

A3 size poster

MATCH UP medicines

Medication reconciliation prevents harm.
 Why? Because up to two thirds of medication histories have errors, and a third of these errors can cause harm.¹
 As patients move through the health system, information about their medicines needs to be current, accurate and move with them during transitions of care – on admission, transfer and discharge. Medication Reconciliation is the process of ensuring this information is accurate and clearly documented.

4 steps to improve patient safety

- 1** Obtain a best possible medication history
name of medicine, dose, frequency and route
- 2** Confirm the accuracy of the history of the history
with a second source e.g. patient's medicines, medication list, GP, community pharmacy
- 3** Reconcile the history with prescribed medicines
bring discrepancies to the attention of the prescriber and document changes
- 4** Ensure accurate medicines information when care is transferred to involving clinician, patient or carer

Medrec
 matching medicines at transitions of care

For more information about medication reconciliation contact:
References: 1. Tam VC, Knowles SR et al. CMAJ 2005;173:850-4.
 2. Cornish PL, Knowles SR et al. Arch Intern Med 2005;165:424-9.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

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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 members is vital for its success.

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

References: 1. Tam VC, Knowles SR et al. CMAJ 2005;173(9): 510-5. 2. Cornish PL, Knowles SR et al. Arch Intern Med 2005;165(4):4-9. 3. Sullivan G, Gleason KM et al. J Nurs Care Qual 2005; 20:95-98. 4. Stowasser DA, Stowasser M, Collins DM. Journal of Pharmacy Practice and Research 2002;22:133-40. 5. Gleason KM, McDaniel RR et al. J Gen Intern Med. DOI:10.1007/s11666-010-1256-6.

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A guide to Medication Reconciliation.

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