The Case for Medication Reconciliation

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- 2 – 3% of all hospital admissions medication related
- Up to 30% unplanned geriatric admissions associated with adverse medicines event
- Approx 190,000 admissions per year
- Estimated cost $660m per year

1. Roughead E, Semple S, Aust and NZ Health Policy 2009
National Medication Scoping Study

- 45 recommendations for improving the safety and quality of medicines use nationally
- 6 high priority recommendations for action by Commission

Recommended Commission actions

High Priority

- Medication accuracy at transitions in care/medication reconciliation
- Lead identification and development of standardisation initiatives
- Standards for user applied labels for medicines in hospitals
- Additional standard medication charts
  - Insulin, residential care, e-version for GPs in rural sector
- Guidance document on safe e-medication management (e-prescribing/administering) systems
  - Requirements, implementation, “look and feel”
- Share lessons nationally through safety alerts, bulletins
Continuity of care

- Key area for improving patient safety
- Interfaces of care prone to error
  - Over 50% of hospital medication errors occur at interfaces of care\(^1\)
- Potential target for interventions to reduce medication error
- Recommendation 11: *Promote medication reconciliation at care transition points*

\(^1\) Sullivan C, Gleason KM et al, *J Nurs Care Qual* 2005
‘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.’

Why medication reconciliation?

Errors on admission

• 10 – 67% medication histories have at least one error ¹
• 85% of prescribing errors at transition of care originate in the medication history and carry through to inpatient orders ²
• Up to one third of these errors have potential to cause harm ³
• Patients ≥ 65 years over 2 times more likely to require treatment/monitoring following an medication error on transition of care ²

1. Tam VC, Knowles SR et al, CMAJ 2005
3. Cornish PL, Knowles SR, Archives Int Med 2005
Why medication reconciliation?

At discharge (Aust data)

- 12% of patients have an error in their discharge prescription\(^1\)
- 15% of discharge medications have discrepancies when reconciled with the medication chart \(^2\)
- Readmission 2.3 times more likely if ≥1 medicines unintentionally omitted from discharge summary\(^3\)

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Why medication reconciliation?

Medication reconciliation reduces errors and adverse events

On admission
- 50% decrease in no. patients with errors on admission
- > 50% decrease in no. patients with errors likely to cause possible or probable harm

Admission, transfer and discharge
- Errors reduced from 213 to 50 per 100 admissions

1. Tam VE, Knowles SR et al CMAJ, 2005
2. Rozich JD, Rsear RK et al Jt Comm J Qual Saf, 2004
Why medication reconciliation?

Reduces workload and rework
- Nursing time at admission $\downarrow > 20$ mins per pt
- Pharmacists time in patient discharge $\downarrow > 40$ mins per pt

Cost effective
- Medication reconciliation interventions at admission cost effective
- Pharmacist-led reconciliation intervention had highest expected net benefits
- *Medication reconciliation cost effective use of NHS resources* 2

1. Rozich JD, Regar RK, Jt Comm J Qual Saf. 2004
Guiding Principle 4
Accurate medication history

An accurate and complete medication history should be obtained and documented at the time of presentation or admission, or as early as possible in the episode of care.

Guiding Principle 6
Medication Action Plan

A Medication Action Plan should:
• be developed with the consumer and relevant health care professionals as early as possible in the episode of care
• form an integral part of care planning for the consumer
• be reviewed during the episode of care and before transfer.

Guiding Principle 9
Communicating medicines information

When a consumer is transferred to another episode of care, the transferring health care provider(s) should supply comprehensive, complete and accurate information to the health care provider(s) responsible for continuing the consumer’s medication management in accordance with their Medication Action Plan.
International Medication Reconciliation Activities

The Joint Commission (US) – National Patient Safety Goal & Accreditation requirement
  • Goal 8 ‘Accurately and completely reconcile medications across the continuum of care’

Canadian Patient Safety Institute – SAFER HEALTHCARE NOW!
  • Medication reconciliation collaborative (500 sites)

Institute for Health Care Improvement (IHI)
  • One of twelve initiatives in 5 million Lives Campaign

2006 WHO Patient Safety Alliance High 5s initiative
  • Assuring medication accuracy at transitions of care
What is the Commission doing?

Medication Continuity Expert Advisory Group

Role
- Advise on conduct of High 5s Medication Reconciliation project
- Advise on national strategies for improving continuity of medication management
- Advise on implementation strategies
  - includes National Medication Management Plan
What is the Commission doing?

**High 5s Project**

- 5 patients safety solutions, 5 countries over 5 years.
- ASQCHC leading clinical handover
- Lead technical agency for Australian High 5s project: *Assuring Medication Accuracy at Transitions of Care* through process of medication reconciliation
High 5s Medication Reconciliation Project

Aim
- Test the feasibility of implementing a standardised medication reconciliation protocol (SOP)
- Determine effect on specified patient safety outcomes
- Publish results and refined SOPs for general implementation

Scope of project – Phase 1
- Patients \( \geq 65 \) years of age
- Admitted to hospital through ED
- Reconciliation on admission

SOP aligns with APAC Guiding Principles to achieve continuity of medication management
National Safety and Quality Standards

Medication Safety Standard Criteria relevant to medication reconciliation

B. Documentation of patient information

The clinical workforce accurately records a patient’s medication history and it is available throughout the episode of care.

*Includes reviewing the patients’ current medication orders against their medication history and reconciling any discrepancies.*

E. Continuity of medication management

The clinician provides a complete list of a patient’s medicines to the receiving clinician and patient when handing over care or changing medicines.
Medication Reconciliation Resources

Toolkit

- Educational materials
  - MATCH UP Medicines – Matching medicines at transitions of care
- National Medication Management Plan (MMP)
- MMP training material
- Admission history training resource
- Other support material
MATCH UP medicines
Medication reconciliation prevents harm.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

Medrec
matching medicines at transitions of care