

SHPA Standards of Practice for the Provision of Medication Reconciliation

These are standards of professional practice and not standards prepared or endorsed by Standards Australia. They are not legally binding.

INTRODUCTION

These standards of practice are based on the recommendations contained in the SHPA standards of practice for clinical pharmacy.¹ When those standards were introduced the term 'medication reconciliation' was not in common usage. The purpose of these standards is to define medication reconciliation and to demonstrate how aspects of the standards of practice for clinical pharmacy can be used to fulfil this obligation.

OBJECTIVE AND DEFINITION

Objective

Medication reconciliation should include processes for the accurate and complete reconciling of medicines, consistent with the continuum of care as required by the Australian Pharmaceutical Advisory Council's guiding principles to achieve continuity in medication management.²

Definition

Medication reconciliation is the standardised process of obtaining a complete and accurate medication history and in the context of the plan for care comparing it to admission, transfer or discharge medication orders. Discrepancies are brought to the attention of the prescriber and if changes are made, they are documented.^{3,7} Medication reconciliation is a vital part of the pharmaceutical review process (Figure 1).

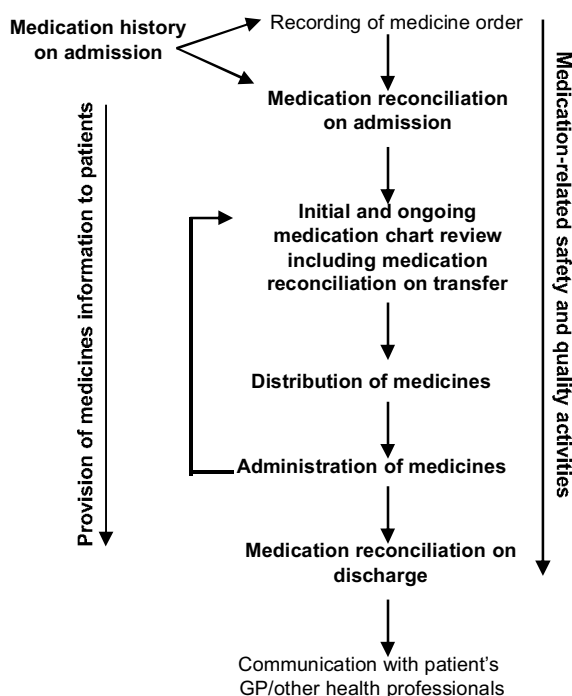


Figure 1. Pharmaceutical review process

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The purpose of medication reconciliation is to ensure patients receive all intended medicines and avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions. It is up to each organisation to determine how this process takes place, but it should be standardised within the organisation. Whenever and however the comparison takes place, it should take place early enough to improve the safety of the organisation's medication management process, and hence consumer safety. Ideally, the information will be available prior to ordering new medicines.³

A medication history is a record of all the medicines actually taken by the consumer in the period before admission or presentation for the episode of care and includes information about previous adverse drug reactions (ADRs) and allergies, and any recently ceased or changed medicines.^{2,6}

Medication reconciliation is a four step process:

- 1. Medication history.** A structured interview conducted at admission with the consumer/carer by an appropriately trained health professional to obtain and document the consumer's medication history, including previous ADRs and allergies, and any recently ceased or changed medicines. Assessment of the consumer's medication taking behaviour including self management and adherence to therapy is also included.
- 2. Confirmation.** Seeking to confirm with the consumer/carer and as many other sources of medication history as deemed appropriate to ensure that the information obtained at interview is correct and comprehensive.
- 3. Reconciliation.**
 - On admission, checking that the confirmed medication history and medicines ordered by the medical officer match, while taking into account the admission plan.
 - During inpatient stay, checking that the confirmed medication history and current medicines are accurately transcribed for every transition the patient makes from one setting to another or when a new medication chart is written up.
 - On discharge, checking that the medicines ordered match the medicines administered at the point of discharge and the discharge plan, reviewing the medication history to check that any medicines withheld on admission have been included where appropriate and that any changes have been noted. Ensure that the reconciled medicines are accurately listed in the discharge summary with the reasons for any changes between admission and discharge.
- 4. Transfer of verified information.** Ensuring that verified medicines information is communicated between all involved in the consumer's care (including the consumer).

EXTENT AND OPERATION

There should be processes in place to ensure that medication reconciliation is performed on admission for every inpatient. This should commence with the taking of an accurate and complete medication history and occur again on each transfer within the organisation or on discharge. An accurate and complete discharge medication list should be provided both to future healthcare providers and to the consumer.

POLICIES AND PROCEDURES

Accurate Medication History

An accurate and complete medication history is a basic step for providing clinical pharmacy services. Pharmacist obtained medication histories have been shown to have a positive effect on patient mortality.⁸ All acute and complex patients should be assessed by a pharmacist as soon as possible after admission. The medication history can be taken by a doctor, pharmacist or registered nurse, although pharmacists have been shown to take the most comprehensive medication histories and were quicker than other health professionals.^{9,10} Pharmacists took 6 to 17 minutes to complete a medication history interview.^{1,8,10} More detailed information on taking an accurate medication history can be found in Appendix A of the standards of practice for clinical pharmacy.¹

The critical component of the accurate medication history is a face-to-face structured interview with the consumer/carer, preferably within 24 hours of admission, or at least before the end of the next working day after admission.¹ The interview may be part of the pre-admission process.

The medication history should list all prescription, non-prescription, and complementary medicines, including herbal and dietary supplements. Ideally, the rationale for the use of each medicine should be identified. For paediatric patients particularly, the formulation of the medicine, how the dose is administered, and the concentration of any mixtures given should be noted.

Consumers/carers should be asked to give consent for health professionals to access their medicine information from other health providers.²

Elective Admissions

An accurate and complete medication history should be documented as part of the pre-admission process. Consumers/carers should be encouraged to bring with them to the pre-admission clinic: all their medicines (prescription and non-prescription medicines, herbal and dietary supplements), lists of medicines, repeat prescriptions, and any other information that could help accurately record what they have been taking (e.g. warfarin book, adverse drug reaction card, CMI). Consumers/carers should be encouraged to have these items with them for reference. Consumers/carers should be advised to continue current medication regimens until their admission. They should be advised which medicines must be withheld before the admission, and of any medicines which are contraindicated or may interact with planned treatment. Any pre-medications required before admission should also be discussed. The plan for ceasing medications prior to procedures should be clearly documented along with the plan for restarting them after the procedure. On admission a check should be made to ensure there have been no changes to medication since the pre-admission clinic. Any medication issues, e.g. compliance, possible ADRs or interactions, should be flagged for attention and addressed before discharge.²

Not all elective admissions have a pre-admission process, e.g. medical admissions, and the medication history should be documented within 24 hours of admission.

Unplanned Admissions

An accurate and complete medication history should be documented as early as possible in the episode of care. This may be difficult depending on the consumer's condition. The emergency medicines pharmacist may be ideally placed to obtain a medication history on admission.¹² Because of the consumer's acute condition and the possible absence of the various prompts (e.g. medicines, repeat prescriptions) it may take longer to obtain and confirm the medication history.

Information may be gathered over several interviews as the consumer/carer recall their medicines and/or the prompts become available. It is important for the medication history to be documented in a way that allows it to be readily accessed and amended or updated when new information becomes available. It is important that issues identified when the medication history is taken are addressed as soon as possible.²

Confirmation

To ensure that the information obtained at interview with the consumer/carer is complete an effort should be made to confirm the information with a second source (e.g. GP, community pharmacist, consumer's own medicines). However, this may not always be possible.

Although a consumer/carer interview should be the primary source of data, a combination of information sources can be used to obtain and validate the medication history. If the consumer is not responsible for medication administration or if a reliable medication history cannot be obtained from the consumer/carer, then alternative sources of patient information should be accessed. These information sources include:

- previous medication dispensing history and/or administration records;
- other health professionals; and
- consumer's own medicines or list of medicines.

Confirmation is a dynamic process, and if more information becomes available reconciliation should occur again.

Reconciliation

The accurate medication history and plan for care should be reconciled against medicines prescribed on admission and discrepancies must be resolved. The reviewer should confer with the prescriber to ascertain whether discrepancies in therapy are intentional or unintentional, and document any resulting changes. Each time a consumer is transferred from one setting to another, whether within the facility or discharged, a reconciliation of their medicines should occur. The previous medication orders should be reviewed alongside new orders and plan for care and again any discrepancies must be resolved.

Transfer of Verified Information

When a consumer is transferred to another episode of care, the transferring health professional should supply comprehensive, complete and accurate information to the health care provider responsible for continuing the consumer's medication management and to the consumer in accordance with their Medication Action Plan. More information is obtained in Appendix I of the SHPA standards of practice for clinical pharmacy.¹ This verified information that should be provided includes the:

- medicine that was issued at transfer and intended source for further supply;
- current treatment regimen (complete and accurate list of *all* current medicines), including the medicine, route, dosage, frequency, dose form, reason for use and intended duration of therapy; and
- description of changes to therapy during the episode of care.⁵

The method of information delivery should be timely, mutually agreed among health care providers, have the consumer's consent and be consistent with privacy and confidentiality legislation.

Consumers should be encouraged to have a current list of their medicines, know about their own medicines, and to bring the list along with them to each healthcare facility.¹³ In the case where the consumer is unable to undertake this task the carer should take responsibility.

RESOURCES

Resources available in hospital settings necessary to carry out meaningful medication reconciliation include sufficient trained staff, appropriate computer software and access, forms for documenting medication histories and the reconciliation process, telephone, electronic transfer or facsimile facilities.

STAFFING STRUCTURE AND LEVELS

Health service managers should provide leadership to ensure that the systems exist and resources are provided to enable medication management along the continuum of care.² There should be sufficient pharmacists to ensure that all elective and non-planned admission consumers have an accurate medication history taken in a timely manner, medicines are reconciled and all discharged consumers are given a discharge summary containing verified medication information.

QUALITY ASSURANCE AND DOCUMENTATION

Documentation should include:

- accurate and complete medication history;
- variances in medication and action taken;
- issues identified when taking the medication history and action taken; and
- discharge summary and Medication Action Plan containing verified medication information.

Good records assist medication reconciliation and provide evidence of professional services. Details of the medication history may be entered on the consumer's medication chart. However, this record may be lost from the bedside when another chart is commenced. There is also insufficient space to record all the details required for the most comprehensive ongoing care.

Ideally, the accurate medication history and evidence of medication reconciliation throughout the episode of care should be documented on a purpose-designed form or in an electronic format. This medication history and reconciliation (MHR) form should be an official hospital form and should remain with the consumer's active medication chart in the bedside folder for the duration of the admission. It should then be filed in the medical record with the medication chart on discharge. The MHR form would aid communication within the healthcare team, to other healthcare providers and for the next episode of care. It may also be recorded in the pharmacy information system (but not at the exclusion of documentation in the medical record). Details that need to be contained in the MHR form are shown in Appendix 1.

The MHR form together with the medication chart should be used to reconcile the discharge prescription. It should be referred to when producing the discharge medication record for the consumer and for discharge liaison with the GP, community pharmacist or nursing home.

Key Performance Indicators

Performance indicators of reconciliation processes within the organisation could include:¹⁴

- percentage of patients whose current medications are documented and reconciled at admission; and
- percentage of admitted patients with a list of known and verified adverse drug reactions documented within 24 hours.

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Appendix 1. Medication history and reconciliation form

Minimum details to be included on the form

- Consumer details
- Date of documentation
- Name of health professional recording the medication history
- Details of medications taken prior to presentation: medicine identified (active ingredient name, brand name, strength, dose form); dose, route and administration schedule (as taken by consumer); when started/duration of therapy; action/indication (as reported by consumer)
- Data source and contact details (where applicable): carers/family; nursing home; community pharmacist; GP; community nurse; St John Ambulance's 'MedicAlert' bracelet and wallet card; consumer's medications; previous hospital records
- Information about previous adverse medicine events and allergies
- Other medication information: patient has and uses own medication list; dose administration aid (e.g. Doseette, Webster-Pak); use of administration device (e.g. nebuliser, spacer)
- Checklist of questions asked in the medication history interview
- Documented evidence that each medicine in the consumer's medication history has been reconciled on admission

Other details that may be recorded on the form

- Presenting complaint
- Past medical history
- Admission weight and height
- Relevant biochemical data
- Documented evidence that medicines have been reconciled at each transfer and on discharge
- Supply on discharge
- Location of consumer's own medications
- Comments: medication and social issues
- Risk assessment: lives alone; history of non-compliance; cognitive impairment; more than four regular medications on admission; recent hospital admissions; medication changes during admission; cannot read; language difficulties; renal or hepatic impairment
- Home visit or HMR referral recommended
- Discharge tasks documented and signed for including: medication counselling; Consumer Medicine Information provided; Discharge Medication Record provided; medication supplied; medication management device supplied; community liaison pharmacist referral; discharge summary provided and where it has been sent

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