Medication Reconciliation

Alwyn Rehab Hospital

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.'

Santell JP Jt Comm, J Qual Patient Safety , 2006

Why do we need to do Medication Reconciliation

Unintentional changes to patients' medicine regimens often happen during hospital admissions, and can cause patient harm during a hospital stay or after discharge:

- Between 10% and 67% of medication histories have at least one error, and up to 33% of these errors have the potential to cause patient harm
- More than 50% of medication errors occur at transitions of care
- 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
- 85% of discrepancies in medication treatment originate from poor medication history taking.

Matching up medicines can help ensure continuity of care, and prevent harm by reducing the opportunity for medication errors.

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 should involve a patient medication interview, where possible.

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.

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 e.g. atenolol ceased prior to surgery.

Supply accurate medicines information

When patients are transferred between 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.

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?

Bruce's Story

68 years of age Retired engineer Former smoker
Enjoys his garden Goes to club 2 -3 times a week
Has COPD, hypertension and recently diagnosed with AF

Bruce's Story

Presents to ED with exacerbation of his COPD •
Admission history taken by RMO •
Medication history taken with assistance of GP refer
ral letter •
History documented in patient's progress notes

Bruce's Story

Medication history documented
Atrovent 2 puffs qid
Seretide 250mg 2 puffs BD
Ventolin 2 puffs prn
Frusemide 40mg mane & midi
Cardizem 240mg OD
Amiodarone 200mg OD
Warfarin mdu
Paracetamol prn for joint pain
Voltaren gel recently

Bruce's Story

Bloods taken INR 4 Treatment decision documented in notes "withhold warfarin until INR therapeutic"

Bruce's Story

Medication charted
Atrovent neb 4 hrly
Seretide 250mg 2puffs BD
Ventolin neb 5mg 6 hrly prn
Frusemide 40mg po mane & midi
Cardizem CD 240mg po mane
Amiodarone 200mg po mane
Paracetamol 2 prn for pain
Prednisone 25mg daily for 7 days
Ampicillin 1g IV 6hrly

Bruce's Story

5 days later Bruce seen by the team Decision to discharge
Ambulance booked for 10am next day
9am RMO paged to write D/C script
Script written from current medication chart. 1 month supply ordered 9.15am script arrived in pharmacy

Bruce's Story

9.30am ward staff ring pharmacy inquiring whether Bruce's D/C medicati
ons are ready as ambulance arriving at 10am
1 month supply medicines dispensed
Bruce's medicines list prepared in the pharmacy
from the discharge prescription and placed in bag with his medicines
10am ambulance officer collects Bruce's D/C medicines from pharmacy

Bruce's Story

Medicines on D/C prescription, patient's medicines list
Atrovent 2 puffs qid
Seretide 250mg 2puffs BD
Ventolin 2 puffs prn
Frusemide 40mg mane & midi
Cardizem 240mg mane
Amiodarone 200mg mane
Prednisone 25mg daily for 2 days
Paracetamol prn

Bruce's Story

Bruce made an appointment to see his GP the week
after he was discharged
5 days following his discharge Bruce suffered a stroke was paralysed
down one side and unable to speak

Assessment

You have now completed this training module.

You will be asked to complete a quiz.

To access the assessment, click here.