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** using electronic tools available at each site.
- 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.**
- Local electronic tools should be used by the workforce to **document the BPMH**, and perform medication reconciliation.
- All patients who take regular medication or have special needs **should have an accurate medication history and plan throughout their hospital stay, and at the point of discharge** (i.e., a medication management plan).

CHANGE SUMMARY

- Updated to reflect electronic documentation processes at each site

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.

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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 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

Medication documentation processes across SCHN vary due to the different electronic platforms and the availability of electronic prescribing. However, the underlying principles of medication reconciliation remain the same and are based on the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Quality and Safety in Health Care Standards, and the NSW Health Medication Management Policy Directive (PD2013_043).

National and state standards 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.

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 and 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 medications (generic name, dose, route, strength and formulation, date of initiation or cessation and indication, over the counter and complementary medications)
- The source(s) of information used to obtain the history
- At least two sources of information
- Information about previous adverse drug events and allergies in keeping with the Adverse Drug Reaction Guideline-SCHN.

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

At SCH medications should be documented using the “adhoc” charting tool in accordance with Appendix A: Obtaining the BPMH

At CHW medications should be documented using the “Document Medication by Hx” function within PowerChart according to the Medication History Quickstart: http://elearning.schn.health.nsw.gov.au/documentation/files/clinical_applications/powerchart/eMM/Doctors/Medication_History.pdf

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. For patients with nil known allergies, this should be documented and confirmed by staff with the date of review.

Medication Reconciliation

Medication reconciliation involves matching the medications the patient should be prescribed according to the BPMH 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 and discussed with the prescriber. Reasons for changes to therapy should be documented in the medical record.

The BPMH, 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 when preparing medication chart orders.

At SCH, medication reconciliation should be performed using the ad hoc charting tool in accordance with Appendix A: Reconciling the BPMH

At CHW, medication reconciliation on admission should be performed using the "Reconciliation" function within PowerChart as per the Medication Reconciliation – Admission Quickstart:

http://elearning.schn.health.nsw.gov.au/documentation/files/clinical_applications/powerchart/eMM/Doctors/Medication_Reconciliation_%20Admission.pdf

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.

At SCH, the discharge reconciliation should be performed using the ad hoc charting tool, and discharge summary in accordance with Appendix A: Updating the BPMH with medication changes

At CHW, medication reconciliation on transfer and discharge should be performed using the "Reconciliation" function within PowerChart as per the Medication Reconciliation – Discharge Quickstart:

http://elearning.schn.health.nsw.gov.au/documentation/files/clinical_applications/powerchart/eMM/Doctors/Medication_Reconciliation_Discharge.pdf

Resources

Education on how to obtain a BPMH and reconcile medications

- National Prescribing Service: Taking a Best Possible Medication History: http://learn.nps.org.au/mod/page/view.php?id=5436
- 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/

Note: Paper-based forms are no longer used at SCHN, however, the underlying principles of medication reconciliation outlined in the resources above should be applied when using the local electronic tools. 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
  - Proportion of patients audited with BPMH
  - Proportion of patients audited using site appropriate documentation tools
    - eMM – BPMH Audit Report
    - eMR – Powerforms Audit
  - 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

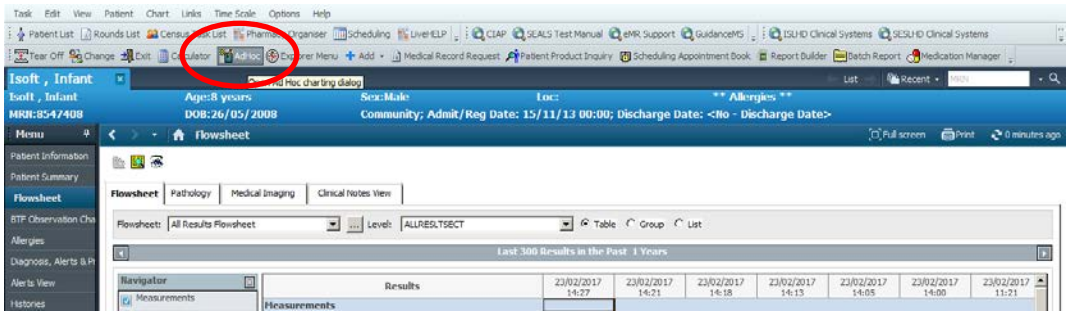
1. World Health Organization Glossary online: http://www.who.int/medicines/areas/coordination/English_Glossary.pdf Accessed 02/07/2013
2. Adverse Drug Reaction Guideline –SCHN http://chw.schn.health.nsw.gov.au/o/documents/policies/guidelines/2013-9082.pdf
3. Australian Commission on Safety and Quality 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.

Appendix A: Processes for Documenting Medications at SCH

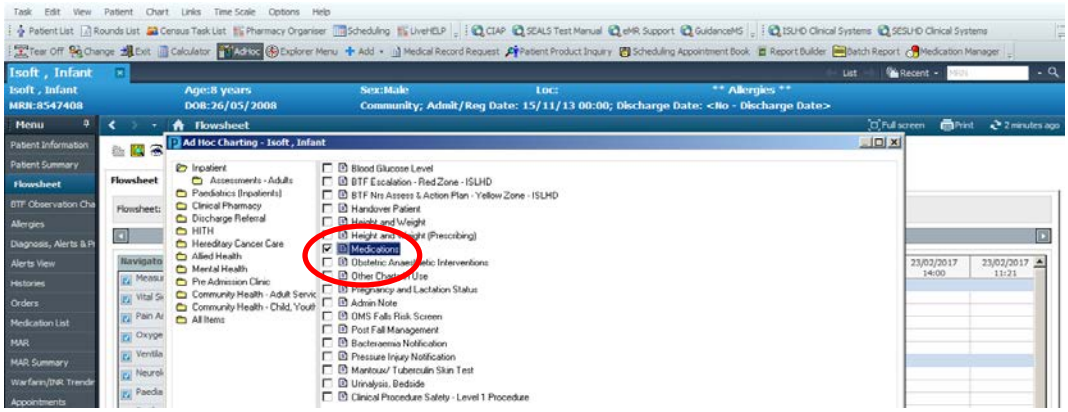
Doctors, nurses and pharmacists at SCH should use the eMR ad hoc charting tool to document the BPMH, update medication lists and confirm changes at discharge.

Obtaining the BPMH

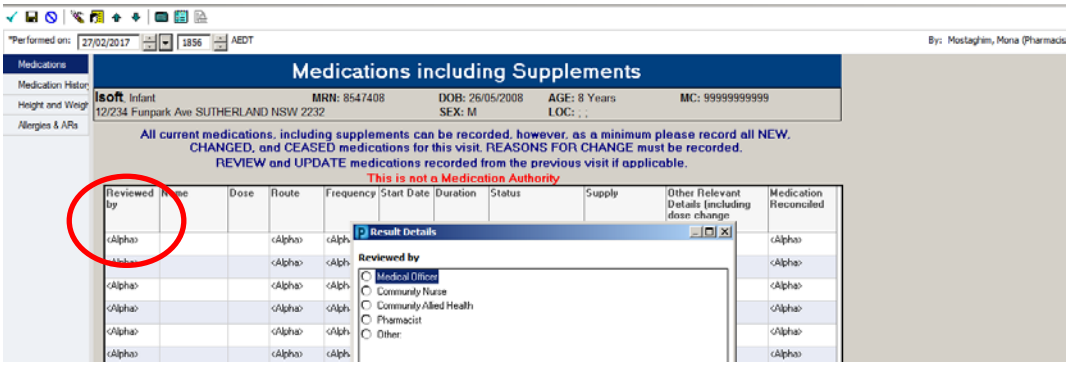
1. Select Ad Hoc Charting



2. Select “medications” and “chart”

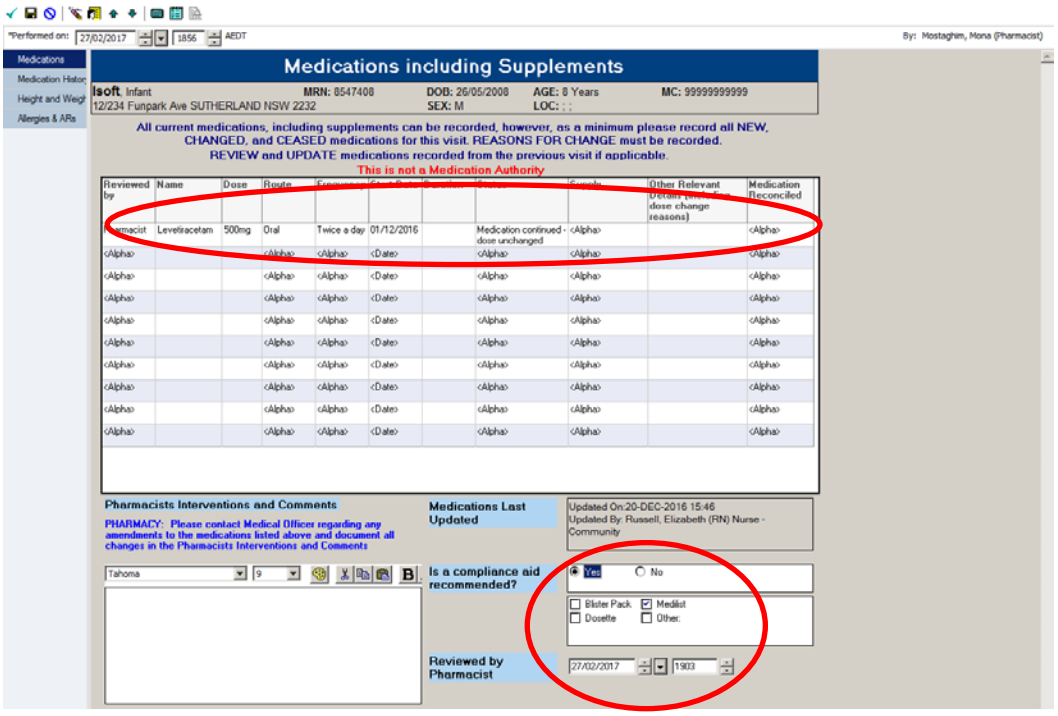


3. Identify your position by clicking in the first cell under the “reviewed by” column and selecting from the listed options

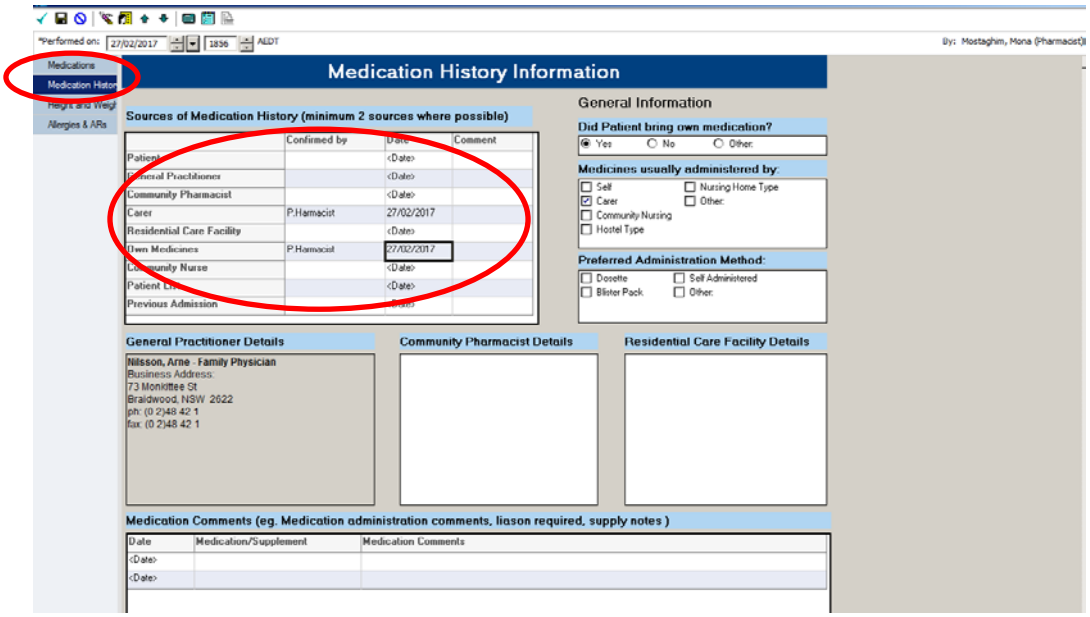


4. Complete the list working across the table.

Additional assessments may be documented including whether a medication list, blister pack or other aids are required. The date and time of documentation should also be documented.

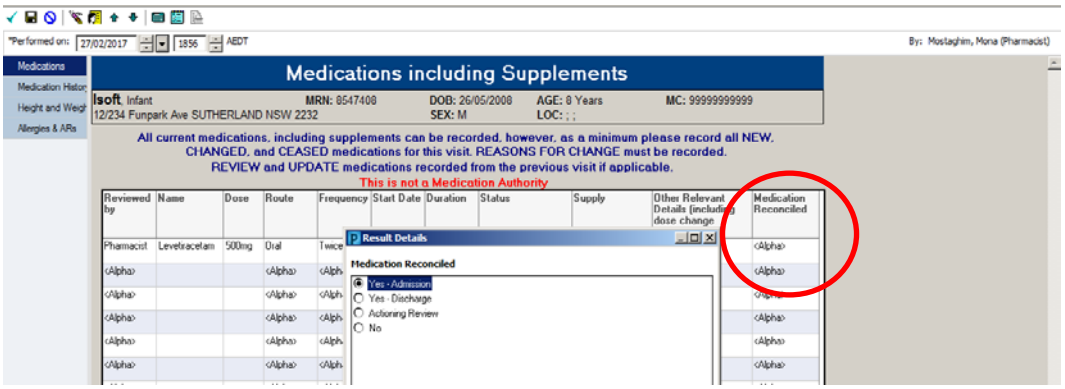


5. Document the sources of information used to obtain the BPMH by selecting the "medication history" tab on the left hand side of the tool and signing your name next to the relevant source.

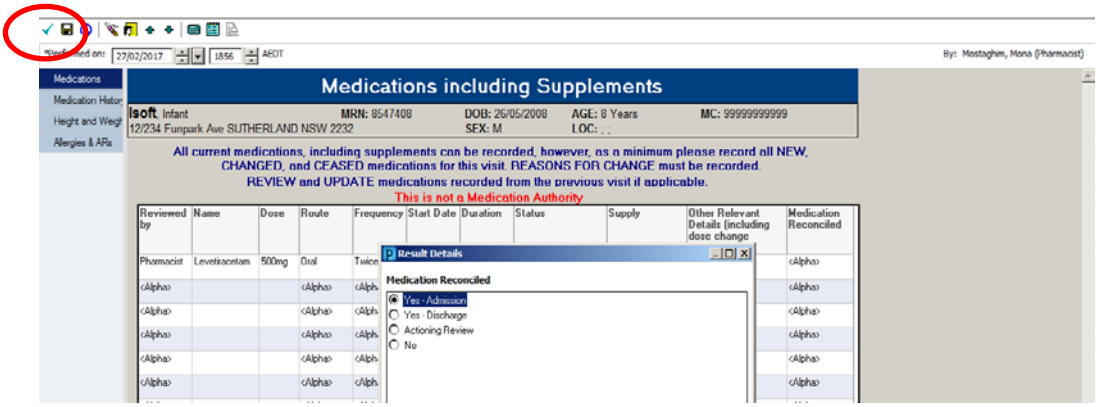


Reconciling the BPMH

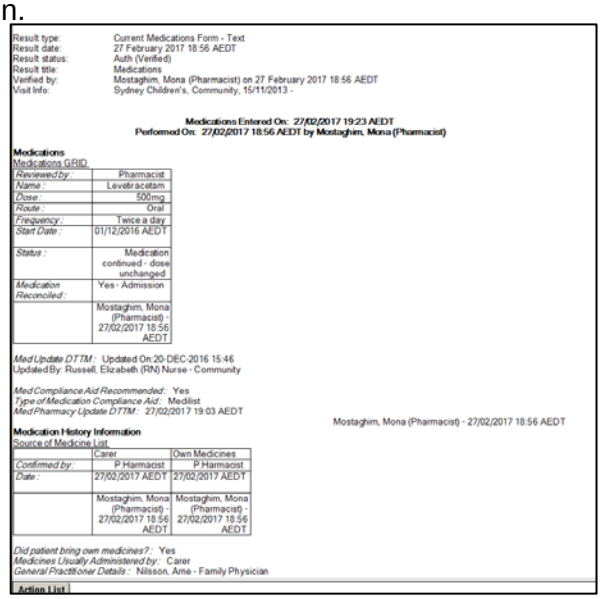
1. In order to reconcile the BPMH within the ad hoc charting medication tool, open the tool. You may be required to re-identify yourself. Click inside the corresponding cell in the "medication reconciliation" column and select the appropriate form of reconciliation i.e., admission or discharge. Select "ok".



2. Finalise the form by selecting the tick sign in the top left hand corner



Once finalised the medications will appear in "flowsheet" under "current medications", in continuous documentation and the documentation tab in powerchart. To produce a printable summary, the list should be accessed from flowsheet or continuous documentation.

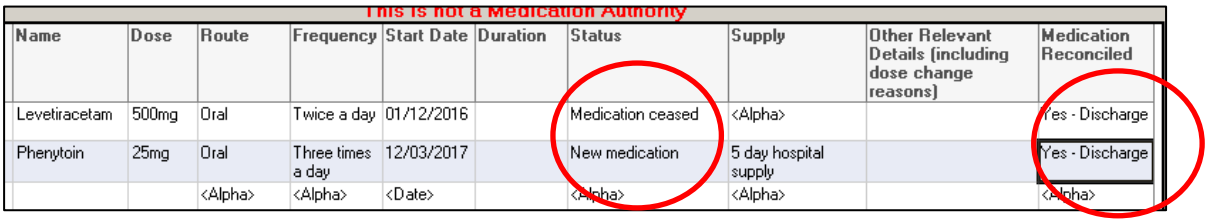


Updating the BPMH with medication changes

The medication history may be updated at transfer of care, including discharge using the same processes outlined under “obtaining a best possible medication history” and “reconciling the BPMH”.

At Discharge

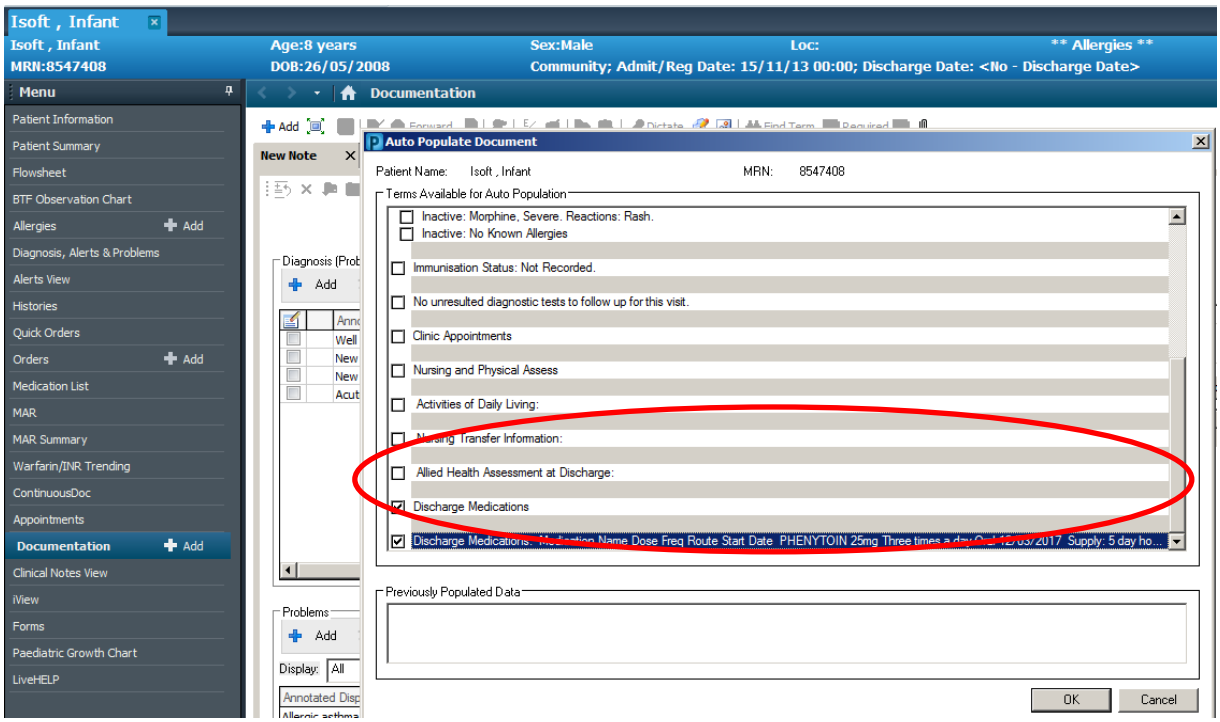
1. The medication list should be reconciled at discharge and any medication changes documented, and signed off by the prescriber.



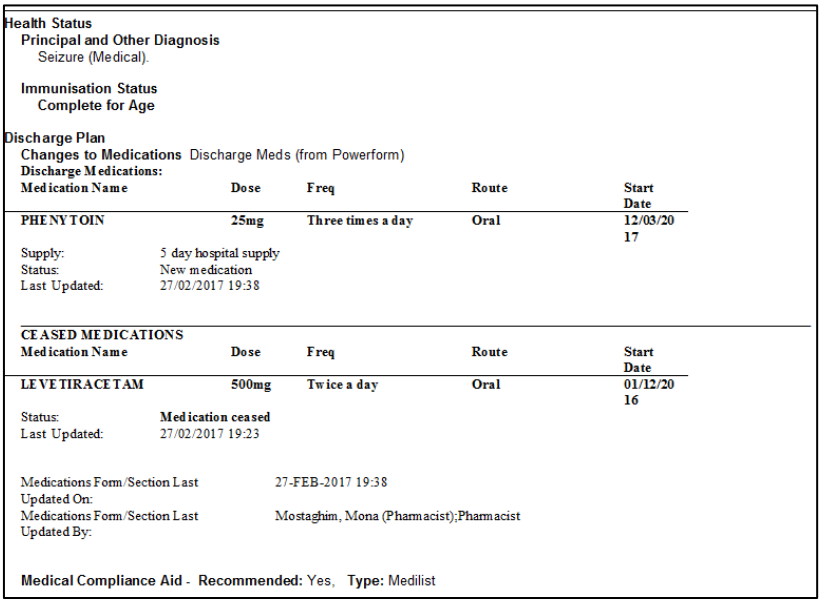
This is not a Medication Authority

Name	Dose	Route	Frequency	Start Date	Duration	Status	Supply	Other Relevant Details (including dose change reasons)	Medication Reconciled
Levetiracetam	500mg	Oral	Twice a day	01/12/2016		Medication ceased	<Alpha>		Yes - Discharge
Phenytoin	25mg	Oral	Three times a day	12/03/2017		New medication	5 day hospital supply		Yes - Discharge
		<Alpha>	<Alpha>	<Date>		<Alpha>	<Alpha>		<Alpha>

2. Medication changes are auto-populated in the discharge summary when “discharge medications” is selected as below:



3. Discharge prescriptions should thereby include a comprehensive summary of medication:



Health Status
Principal and Other Diagnosis
Seizure (Medical).

Immunisation Status
Complete for Age

Discharge Plan
Changes to Medications Discharge Meds (from Powerform)
Discharge Medications:

Medication Name	Dose	Freq	Route	Start Date
PHENYTOIN	25mg	Three times a day	Oral	12/03/2017

Supply: 5 day hospital supply
Status: New medication
Last Updated: 27/02/2017 19:38

CEASED MEDICATIONS

Medication Name	Dose	Freq	Route	Start Date
LEVETIRACETAM	500mg	Twice a day	Oral	01/12/2016

Status: **Medication ceased**
Last Updated: 27/02/2017 19:23

Medications Form/Section Last Updated On: 27-FEB-2017 19:38
Medications Form/Section Last Updated By: Mostaghim, Mona (Pharmacist);Pharmacist

Medical Compliance Aid - **Recommended:** Yes, **Type:** Medilist

4. Discharge summaries with completed medication summaries are used for hospital discharge supplies from SCH pharmacy if the summary has the necessary requirements:

- Include weight and allergies from eMR
- List ALL medications, even if not supplied by SCH
- The “supply” column must be completed to indicate the number of days of therapy needed from SCH pharmacy
- The entire discharge summary must be printed, and each medication page signed by the medical officer
- Printed and signed copy must be delivered to pharmacy

Note 1: Changes to the prescription need to be made by the medical officer, reprinted, signed and received in pharmacy for the medication to be released

Note 2: Electronic prescriptions cannot be used for Schedule 8 **OR** PBS medicines