How to take a best possible medication history

Wherever appropriate, interview the patient or their carer/family. Ensure the patient knows who you are, and why you are gathering this information. Explain the importance of having accurate medicines information.

Approach the interview in a **systematic way,** using a form such as the National Medication Management Plan to guide you. Use open-ended questions and gather information about:

- ✔ The names of all medicines taken, including prescription, over-the-counter, and complementary medicines.
- ✔ The dose taken, including strength, dose form and concentration, where relevant.
- ✔ The dose frequency.
- ✔ The duration of treatment.
- ✔ The indication for therapy.
- ✔ Other important information includes recent changes to treatment, and previous adverse drug reactions.

Vulnerable points in transition of care

Whenever there is a transfer of a patient's care, there is an opportunity for errors to be introduced into their medicines regimen. These points of transition require special attention:

- ✔ Admission to hospital.
- ✔ Transfer from the Emergency Department to other care areas (wards, Intensive Care, or home).
- ✔ Transfer from the ICU to the ward.
- ✔ Transfer from hospital to home, residential aged care facility or another hospital.

At these points, clinicians should ask:

- ✔ Is it clear what the patient should be taking?
- ✔ Have any medicines been withheld that should be restarted?
- ✔ Is there anything the patient has been prescribed that they no longer need?
- ✔ Have all changes to treatment been clearly documented for the next caregiver?

Medication reconciliation is everybody's business. Strong collaboration, communication and teamwork among staff involved in the patient's care - medical, nursing, ambulance and pharmacy staff AND the patient, their carer or family members is vital for its success.

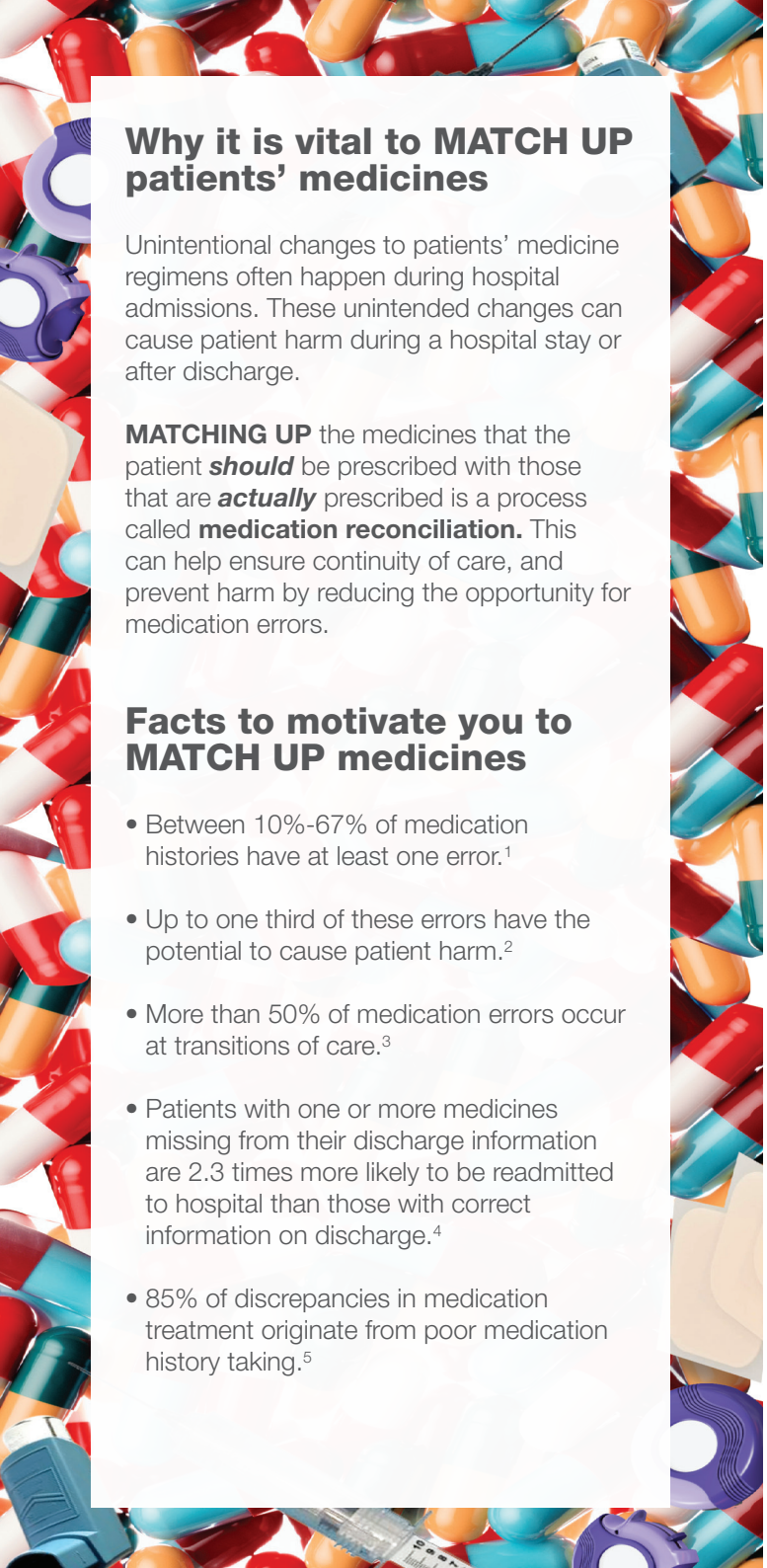
MATCH UP medicines:
Help prevent adverse medicine events in our hospital.

References: 1. Tam VC, Knowles SR *et al. CMAJ* 2005;173(5): 510-5. 2. Cornish PL, Knowles SR *et al. Arch Intern Med* 2005;165:424-9. 3. Sullivan C, Gleason KM *et al. J Nurs Care Qual* 2005; 20:95-98. 4. Stowasser DA, Stowasser M, Collins DM. *Journal of Pharmacy Practice and Research* 2002;32:133-40. 5. Gleason KM, McDaniel MR *et al. J Gen Intern Med*; DOI:10.1007/s11606-010-1256-6.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

A guide to Medication Reconciliation.

Medrec
matching medicines at transitions of care



Why it is vital to MATCH UP patients' medicines

Unintentional changes to patients' medicine regimens often happen during hospital admissions. These unintended changes can cause patient harm during a hospital stay or after discharge.

MATCHING UP the medicines that the patient ***should*** be prescribed with those that are ***actually*** prescribed is a process called **medication reconciliation.** This can help ensure continuity of care, and prevent harm by reducing the opportunity for medication errors.

Facts to motivate you to MATCH UP medicines

- Between 10%-67% of medication histories have at least one error.[1]
- Up to one third of these errors have the potential to cause patient harm.[2]
- More than 50% of medication errors occur at transitions of care.[3]
- Patients with one or more medicines missing from their discharge information are 2.3 times more likely to be readmitted to hospital than those with correct information on discharge.[4]
- 85% of discrepancies in medication treatment originate from poor medication history taking.[5]

Medication reconciliation:

4 simple steps to improve patient safety

1 Obtain a best possible medication history

Using information from patient interviews, GP referrals and other sources, compile a comprehensive list of the patient's current medicines. Include prescription, over-the-counter and complementary medicines and information about the medicine's name, dose, frequency and route.

This medication history, sometimes referred to as a *Best Possible Medication History* (BPMH), should involve a patient medication interview, where possible. The BPMH is different and more comprehensive than a routine primary medication history, which is often a quick medication history.

2 Confirm the accuracy of the history

Use a second source to confirm the information obtained, and ensure you have the best possible medication history. Verification of medication information can include:

- ✔ Reviewing the patient's medicines list.
- ✔ Inspection of medicine containers.
- ✔ Contacting community pharmacists and GPs, with the patient's consent.
- ✔ Communicating with carers or the patient's family members.
- ✔ Reviewing previous patient health records.

3 Reconcile the history with prescribed medicines

Compare the patient's medication history with their prescribed inpatient treatment. Check that these **match**, or that any changes are clinically appropriate.

Where there are discrepancies, discuss these with the prescriber and ensure that the reasons for changes to therapy are documented eg. atenolol ceased prior to surgery.

4 Supply accurate medicines information

When patients are transferred between wards, hospitals or to their home or residential care facility, ensure that the person taking over their care is supplied with an accurate and complete list of the patient's medicines.

Ensure that the care provider, patient and/or their carer are also provided with information about any changes that have been made to medicines.