

5.8 Percentage of patients whose discharge summaries contain a current, accurate and comprehensive list of medicines

Purpose

This indicator addresses the effectiveness of processes that promote continuity of care in medication management and aim to minimise adverse medicine events when care is transferred.

Background and evidence

Adverse medicine events are commonly caused by lack of effective communication about medicines, especially in the transition between the community and hospital settings.¹ When patients are transferred between hospitals or to their home or residential care facility, healthcare professionals must ensure that the healthcare professional taking over the patient's care is supplied with an accurate and complete list of the patient's medicines.^{2,3} However, studies have shown that unintended discrepancies in the medication information provided on discharge are common.^{4,5} The process of medication reconciliation reduces opportunities for medication discrepancies and helps to ensure that the information communicated to ongoing care providers at discharge is verified and accurate.⁶

Key definitions

Patients refers to all patients admitted for at least 24 hours whose care is transferred from the hospital inpatient setting to home or a community-based care facility.

List of medicines refers to the list of the patient's ongoing medicines that will be communicated to the healthcare professional(s) taking over the patient's care after discharge. This should always be a comprehensive list of the patient's ongoing medicines, current at the point of discharge, whether or not all medicines are supplied by the hospital.

The list of medicines in the discharge summary should list:

- all on-going medicines to be taken by the patient, including the dose and frequency for each medicine. The list should include medicines to be taken by all routes, i.e. oral, topical, parenteral etc.
- all prescription, over-the-counter, and complementary medicines
- all regular, intermittent and "as required" medicines.

Current, accurate and comprehensive means that the list of medicines in the discharge summary contains all the information required for the healthcare professional(s) taking over care after discharge to continue the patient's pharmaceutical care effectively. To determine whether the list of medicines in the discharge summary is current, accurate and comprehensive, the auditor should compare the summary with the:⁶

- medicines prescribed on all current medication charts at the point of discharge. Due consideration should be given to the documented discharge plan, including medicines started, ceased or altered on discharge
- medication management plan or reconciliation form (if used) for any changes to the medication regimen made during the episode of care
- patient's admission medication history/list of medicines taken prior to presentation to hospital to check that any medicines withheld on or during admission are included as appropriate and that all changes are accounted for.

All medicines, doses and frequencies should match up. Any discrepancies that cannot be accounted for by the auditor should be taken to mean that the list of medicines in the discharge summary is not current, accurate and comprehensive.

Data collection for local use

Please refer to the section *Using the National Quality Use of Medicines Indicators for Australian Hospitals* for guidance on sample selection, sample size, measurement frequency and other considerations.

Inclusion criteria: Adult, paediatric and neonatal patients admitted to hospital for greater than 24 hours who are taking one or more medicines at discharge.

Exclusion criteria: Patients transferred to another acute care facility; patients cared for in the emergency department.

Recommended data sources: Discharge documentation, medication charts, medication management plans or reconciliation forms and medical records.

The data collection tool for QUM Indicator 5.8 assists data collection and indicator calculation.

Indicator calculation

$$\frac{\text{Numerator}}{\text{Denominator}} \times 100\%$$

Numerator = Number of patients taking medicine(s) at discharge whose discharge summaries contain a current, accurate and comprehensive medicines list

Denominator = Number of patients taking medicines at discharge in sample

Limitations and interpretation

There may be a number of ways to identify a sample of patients taking medicines at discharge. Certain sampling methods may lead to inadvertent exclusion of some patients. For example, the use of pharmacy dispensing records will exclude those patients who did not have their discharge medicines dispensed by the hospital. It is recommended that patients be identified using inpatient medication charts and/or medication management plans in combination with the medical record.

This indicator does not take into account that the list of medicines in the discharge summary should also include details regarding medication therapy changes during the inpatient episode.^{3,6} It is therefore strongly recommended that this indicator is collected concurrently with *Indicator 5.3: Percentage of discharge summaries that include medication therapy changes and explanations for changes*.

Performance against this indicator is likely to be improved if medicines lists in discharge summaries undergo a process of medication reconciliation. Medication reconciliation is an essential component of effective clinical handover and involves matching the medicines that the patient should be prescribed with those that are actually documented and resolving any discrepancies. This process helps to prevent harm by improving continuity of care and reducing the opportunity for medication errors.

Continuity of care

Concurrent measurement of the following indicators will provide a comprehensive measure of the organisation's performance of continuity of medication management:

- *Indicator 3.1: Percentage of patients whose current medicines are documented and reconciled at admission*
- *Indicator 5.3: Percentage of discharge summaries that include medication therapy changes and explanations for changes*
- *Indicator 5.9: Percentage of patients who receive a current, accurate and comprehensive medication list at the time of hospital discharge.*

Further information

The Australian Commission on Safety and Quality in Health Care medication reconciliation web page includes information on the process of medication reconciliation and resources to support its implementation, and is available from www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation

Use of a medication management plan (MMP) or similar form can improve the accuracy of information recorded on admission and assist with medication reconciliation at transitions of care. A national MMP and tools to support implementation are also available from the Australian Commission on Safety and Quality in Health Care web site at www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/nmmp/

Medication Safety Self Assessment for Australian Hospitals⁷ (MSSA) can help identify potential strategies for improvement with this and other indicators. MSSA encourages development of robust systems for safe prescribing, dispensing, administration and monitoring of medicines. MSSA is available at www.cec.health.nsw.gov.au

This indicator can be used to assist hospitals in meeting the National Safety and Quality Health Service Standard 1 [items 1.2.1, 1.2.2, 1.5.2, 1.6.1, 1.6.2,], Standard 4 [items 4.1.2, 4.2.2, 4.5.1, 4.5.2, 4.8.1, 4.12.3, 4.12.1, 4.12.4] and Standard 6 [items 6.4.1, 6.5.1].⁸

References

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