FACT SHEET

Medicines in focus

This fact sheet addresses medication safety and management in relation to the Australian Commission on Safety and Quality in Health Care's (ACSQHC) *National Safety and Quality Health Service* (NSQHS) *Standards*[1] and the ACSQHCs' *Australian Safety and Quality Goals for Health Care*[2], EQUIP 5 from the Australian Council on Healthcare Standards (ACHS)[3-5], and the APAC *Guiding principles to achieve continuity in medication management*[6].

Medication reconciliation - How do pharmacists add value?

Medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions.[1] Medication errors can occur at all interfaces of care.[12] Medication reconciliation and review can significantly decrease medication errors and events and contributes to patient safety[12,7,15]

Medication reconciliation[12-14] is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines (using a standardised and consistent approach), **matching** the medicines the patient **should** be prescribed to those they are **actually** prescribed. Any discrepancies are discussed with the prescriber and reasons for changes to therapy are documented.

Medication reconciliation:

- is a requirement for meeting the Australian Commission on Safety and Quality in Healthcare's (ACSQHC) Medication Safety Standard, in particular Standard 4: actions 4.6.1, 4.6.2, 4.7.1 and 4.8.11
- is recognised as a key strategy towards improving medication safety12,7 thereby reducing harm from medication misadventure
- is conducted to ensure patients receive all intended medicines and avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions[13]
- should be delivered to all patients but in particular those identified at risk: in transition, or as a result of changes in their medical condition.

How pharmacists add value

Pharmacists are focused on safe, effective and efficient medication management for patients. Research shows they have the skills to conduct effective, accurate and timely medication reconciliation.

Pharmacists reduce treatment delays and costs as well as improve patient safety by:

- undertaking medication reconciliation and review, documenting known allergies and adverse drug events, identifying and addressing medication-related issues, assessing the patient's ability to manage their medication regimen and advising accordingly, counselling and educating patients about their medicines, and providing an updated medicines list
- undertaking medication reconciliation and review at all individual patient's transition points across the continuum of care: including primary care, hospital care and in aged care facilities – i.e. on admission/ transfer into hospital, on transfer between units, and on discharge/ transfer from hospital, and provide that verified information for ongoing care [1,12,13]
- assisting and educating other members of the healthcare team to conduct standardised, systematic, structured and efficient medication reconciliation[25,2,17]
- assisting organisations to identify a structured approach in meeting accreditation requirements[2-4,11] and the Australian Pharmaceutical Advisory Council's (APAC) *Guiding principles to achieve continuity in medication management*[6] – a requirement for maintaining access to the PBS in hospitals.

Trial of medication liaison services involving a clinical pharmacist conducting medication reconciliation along with other clinical activities resulted in improved patient outcomes, more medication changes to optimise therapy, a tendency for reduced readmissions, and significant decrease in community healthcare professional visits.[21]

Pharmacist undertaking and recording medication histories prior to the doctor prescribing had a positive impact on accuracy and reduced discrepancies in prescribing in a hospital ED.[40]

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Table 1 - Selected health service standards, goals and guiding principles, and how pharmacists can help

Selected Standards	How pharmacists help	Medication reconciliation : what to consider
ACSQHC's NSQHS Standard 4: Medication Safety[1] **The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.** **Actions required** for this criterion include: **4.6.1** A best possible medication history is documented for each patient **4.6.2** The medication history and current clinical information is available at the point of care **4.7.1** Known medication allergies and adverse drug reactions are documented for each patient **4.8.1** Current medicines are documented and reconciled at admission and transfer of care between healthcare settings The clinician provides a complete list of a patient's medicines to the receiving clinician and patient when handing over care or changing medicines. **ACSQHC's Safety and Quality Goal 1:** Priority area 1.1 Medication Safety[2]: Reduce harm to people from medications through safe and effective medication management **APAC Guiding Principles[6]** **Principle 4**: Accurate medication history **Principle 5**: Assessment of current medication management **Principle 7**: Supply of medicines information to consumers **Principle 9**: Communicating medicines information **ACHS's EQuIP 5 (Evaluation and quality improvement program)[3-5] mandatory criteria directly related to medicines:** **1.5.1** Medications are managed to ensure safe and effective patient outcomes **Performance Indicators include:** Number of newly admitted patients that had a medication reconciliation completed within 24 hours/total number of patients admitted.	» Pharmacists undertake medication reconciliation for all at risk patients and add value to the healthcare team. » Research shows pharmacists are most efficient and accurate at conducting medication reconciliation which can reduce medication errors and adverse events.[22,24,41] » Pharmacists educate/support other healthcare team members to deliver a standardised and consistent approach to medication reconciliation. » Research from Australia has shown that clinical pharmacist review to optimise the use of medicines contributed to reduced length of stay, reduced potential for hospital readmission and associated savings in the cost of care.[35] » Large research studies from the US have found that pharmacist-provided clinical pharmacy services which include admission drug/ medication histories and adverse drug reaction monitoring, and increased staffing of clinical pharmacists are associated with reduced hospital mortality rates and decreased medication errors. [36,39] » A study of 49 National Health Service organisations in the UK found an association between the number of pharmacists employed (more pharmacists on staff and involved in clinical activities) and lower mortality rates.[37]	**Executive and Board** » What is your organisations process to meet the ACSQHC's NSQHS Standards[1] and Australian Safety and Quality Goals for Healthcare[2], and the APACs *Guiding Principles to Achieve Continuity in Medication Management*[6]? » Is medication reconciliation completed in the first 24-48 hours for all patients (in particular those at risk[2]) who present or are admitted into hospital? Is a standardised and consistent approach followed and is training and support offered to provide this? » Are pharmacists included in your healthcare teams to assist with compiling an accurate medication history for use when the medication chart is first written up, and for medication reconciliation at discharge? » Is medication reconciliation part of your discharge process? Is discharge information including an accurate medication list provided in a timely manner to the patient's GP/ healthcare provider? » Do you collect data on pre-admission and post discharge medication misadventure? » Is your organisation committed to providing medication reconciliation for patients (including pharmacists at the bedside) and adequate, ongoing funding and training to support this? **Directors of Pharmacy** » Is funding available for clinical pharmacists as part of healthcare teams in your current business model or future funding submissions? » Have you prepared a business case to take to the executive that shows the numbers of pharmacists required to deliver medication reconciliation, and how they can support your organisation in meeting NSQHS Standards and Goals? **Patients/consumers** » Is there a pharmacist available throughout your process of care to review your medication, assist you with medication-related concerns, provide you with medicines information and education, and to update your current medicines list?

An electronic version and complete list of references is available at ***http://www.shpa.org.au*** *(Updated November 2012)*

The Society of Hospital Pharmacists of Australia (SHPA) is the professional body which represents over 4,000 pharmacists, pharmacy students, pharmacy technicians and associates practising in all parts of the Australian health system.

SHPA vision

Excellence in Medicines Management.

SHPA purpose

Deliver value through people, systems and processes and processes for the best patient outcomes