medication History (BPMH) from at least two sources.
- The national Medication Management Plan (MMP) should be used by the workforce to document the BPMH and medication reconciliation and should be kept together with the Paediatric National Inpatient Medication Chart (PNIMC).
- All patients who take regular medication or have special needs should have a medication management plan.

CHANGE SUMMARY

- N/A – new document.

READ ACKNOWLEDGEMENT

- Training/Assessment Required – Nursing, Pharmacy and Medical Staff must attend training or complete online the National Prescribing Service online module "Taking a Best Possible Medication History".
- All clinical staff are to read and acknowledge they understand the contents of this document.

TABLE OF CONTENTS

Glossary of Terms

Adverse Drug Reaction:

An adverse drug reaction is a response to a medicinal product which is noxious and unintended and which occurs at doses normally used in humans for the prophylaxis, diagnosis or therapy of disease or for the restoration, correction or modification of physiological function.

Best Possible Medication History:

A list of all the medicines a patient is taking prior to admission (including prescribed, over the counter and complementary medicines) and obtained from interviewing the patient and/or their carer where possible and confirmed using a number of different sources of information. BPMH should include at least two sources of information and any known allergies and previous adverse medication events.

Medication

A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise enhancing the physical or mental welfare of people. Prescription, non-prescription and complementary medicines irrespective of their administered route are included.

Medication Management Plan:

The national standard form used by nursing, medical, pharmacy workforce to record medicines taken prior to presentation to hospital and other information (such as compliance and suitable administration) required for reconciling patients' medicines on admission, intra-hospital transfer and at discharge.

Medication Reconciliation:

The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care the verified information is transferred to the next care provider.

Paediatric National Inpatient Medication Chart (PNIMC)

The national standard medication chart for paediatric inpatients in all Australian hospitals.

Background

Australian Commission on Safety and Quality in Health Care (ACSQHC) National Quality and Safety in Health Care Standards and NSW Health Medication Management Policy Directive (PD2013_043) require all health care facilities have formal processes for obtaining, verifying and documenting Best Possible Medication History (BPMH) from at least two sources. This includes consideration of any medications brought in by (or with) the patient at the time of admission, any known allergies and previous adverse medication events.

The national Medication Management Plan (MMP) is designed to document the BPMH and to record the key steps of medication reconciliation. The MMP should be used across SCHN to document and reconcile patient medications on admission, and changes occurring at intra-hospital transfer(s) and discharge. The MMP has been deemed suitable for use in both adult and paediatric settings.

Process

Obtaining a Best Possible Medication History (BPMH)

The BPMH should be initiated by medical, nursing or pharmacy staff as soon as possible in the episode of care to ensure timely appropriate medication management.

The BPMH is more comprehensive than a primary medication history and involves:

- A list of medications including recently started, ceased or changed medication (generic name, dose, route, strength and formulation, date of initiation and indication, over the counter and complementary medications)
- The source(s) of the information;
- Information about previous adverse drug events and allergies in keeping the Adverse Drug Reaction Guideline-SCHN.

The initial medication list may be documented on the MMP in the Emergency Department for completion of the BPMH as soon as practicable.

Information about adverse drug events and allergies must be documented according to the Adverse Drug Reaction Guideline- SCHN for all patients from the time of admission. This requires:

Clearly documenting in the healthcare record:

- Medication name,
- Type of reaction,
- When the reaction occurred and
- Name and signature of the staff member completing the documentation and date of review.

Where the reaction or date of reaction are not known this should be documented with the medication and the words “unknown” in the corresponding sections. Patients with nil known allergies this should be documented with the name and signature of the staff member with the date of review.

Medication Reconciliation

Medication reconciliation involves matching the medications the patient should be prescribed to those that are actually currently prescribed to identify accidental errors.

Where there are discrepancies, these should be discussed with the previous prescriber/s then rectified either by adjusting the currently prescribed medications to reflect the intended

treatment, or by documenting the reasons for the changes to the therapy in the patient's health care record.

Where discrepancies are identified by a nurse or pharmacist these must be documented on the MMP and discussed with the prescriber. Reasons for changes to therapy should be documented in the medical record.

The list of current medications documented on the MMP, the patient's clinical condition and documented ADRs should be used to inform medication treatment decisions throughout the admission and should also be used for reference by prescribers preparing medication chart orders for a patient on admission where previously completed.

At transfer of care and discharge

Staff must ensure:

- The appropriateness to continue each medication in the receiving area;
- Essential medications withheld on admission are recommenced if clinically appropriate;
- Changes to the patient's medication regimen are identified and communicated to the person taking over the patient's care, together with the reason for the change;
- A current and accurate list of medications is provided to the person taking over the patients care.

Within the healthcare facility particular concern exists when patients are transferred between:

- Intensive Care Unit (ICU) and general wards
- Operating Theatres or recovery and general wards
- General wards and rehabilitation units

It is important that patient monitoring requirements are documented and communicated to healthcare providers and patients and that the patient has an adequate supply of medicines to continue treatment upon discharge.

Filing and Access

The medication history and other relevant clinical information should be accessible when decisions are made to prescribe medicines this includes the PNIMC and preoperative medical record in either hard copy or electronic form.

Once initiated the MMP must be stored together with the current PNIMC throughout the episode of care. The MMP is to be maintained as part of the healthcare record upon discharge.

Resources

Education

- Medication Management Plan User Guide: http://www.safetyandquality.gov.au/publications/medication-management-plan-user-guide/
- Australian Commission on Safety and Quality Medication Management Plan training presentation: http://www.safetyandquality.gov.au/wp-content/uploads/2012/02/MedicationManagementPlan.pdf
- Match Up Medicine educational materials: www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/match-up-medicines/
- National Prescribing Service: Taking a Best Possible Medication History: http://learn.nps.org.au/mod/page/view.php?id=5436

Monitoring Medication Reconciliation

The following may be used to monitor medication management and continuity of care across SCHN.

- Training
  - Records of attendance for staff training on obtaining and documenting a BPMH
  - Records of staff completion of online modules on obtaining and documenting a BPMH
- Medication Management Processes and Documentation
  - Rate of Medication Management Plan (MMP) utilisation
  - NSW TAG QUM Indicators:

    3.1 Percentage of patients whose current medicines are documented and reconciled at admission
    3.2 Percentage of patients whose known adverse drug reactions are documented on the current medication chart
    5.3 Percentage of discharge summaries that include medication therapy changes and explanations for changes
    5.6 Percentage of patients with asthma that are given a written asthma action plan at discharge AND a copy is communicated to the primary care clinician
    5.8 Percentage of patients whose discharge summaries contain a current, accurate and comprehensive list of medicines
    5.9 Percentage of patients who receive a current, accurate and comprehensive medication list at the time of hospital discharge
    6.2 Percentage of patients that are reviewed by a clinical pharmacist within one day of admission
    7.3 Percentage of patients who receive written and verbal information on regular psychotropic medicines initiated during their admission
  - The Clinical Excellence Commission Continuity of Medication Management Program Monitoring Practice audit tools: http://www.cec.health.nsw.gov.au/programs/continuity-of-medication-management/monitoring-practice#mmpue

References

1. World Health Organisation Glossary online: http://www.who.int/medicines/areas/coordination/English_Glossary.pdf Accessed 02/07/2013
2. Adverse Drug Reaction Guideline –SCHN http://chw.schn.health.nsw.gov.au/o/documents/policies/guidelines/2013-9082.pdf
3. Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards. Sydney. Australian Commission on Safety and Quality in Health Care, 2011.
4. Medication Handling in NSW Public Health Facilities (PD2013_043) http://www0.health.nsw.gov.au/policies/pd/2013/pdf/PD2013_043.pdf Published 27-Nov-2013 Accessed 25/6/15
5. Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 4: Medication Safety (October 2012). Sydney. ACSQHC, 2012.