How do I obtain the 'most accurate' medicine, allergies and ADRs list for a patient?

Wherever appropriate, interview the patient or their carer/family. Ensure the patient knows who you are and why you are gathering this information. Explain about the value of the medication history and possible consequences if it is inaccurate. The patient is more likely to provide accurate information if they understand its importance.

Approach the review in a systematic way. 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 and route of administration
- the duration of treatment
- the indication for therapy
- recent changes to treatment
- previous adverse drug reactions and allergies.

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. The following transition points require special attention:

- admission to hospital
- transfer from the emergency department to other care areas or home
- transfer from intensive care to the ward
- transfer or discharge 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 right now?
- 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 between medical, nursing, ambulance and pharmacy staff involved in the patient's care AND the patient, their carer or family members is vital for its success.

References:

1. World Health Organisation. 2007. Assuring Medication Accuracy at Transitions of Healthcare. Patient Safety Solution Volume 1, Solution 6. URL: http://www.ccforpatientsafety.org/. Accessed 1 June 2011.
2. Tam VC, Knowles SR, Cornish PL, et al. 2005. Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review. CMAJ 173(5): 510-5.
3. Cornish PL, Knowles SR, Marchesano R, et al. 2005. Archives of Internal Medicine 165: 424 -9.
4. Sullivan C, Gleason KM, Rooney D, et al. 2005. Medication reconciliation in the acute care setting: opportunity and challenge for nursing. Journal of Nursing Care Quality 20: 95-98.
5. Stowasser DA, Stowasser M, Collins DM. 2002. A randomised controlled trial of medication liaison services - acceptance and use by health professionals. Journal of Pharmacy Practice and Research 32: 133-40.
6. Gleason KM, McDaniel MR, Feinglass J, et al. 2010. Results of the Medications At Transitions and Clinical Handoffs (MATCH) study: an analysis of medication reconciliation errors and risk factors at hospital admission. Journal of General Internal Medicine 25(5):441-447.
7. Safe Medication Management Programme. 2011. Medicine Reconciliation Standards, Version 2, January 2011 http://www.safemedication.org.nz. Accessed 1 June 2011.

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

newzealand.govt.nz

Produced by the Health Quality and Safety Commission as part of the Medication Safety programme. www.hqsc.govt.nz

New Zealand's Health Quality and Safety Commission thanks the Australian Commission on Safety and Quality in Health Care for permission to use their match up medicines materials.

Medicine Reconciliation

A guide for health professionals

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Medicine reconciliation

Changes to patients' medicine often happen during transitions of care, ie, admission, transfer or discharge from health care facilities. Some of these changes are unintentional due to poor information and some are intentional but not clearly documented. Both types of change can result in medication errors and/or patient harm.

Medicine reconciliation is about obtaining the most accurate list possible of patient medicines, allergies and adverse drug reactions (ADRs) and comparing this with the prescribed medicines and documented allergies and ADRs. Any discrepancies are then documented and reconciled.

Medicine reconciliation is an evidence-based process, which has been demonstrated to significantly reduce medication errors or medication-related harm that can occur at transition points of care[1].

Did you know?

International studies show:

- between 10 and 67 percent of medication histories have at least one error[2]
- up to one-third of these errors have the potential to cause patient harm[3]
- more than 50 percent of medication errors occur at transitions of care[4]
- 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[5]
- 85 percent of discrepancies in medication treatment originate from poor medication history taking[6].

For more information on medicine reconciliation, email: info@hqsc.govt.nz

3 key steps to improve patient safety[7]

1. Collect the most accurate list of medicines, allergies and ADRs from a minimum of two source types.

There is a difference between medication history taking and obtaining the 'most accurate' list of medicines, allergies and ADRs.

Consult and confirm with the patient (or family/caregivers) first, when possible, prior to using secondary sources like the GP or community pharmacist.

Include prescription, over-the-counter and complementary medicines.

2. Compare the most accurate list of medicines, allergies and ADRs with the prescribed medicines, allergies and ADRs. Check that these match or that any changes are clinically appropriate.

Any differences found not documented (ie undocumented) even if clinically indicated, are a discrepancy.

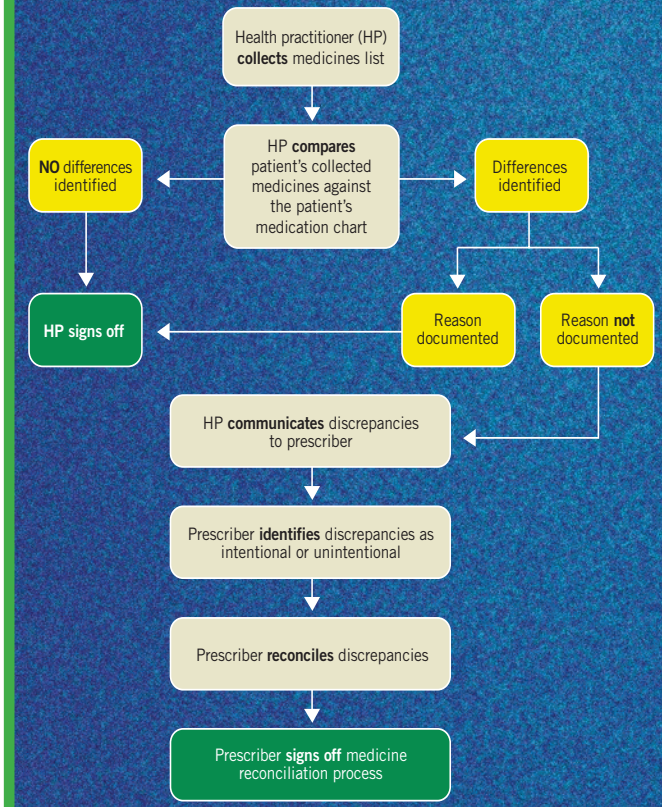
3. Communicate the most accurate list of medicines, allergies and ADRs information.

Accurate communication of changes to a patient's medicines, allergies and ADR list is essential in reducing medication errors.

Where there are discrepancies, the prescriber must reconcile these and ensure that the changes and the reasons for them are documented so that appropriate patient care can continue.

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 the patient's most accurate list of medicines, allergies and ADRs.

Medicine Reconciliation Process



Footnote: Allergies and ADR differences found are presented to the prescriber for an appropriate clinical decision and documentation. They are classified as differences rather than discrepancies as they are unable to be reconciled.