Purpose

To ensure that patients receive consistent service with regard to optimising the extraction of a BPMH and medication reconciliation on admission to hospital. Patients over 65 years of age, (and those patients deemed at high risk by the SMPU, Queensland, 2006 risk rating table) admitted to an inpatient ward through the Emergency Department should have a BPMH taken, and medications reconciled within 24 hours of admission.

Definitions

BPMH = Best Possible Medication History (acknowledges that this may not be 100% accurate)

Medication Reconciliation = the process of matching the BPMH with the inpatient medication chart, and addressing discrepancies if present

MAP = Medication Action Plan and Handover form

eLMS = Enterprise-wide Liaison Medication System

Medication = All prescribed and non-prescribed medications which include:

- prescribed (medications the patient is instructed to take by the prescriber)
- non-prescribed (the prescriber did not advise the patient to take the medications) (e.g., over-the-counter (OTC) or herbal medications)
- recreational and ‘PRN’ (i.e., “as needed”) medications required by patient

ED = Emergency Department

AO = Administrative Officer

GP = General Practitioner

MO = Medical Officer

RN = Registered Nurse

SMPU = Safe Medication Practice Unit, now called Safe Medication Management Unit, under Medication Services Queensland

SOP = Standing operating procedure

Work Instruction

1. Identify patients over 65 or at high risk (using the criteria in the General Level Framework Table 3 High risk medicines and high risk patient groups) being admitted to an inpatient ward through the ED and perform a BPMH on these patients at the earliest clinically appropriate opportunity.
### 1. High risk medicines

- Drugs with a narrow therapeutics range e.g. digoxin, lithium
- Drugs requiring specialised monitoring/interpretation e.g.
  - Anticoagulants
  - Cytotoxics
  - NSAIDs or COX-2 inhibitors
  - Opiate analgesics
  - Anti-epileptics
  - Insulin
  - IV Electrolyte supplementation
  - Weekly Dosing regimens

### 2. High risk patient groups

- Renally impaired
- Cardiac disease
- Liver Disease
- Transplantation
- Mental health problems
- Cancer
- Paediatrics
- Elderly

(Safe Medication practice Unit, Queensland 2006)

2. Conduct a BPMH interview on admission with the checklist provided on MAP form. This can be conducted by appropriately trained RNs, MOs, and pharmacists.
   a. Educate and encourage patients to bring all medications and prescriptions/repeats with them to the hospital. These medications should not be sent home with relatives/carers, but should be stored securely, in green ‘Patient’s Own Medicine’ bags and locked bedside drawers, for review/reissuing/relabeling by the pharmacist throughout admission and on discharge.

3. Document the BPMH and medication information obtained on the MAP form in accordance Medication History and Reconciliation on Admission Procedure.
   Record:
   - Patient details
   - Date of BPMH documentation
   - All medicines taken on admission:- generic name, strength, form, dose, frequency, indication and duration, and any recently changed or ceased medications
   - Source of this information
   - Name of person who recorded the medication history
   - Information about previous adverse drug reactions and allergies
   - Compliance issues
   - Any other relevant information
   - Community health care providers (e.g. community pharmacy, GP, specialist, residential facility) name and contact number
   - If patient's own medicines are available, confirm with patient that these have been kept under appropriate storage conditions.(see ‘Reissuing Patient’s Own Medicines on Discharge’ - Procedure No. 5.5.1)
   - Additionally Medical Officers are to complete the Doctor’s Plan on admission column

4. Where appropriate, confirm the BPMH obtained with the patient’s community health care providers. All BPMHs should be confirmed with details obtained from a CURRENT secondary source such as:
   - community pharmacies
   - GPs and other community health care providers
   - Faxes of medication lists can be requested by AOs from external sources, using the ‘Request for Release of Patient Information’ form.
     - Request a ‘medication summary’ from a GP clinic
     - Request a ‘dispensing history’ and/or ‘Webster packing profile’ from a community pharmacy
     - NB many patients will have more than one community pharmacy
     - Request a ‘CURRENT medication chart’ from a nursing home
WORK INSTRUCTION 1553 BPMH & Medication Reconciliation – Clinical Staff (Medical Officers, Nursing Staff, Pharmacists)

- family/carers/home care providers
- patient medication lists
- residential care facilities
- previous patient health records/eLMS
  - eLMS can be accessed online by pharmacists and doctors (read-only), or by utilising ‘The Viewer’
- patient’s own medicines

- Record the source and date of the confirmation on the MAP.
- Document the name and discipline of the person who performed the BPMH, or section of the BPMH
  - Any subsequent additions/amendments to the BPMH must be annotated with the date, name and discipline of the person responsible
- Cross reference on the front of the medication chart, and in progress notes if appropriate: ‘see MAP’

5. Once the MOs have completed the inpatient medication chart, match the medications on the BPMH with the medication chart. To maximise capture of discrepancies, the reconciliation should be performed by a health professional independent of the prescribing MO.

a. Check that each medicine has been correctly transcribed onto the medication chart in accordance with the MO’s plan.

b. Clarify any discrepancies with the treating team immediately if urgent and document along with non-urgent discrepancies on the Issues page on the front of the MAP to facilitate clinical handover of medication issues and actions.

c. Tick the reconcile column on the MAP once reconciliation is complete for that medicine. (Do not mark this column until any discrepancy has been adjusted or clarified and the medication has been reconciled i.e. matches the plan).

d. Document any resulting changes in the Dr’s Plan and Reconciliation columns, as well as in the Medication Changes During Admission section, with the rationale if appropriate. (Note: ‘Dr’s plan’ is not always readily available. If there is no documentation or evident clinical reason for change, the treating team should be contacted for clarification).

e. Document the name and discipline of the person who reconciled the BPMH with the inpatient medication chart, and time and date when this occurred.

6. The MAP form should be kept with the active medication chart, and on discharge it should be filed with the medication charts in the patient’s medical record for that admission.

If BPMH already completed
- If necessary confirm, add or amend details.
- Reconcile the BPMH with inpatient medication chart once completed and clarify any discrepancies as indicated above

If a full BPMH cannot be obtained
- Begin documenting any medication history known on the MAP form – this can be later clarified by other clinical staff throughout the admission
- If incomplete (e.g. ‘waiting for patient’s own medications to confirm’) or if any medication issues for follow up note this on the Issues page
SPECIFIC DISCIPLINE REQUIREMENTS

MOs

- Review clinical appropriateness of BPMH on admission
- Chart medications as appropriate onto inpatient medication chart
- Communicate/document 'Dr’s plan' clearly with team members
- Review Issues page on front of MAP regularly for medication issues

Pharmacists

- Review clinical appropriateness of BPMH on admission
- Prioritise patient interviews based on risk e.g. over 65 years of age, on medications, medication related admissions
- Enter BPMH into eLMS and print and attach to MAP (if appropriate) once satisfied with the content
- Annotate changes on medication chart in purple pen (nursing staff are not to annotate on medication charts to avoid confusion)
- Pharmacist to document in purple pen where appropriate
  - Purple pen use indicates pharmacist input
- Discharge pharmacist to include changes on eLMS discharge medication summary if satisfied with medication history information available

Secondary Document Information

<table>
<thead>
<tr>
<th>References</th>
<th>High 5s Standard Operating Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• <a href="https://www.high5s.org/bin/view/Manual/AssuringMedicationAccuracyAtTransitionsInCare">https://www.high5s.org/bin/view/Manual/AssuringMedicationAccuracyAtTransitionsInCare</a></td>
</tr>
<tr>
<td></td>
<td>• <a href="https://www.high5s.org/bin/view/Main/WebHome">https://www.high5s.org/bin/view/Main/WebHome</a></td>
</tr>
<tr>
<td></td>
<td>• I:\COMMON\Pharmacy\5s WHO Reconciliation Project\Procedures\WHO High 5s SOPs</td>
</tr>
</tbody>
</table>

| Evaluation | Evaluation will take place along with the evaluation of High 5s Project |
| Author     | WHO High 5s Project Officers |

<table>
<thead>
<tr>
<th>Stakeholders Consulted (Title)</th>
<th>Date Consulted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy – Operational Meeting</td>
<td>July 2014</td>
</tr>
<tr>
<td>Emergency Department Business Meeting</td>
<td>July 2014</td>
</tr>
<tr>
<td>Senior Nurses Advisory Committee</td>
<td>July 2014</td>
</tr>
<tr>
<td>Medical Services Business Meeting</td>
<td>July 2014</td>
</tr>
<tr>
<td>Clinical Directors Meeting</td>
<td>14th April 2011</td>
</tr>
<tr>
<td>Medication Management Committee (previously Drug &amp; Therapeutics Committee)</td>
<td>July 2014</td>
</tr>
<tr>
<td>WHO High 5s Working Group</td>
<td>July 2014</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Version Change History</th>
<th>Amendments</th>
<th>Approved Date</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>V#</td>
<td>Amendments</td>
<td>Date</td>
<td>Position</td>
</tr>
<tr>
<td>1:11</td>
<td>New document</td>
<td>21/07/2011</td>
<td>Drug &amp; Therapeutics Committee</td>
</tr>
<tr>
<td>1:2</td>
<td>Updated web links, formatting, information technology system and nomenclature</td>
<td>July 2014</td>
<td>Medication Management Committee</td>
</tr>
</tbody>
</table>
CONFIDENTIAL COMMUNICATION

If this request is received in error, please advise the sender by telephone and return the document by mail at our expense.

Queensland Government
Metro South Health Service District
Redland Hospital
CPG Box 685, Cleveland Q 4163

Request for Release of Patient Information

<table>
<thead>
<tr>
<th>TO</th>
<th>Fax</th>
<th>Date</th>
<th>Name</th>
<th>Organisation</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM</td>
<td>Fax</td>
<td>Phone</td>
<td>Name</td>
<td>Position</td>
<td>Clinic/Ward/Dept</td>
</tr>
</tbody>
</table>

This request is valid for one release only.

INFORMATION REQUIRED

Please tick [] all types of information needed and PRINT specific details legibly.

<table>
<thead>
<tr>
<th>x</th>
<th>PRIORITY</th>
<th>INFORMATION REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Urgent (patient waiting)</td>
<td>□ Discharge summaries:</td>
</tr>
<tr>
<td></td>
<td>□ Urgent (appointment/visit at _____ hrs)</td>
<td>□ ECGs/stress tests:</td>
</tr>
<tr>
<td></td>
<td>□ Routine (date needed by <em><strong>/</strong></em>/___)</td>
<td>□ Pathology/pathology results:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Progress notes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Medical Imaging reports:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Letters:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ OPD clinic notes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ ED notes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Theatre notes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Current medication summary/chart:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Others:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ 3 month-dispensing history &amp; any other significant dispensing:</td>
</tr>
</tbody>
</table>

S62(E) Health Services Act (HSA) permits release of patient information without explicit patient authority to other Qld Health clinicians directly involved in the care of that patient. S62(1)(b) HSA permits information release by a health professional "under the recognised standards of their profession, to a general practitioner who has had responsibility for the care & treatment of the person."

I request the above information to facilitate the care & treatment of this patient.

Signature:

AUTHORITY TO RELEASE PATIENT INFORMATION (If required)

I consent to the above release of clinical information:

Signed: Date: / /

Printed name:

Substitute Decision-Makers, please indicate your relationship to the patient:

☐ Parent/Guardian of a Minor  ☐ EPOA (Personal Matters)  ☐ Court-appointed Guardian
☐ Statutory Health Attorney  ☐ Other:

HEALTH INFORMATION MANAGEMENT/MEDICO-LEGAL SERVICE USE ONLY

Details of pages released:

☐ DIC summary  ☐ Path/histo  ☐ Imaging  ☐ OPD  ☐ OT
☐ ECG/Stress  ☐ Prog Notes  ☐ ED  ☐ Letters  ☐ Other

Released via:

☐ Fax  ☐ Reg'd Mail  ☐ Internal Mail  ☐ Phone By: on / /

File completed information request in the correspondence section of the patient's health record.
WORK INSTRUCTION 1553 BPMH & Medication Reconciliation

BPMH & Medication Reconciliation – Clinical Staff (Medical Officers, Nursing Staff, Pharmacists)

© current medication history
♫ current BPMH taken
♦ current reconciliation
♥ future BPMH taking
♣ future reconciliation
not available after hours

- QAS
  - Own meds
  - Pt/carer
  - Pt list
  - NH

- NP/RN
  - Own meds
  - Pt/carer
  - Pt list
  - NH

- Triage RN – if relevant
  - Own meds
  - Pt/carer
  - Pt list
  - NH

- ED RMO/ED Pharmacist
  - Own meds
  - Pt/carer
  - Pt list
  - NH
  - GP/specialist
  - QAS
  - Previous admission

- Med Reg
  - Own meds
  - Pt/carer
  - Pt list
  - NH
  - GP/specialist
  - QAS
  - Previous admission

- RN
  - Own meds
  - Pt/carer
  - Pt list
  - NH
  - GP/specialist
  - QAS
  - Previous admission

- Admit to ward

- Ward RN
  - Own meds
  - Pt/carer
  - Pt list
  - NH
  - GP/specialist
  - QAS
  - Com P’cist
  - Previous admission

- Ward Pharmacist
  - Own meds
  - Pt/carer
  - Pt list
  - NH
  - GP/specialist
  - QAS
  - Com P’cist
  - Previous admission

- AO
  - Requests medication information on behalf of the RN/RMO/Pharmacist from:
    - Community Pharmacy
    - GP/specialist
    - Nursing Home

- Walk in