MATCH UP medicines

Medication reconciliation prevents harm.

USING THE Medication Management Plan

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

Medrec

Overview

- Medication errors at interfaces of care
- What is **Medication Reconciliation?**
- Why medication reconciliation is important
- What is a **Best Possible Medication History?**
- Using **Medication Management Plan** (MMP) to record the BPMH and medication reconciliation

Medication errors at interfaces of care

- Medication errors are one of the leading causes of injury to hospital patients
- More than 50% of medication errors occur at transitions of care[1]
  - **Admission, transfer and discharge**
- 20% of adverse drug events result from errors at interfaces of care[2]

Medication Reconciliation

Aim: Reduce medication errors and prevent adverse drug events at transfer of care

How: 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. Any changes are documented.[3]

Medication Reconciliation Steps

Involves:

1. **Compiling a best possible medication history (BPMH)** via a structured interview

2. **Confirming** the medication history with at least one other source

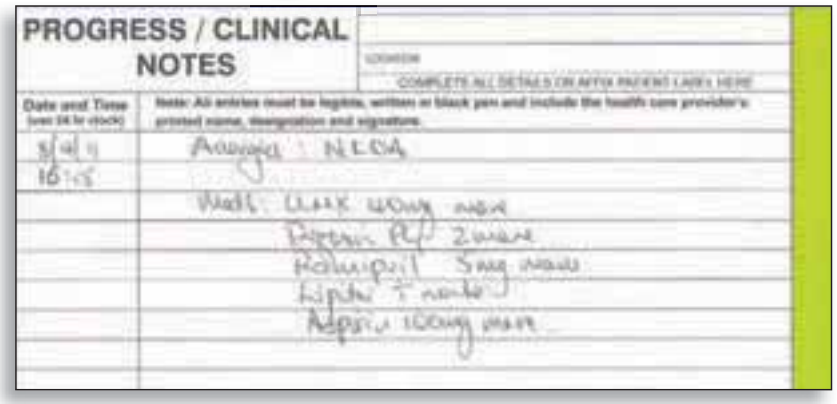
3. **Reconciling the BPMH** with medication orders on admission, transfer and discharge

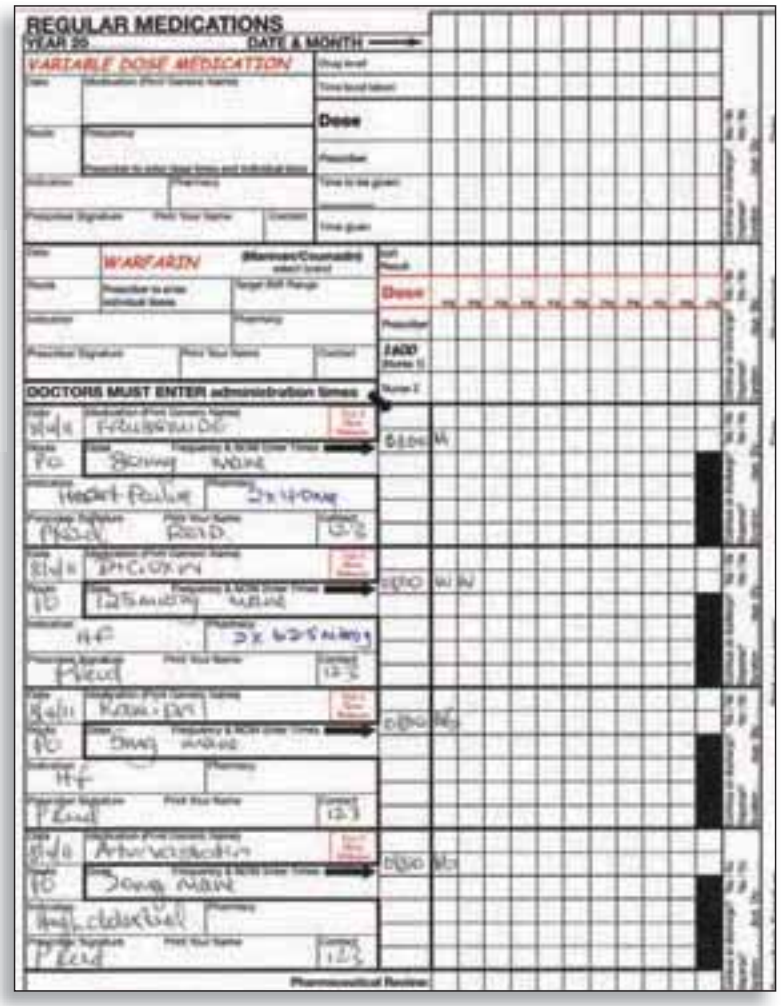
4. **Supplying** accurate medicines information when care is transferred

Why is Medication Reconciliation important?

- Up to 67% of medication histories contain one or more errors[4]
- Up to a third have potential to cause harm[5]
- 30 – 70% patients ≥ 1 unintended variation between medication history and admission orders [5,6]
- 12 – 15% patients have an error on discharge prescription[7,8]
- Readmission 2.3 times more likely if ≥ 1 medicines unintentionally omitted from the discharge summary[9]

Common System Failures - example





System Failures - examples

Case 1.

"Thyroxine omitted from drug chart on admission. Not noted throughout her stay and sent home without [medicine]. GP noted omission [on date] and restarted after showing clear cut hypothyroidism. Readmitted with worsening of her pre-existing extensive co-morbidity. Initially did well but deteriorated and died days following admission".

Case 2.

"Failure to re-prescribe cardiovascular medication prior to discharge. The drugs were correctly stopped on admission due to cardiovascular instability following a significant upper gastrointestinal bleed. The patient after discharge became symptomatic with probable congestive cardiac failure, saw her GP who reinstated [the] medication. Unfortunately, the patient died at home [a few] days after discharge."

System Failures - examples

Case 1.

"Thyroxine omitted from drug chart on admission. Not noted throughout her stay and sent home without [medicine]. GP noted omission [on date] and restarted after showing clear cut hypothyroidism. Readmitted with worsening of her pre-existing extensive co-morbidity. Initially did well but deteriorated and died days following admission".

Case 2.

"Failure to re-prescribe cardiovascular medication prior to discharge. The drugs were correctly stopped on admission due to cardiovascular instability following a significant upper gastrointestinal bleed. The patient after discharge became symptomatic with probable congestive cardiac failure, saw her GP who reinstated [the] medication. Unfortunately, the patient died at home [a few] days after discharge."

System Failures - examples

Case 1.

"Thyroxine omitted from drug chart on admission. Not noted throughout her stay and sent home without [medicine]. GP noted omission [on date] and restarted after showing clear cut hypothyroidism. Readmitted with worsening of her pre-existing extensive co-morbidity. Initially did well but deteriorated and died days following admission".

Case 2.

"Failure to re-prescribe cardiovascular medication prior to discharge. The drugs were correctly stopped on admission due to cardiovascular instability following a significant upper gastrointestinal bleed. The patient after discharge became symptomatic with probable congestive cardiac failure, saw her GP who reinstated [the] medication. Unfortunately, the patient died at home [a few] days after discharge."

Can medication reconciliation reduce medication errors?

Stage of reconciliation	Medication errors before medication reconciliation	Medication errors after medication reconciliation
Admission[10]	**60%** patients	**5%** patients
Transfer from ICU[11]	**94%** patients	near zero
Admission, transfer and discharge[12]	213 errors/100 admissions	50 errors/100 admissions

Key components of a successful process

- Formal, structured process
  - Assigned roles (BPMH, reconciliation)
- Strong collaboration and team work
  - Shared accountability (doctors, nurses, pharmacists)
  - Includes patient, carer or family member
- Timely
  - Ideally within 24 hours of admission
- Standardised form to document history and reconciliation
  - Medication Management Plan

National Medication Management Plan

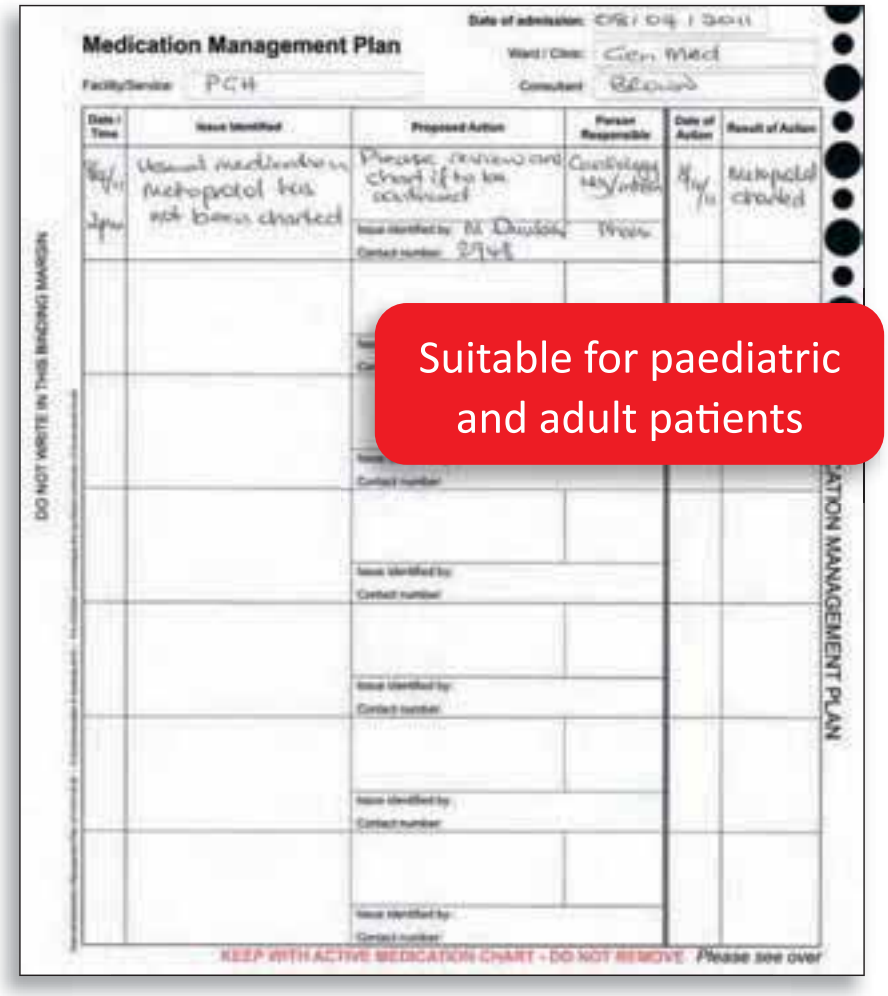
Supports steps of Medrec

1. Obtain and document Best Possible Medication History (BPMH)

2. Confirm the medication history

3. Reconcile history with prescribed medicines. Document issues, discrepancies and actions

4. Supply accurate information when care transferred

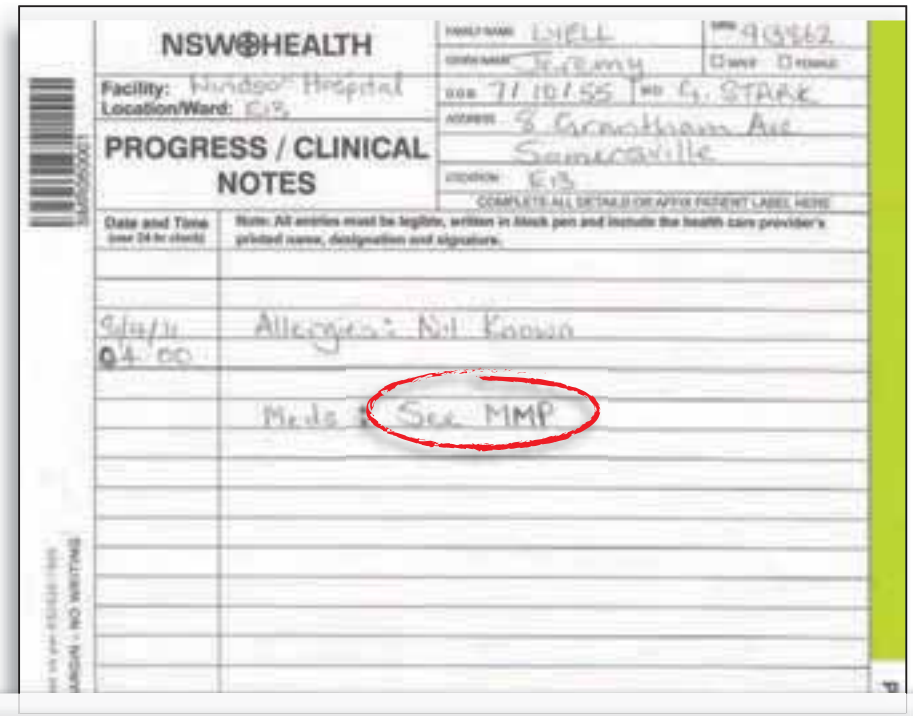


AUSTRALIANCOMMISSIONON SAFETYANDQUALITYINHEALTHCARE

Medrec

Benefits of the MMP

- The MMP is the one place that BPMH and medication issues are recorded (no need to search through the notes to find the truth!)
- In the progress notes Clinicians can write "see MMP" for medication history
- No need for repetitive history taking and documentation in the progress notes
- Saves TIME!
- Improves efficiency at discharge



Best Possible Medication History

"A BPMH is a medication history obtained by a clinician which includes a thorough history of all regular medication use (prescribed and non-prescribed), using a number of different sources of information" [13]

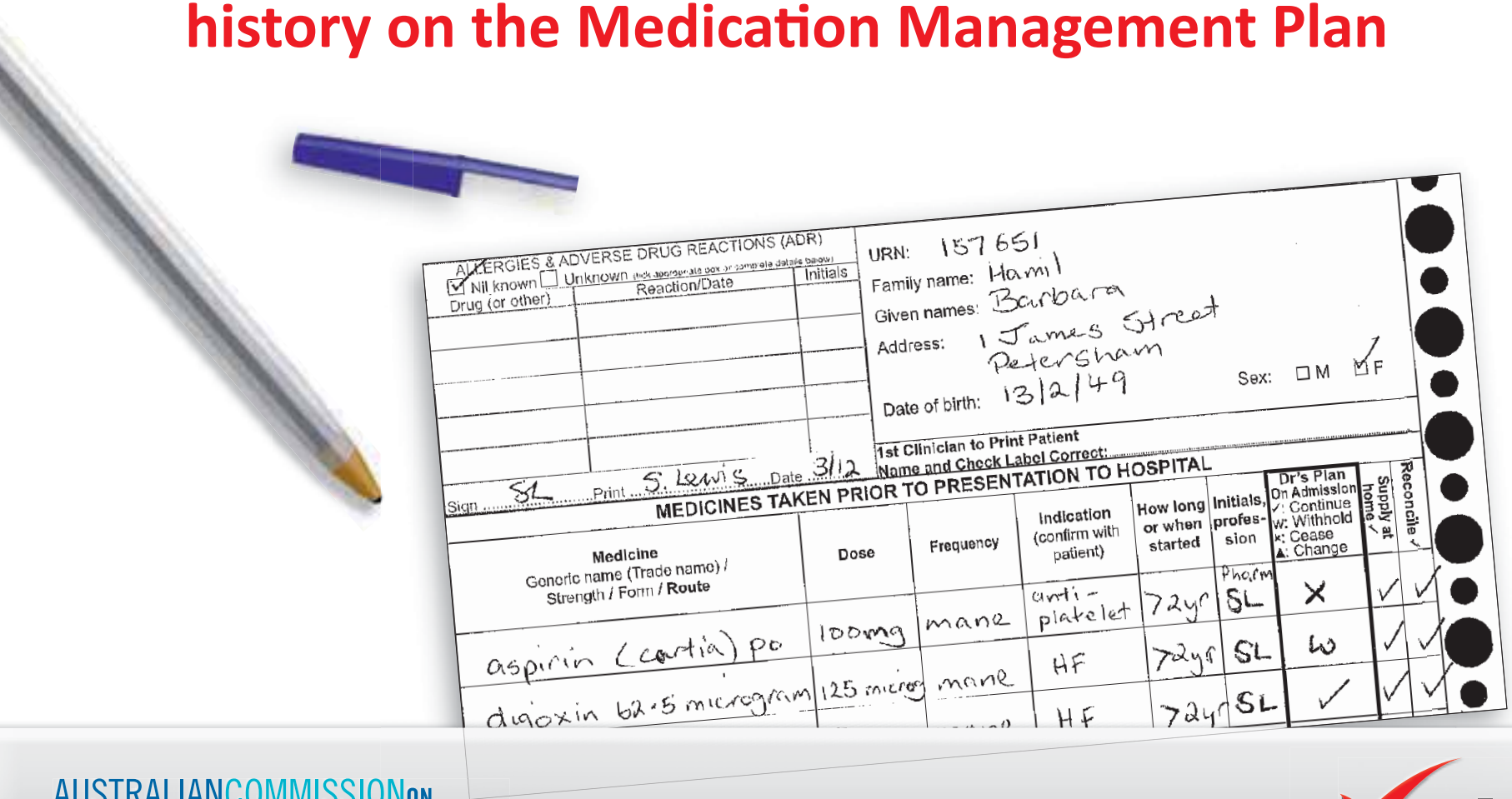
It is the baseline from which:

- drug treatment is continued on admission
- therapeutic interventions are made
- self caring will be continued after discharge

Content of Best Possible Medication History

- Details of previous adverse drug events (ADEs) and allergies
- ALL medicines a consumer is taking at the time of presentation to hospital:
  - Prescribed medicines
  - Non-prescribed, over-the counter (OTC) medicines
  - Complementary/herbal medicines
  - PRN meds
- Recently ceased or changed medication

Recording the best possible medication history on the Medication Management Plan



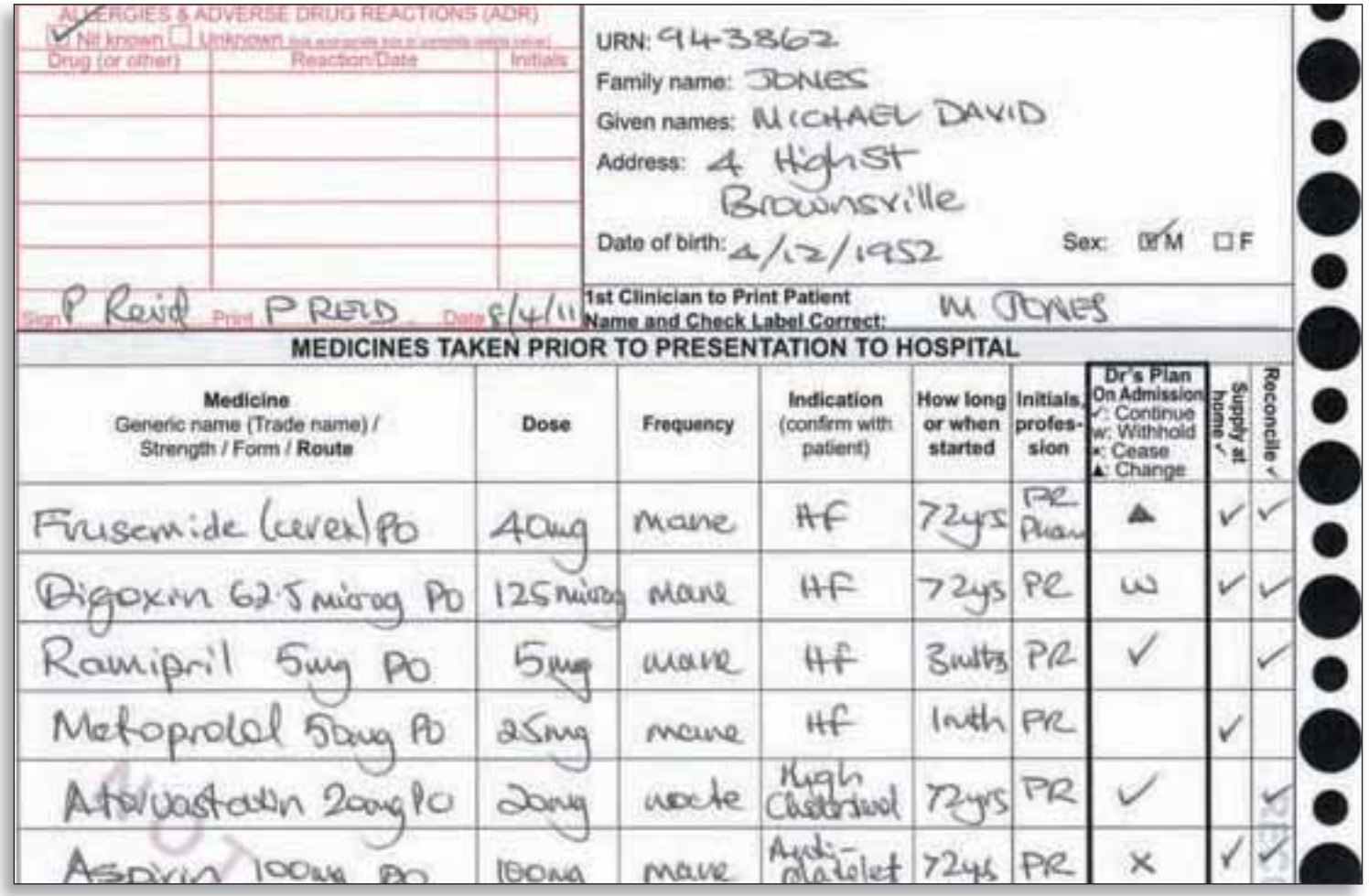
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE

Medrec

Step 1: Obtain the BPMH – patient interview

- Use the medication history checklist on the MMP
- Ask the patient if they know which medications they take
- Use the patient's own medications or the patient's medication list as a prompt ONLY
- If they are unsure, ask if you can contact their community pharmacy, GP or family member to confirm
- Go through each medication **one at a time** with the patient to establish:
  - How they take it (dose and frequency)
  - Why they think they take it (where applicable)
  - If it is taken regularly or prn (where appropriate)
  - How long they have been taking it
  - If they have supplies of medicines at home
- Document on the MMP

Step 1: Obtain the BPMH – Documentation



ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
☑ Nil known ☐ Unknown

Drug (or other)	Reaction/Date	Initials

Sign P Reid Print P REID Date 8/4/11

URN: 9438862
Family name: JONES
Given names: MICHAEL DAVID
Address: 4 High St Brownsville
Date of birth: 4/12/1952 Sex: ☑M ☐F

1st Clinician to Print Patient Name and Check Label Correct: M JONES

MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL

Medicine (Generic name (Trade name) / Strength / Form / Route)	Dose	Frequency	Indication (confirm with patient)	How long or when started	Initials profession	Dr's Plan On Admission ✓: Continue w: Withhold ×: Cease ▲: Change	Supply at home ✓	Reconcile ✓
Frusemide (Lasix) PO	40mg	mane	HF	72yrs	PR Pharm	▲	✓	✓
Digoxin 62.5 microg PO	125 microg	mane	HF	72yrs	PR	w	✓	✓
Ramipril 5mg PO	5mg	mane	HF	3mths	PR	✓		✓
Metoprolol 50mg PO	25mg	mane	HF	1mth	PR		✓	
Atorvastatin 20mg PO	20mg	nocte	High Cholesterol	72yrs	PR	✓		✓
Aspirin 100mg PO	100mg	mane	Anti-platelet	72yrs	PR	×	✓	✓

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Medrec

Step 1: Obtain the BPMH – ceased medicines

CHECK MEDICINES RECENTLY CHANGED, INITIATED OR CEASED!

Document on the MMP

RECENTLY CEASED OR RECENT CHANGES TO MEDICINES prior to presentation to
Asprin ceased on 21st March

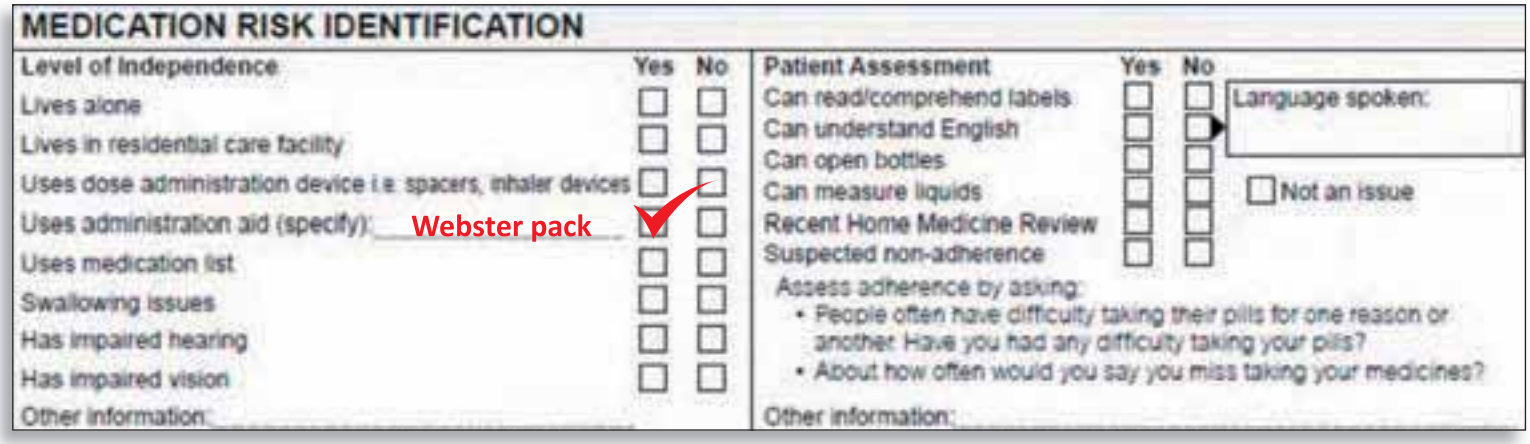
Step 1: Obtain the BPMH - checklist

MEDICATION HISTORY CHECKLIST

- ☐ Prescription medicines
- ☐ Sleeping tablets
- ☐ Inhalers, puffers, sprays, sublingual tablets
- ☐ Oral contraceptives, hormone replacement therapy
- ☐ Over-the-counter medicines
- ☐ Analgesics
- ☐ Gastrointestinal drugs *(for reflux, heartburn, constipation, diarrhoea)*
- ☐ Complementary medicines *(e.g. vitamins, herbal or natural therapies)*
- ☐ Topical medicines *(e.g. creams, ointments, lotions, patches)*
- ☐ Inserted medicines *(e.g. nose/ear/eye drops, pessaries, suppositories)*
- ☐ Injected medicines
- ☐ Recently completed courses of medicine
- ☐ Other people's medicine
- ☐ Social and recreational drugs
- ☐ Intermittent medicines *(eg. weekly or twice weekly)*

Use of the checklist on the MMP ensures all routes of administration are covered as well as non-prescribed meds, herbals, etc

Step 1: Obtain the BPMH – risk assessment



MEDICATION RISK IDENTIFICATION

Level of Independence	Yes	No
Lives alone	☐	☐
Lives in residential care facility	☐	☐
Uses dose administration device i.e. spacers, inhaler devices	☐	☐
Uses administration aid (specify): Webster pack	☑	☐
Uses medication list	☐	☐
Swallowing issues	☐	☐
Has impaired hearing	☐	☐
Has impaired vision	☐	☐
Other information:		

Patient Assessment	Yes	No
Can read/comprehend labels	☐	☐
Can understand English	☐	☐
Can open bottles	☐	☐
Can measure liquids	☐	☐
Recent Home Medicine Review	☐	☐
Suspected non-adherence	☐	☐

Language spoken:

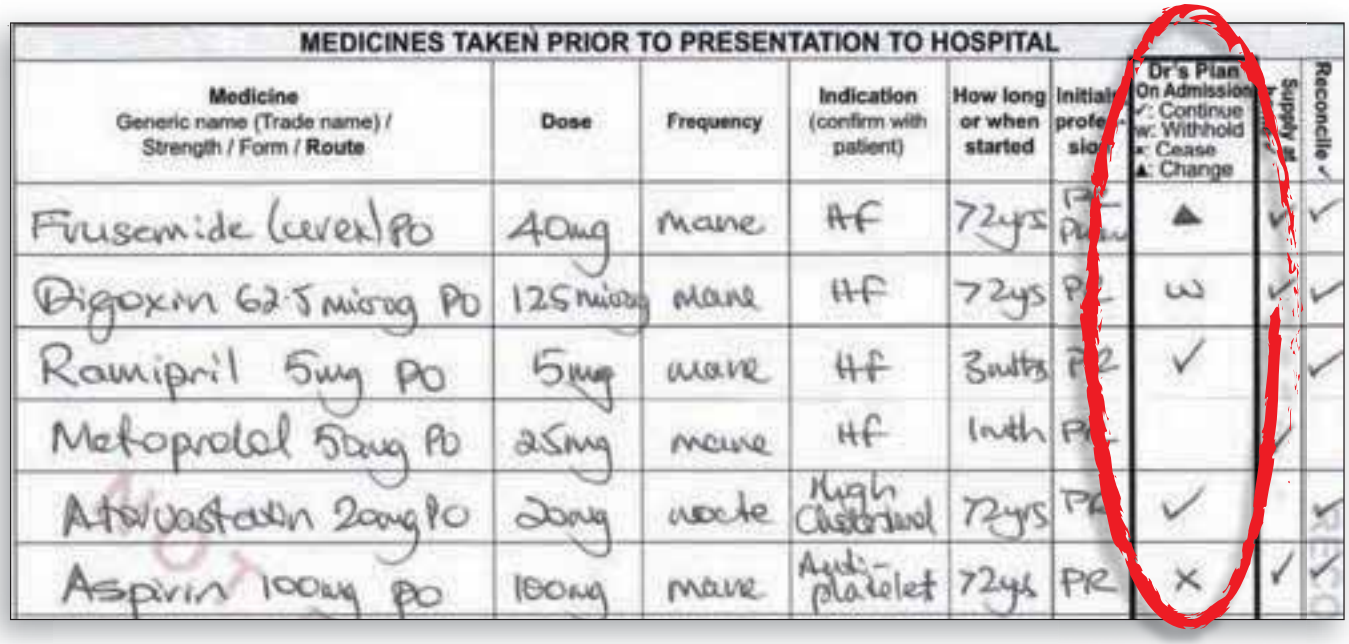
☐ Not an issue

Assess adherence by asking:

- People often have difficulty taking their pills for one reason or another. Have you had any difficulty taking your pills?
- About how often would you say you miss taking your medicines?

Other information:

Step 1: Obtain the BPMH – Dr's Plan



MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL

Medicine Generic name (Trade name) / Strength / Form / Route	Dose	Frequency	Indication (confirm with patient)	How long or when started	Initial	Dr's Plan On Admission ✓: Continue w: Withhold ×: Cease ▲: Change	Supply at	Reconcile ✓
Frusemide (Lasix) PO	40mg	mane	Hf	72yrs	PR	▲	✓	✓
Digoxin 62.5 microg PO	125 microg	mane	Hf	72yrs	PR	w	✓	✓
Ramipril 5mg PO	5mg	mane	Hf	3mths	PR	✓		✓
Metoprolol 50mg PO	25mg	mane	Hf	1mth	PR		✓	
Atorvastatin 20mg PO	20mg	nocte	High Cholesterol	72yrs	PR	✓		✓
Aspirin 100mg PO	100mg	mane	Anti-platelet	72yrs	PR	×	✓	✓

- Record Dr's plan to continue, withhold, cease or change the medicines on admission for each medicine
- Doctors plan column helps with reconciliation
- Supply at home column helps with discharge planning

Notes for Paediatric Patients

MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL

Medicine Generic name (Trade name) / Strength / Form / Route	Dose	Frequency	Indication (confirm with patient)	How long or when started	Initials, profession	Dr's Plan On Admission ✓: Continue w: Withhold ×: Cease ▲: Change	Supply at home ✓	Reconcile ✓
Omeprazole 10mg tabs po	10mg	morning	gut protection	4 mths	jcd pharm	✓	✓	✓
(Disperse tabs in water 5g give via NG tube)								
Topiramate 25mg tabs po	3/4 tab	morning night	seizures	1 week	jcd	✓	✓	✓
(Disperse one tablet in 5mL water 5g give 6mL via NG tube)								

- Record details of the method of administration usually used in the "medicine" column
- This should include the route and the formulation

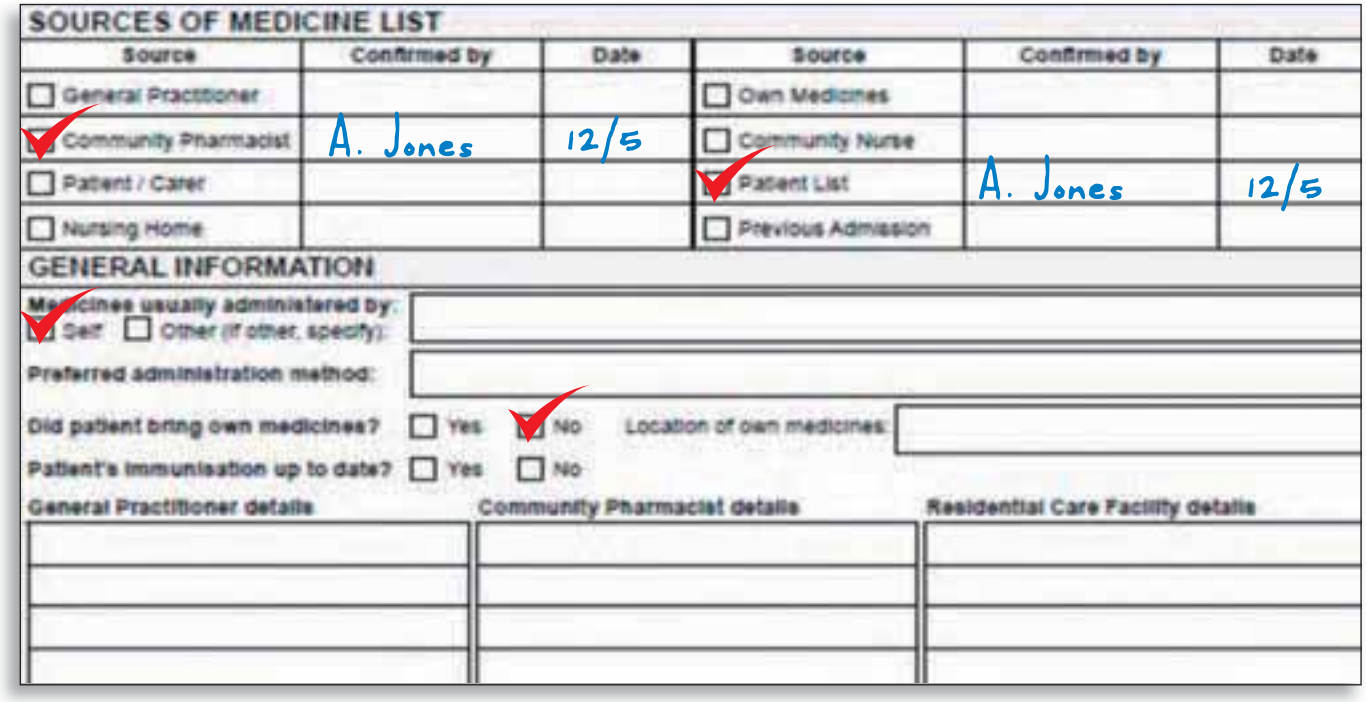
Step 2: Confirm the history

Confirm the history with *at least one* other source of information.
If cannot confirm – *annotate.*

- Personal medication list
- Own medications
- Community pharmacy
- Carer/family
- Local GP
- Referral letters (check date)
- Dose administration aid
- Recent admission notes
- Nursing home/Care facility
- Other hospital records (check date)

Step 2: Documenting sources

Tick sources used on the MMP and document who confirmed it and date



SOURCES OF MEDICINE LIST

Source	Confirmed by	Date	Source	Confirmed by	Date
☐ General Practitioner			☐ Own Medicines		
☑ Community Pharmacist	A. Jones	12/5	☐ Community Nurse		
☐ Patient / Carer			☑ Patient List	A. Jones	12/5
☐ Nursing Home			☐ Previous Admission		

GENERAL INFORMATION

Medicines usually administered by: ☑ Self ☐ Other (if other, specify):

Preferred administration method:

Did patient bring own medicines? ☐ Yes ☑ No Location of own medicines:

Patient's immunisation up to date? ☐ Yes ☐ No

General Practitioner details	Community Pharmacist details	Residential Care Facility details

Step 3: Reconcile the Medication History with the Admission Orders

MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL								
Medicine Generic name (Trade name)/ Strength / Form / **Route**	**Dose**	**Frequency**	**Indication** (Confirm with patient)	**How long or when started**	**Initials Profes-sion**	**Dr's Plan On Admission** ✓: Continue w: Withhold X: Cease ▲: Change	**Supply at home ✓**	**Reconcile ✓**
asprin (cartia) po	100mg	mane	anti-platelet	>2yr	Pharm SL	X	✓	✓
digoxin 62.5 microgram	125microg	mane	HF	>2yr	SL	w	✓	✓
ramipil 5mg po	5mg	mane	HF	>2yr	SL	✓	✓	✓
frusemide (urex) po	40mg	mane	HF	>2yr	SL		✓	✓
atorvastatin 10mg po	10mg	mane	high cholesterol	>2yr	SL			

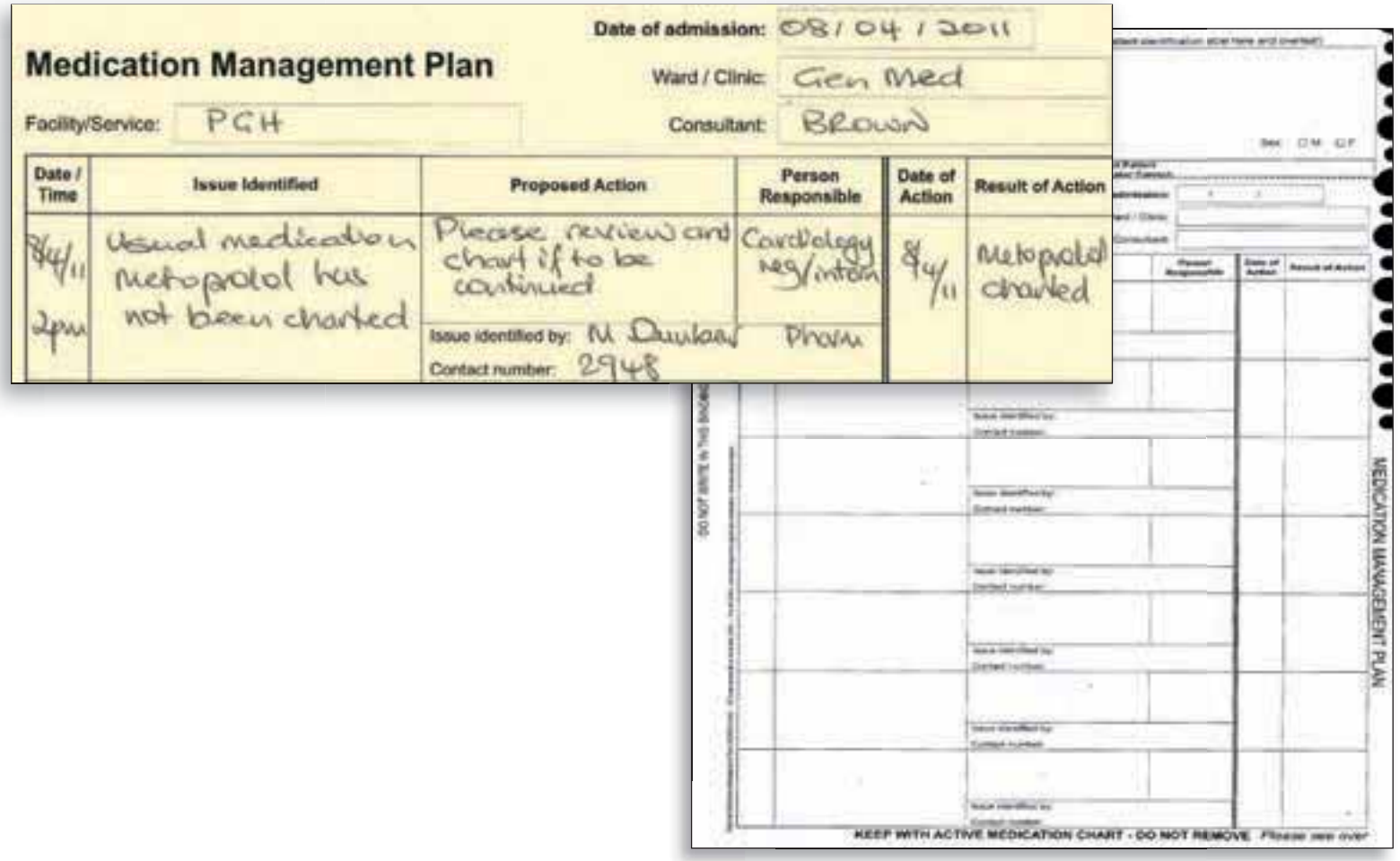
- Check each medicine taken prior to presentation against the medicines prescribed on the NIMC
- Tick in reconcile column medicines which match (e.g. name, strength, dose, frequency), taking into consideration the Doctor's recorded plan.

Amending a Medication History

- If you are **adding** to a documented medication history
  - List the additional medicines
  - Initial and add designation beside each new medicine
  - Document sources used
  - Sign, name and date the bottom of the page next to initial history taker.

- If you are **amending** a medication history
  - Neatly cross through any documentation as required
  - Initial and date any changes
  - Sign and date at the bottom next to initial history taker.

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

Facility/Service: PCH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dunbar	Pharm		
		Contact number: 2948			

MEDICATION MANAGEMENT PLAN

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE

AUSTRALIANCOMMISSIONON SAFETYANDQUALITYINHEALTHCARE

Medrec

Documenting medication issues & actions

Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

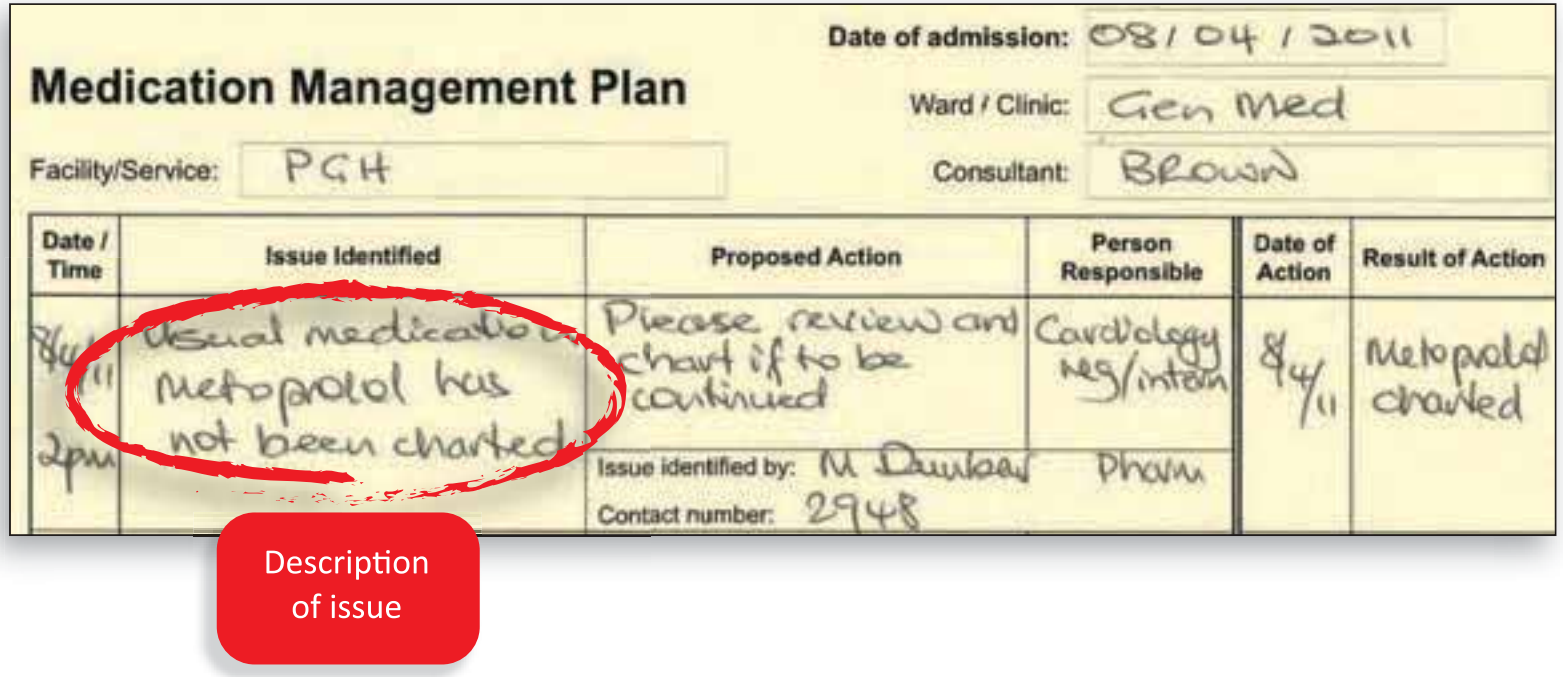
Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dunbar Pharm			
		Contact number: 2948			

Date & Time

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

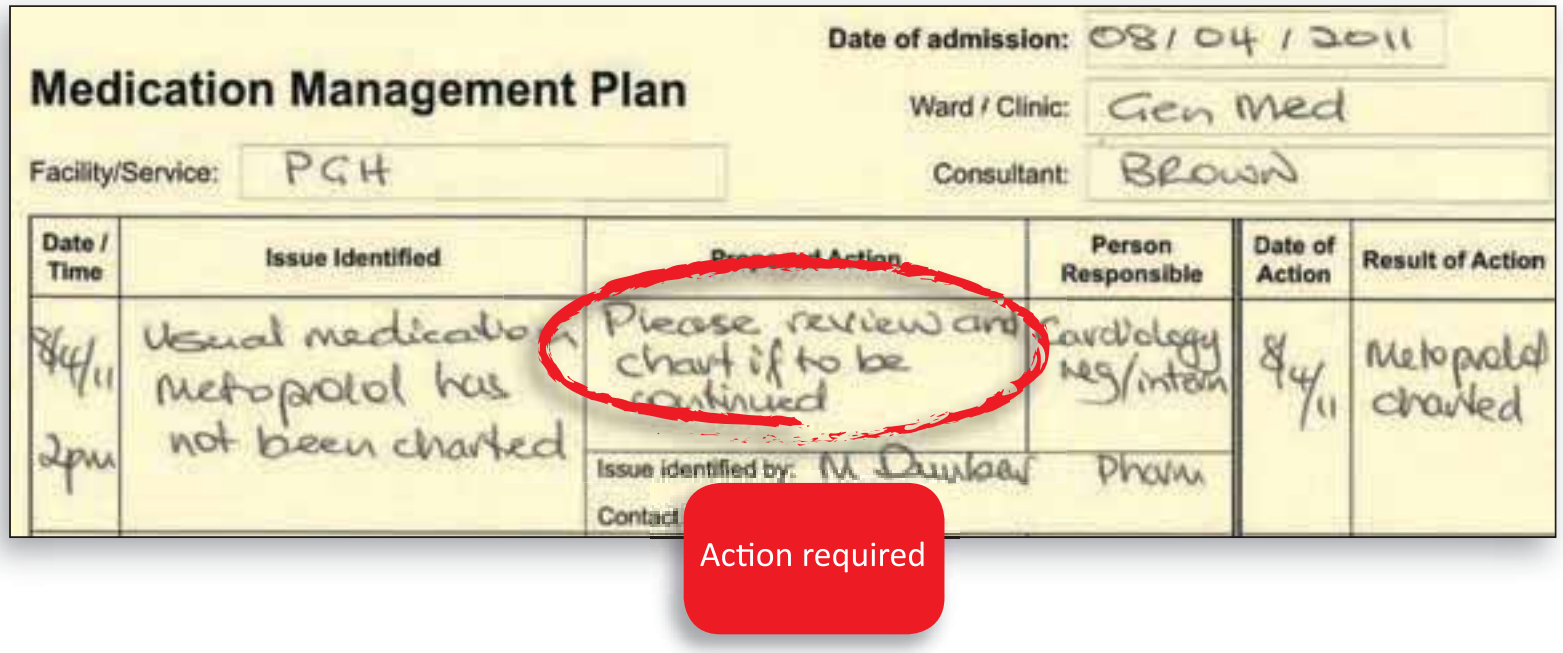
Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dunbar Pharm			
		Contact number: 2948			

Description of issue

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08/04/2011

Ward / Clinic: Gen Med

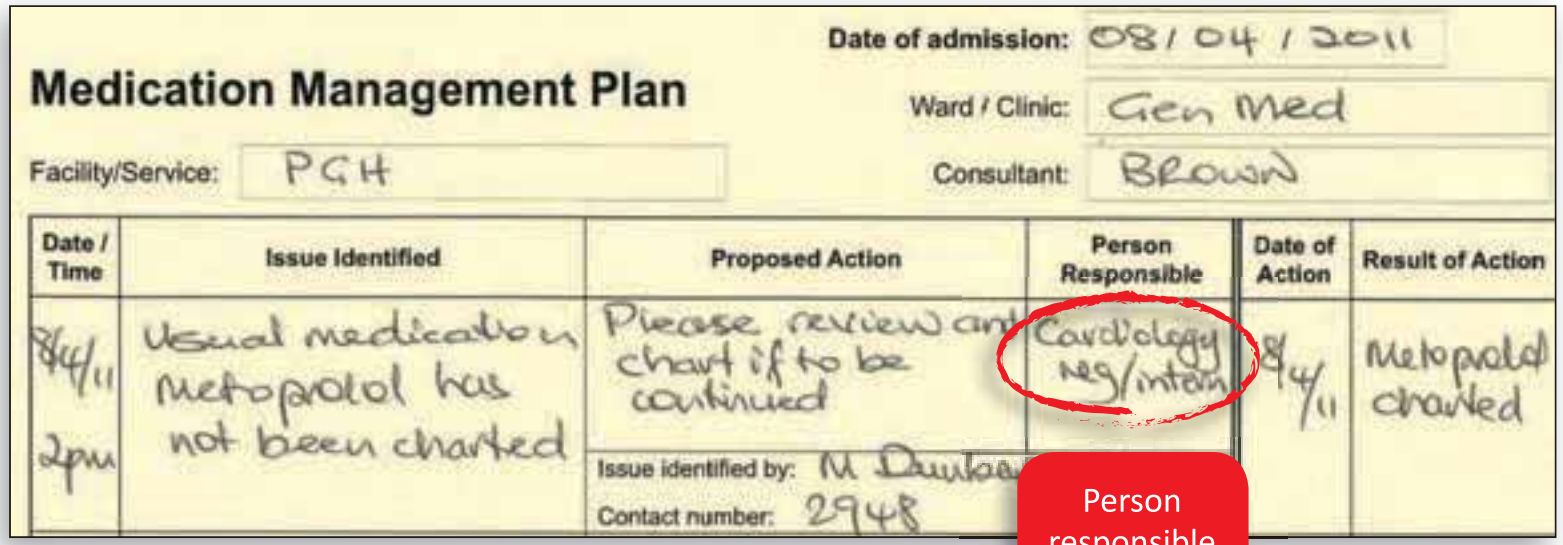
Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dawbar Pharm			
		Contact			

Action required

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08/04/2011

Ward / Clinic: Gen Med

Facility/Service: PGH

Consultant: Brown

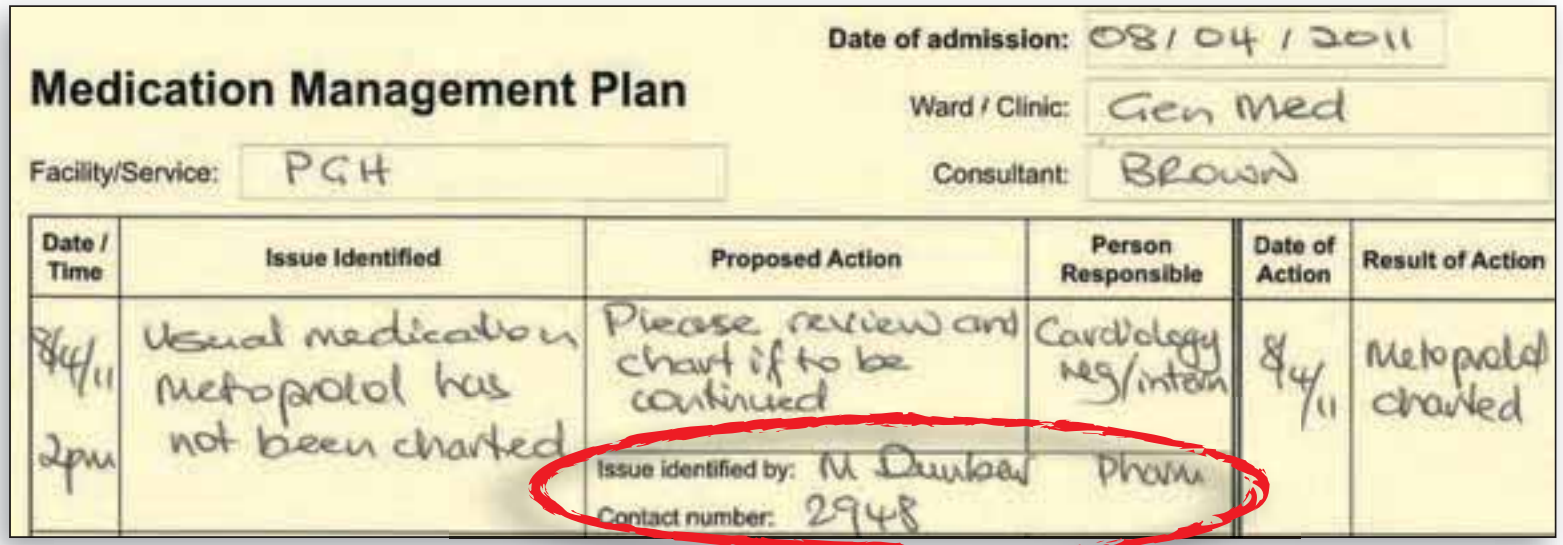
Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted

Issue identified by: M Dunbar

Contact number: 2948

Person responsible for action

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

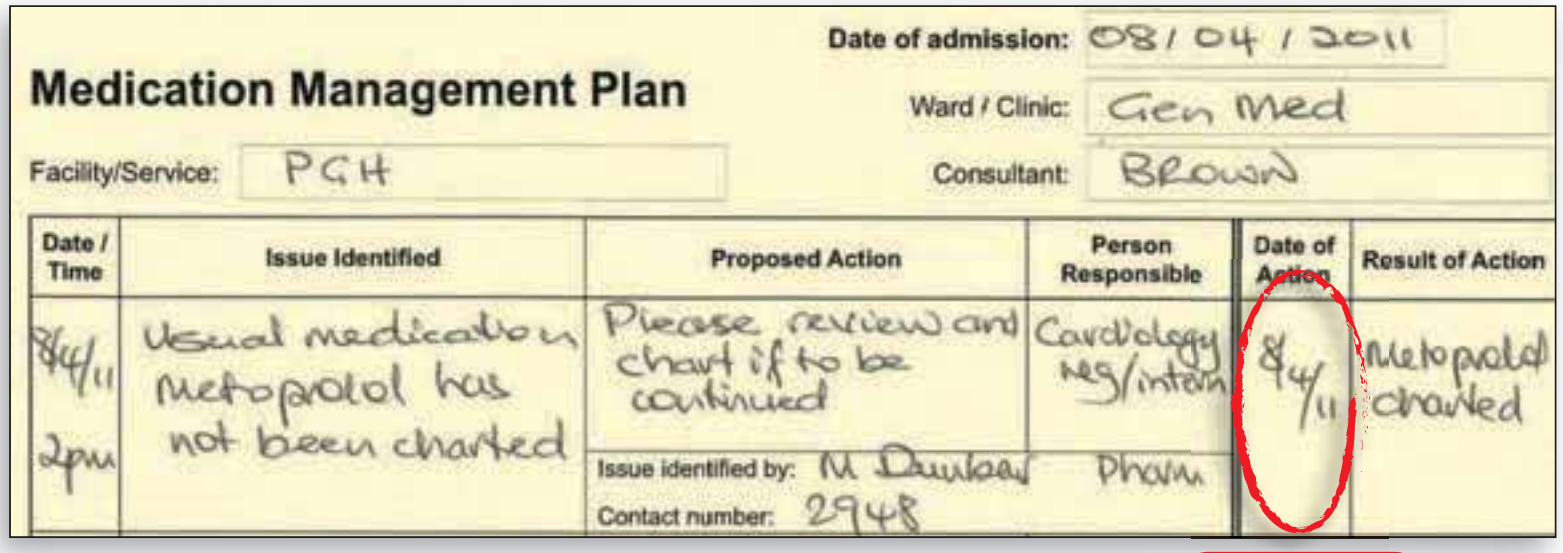
Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dunbar Pharm			
		Contact number: 2948			

Name and contact number of person identifying issue

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

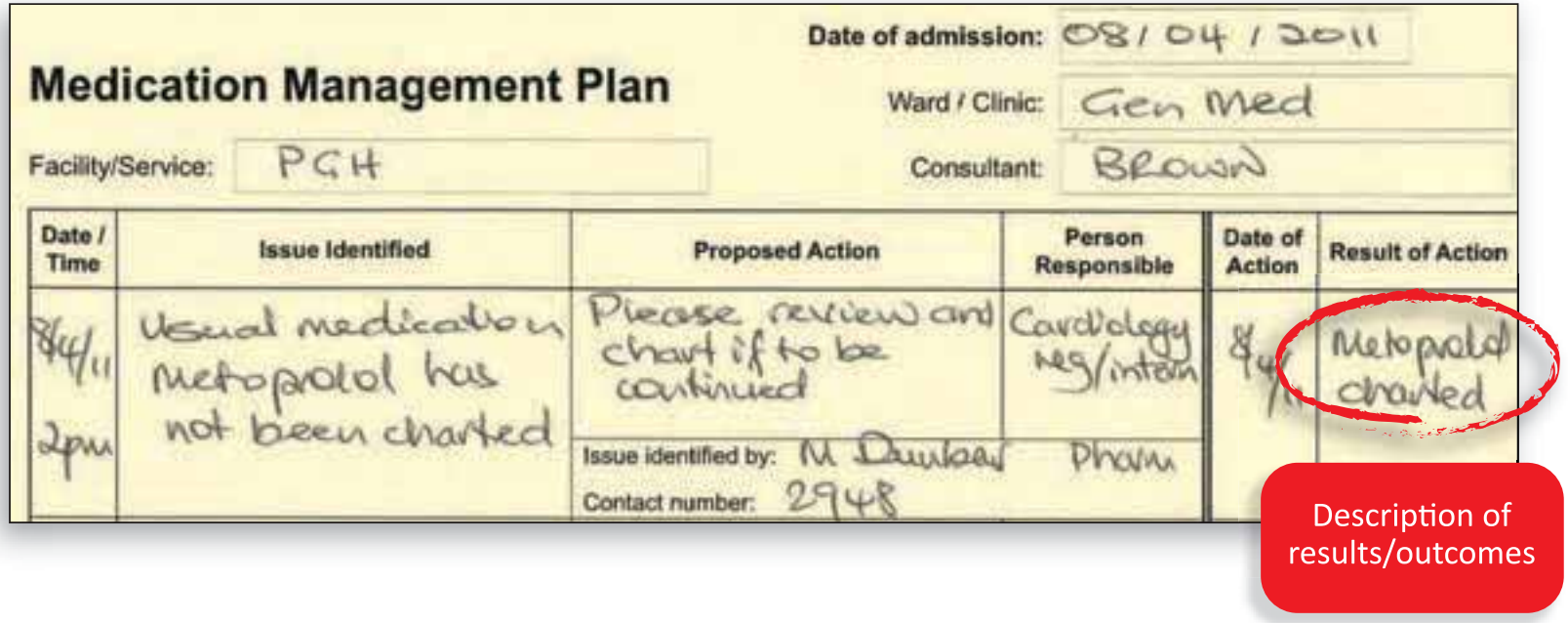
Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dunbar Pharm			
		Contact number: 2948			

Document date of action

Documenting medication issues & actions



Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4	Metoprolol charted
		Issue identified by: M Dunbar Pharm			
		Contact number: 2948			

Description of results/outcomes

Documenting medication issues & actions

Medication Management Plan

Date of admission: 08 / 04 / 2011

Ward / Clinic: Gen Med

Facility/Service: PGH

Consultant: Brown

Date / Time	Issue Identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/4/11 2pm	Usual medication Metoprolol has not been charted	Please review and chart if to be continued	Cardiology reg/intern	8/4/11	Metoprolol charted
		Issue identified by: M Dunbar Pharm			
		Contact number: 2948			

Any urgent medication issues should be brought to the attention of the attending medical officer as soon as possible using more direct forms of communication such as telephone or pager.

Medication Changes During Admission

Document:

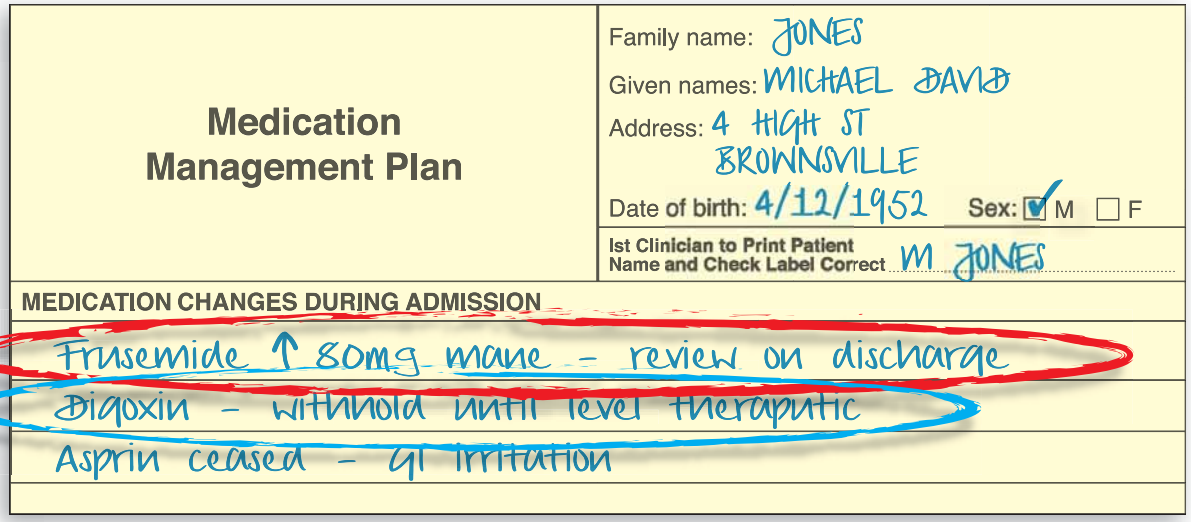
1. medication changes during admission which may be required at discharge to inform the patient (carer), GP or community pharmacy

Medication Management Plan	Family name: JONES Given names: MICHAEL DAVID Address: 4 HIGH ST BROWNSVILLE Date of birth: 4/12/1952 Sex: ☑ M ☐ F 1st Clinician to Print Patient Name and Check Label Correct M JONES
MEDICATION CHANGES DURING ADMISSION	
Frusemide ↑ 80mg mane - review on discharge	
Digoxin - withhold until level therapeutic	
Asprin ceased - GI irritation	

Medication Changes During Admission

Document:

1. medication changes during admission which may be required at discharge to inform the patient (carer), GP or community pharmacy
2. reason for any medicines withheld, restarted on discharge or ceased.



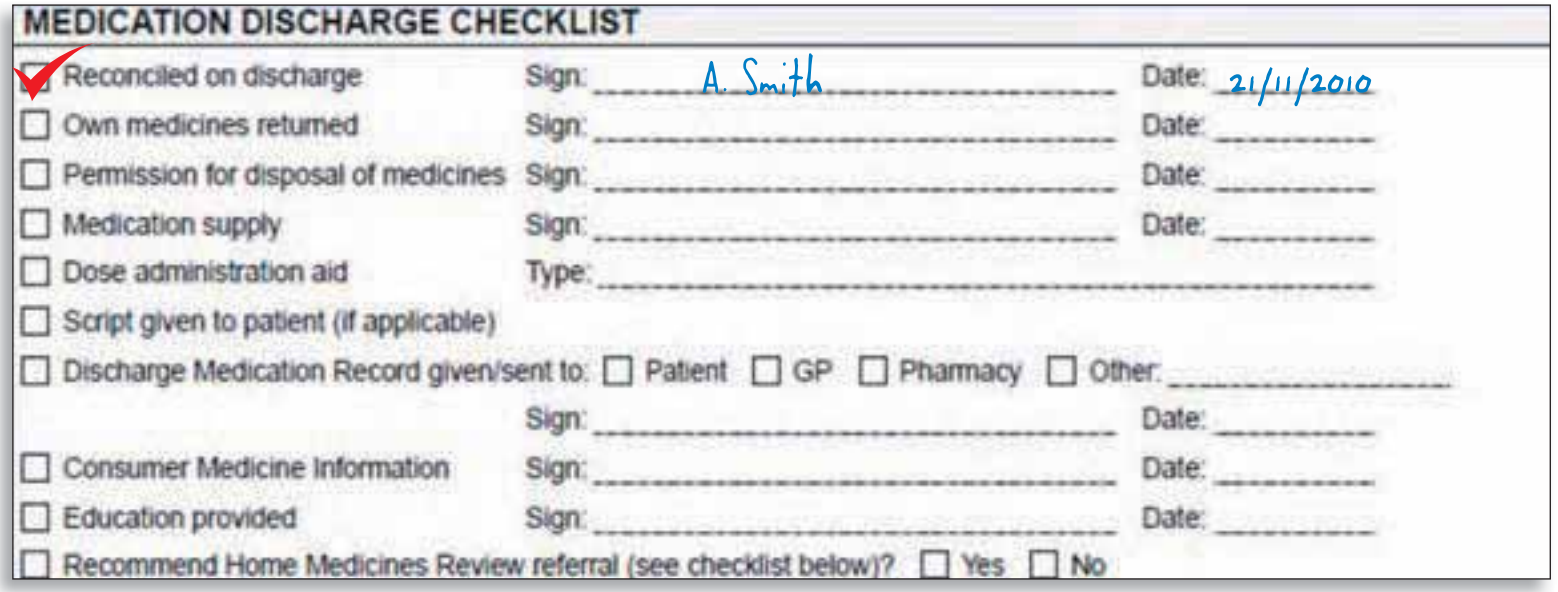
Medication Management Plan

Family name: JONES
Given names: MICHAEL DAVID
Address: 4 HIGH ST
BROWNSVILLE
Date of birth: 4/12/1952 Sex: ☑ M ☐ F
1st Clinician to Print Patient Name and Check Label Correct M JONES

MEDICATION CHANGES DURING ADMISSION

Frusemide ↑ 80mg mane - review on discharge
Digoxin - withhold until level therapeutic
Asprin ceased - GI irritation

Medication Discharge Checklist



MEDICATION DISCHARGE CHECKLIST

- ☑ Reconciled on discharge — Sign: A. Smith — Date: 21/11/2010
- ☐ Own medicines returned — Sign: _____ — Date: _____
- ☐ Permission for disposal of medicines — Sign: _____ — Date: _____
- ☐ Medication supply — Sign: _____ — Date: _____
- ☐ Dose administration aid — Type: _____
- ☐ Script given to patient (if applicable)
- ☐ Discharge Medication Record given/sent to: ☐ Patient ☐ GP ☐ Pharmacy ☐ Other: _____ — Sign: _____ — Date: _____
- ☐ Consumer Medicine Information — Sign: _____ — Date: _____
- ☐ Education provided — Sign: _____ — Date: _____
- ☐ Recommend Home Medicines Review referral (see checklist below)? ☐ Yes ☐ No

Recommending a Home Medicines Review

RECOMMENDING A HOME MEDICINES REVIEW REFERRAL CHECKLIST

Consider recommending a Home Medicines Review referral because:

- ☐ Difficulty managing medicines
- ☐ Suspected non compliance
- ☐ Inability to manage drug related therapeutic devices
- ☐ Taking more than 5 medicines
- ☐ Taking more than 12 doses per day
- ☐ Significant changes to medication regimen during admission
- ☐ Medication requiring therapeutic monitoring
- ☐ Other: _____

Additional Points

- Avoid using unsafe / error prone abbreviations on the MMP

  http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/com-pubs_NIMC-con/$File/32060.pdf

- Write legibly on the MMP in ink – black pen preferred
- Do not use erasers or whiteout – cross out errors and rewrite the correction
- Check drug names and doses if you are unsure
- Take care with combination products

Filing the MMP

- The NIMC and the MMP together form the medication record for each patient
- Once admitted, the MMP should stay with the patient's NIMC and other charts throughout their admission
- At time of discharge, the MMP should be filed in the patient's notes

SUMMARY

- MMP is an important tool to COMMUNICATE with other team members
- Medication Reconciliation including BPMH saves time, and avoids confusion with different sources of information in multiple locations
- The ONE source of information means easy access to information and no repetitive documenting in notes
- Medication Reconciliation prevents adverse medicines events at transitions of care

MATCH UP medicines

Medication Reconciliation Prevents Harm

SUMMARY

- MMP is an important tool to COMMUNICATE with other team members
- Medication Reconciliation including BPMH saves time, and avoids confusion with different sources of information in multiple locations
- The ONE source of information means easy access to information and no repetitive documenting in notes
- Medication Reconciliation prevents adverse medicines events at transitions of care

SUMMARY

- MMP is an important tool to COMMUNICATE with other team members
- Medication Reconciliation including BPMH saves time, and avoids confusion with different sources of information in multiple locations
- The ONE source of information means easy access to information and no repetitive documenting in notes
- Medication Reconciliation prevents adverse medicines events at transitions of care

MATCH UP medicines

Medication Reconciliation Prevents Harm

MMP Support materials

- User Guide
- Poster

Available at www.safetyandquality.gov.au

Acknowledgements

The Australian Commission on Safety and Quality in Health Care acknowledges:

- the significant contribution of Queensland Health to the development of the MMP and this presentation

Queensland Government
Queensland Health

- the contribution of the Prince of Wales Hospital to this presentation

NSW Health
South Eastern Sydney Local Health District

References

1. Sullivan C, Gleason KM, et al. ***J Nurs Care Qual 2005***; 20:95-8
2. Rozich JD, Resar RK. ***J Clin Outcomes Manage 2001***; 8:27-34
3. Santell JP. ***Jt Comm J Qual Patient Safety 2006***; 32:225-9
4. Tam VC, Knowles et al. ***CMAJ 2005***; 173(5):510-5
5. Cornish PL, Knowles SR et al. ***Arch Intern Med 2005***; 165:424-9
6. Gleason KM, Groszek JM et al. ***Am J Health-Sys Pharm 2004***; 61;1689-94
7. Duguid MJ, Gibson M et al. ***J Pharm Pract and Res 2002***; 32: 94-5
8. Coombes I, et al. ***Aust J Hosp Pharm 2001***; 31:102-6
9. Stowasser DA, Stowasser M, Collins DM. ***J Pharm Pract Res 2002***; 32:133-40
10. Whittington J, Cohen H, ***Qual Management in Health Care 2004***; 13:53-9
11. Pronovost p, Weast B et al. ***J Critical Care 2003***; 18:201-5
12. Rozich JD, Resar RK, et al. ***Jt Comm J Qual Patient Safety 2004***; 30:5-14
13. http://www.saferhealthcarenow.ca/EN/Interventions/medrec/Documents/Acute%20Care/Med%20Rec%20(Acute%20Care)%20Getting%20Started%20Kit.pdf (accessed 2011 July 28)