MATCH UP Medicines
Medication Reconciliation Resources
National Medication Management Plan and support materials

Margaret Duguid
Pharmaceutical Advisor
Australian Commission on Safety and Quality in Health Care
Overview

• What is medication reconciliation
• Safe practice recommendations
• Medication Reconciliation Toolkit
• National Medication Management Plan
• Training materials and other resources
What is Medication Reconciliation

A process for obtaining and documenting a complete and accurate list of a patient’s current medicines upon admission and comparing this list to the prescriber’s admission, transfer and/or discharge orders to identify and resolve discrepancies.

A formal, systematic process

Healthcare professionals partner with patients to ensure accurate and complete medication information transfer at interfaces of care

Designed to prevent potential medication errors and adverse drug events
Purpose of Medication Reconciliation

Reduce preventable errors

- Unintentional discrepancies
  e.g. eye drops for glaucoma omitted as medication history incomplete
- Undocumented intentional discrepancies
  e.g. antihypertensive ceased on admission intention to restart not documented

Patients receive medicines as intended
The Medication Reconciliation Process

Four key steps

1. Obtain and document best possible medication history
2. Confirm medication history
3. Reconcile history with prescribed medicines and follow up discrepancies
4. Supply accurate information when care transferred
Effective medication reconciliation

• To be successful needs to be built into the process of care – not added to it:
  – e.g. replace multiple histories with one that is used throughout episode of care

• **Integrate** steps into existing processes:
  – Patient flow, medication management system

• Best conducted in environment of shared accountability

• Multiple approaches
  – Models will differ from hospital to hospital, team to team
Proactive Model

Occurs when the BPMH is conducted before admission medication orders

**STEP 1**

Create the BPMH

**STEP 2**

Using the BPMH, admission medication orders (AMOs) are written by the prescriber

**STEP 3**

Verify every medication in BPMH has been assessed by prescriber.

1. Create the BPMH
2. Using the BPMH, admission medication orders (AMOs) are written by the prescriber
3. Verify that the prescriber has assessed every medication on the BPMH, identifying and resolving any outstanding discrepancies with the prescriber

Source: High 5s Medication Reconciliation Getting Started Kit 2010
Retroactive Model

- Occurs when the BPMH along with formal admission reconciliation occurs after admission medication orders are written

**STEP 1**
Primary Medication History

**STEP 2**
Admission Medication Orders (AMO)

**STEP 3**
BPMH

**STEP 4**
Compare BPMH with AMOs and resolve any discrepancies

1. Primary medication history is taken
2. AMOs are written by prescriber
3. Create the BPMH
4. Compare the BPMH against the patient’s AMOs, identify and resolve discrepancies

Source: High 5s Medication Reconciliation Getting Started Kit 2010
Safe practice recommendations

1. Develop a formal and systematic approach to reconciling patient medicines across the continuum
   - Multidisciplinary, reps from key depts (ED, ICU, pre-admission, med/surg units, pharmacy, Q&S unit)

2. Create P&Ps that outline roles, tasks in each step in the process

3. Adopt a standardised form for collecting pre-admission medicines list and reconciling medicines
   - Place in consistent, highly visible location with patient’s chart - easily accessible when medicines are ordered
   - Electronic and paper

Massachusetts Coalition for prevention of medical errors
http://www.macoalition.org/initiatives.shtml
4. Assign **responsibility** for obtaining BPMH to someone with sufficient expertise
   • Shared accountability (MO, nurse and pharmacist work together)
5. Assign **responsibility** for resolving **variances** to someone with sufficient expertise
6. Establish **specific time frames** within which medicines should be reconciled
   • < 24 hours, within 4 hours for high risk medicines
Safe practice recommendations

7. Provide clinicians ready access to drug information and a pharmacist consult when needed

8. Improve access to complete medicines lists at admission

9. Provide orientation and ongoing training to all health professionals

10. Monitor performance and provide feedback
EXAMPLE OF Assuring Medication Accuracy at Transitions in Care

Policy

Provider

Orientation, Education, Advice, Drug information

Form

Assign responsibility

Current Medication List

Place the form in a highly visible location in the chart

Initial orders

Reconcile Medications

New or revised orders

Compare the list with the new orders to identify omissions, duplications, dosing errors, or potential interactions within specified time frames:
- within 24 hours of admission
- shorter time frames for high-risk drugs, potentially serious dosage variances
Reconcile any discrepancies

Patient

Transitions in setting, service, level of care, or provider. Communicate list to the next provider and to the patient.

Repeat Process

This example is not necessarily appropriate for all healthcare settings.
Medication reconciliation toolkit
Medication reconciliation toolkit

• Initial focus on the admission process
  – In line with High 5s medication reconciliation project
  – If medication history on admission incorrect errors flows through to discharge
  – 49% of prescribing reconciliation failures occur at admission *
  – Other Commission work occurring on discharge process


AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE
Medication reconciliation toolkit

Toolkit contents

• Educational materials
  – Medication reconciliation
• National Medication Management Plan (MMP)
• MMP training material
• Admission history training resource
• Other support material
• New tools on order
MATCH UP medicines
Medication reconciliation prevents harm.
MATCH UP medicines

- Poster
- Brochure
- Powerpoint template
- Customise with hospital logo
MATCH UP medicines Brochure

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

<table>
<thead>
<tr>
<th>1. Obtain a best possible medication history</th>
<th>2. Confirm the accuracy of the history</th>
</tr>
</thead>
</table>
| 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. | 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 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. |

<table>
<thead>
<tr>
<th>3. Reconcile the history with prescribed medicines</th>
<th>4. Supply accurate medicines information</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>
Step 1. 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.
Step 2. Confirm the accuracy of the medication

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 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.
Step 3. Reconcile history with prescribed medicines

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.
Step 4. Best possible medication history

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.
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 member is vital for its success.

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

A guide to Medication Reconciliation.

National Medication Management Plan
Medication Management Plan

Adopt a *standardised form* for collecting pre-admission medicines and reconciling variances

- Place in consistent, highly visible location in patient notes
- Easily accessible when medicines are prescribed
- Electronic and paper

Massachusetts Coalition for prevention of medical errors
http://www.macoalition.org/initiatives.shtml
National Medication Management Plan

History

• NIMC Workshop September 2008
  – Recommended a form replace section on front of NIMC for recording medicines prior to admission

• Working party convened
  – Collated charts from around Australia
  – Identified core elements
    • APAC Guiding Principles to Achieve Continuity of Medic’n Manag’t
    • SHPA practice standards for medication reconciliation
  – Built on 5 years work by Queensland Health in design of form
National Medication Management Plan

History cont’d

• Considered by Commission Medication Safety Program committees
• Modified for use in paediatrics
  – Trialled at Royal Children’s Hospital, Brisbane
  – Consultation thru Children’s Hospital Australasia
• Approved by Commission’s Interjurisdictional and Private Hospital Sector Committees
National Medication Management Plan

Supports key steps of Medrec

1. Obtain and document best possible medication history
2. Confirm medication history
3. Reconcile history with prescribed medicines
4. Document issues/discrepancies and actions
5. Supply accurate information when care transferred

Keep with medication chart for easy access
National Medication Management Plan

- Capture of complete and accurate medication history on admission
- Allows for shared accountability
- Doctors plan column helps with reconciliation
- Identifies is supply required at discharge
National Medication Management Plan

Prompts for and consolidates information

- Recently ceased or changed medicines
- Confirmation of history
  - Several sources may be needed
- General information
  - Who administers
  - Immunisation status (children)
  - Community contacts
- Checklist to assist in completing history
National Medication Management Plan

To ensure patient receives all intended medications
Column to reconcile each medicine
Medication Management Plan

- Medication issues and actions
  - Changes made when discrepancies identified
  - Medication review issues identified & resulting changes
  - Clinical Handover
Medication Management Plan

Assists with discharge

✔ Medication Risk Identification
  – Informs discharge process
  – Identify if assistance required to manage medicines at home

✔ Medication Changes During Admission
  – Inform the patient or GP

✔ Comments
  ✔ Specific administration, supply requirements on discharge

✔ Discharge Checklist

✔ Referral for Home Medicines Review Considered
NMMP Support materials

• User Guide
  – Use to record BPMH, reconcile medicines
  – Privacy issues
  – Page by page instructions for use
• Forms basis for P&Ps on medication reconciliation

National Medication Management Plan
User Guide

August 2010
NMMP User Guide

- Provides examples on how to complete the form

**Medication Management Plan**

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Issue Identified</th>
<th>Proposed Action</th>
<th>Person Responsible</th>
<th>Date of Action</th>
<th>Result of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/7/10</td>
<td>Patient normally takes metoprolol at home, not been charted</td>
<td>Please notify pharmacy, chart it to be continued.</td>
<td>MO</td>
<td>8/7/10</td>
<td>Metoprolol charted</td>
</tr>
</tbody>
</table>

**Date of admission:** 08/07/2010

**Ward/Clinic:** Gen Med

**Consultant:** Brown

**Issue identified by:** W Dunbar Pharm

**Contact number:** 2948

*AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE*

*Medrec: matching medicines at transitions of care*
Paediatric Patients

Record details on the method of administration usually used in the “medicine” column. This should include the route (e.g. “NG”) and the formulation (e.g. “oral mixture”). It may be necessary to use an additional line for detailed information (e.g. “10mg tablet dispersed in 10mL water, give 1mL”).

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dose</th>
<th>Frequency</th>
<th>Indication (confirm with patient)</th>
<th>How long or when started</th>
<th>Initial profession</th>
<th>Dr’s Plan On Admission</th>
<th>Supply at Home</th>
<th>Supply at Site</th>
<th>Reconcile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omeprazole long tabs po</td>
<td>10mg</td>
<td>morning</td>
<td>gut protection</td>
<td>4 wks</td>
<td>J &amp; J phann</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>(Disperse tabs in water &amp; give via NG tube)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naproxen 250mg tabs po</td>
<td>3/4 tab</td>
<td>night</td>
<td>seizures</td>
<td>1 week</td>
<td>J &amp; J phann</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>(Disperse one tablet in 8mL water &amp; give 8mL via NG tube)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Guide to completing the Medication Management Plan (MMP) Form

**Medication History Interview**
- Document the interview
  - Include a MMP form should be completed for every patient on admission. Otherwise target select patients (e.g., high-risk patients). For example:
    - Using or new medications
    - History of allergy or on an ADR which may have contributed to the admission
    - With a reported poor level of adherence/compliance
    - With a reported recent stop in function
  - Document the medication information obtained on admission or page 3 of the Medication Management Plan (MMP) form.
  - All admissions record
    - Visit the community pharmacy name and contact number (page 2) in the GENERAL INFORMATION section.
    - All medications taken on admission in the MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL section (page 3) – generic name (brand name strength, form, route, dose, frequency, indication, and duration, using the correct labels provided.
    - Source of this information (page 2)
  - Any recently ceased or altered medications should be documented in the RECENTLY CEASED OR RECENT CHANGES TO MEDICATION section (page 2).

**Confirmation of the medication history**
- Confirm the history with a second source if possible and document in the SOURCES OF MEDICINE LIST section (page 2).
- Report any errors or discrepancies.

**Reconciling the medication history**
- Check that each medication listed on the medication chart is consistent with the discharge plan.
- Check the required columns on the medication chart and reconcile with the discharge plan.
- Fill in any missing data or errors (if noted in the discharge plan).

**Medication issues and management plan**
- Identify and document any medication issues on page 2 of the MMP form.
- Document proposed action required and patient responsibility.
- Identify and document a contact number.
- Document date and result of action taken (this may occur at a later date).

**Medication discharge checklist & referral for home medicines review**
- Use the medication list (status and need for discharge and medications taken over the course of the discharge period to create the discharge prescription. Cross-check the discharge summary and follow up any discrepancies.
- Complete the discharge prescription when reviewing a discharge medication checklist (DMC) for the patient.
- Ensure all prescribes on the discharge sheet have been reviewed and completed if appropriate.
- On discharge send DMC to GP, community pharmacist, and other community health care provider (if applicable) and document on page 4 of the MMP form.
- If appropriate request a Home Medicines Review to be organized by the GP and documented for this event on page 4 of the MMP form.

**Discharge reconciliation & liaison**
- The MMP form should be kept with the active medication chart and on discharge filled in the medical record with the medication chart for that admission.
Medication Reconciliation
Matching Medicines at Transition of Care

Using the National Medication Management Plan
Overview of contents

✓ What is “Medication Reconciliation”?  
✓ Why do it?
✓ What is the National Medication Management Plan form?
✓ How is it used?
✓ Discussion
Guide to using the Medication Management Plan (MMP) Form

**Key aspects of the Medication Management Plan form:**
- Medication history, checklists & medicine list in middle of chart
- Medication issues requiring action on front of chart
- Discharge checklist & information required on discharge on back of chart

- Document medicines taken prior to hospital admission including non-prescription including complementary medicines.
- Confirm medication with second source. (e.g. GP, patient’s own medicines)
- Document medicine/s recently ceased or changed.
- Document Dr’s plan for each medicine listed.
- Reconcile history with active medication orders & tick in reconcile column.
- Document medication management issues for patients. e.g. requires administration aid.
- Use checklist to obtain complete medication history.
- Document information relevant to discharge. (e.g. administration aid)
- Pharmacist/nurse completes medication discharge checklist.
- Assess if patient requires referral for Home Medicine Review.
- Keep MMP form with active medication chart for easy access.
- Medical, nursing, pharmacy staff involved in patient’s care should record the information according to hospital policy.

Matching medicines at transitions of care
Other resources
Medication History Taking

Power point presentation with videos
Admission History Education Resource

Can be used for
• Facilitated group sessions
• Self directed learning

Contains
• Instructional notes
• Contents
  – What is involved in obtaining an accurate history
  – 8 steps in medication history interview
  – Communication technique
Session objectives

1. Outline the processes required to obtain and document an accurate medication history

2. Demonstrate effective communication skills
   ✓ appropriate and inappropriate questioning styles/responses

3. Describe the limitations and benefits of information sources available to elicit and confirm a medication history
Obtaining an accurate medication history: What does it involve?

✓ Structured process
   1. Review of sources of patient information
   2. Patient/carer medication history interview
   3. Organisation of patient data

✓ Confirmation
   - Ensuring completeness and accuracy
   - Not relying on a single source
Medication history interview

8 steps*

1. Obtain relevant patient background
2. Open the consultation
3. Confirm and document allergies and adverse drug events
4. Take and document a comprehensive medication history
5. Undertake a thorough adherence assessment
6. Assess patient’s ability to manage their own medication
7. Confirm medication history
8. Reconcile medication history with current medication chart and current medical problems

*This 8 step procedure has been developed using the Society of Hospital Pharmacists of Australia’s Standards of Practice for Clinical Pharmacy (2005) and the Queensland Health Safe Medication Practice Unit – A Competency Framework for Pharmacy Practitioners to Provide Minimum Standard of Pharmaceutical Review: the General Level Framework Handbook (2006).
Communication technique

✔ Verbal versus non verbal communication
  – Body positioning
  – Voice tone
  – Eye contact

✔ Consider the patient’s perspective
  – How would you feel if in their situation?
  – Is the patient able to hear clearly/do they need assistance?
Case study – Medication history interview videos

As you watch the video, use the Medication Management Plan form to document what you think the patient is taking and what you would want to clarify.

✓ Consider communication skills
  – Verbal and non-verbal cues
  – Communication technique
  – Consider patient’s perspective
<table>
<thead>
<tr>
<th>Medicine</th>
<th>Dose</th>
<th>Frequency</th>
<th>Indication</th>
<th>How long</th>
<th>Other information obtained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin 100mg tab</td>
<td>1</td>
<td>mane</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avapro HCT 150/12.5mg</td>
<td>1</td>
<td>mane</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frusemide 40mg tab</td>
<td>2</td>
<td>mane</td>
<td>Fluid</td>
<td></td>
<td>Increased 2 days ago by GP</td>
</tr>
<tr>
<td>Metoprolol 50mg tab</td>
<td>1</td>
<td>bd</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simvastatin 40mg tab</td>
<td>1</td>
<td>evening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coloxyl &amp; Senna tab</td>
<td></td>
<td>prn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>Dose</td>
<td>Frequency</td>
<td>Indication</td>
<td>How long</td>
<td>Other information obtained</td>
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<td>-----------</td>
<td>------------</td>
<td>----------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Aspirin 100mg tab</td>
<td>1</td>
<td>mane</td>
<td>Thins blood</td>
<td>2 yrs</td>
<td>Started post MI</td>
</tr>
<tr>
<td>Avapro HCT 150/12.5mg</td>
<td>1</td>
<td>mane</td>
<td>BP</td>
<td>2/12</td>
<td></td>
</tr>
<tr>
<td>Frusemide 40mg tab</td>
<td>2</td>
<td>mane</td>
<td>Fluid</td>
<td>6 yrs</td>
<td>Increased 2 days ago by GP. Regularly omits doses</td>
</tr>
<tr>
<td>Metoprolol 50mg tab</td>
<td>1</td>
<td>bd</td>
<td>BP</td>
<td>2 yrs</td>
<td></td>
</tr>
<tr>
<td>Simvastatin 40mg tab</td>
<td>1</td>
<td>evening</td>
<td>Cholesterol</td>
<td>2 yrs</td>
<td></td>
</tr>
<tr>
<td>Coloxyl &amp; Senna tab</td>
<td></td>
<td>prn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salbutamol MDI</td>
<td>2</td>
<td>qid</td>
<td>SOB</td>
<td>2 days</td>
<td>Commenced by GP</td>
</tr>
<tr>
<td>Temazepam 10mg</td>
<td>1</td>
<td>nocte</td>
<td>Sleep</td>
<td>Years</td>
<td>Left at home – keeps by bedside</td>
</tr>
<tr>
<td>Paracetamol 500mg tab</td>
<td>2</td>
<td>prn</td>
<td>Headache</td>
<td></td>
<td>Only takes occasionally</td>
</tr>
<tr>
<td>Hydrocobalamin 1000 mcg</td>
<td>1000</td>
<td>2 monthly</td>
<td>Vit B12</td>
<td></td>
<td>Due this Wednesday</td>
</tr>
<tr>
<td>IMI</td>
<td>mcg</td>
<td></td>
<td>replacement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Latanaprost eye drops</td>
<td>1</td>
<td>nocte</td>
<td>Glaucoma</td>
<td>5-6 yrs</td>
<td>Keeps in fridge</td>
</tr>
<tr>
<td></td>
<td>RE</td>
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</tbody>
</table>
Assuring Medication Accuracy at Transitions of Care: Medication Reconciliation

“The interface between different care settings is particularly prone to error and a potential target for interventions to reduce medication error.”


Communication problems between settings of care, or between health professionals, are a significant factor in causing medication errors and adverse drug events. Unintended changes to patients’ medicines regimens often happen during hospital admissions. These unintended changes can cause serious problems during a hospital stay or when patients are discharged.

The process of medication reconciliation has been shown to reduce errors and adverse events associated with poor quality information at transfer of care and inaccurate documentation of medication histories on patient admission to hospital.

Assuring medication accuracy at transitions of care through the process of medication reconciliation is one of five patient safety priorities nominated by the World Health in Patient Safety.

What is medication reconciliation?

Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient’s current medicines. Matching the medicines the patient should be prescribed to those they are actually prescribed. Where there are discrepancies, these are discussed with the prescriber and reasons for changes to therapy documented. When care is transferred (e.g. between wards, hospitals or home), a current and accurate list of medicines, including reasons for change is provided to the taking over the patient’s care. Points of transition that require special attention are:

- Admission to hospital
- Transfer from the Emergency Department to other care areas (wards, Intensive Care, or home)
- Transfer from the Intensive Care Unit to the ward
The national Medication Management Plan (MMP) is an initiative of the Australian Commission on Safety and Quality in Health Care (ACM). The MMP provides health service providers with a standardised form that can be used by nursing, medical, pharmacist, and allied health staff to improve the accuracy of information recorded on admission and available to the clinician responsible for therapy decision making.

A standardised form to record the medicines taken prior to presentation at the hospital and use for reconciling patients’ medicines at admission, intra-hospital transfer, and at discharge is considered essential for the medication reconciliation process. The national MMP provides Australian hospitals with a suitable form to use for this purpose. The MMP form has been designed for use in adult and paediatric patients.

The MMP is based on the Medication Action Plan developed by the Safe Medication Management Unit, Queensland Health. This document is used in consultation with nurses, doctors, and pharmacists. The MMP aligns with the Australian Pharmaceutical Advisory Council’s principles to achieve continuity in medication management. It incorporates the minimum data set for a medication history outlined in Table 4 - Accurate medication history.

Support materials for the National Medication Management Plan

Guide on how to complete the MMP

Issues Register for National Medication Management Plan

The Commission maintains the Medication Management Plan (MMP).

A register of change requests, and outcomes of considerations will become available at a later date.

World Health Organization's High 5s Medication Reconciliation Program

Sixteen Australian health services are participating in the World Health Organization's High 5s Medication Reconciliation Program. Participating health services will test a standard operating protocol designed to assure medication accuracy at transitions of care. It is an opportunity for participating hospitals to engage in medication reconciliation in high-risk areas. They will have high visibility and recognition from implementing and evaluating the standard operating protocol, and for their leadership in standardising patient care processes.

This is a five-year project. The first phase of the project is the introduction of medication reconciliation for patients 65 years of age and older who are admitted to an inpatient ward from the emergency department. In subsequent phases, the scope will be expanded to include all patients from all points to inpatient and outpatient settings.
Under Development

- OSSIE Guide to medication reconciliation
  - Implementation template
- Performance measures/indicators
- E- medication reconciliation
- Consumer information
- On-line training tool for NMMP

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

Medrec
matching medicines at transitions of care
## Resources vs best practice recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic process for reconciling medicines</td>
<td>OSSIE guide to medication reconciliation&lt;br&gt;Medrec materials&lt;br&gt;NMMP guide, PPT</td>
<td>✔</td>
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<tr>
<td>P &amp; Ps for each step in process</td>
<td>User guide for NMMP</td>
<td>✔</td>
</tr>
<tr>
<td>Standardised form for history and reconciling</td>
<td>NMMP</td>
<td>✔</td>
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<tr>
<td>Recommendations</td>
<td>Resource</td>
<td>Status</td>
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<td>---------------------------------------------</td>
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<tr>
<td>Assign roles and responsibilities</td>
<td>OSSIE Guide to medication reconciliation, NMMP User guide</td>
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<tr>
<td>Improve access to complete medicines list at admission</td>
<td>Advocate patient medicines lists, consumer education</td>
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<tr>
<td>Training health professionals</td>
<td>Medrec materials, History ppt &amp; videos, NMMP guide, PPT</td>
<td>✔</td>
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<tr>
<td>Monitoring and feedback</td>
<td>QUM indicators, performance measures</td>
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</table>
Acknowledgements

- Safe Medication Management Unit, Queensland Health for the use of their materials and permitting their adaption for national use
- National Medication Action Plan Reference Group
- Medication Continuity Expert Advisory Group
- High 5s hospitals for their suggestions for the MATCH UP medicines materials, videos on history taking