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Introduction

The Medication Safety and Quality Unit of the Clinical Excellence Commission (CEC) was established to assist local health districts and hospitals to improve their medicines’ use systems. This is achieved by enabling them to comply with medicines-related national standards for quality and safety, and to identify and respond to existing and emerging risks to the safety and quality of medicines use.

The Continuity of Medication Management (CMM) Program aims to improve the safety and quality of medicines use when patients transfer between health care settings. Medication Reconciliation has been chosen as the focus of this CMM program as formalised medication reconciliation processes have been recognised internationally and nationally as a strategy to improve patient safety and the continuity of medication management. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has included continuity of medication management and medication reconciliation in the National Safety and Quality Health Service (NSQHS) Standards.\(^1\) All health services are required to meet these standards.

Although straightforward in concept, the process of implementing medication reconciliation across health services is complex. The CEC developed a Medication Reconciliation Toolkit in 2015 to support LHDs and individual hospitals in their implementation efforts, providing tools, resources and guidance on how to incorporate medication reconciliation into everyday practice.

The content of this Medication Reconciliation Education Package, developed by the CEC Medication Reconciliation Education Package Working Party in collaboration with the CEC Continuity of Medication Management Expert Advisory Group and NSW hospital clinicians, is to be used in conjunction with facility-led implementation of formal medication reconciliation processes.

Background

Ensuring the continuity of medication management is the responsibility of all clinicians. Commissioner Garling saw the need for multidisciplinary teams to work together to provide good patient care. This vision of a multidisciplinary team is especially important when addressing medication reconciliation, since so many different clinicians are involved. Implementation of processes to improve medication reconciliation can be complex and requires careful planning. It is important that the responsibility for each task is clearly allocated within the multidisciplinary team in order to reduce duplication of effort and to ensure that no steps in the process are missed. Research has shown that an ‘inter-professional team approach’ is best for implementing processes to achieve continuity in medication management (see Guide to Engaging a Multidisciplinary Quality Improvement Project Team for more information).

Each clinical area should determine the roles and responsibilities for each member of their health care team with respect to medication reconciliation at admission, transfers and discharge. These roles and responsibilities may change or differ depending on the needs or vulnerability of the patient, the transfer of care being undertaken and the clinical mix of available staff.

In facilities where there are very low levels of medical and pharmacy workforce, such as in rural and remote areas of NSW, participation in medication reconciliation processes by nursing and midwifery staff is essential in helping to reduce errors and patient harm that occurs from incomplete, haphazard processes that are reliant on individual health care professionals. Determining roles, responsibilities and documentation requirements at the local level assists facilities to standardise the medication reconciliation process (see Guide for Determining Roles, Responsibilities and Documentation Requirements for more information).

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**Purpose**

The aims of the Medication Reconciliation Education Package are to:

- Provide a suitable resource for facilities to use to train nursing staff in medication reconciliation processes.
- Increase knowledge and skill amongst nursing staff in undertaking medication reconciliation processes.
- Improve medication reconciliation rates.

The Package is designed to be a comprehensive resource to enable NSW Public Health facilities to provide training to nurses, nurse practitioners and midwives on all steps of the medication reconciliation process. It also includes evaluation resources to assess the effectiveness of the training.

Medication reconciliation tasks may be delegated to an Enrolled Nurse (EN) under the direction and supervision (either direct or indirect) of a Registered Nurse (RN) or midwife. The RN or midwife is responsible for delegating appropriately considering the EN’s knowledge, skill, education and the context of the nursing care provided. The roles and expectations, including the level of supervision, of ENs in medication reconciliation processes should be clearly communicated at each facility either through local policy, position descriptions or orientation procedures.\(^4\),\(^5\),\(^6\),\(^7\)

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\(^5\) NSW Nurses and Midwives' Association. Policy on enrolled nurses. NSW; 2016.
\(^6\) Nursing and Midwifery Board of Australia. Supervision guidelines for nursing and midwifery. Melbourne; 2015.
\(^7\) Nursing and Midwifery Board of Australia. A national framework for the development of decision-making tools for nursing and midwifery practice. Melbourne; 2007.
Content

The Medication Reconciliation Education Package consists of:

1. Facilitator Handbook
2. Participant Handbook
3. Evaluation Resources:
   • Participant Surveys:
     o Pre-Workshop Survey
     o Post-Workshop Survey
     o Follow Up Survey
   • Admission Medication Reconciliation Audit:
     o Admission Medication Reconciliation Audit Tool
     o Admission Medication Reconciliation Audit Tool User Guide
4. Pre-Workshop Materials:
   • CEC Best Possible Medication History (BPMH) Interview Guide
   • CEC Medication Reconciliation Education Package Frequently Asked Questions (FAQ) Sheet
   • HETI Continuity of Medication Management eLearning Module
   • National Medication Management Plan (MMP) and User Guide
5. Medication Reconciliation Workshops 1-3 PowerPoint® presentations and facilitator notes
6. Workshop Activity Materials:
   • Workshop 2. Role Play
   • Workshop 3. Discharge Reconciliation Activity
7. Medication Reconciliation Follow Up Discussion PowerPoint® presentation and facilitator notes
8. List of Useful Websites and Resources
Learning Outcomes

By completing Workshop 1 – Introduction: the Case for Medication Reconciliation, participants should be able to:

- Describe medication reconciliation.
- Identify why medication reconciliation is an effective approach to ensure CMM.
- Understand how medication reconciliation processes fit into current practice.

By completing Workshop 2 – Medication Reconciliation on Admission, participants should be able to:

- Define what a BPMH is and why it is important to patient care.
- Use a structured approach when interviewing patients to obtain a Best Possible Medication History (BPMH).
- Be familiar with where to document a BPMH and related information.
- Identify the types of medicines information sources that can be used to collect and confirm a BPMH, including their benefits and limitations.
- Demonstrate effective patient interview techniques via role plays.

By completing Workshop 3 - Medication Reconciliation: Beyond Admission, participants should be able to:

- Understand the last two steps of the medication reconciliation process; reconciliation and supply of medicines information.
- Identify how the MMP can assist in these steps.
- Describe what a medication discrepancy is and how to resolve them.
- Demonstrate skills in discharge reconciliation and the supply of medicines information to patients.

By completing the Medication Reconciliation Follow Up Discussion, participants will be able to:

- Discuss their experience with medication reconciliation processes since completing the workshop/s.
- Share successes, learnings or challenges with colleagues.
- Provide feedback to local managers and the CEC to inform future steps.
**Requirements for Facilitators**

Facilitators are expected to have read and understood the pre-workshop material and workshop presentations and facilitator notes prior to facilitating the workshops.

Facilitators should be familiar with the current practice of medication reconciliation within the facility and be comfortable to customise the workshop presentations and activities to the local context.
EVALUATION RESOURCES
Introduction

In order to address the aims of the Education Package at a local level a number of evaluation resources have been provided for facilitators to use, these include;

- Participant pre-, post- and follow up workshop surveys to determine if there is an increase in knowledge and skill amongst nursing staff in undertaking medication reconciliation processes.
- Admission Medication Reconciliation Audit to determine if the education provided contributes to improvement in medication reconciliation rates.
Participant Surveys

The purpose of the pre-workshop survey is to determine the baseline knowledge and skill of the participant regarding medication reconciliation processes, which pre-workshop materials were completed and the value of these materials, and what participants hope to achieve from the education.

The purpose of the post-workshop survey is to determine whether knowledge and skill regarding medication reconciliation processes improves from baseline, the perceived value of the workshop and how the workshop content could be improved in the future.

The purpose of the follow up survey is to determine what medication reconciliation processes participants have been using in real life practice and if there is any further training they feel is necessary to support their practice. The survey will assist in providing feedback to local managers and the CEC to inform future steps.

For the purpose of data analysis setting up the surveys in a survey tool such as the CEC QARS (Quality Auditing Reporting System), Survey Monkey or Survey Manager would be helpful.

For participants:

1. Complete pre-workshop material
2. Complete pre-workshop survey immediately prior to the workshop/s
3. Attend workshop/s
4. Complete post-workshop survey
5. Apply knowledge to real life practice (over the following 3 - 6 months)
6. Attend a discussion group meeting organised by a local facilitator
7. Complete follow up survey

For facilitators:

1. Hand out pre-workshop survey to participants immediately prior to conducting the workshop
2. Conduct the workshop/s
3. Hand out post-workshop survey to participants at the end of the workshop/s
4. Organise a discussion group meeting approximately 3 - 6 months after the workshop/s
5. Facilitate a discussion with the group (using the Follow Up Discussion PowerPoint® presentation)
6. Hand out follow up survey
7. Send completed follow up surveys to the CEC CMM Program Lead
1. Name or identifier:

2. At which facility do you work?

3. What is your current role/position?
   - Clinical Nurse Consultant
   - Clinical Nurse Educator
   - Enrolled nurse
   - Midwife
   - Nurse Unit Manager
   - Registered nurse
   - Other (please specify):

4. Have you undertaken any previous face-to-face workshops or training sessions on medication reconciliation?
   - Yes
   - No
   - Not sure

5. If yes, please briefly describe what it was and where you received the training:
6. At what level would you describe your knowledge regarding medication reconciliation?

○ Expert
○ Intermediate
○ Novice

7. Which pre-workshop materials have you read or completed prior to attending this workshop?

○ CEC Best Possible Medication History (BPMH) Interview Guide
○ CEC Medication Reconciliation Education Package Frequently Asked Questions (FAQ) Sheet
○ HETI Continuity of Medication Management eLearning Module
○ National Medication Management Plan (MMP)
○ National MMP User Guide
○ Other (please specify):

8. Please rate how strongly you agree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The pre-workshop material helped increase my knowledge regarding medication reconciliation</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Having a standard medication reconciliation process in my workplace can improve patient safety</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am aware of the procedures and processes that relate to medication reconciliation in my workplace</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
8. Please rate how strongly you agree with the following statements:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing and midwifery, medical and pharmacy staff, all have a part to play in medication reconciliation</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am currently involved in aspects of medication reconciliation in my workplace</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I currently have the skills to take a best possible medication history (BPMH) for a patient in my care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I know where to document information relating to medication reconciliation (according to local policy or procedures)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>When I have a concern about a medication ordered for a patient under my care, I can approach the attending doctor or medical team to resolve the issue</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I understand the importance of providing information to patients about their medications on discharge</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

9. What personal objectives do you hope to achieve from attending these workshops?
1. Name or identifier:

2. Which of the medication reconciliation workshops did you just complete?
   - Introduction: the Case for Medication Reconciliation
   - Medication Reconciliation on Admission
   - Medication Reconciliation: Beyond Admission

3. At what level would you NOW describe your knowledge regarding medication reconciliation?
   - Expert
   - Intermediate
   - Novice

4. If not already done prior to the workshop, which of these materials will you now consider reading or completing?
   - CEC Best Possible Medication History (BPMH) Interview Guide
   - CEC Medication Reconciliation Education Package Frequently Asked Questions (FAQ) Sheet
   - HETI Continuity of Medication Management eLearning Module
   - National Medication Management Plan (MMP)
   - National MMP User Guide
   - Other (please specify):
5. Please rate how strongly you agree with the following statements:

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The content of the workshop presentation/s was relevant to my area of practice</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>The workshop presentation/s was pitched at an appropriate level</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I will apply my learnings from this workshop into my daily practice</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

6. Please complete the following questions if you completed the ‘Introduction: the Case for Medication Reconciliation’ workshop:

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The workshop increased my knowledge regarding medication reconciliation</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Having a standard medication reconciliation process in my workplace can improve patient safety</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am more aware of the procedures and processes that relate to medication reconciliation in my workplace</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>This workshop has increased my interest to take part in at least one aspect of medication reconciliation in my workplace</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
7. Please complete the following questions if you completed the ‘Medication Reconciliation on Admission’ workshop:

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I currently have the skills to take a best possible medication history for a patient under my care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I know where to document information relating to medication reconciliation (according to local policy or procedures)</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

8. Please complete the following questions if you completed the ‘Medication Reconciliation: Beyond Admission’ workshop:

<table>
<thead>
<tr>
<th></th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I have a concern about a medication ordered for a patient in my care, I am confident in approaching the attending doctor or medical team to resolve the issue</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I understand the importance of providing information to patients about their medications on discharge</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

9. What personal objectives did you achieve from attending these workshops?
10. What is one thing you would like to improve in your work practice in regard to medication reconciliation?

11. Did you think the workshop/s you attended were a useful professional development activity?

○ Yes

○ No

12. Why or why not? Please provide any comments, suggestions or reasons for your answer.

13. How do you think the workshop content could be improved for the future?

14. Do you have any other comments or suggestions regarding the Education Package? (e.g. pre-workshop materials, workshops, other resources)

Thank you for taking the time to complete the surveys
1. Name or identifier:

2. At which facility do you work?

3. What is your current role/position?
   - Clinical Nurse Consultant
   - Clinical Nurse Educator
   - Enrolled nurse
   - Midwife
   - Nurse Unit Manager
   - Registered nurse
   - Other (please specify):

4. Which of the medication reconciliation workshops did you attend?
   - Introduction: the Case for Medication Reconciliation
   - Medication Reconciliation on Admission
   - Medication Reconciliation: Beyond Admission

5. At what level would you describe your knowledge regarding medication reconciliation?
   - Expert
   - Intermediate
   - Novice
6. Please indicate the relevant frequency of carrying out the following activities in your current practice?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Regularly (daily basis)</th>
<th>Frequently (every 2 – 3 days)</th>
<th>On occasion (weekly)</th>
<th>I require further training to carry out this activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where possible or early on in their admission, I take a best possible medication history for the patients in my care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I have identified medication discrepancies between a patient’s medication history and their current medication orders</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I effectively resolve medication issues with the attending doctor when I have concerns about a medication order for a patient in my care</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I clearly document the outcome of a medication issue after discussion with the attending doctor or medical team</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>I am involved in educating and communicating medicines information to my patients and/or their carers when they are discharged from the facility</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>On transfer or discharge, I double check that the medications that the patient has been on matches with the medications the patient is going to continue with</td>
<td>○</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
7. Do you still think that medication reconciliation processes are relevant to your practice?

○ Yes

○ No

○ Other (please specify):

8. Are there any other nursing or midwifery staff on your ward/clinical area that are involved with and carry out medication reconciliation processes?

○ Yes

○ No

○ Not sure

9. If there was an opportunity to attend another workshop to advance your skills in medication reconciliation, would you be interested in attending?

○ Yes

○ No

○ Maybe

10. What particular skills related to medication reconciliation are you interested in upskilling or gaining more advanced training in?

11. What is the name of your current clinical nurse educator?
12. Any other comments or suggestions regarding your involvement in this training?

13. If you wish to receive information regarding further education opportunities, please let the CEC know the best email address to contact you on:
**Admission Medication Reconciliation Audit**

In order to determine if there have been improvements in medication reconciliation rates as a result of the education, it is essential that a baseline audit, and audits at regular intervals thereafter, should be conducted at a facility level. As an example, the facilities involved in piloting the Education Package were required to conduct a baseline audit and a follow up audit 3 months after holding the education.

Implementation of standardised medication reconciliation processes at your facility will contribute to meeting Criterion 4.6, 4.8, and 4.12 of the NSQHS Standards, and ongoing auditing of these processes will provide evidence of monitoring medication safety processes to improve the effectiveness of systems in place.

The CEC has developed audit tools to assess compliance with medication reconciliation processes and are available via the [CEC CMM webpage](#). An Admission Medication Reconciliation Audit Tool and User Guide have been developed for the Medication Reconciliation Education Package.

An electronic version of this Audit Tool has also been developed in the [CEC QARS (Quality Auditing Reporting System)](#) and available for use in NSW Public facilities, it is helpful for analysing your results. The name of the Tool is CEC Admission Medication Reconciliation Audit Tool and can be easily accessed through the ‘Audit Setup’ function.

Auditing may be conducted by intern and registered pharmacists, registered nurses and doctors who are familiar with the concepts of medication reconciliation and quality improvement methodology. For more details on the audit method refer to the Admission Medication Reconciliation Audit Tool User Guide.

Reporting of the audit results back to frontline clinicians and at the executive or manager level is encouraged to promote a culture that consistently works towards improvement.
Audit Instructions

Sample selection
A random selection of 20 patients’ in total is ideal; this can be 20 at one time or 5 patients per week over a month. Selection may be done prospectively as only the admission components (medication history and admission reconciliation) are assessed with this audit.

Eligible criteria
All hospital patients > 18 years old that have been admitted for greater than 24 hours.

Exclusion criteria
- Admitted for less than 24 hours
- Died during the admission
- Provided palliative care only
- Admitted directly to ICU (unless specifically targeting these patients).

See the Admission Medication Reconciliation Audit Tool User Guide for more information on component definitions related to medication reconciliation.

An electronic version of this Audit Tool has also been developed in the CEC QARS (Quality Auditing Reporting System) and available for use in NSW Public facilities. Utilising QARS can be helpful for analysing your results. The name of the Audit is CEC Admission Medication Reconciliation Audit and can be easily accessed through the ‘Audit Setup’ function (Questionnaire Identification number 3618).
## Audit Questions

**Facility name:**………………………………..  **Auditor name:**…………………………………..

**Date of audit:**…………………………………..  **Patient number:**…………………………………..

<table>
<thead>
<tr>
<th>Question</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How old is the patient?</td>
<td></td>
</tr>
<tr>
<td>2. Was the patient’s current allergy status documented and available at the point of prescribing? (e.g. electronic patient profile for electronic prescribing, NIMC for paper charts)</td>
<td></td>
</tr>
<tr>
<td>Selecting ‘Yes’ also includes when the patient has ‘No Known Allergies’ documented</td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>3. Was this patient a transfer from another hospital?</td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>4. Was a clear medication history documented on admission to this facility?</td>
<td></td>
</tr>
<tr>
<td><em>If the patient was on no regular medications prior to admission, select ‘N/A’ (if No or N/A; finish)</em></td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>○ N/A</td>
<td></td>
</tr>
</tbody>
</table>
### Audit Questions

**Facility name:** ……………………………………..  **Auditor name:** ……………………………………..

**Date of audit:** ……………………………………..  **Patient number:** ……………………………………..

<table>
<thead>
<tr>
<th>Question</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. If the answer to Question 4 was ‘Yes,’ where was the medication history documented? (multiple choice)</td>
<td></td>
</tr>
<tr>
<td>○ Within the electronic medication management system</td>
<td></td>
</tr>
<tr>
<td>○ eMR notes</td>
<td></td>
</tr>
<tr>
<td>○ eMR Medication PowerForm</td>
<td></td>
</tr>
<tr>
<td>○ Medication Management Plan (MMP)</td>
<td></td>
</tr>
<tr>
<td>○ Locally adapted MMP</td>
<td></td>
</tr>
<tr>
<td>○ Front of the National Inpatient Medication Chart (NIMC)</td>
<td></td>
</tr>
<tr>
<td>○ Other</td>
<td></td>
</tr>
<tr>
<td>6. Was there documentation of more than one source of medicines information used to collect and confirm the medication history?</td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>7. Was the medication history available at the point of care? (i.e. with the active inpatient orders or inpatient medication chart)</td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>8. Was there documented evidence of a formal reconciliation process between the medicines in the medication history and the medicines actually prescribed as an inpatient? (if No; go to Q10)</td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>9. Where was this documented? (i.e. doctor’s decisions around reconciliation of medications) (single choice)</td>
<td></td>
</tr>
<tr>
<td>○ Within the electronic medication management system</td>
<td></td>
</tr>
<tr>
<td>○ eMR notes</td>
<td></td>
</tr>
<tr>
<td>○ eMR Medication PowerForm</td>
<td></td>
</tr>
<tr>
<td>○ MMP</td>
<td></td>
</tr>
<tr>
<td>○ Locally adapted MMP</td>
<td></td>
</tr>
<tr>
<td>○ Front of the NIMC</td>
<td></td>
</tr>
<tr>
<td>○ Other</td>
<td></td>
</tr>
<tr>
<td>10. Was every medication in the medication history prescribed as an inpatient medication order? (i.e. no omitted medications, note medications could be intentionally or unintentionally omitted) (if Yes; finish)</td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
</tbody>
</table>
## Audit Questions

**Facility name:** ..............................................  **Auditor name:** ..............................................

**Date of audit:** ..............................................  **Patient number:** ..............................................

<table>
<thead>
<tr>
<th>Question</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. If no, was the reason for the omitted medication/s documented?</td>
<td></td>
</tr>
<tr>
<td><em>If there were multiple medications omitted, only select ‘Yes’ if all the medications had a reason documented</em></td>
<td></td>
</tr>
<tr>
<td><em>(if Yes; finish)</em></td>
<td></td>
</tr>
<tr>
<td>○ Yes</td>
<td></td>
</tr>
<tr>
<td>○ No</td>
<td></td>
</tr>
<tr>
<td>12. What medication/s were omitted without a reason documented?</td>
<td></td>
</tr>
<tr>
<td>__________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>__________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>__________________________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>
Introduction

The Admission Med Rec Audit Tool is an observational tool that collects information on whether components of continuity of medication management are evident for each patient on admission. It provides a quick overview of the processes that are occurring and those which are not.

This audit tool captures several components of continuity of medication management:
1. Documentation of allergy status
2. Documentation of a clear medication history
3. Confirmation or verification of the medication history
4. Accessibility of the medication history at the point of care
5. Reconciliation of medications in the medication history with the medications actually prescribed
6. Number of omitted home medications without a reason documented for the omission.

Method

It is recommended that at least 20 randomly selected records, distributed evenly across the wards/units to be included in the quality improvement activity, be reviewed. These 20 patients do not need to be reviewed on the same day, the tool allows for collection over a period of time (e.g. five patients could be reviewed each week for a month). Frequent small samples have been shown to be more manageable and provide sufficient data to support ongoing quality improvement activities.

The following patients should be excluded from the audit:
- Admitted for less than 24 hours
- Died during the admission
- Were provided palliative care only
- Admitted directly to ICU (unless specifically targeting these patients).

Auditing may be conducted by intern and registered pharmacists, registered nurses and doctors who are familiar with the concepts of medication reconciliation and quality improvement methodology. They must familiarise themselves with the component definitions.

Audit Instructions

1. Read this Audit Tool User Guide.
2. Read/revise local guidelines and procedures regarding medication history taking, recording medication-related information or make enquiries in regard to current practices.
3. Decide on the wards/units and number of patient records to review.
4. Determine whether this is a collection to determine a baseline or progress.

5. Complete all questions specified by the Audit Tool.

6. Ensure that all original paper or electronic records from the audit are returned to the relevant audit coordinator at each facility.

**Component Definitions**

Below are the definitions for the relevant components of continuity of medication management used within the audit.

<table>
<thead>
<tr>
<th>Component</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear medication history</td>
<td>Select ‘Yes’ if there was a documented list of medications taken prior to admission that included the name, dose and frequency of each medication. If the patient was on no regular medications prior to admission, select ‘N/A’.</td>
</tr>
<tr>
<td>Sources of medicines information</td>
<td>Select ‘Yes’ if there was documentation of more than one source of medicines information used to collect and confirm the medication history. Sources of medicines information include: patient or carer interview, patient’s own medications, dose administration aids, patient medicines list, nursing home or hostel medication chart/s, GP medication list or referral letter, community pharmacy dispensing history, previous hospital discharge summary or the HealtheNet Portal.</td>
</tr>
<tr>
<td>Documented evidence of a formal reconciliation process</td>
<td>Select ‘Yes’ if there was evidence that a formal medication reconciliation process had occurred i.e. there was documentation to support that the medications in the history had been used to ensure that the medications ‘actually’ prescribed match those that ‘should’ be prescribed. Evidence may include documented changes to orders resulting from identified discrepancies or documentation that reconciliation had been completed on a form dedicated for this purpose.</td>
</tr>
<tr>
<td>Component</td>
<td>Definition</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Availability at the point of care        | An omitted medication is any medication that was documented in the medication history but not prescribed as an inpatient medication order. These could be:  

  i) Intentional - a clear clinical reason/documentation for the omission e.g. stopping warfarin in a patient with an acute bleed, OR  

  ii) Unintentional - no clear reason documented for omitting the medication. |
| Omitted medication                       |                                                                                                                                              |
| Reason documented for the omission      | Select ‘Yes’ if the reason for omitting the medication was documented in the patient record. Only select ‘Yes’ if all the medications omitted had a reason documented.  
Select ‘No’ if there was no clear reason/s documented. |
PRE-WORKSHOP MATERIALS
Pre-Workshop Materials

Participants should be provided with access or a copy of each resource, and be strongly encouraged to complete the material prior to attending the workshop/s.

The pre-workshop materials produced by the CEC are available in both the Facilitator and Participant handbooks. Other pre-workshop materials are available via the hyperlinks listed below.

The pre-workshop materials include the:

- CEC Best Possible Medication History (BPMH) Interview Guide.
- National Medication Management Plan (MMP) Form which can be accessed via this link.
- National Medication Management Plan (MMP) User Guide which can be accessed via this link.

All participants should complete the HETI Continuity of Medication Management eLearning module via My Health Learning (formerly HETI Online) prior to attending the workshop/s. The details of the module include:

- Continuity of Medication Management eLearning module:
  - Course code: 157075702.
  - Duration: 35 – 45 minutes.
A patient/carer, when possible, is a crucial aspect of obtaining a best possible medication history. The structured approach to interviewing a patient/carer provided in this guide is intended to encourage standardisation and improve the capture of important accurate medicine information. Clinicians may need to adapt the approach used in this guide depending on circumstances.

1. **Review relevant patient information**
   Background information about the patient’s health and social status can assist in establishing the existence of, or potential for, medication related problems.

   For example, **age** - the younger and older patients are at most risk of medication-related problems. A patient’s age will indicate their likely ability to metabolise and excrete medicines which has implications for appropriate selection of drug and dosage.

   For example, **presenting condition** - could their symptoms be adverse effects related to their prescribed medicines or complementary medicines? Or could lack of symptom control indicate poor adherence, inadequate dose or inappropriate agent?

   Establishing this background information will allow you to identify issues to focus on during the interview, provide insight into the types of medications the patient may be taking and will assist in assessing the appropriateness of therapy (especially if your role in the patient’s care includes reviewing and/or prescribing medications).

2. **Introduce yourself and explain the purpose of the interview**
   Provide a clear introduction to the interview. Determine the individual responsible for the administration and management of medicines, if this is the patient and they are able to communicate, confirm the time is convenient and adopt a suitable position to enable the interview to take place.

   If the patient is not responsible an interview with the carer should be organised.

3. **Ask about previous adverse medication events or allergies**
   Confirming an allergy or adverse medication event often requires more than one question as often patients do not understand what an adverse event is e.g. you might ask “…are there any medicines you are allergic to or have had a bad reaction to?”

   To document an accurate and comprehensive allergy and adverse medication event history, confirm the details of any medication allergies or adverse reactions with the patient/carer and document details of the drug, reaction and date of the reaction (if known) on the medication chart and in the patient’s medical record according to hospital policy.

   Comprehensive information is important as it may be used to determine whether re-exposure could be clinically appropriate when alternatives are not available.

4. **Ask about prescription, non-prescription and complementary medicines**
   Include information about the brand, strength, form, route, dose and frequency, duration of therapy and indication i.e. why the patient thinks they are taking the medication. Remember to ask specifically about prescription, non-prescription and complementary medications.

   The medication list should include recent changes to medicines including dose increase/decrease and any recently ceased medicines. Reasons for any change should also be recorded, where known.

   The medication list should include recent changes to medicines including altered medicines (e.g. dose increase/decrease) and any recently ceased medicines. Reasons for any change should also be recorded, where known.
Don’t assume that if a patient brought in a medicine that they are actually taking it.

Guide the interview responses by treating each medication separately, obtaining all information before moving onto the next medication. This reduces confusion and facilitates accurate documentation.

5. Use a checklist
Use of a checklist will improve the accuracy and completeness of the medication history. It reduces the likelihood of omitting relevant details. It prompts the patient’s memory of medications that they did not bring with them or where not brought in by the paramedics (e.g. medications stored in the refrigerator), they use on occasion only or had not perceived as a medication.

**Medication History Checklist**
- Prescription medications
  - Sleeping tablets
  - Inhalers, puffers, sprays, sublingual tablets
  - Oral contraceptives, hormone replacement therapy
- Non-prescription medications e.g. OTC medicines
- Complementary medications e.g. vitamins, herbal or natural therapies
- Analgesics
- Gastrointestinal medications e.g. for reflux, heartburn, constipation or diarrhoea
- Topical medications e.g. creams, ointments, patches
- Inserted medications e.g. nose/ear/eye drops, pessaries, suppositories
- Inject medications
- Intermittent medications e.g. weekly
- Recently completed courses of medication
- Social and recreational drugs
- Other people’s medicines

6. Assess patients understanding, attitude and adherence
Seek information on the patient’s:
- Understanding of rationale for treatment
- Perception of the purpose of the medicines and their effectiveness
- Perception of potential adverse effects
- Understanding of monitoring of disease/medicine.

These perceptions may impact on the patient’s adherence to prescribed treatment. To obtain honest, open responses regarding a patient’s adherence choose questions which are non-judgemental and normalise non-adherence.

**Assess Adherence**
- ‘People often have difficulty taking their medicine for one reason or another… Have you had any difficulty taking your medicine?’
- ‘About how often would you say you miss taking your medicine?’

7. Organise and record medicines information
It is important that the medication history is documented in a way that allows it to be readily accessed by all members of the healthcare team.

Suitable areas include the front of the National Inpatient Medication Chart, the NSW Medication Management Plan or similar form and in the electronic medical record.

The information gathered during the patient interview, as listed, should be documented clearly and succinctly. This includes the other sources of information used to clarify and validate the information obtained during the interview.

**Tips**
Begin with open ended questions:
- ‘What medicines do you take or use regardless of how you feel?’
- ‘What medicines do you only take or use when you need them?’
- ‘Do you take or use any medicines for pain/to help you with sleep/heartburn/allergies?’

Ask about medications for specific conditions identified from the medical history:
- ‘What medicine do you take or use for your diabetes/high blood pressure etc.? ’

End with specific probing questions:
- ‘How often do you take or use your pain medicine?’
- ‘Do you take that in the morning or at night?’

Use prompts to assist the patient’s memory e.g. medication lists or patient’s own medications. Provide the patient opportunity to recall the name, how they take it and the purpose of the medicine. Do not read the list or label aloud asking if it is correct.
What is medication reconciliation?

Medication reconciliation is a patient-centred, structured and standardised process conducted in health care facilities to reduce adverse medication events by ensuring patients receive all intended medicines (reduces transcription, omission, commission and duplication errors) at transfers of care. It involves 4 steps:

1. Collecting information to compile a medication history
2. Confirming the accuracy of the information (also known as obtaining the Best Possible Medication History - BPMH)
3. Comparing the history with the prescribed medicines at every transfer of care
4. Supplying accurate medicines information to the patient/carer and next care provider/s

The process of medication reconciliation facilitates the transfer of accurate, current and comprehensive medicines information at admission, transfer and discharge, what is more commonly known as continuity of medication management (CMM).

Why is medication reconciliation important?

Unintentional changes to patients’ medicines at transfer of care can result in considerable harm and have been linked to poorer health outcomes, increased hospital readmissions and mortality. Around half of hospital medication errors occur on admission, transfer and discharge. Around 30% of these have the potential to cause patient harm.¹

What are the benefits of medication reconciliation on patient safety and clinician workload?

Implementing formalised medication reconciliation at admission, transfer and discharge has been found to reduce medication errors by 50 - 94% and reduces those with the potential to cause harm by over 50%.² The time savings for nurses of 20 minutes per patient at admission and pharmacists of 40 minutes per patient at discharge have been reported.¹

Formalised medication reconciliation processes have been recognised nationally and internationally as a strategy to improve patient safety and the continuity of medication management. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has included medication reconciliation in the National Safety and Quality Health Service (NSQHS) Standards.³ All health services are required to meet these standards.

Where are medication reconciliation processes documented?

Ideally, medication reconciliation processes should be documented in one place that is at the point of care (i.e. with the patient’s current medication chart) and accessible to all members of the health care team. A standardised form such as the Medication Management Plan - MMP (or equivalent locally agreed form) or an electronic medication management system should be used. This will facilitate the documentation of a BPMH, the plan for medicines on admission, reconciliation of medications on admission, transfer and discharge, identification and tracking of medication discrepancies and/or issues, documentation of changes to medications during the admission and supply of accurate medicines information on transfer and discharge to the patient and next care provider.

FREQUENTLY ASKED QUESTIONS

Medication Reconciliation Education Education Package
(Nursing & Midwifery)
Do nurses & midwives have a role in medication reconciliation?

Ensuring the continuity of medication management is the responsibility of medical officers, nurses and pharmacists. Research has shown that an ‘inter-professional team approach’ is best for implementing processes to achieve continuity in medication management. Medication reconciliation supports a number of complex medication management processes including prescribing and safe medication administration and depends on clear communication, documentation and teamwork.

In facilities where there are low levels of medical and pharmacy workforce, such as in rural and remote areas of NSW, participation in medication reconciliation processes by nursing and midwifery staff is crucial in helping reduce errors and patient harm that can occur from incomplete, haphazard processes that are reliant on individual health care professionals. Determining roles, responsibilities and documentation requirements at the local level will assist facilities to standardise the medication reconciliation process.

Is there any legal impediment to nursing staff being involved in medication reconciliation?

Advice was sought from the NSW Ministry of Health Legal Branch in 2015 regarding this query, which in turn received advice from the Nursing and Midwifery Council of NSW. The Legal Branch identified no legal impediment under the NSW Poisons and Therapeutic Goods legislation or the Health Practitioner Regulation National Law for nurses or midwives to undertake the tasks involved in medication reconciliation. In terms of nursing scope of practice, it was noted by the Council, and recognised by the Legal Branch, that in many settings this would require education, policy development and organisational support for practice change. Facilities should ensure that each registered nurse or midwife required to conduct one or more medication reconciliation tasks has been appropriately trained and confirmed as competent to do so.

Can enrolled nurses be involved in medication reconciliation processes?

Medication reconciliation tasks may be delegated to an enrolled nurse (EN) under the direction and supervision (either direct or indirect) of a Registered Nurse (RN) or midwife. The RN or midwife is responsible for delegating appropriately considering the EN’s knowledge, skill, education and the context of the nursing care provided. This Education Package will provide the training required to increase competency in medication reconciliation processes. The roles and expectations of ENs, including the level of supervision, in medication reconciliation processes should be clearly communicated at each facility either through local policy, position descriptions or orientation procedures.

References

GUIDE TO FACILITATING THE WORKSHOPS
Guide to Facilitating the Workshops

The medication reconciliation workshops are designed to be conducted as face-to-face events, with small groups of clinicians led by a facilitator. They could also be used by individuals as a self-directed learning activity, with later group discussion via tele or videoconference. There are a total of three workshops, which can be run either as separate learning sessions or all together in succession. The order and number of workshops conducted is left to the discretion of the facilitator and time availability.

Workshop Outline

<table>
<thead>
<tr>
<th>Workshop</th>
<th>Approx. Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction: the Case for Medication Reconciliation</td>
<td>30 mins</td>
</tr>
<tr>
<td>2. Medication Reconciliation on Admission</td>
<td>1 hour 30 mins</td>
</tr>
<tr>
<td>3. Medication Reconciliation: Beyond Admission</td>
<td>1 hour 30 mins</td>
</tr>
</tbody>
</table>

Resources Required

General resources required to facilitate the workshops include:

- PC or notebook computer with an active USB drive.
- USB containing the medication reconciliation workshop PowerPoint® presentations.
- Butchers paper and markers or white board and white board markers.
- ‘Post it’ notes.
- Medication reconciliation workshops 1-3 PowerPoint® presentations and facilitator notes.
- Participant pre- and post-workshop surveys.
• Access to the YouTube video Medication Reconciliation Myth #2: It’s Not My Job. It can be accessed through the internet (you may need to contact your local IT department to facilitate this) or by loading the video onto a USB before the workshops.

The specific resources required for the role play and discharge medication reconciliation activities are outlined later in the Handbook.

**Workshop PowerPoint® Presentations**

Each workshop includes a comprehensive PowerPoint® presentation. The facilitator should feel comfortable in adapting them as appropriate to suit the needs of the group and the local context. The aim is not just to impart knowledge but to encourage discussion and interaction amongst participants.

Each workshop PowerPoint® presentation is accompanied by detailed facilitator notes. The notes provide instructions to the facilitator on what they may need to do prior to the workshop and during the workshop to ensure they are interactive and run smoothly. The notes also include a list of materials that are required for the activities and notes on pertinent points to mention during the workshop/s.

Alternatively, an individual clinician can use the notes while viewing the presentation to undertake the workshop/s independently.

Specific presentation slides which can be adapted according to local incidents or context include:

- **Workshop 1. Introduction: the Case for Medication Reconciliation**
  - Slide 9 - Include local examples of medication-related incidents that may have occurred when patients have moved between health care settings e.g. on admission, transfers between wards or hospitals or on discharge.

- **Workshop 2. Medication Reconciliation on Admission**
  - Adapt this workshop based on local procedures including documentation requirements of the facility e.g. the type of form/system used to document medicines information.

- **Workshop 3. Medication Reconciliation: Beyond Admission**
  - As for workshop 2, this workshop should be adapted based on local procedures including documentation requirements of the facility.
- Slides 22–23 – Include relevant examples of ward/hospital types that are common transfers in your facility.

- This workshop may require adaptation based on if prior workshops have been completed. Some of the information is duplicated and should be removed if the workshops are being run in succession.

**Group Discussions**

There are a number of opportunities for group discussion throughout the workshops. These opportunities are highlighted in the PowerPoint® presentation facilitator notes and are intended to increase participant input and explore what issues may be relevant at a local level. The number of group discussions included should be decided by the facilitator.

**Surveys**

Ensure that each participant completes both a pre- and post-workshop survey. The surveys will provide useful feedback in terms of knowledge and skill gained, the perceived value of the workshops and if the content can be improved for the future.
WORKSHOP 2: ROLE PLAY
Role Play Facilitator Instructions

A role play has been incorporated into Workshop 2 to enable the workshop to be more interactive and facilitate adult learning in practice. The facilitator is to take on the part of the ‘patient’ being interviewed and a volunteer from the audience is to take on the part of the ‘interviewer.’

The role play should be conducted at the beginning of the workshop to explore how participants routinely take a medication history. The role play should then be repeated at the end of the workshop to demonstrate knowledge gained. Repeating the role play will hopefully show the benefits of using a structured approach to the patient interview process.

Prior to the role play the facilitator should familiarise themselves with the medications that the patient in the scenario is taking/using and their medical conditions (see Role Play – Facilitator Prompt Sheet). They should also try to take on the persona of the patient during the interview. When asked about their medications they should divulge the names of the prescribed oral medications they can recall easily. They should answer questions literally without providing more information than they have been prompted for. If possible the facilitator should make available the boxes and bottles of the medications the patient takes/uses to be used in conjunction with the patient interview.

The audience should record the medications (preferably on the documentation tool used within the facility e.g. an MMP) as they are divulged by the patient.

The workshop presentation should then be provided and the role play repeated with a different volunteer. At the end of the second role play the full list of the patient’s medications (see slide 49) should be displayed to participants so they can compare the information gained in the first and second role play. The aim is that participants obtain more ideas on how to ask questions and do not forget to ask about specific types of medications such as non-oral medications, and therefore should have more medications listed the second time the role play is conducted.

If time is restricted the role play can be used either prior to or after the workshop only.
Resources Required for the Role Play

Resources required for the role play include:

- One or two copies of the MMP or equivalent locally agreed form should be provided for each participant to write on during the role play (ideally one to fill out before the presentation and one for at the end of the presentation to compare with).
- A copy of the Role Play Facilitator Prompt Sheet which lists all the medications the patient in the role play take/uses at home for the facilitators reference.
- If possible, the boxes/bottles of the medications that the patient in the role play takes/uses at home:
  - Telmisartan (Micardis) 80mg tablets
  - Lantus Solostar
  - Novorapid Flexpen
  - Latanoprost (Xalatan) eye drops
  - Seretide 250/25 Metered Dose Inhaler (MDI)
  - Ventolin 100microg MDI
  - Rabeprazole 20mg tablets
  - Paracetamol (Panadol Osteo) 665mg
  - Buprenorphine (Norspan) 5microg/hr patch
  - Calcium (Caltrate) 600mg tablets
  - Cholecalceriferol (Ostelin) 1000 unit capsules
  - Risedronate (Actonel) 35mg tablets
  - Blackmores glucosamine 1500mg tablets
  - Blackmores Fish Oil 1000mg capsules
  - Movicol sachets
**Scenario Background**

Mr C.P. is a 78 year old female who presents to the Emergency Department of her local hospital with chest pain. She has no history of ischaemic heart disease (IHD) but has the following medical conditions: hypertension, diabetes, glaucoma, asthma, back pain, osteoporosis, osteoarthritis and most recently reflux.

Prior to the role play the facilitator should familiarise themselves with Mrs C.P.’s medications.

The audience are to record the medications mentioned during the role play on the Medication Management Plan (MMP) or equivalent locally agreed form that is used within the facility.

<table>
<thead>
<tr>
<th>Medicine Name / Strength</th>
<th>Dose</th>
<th>Frequency</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telmisartan (Micardis) 80mg</td>
<td>1 tablet</td>
<td>morning</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Lantus Solostar</td>
<td>50 units</td>
<td>night</td>
<td>Type 2 diabetes</td>
</tr>
<tr>
<td>Novorapid Flexpen</td>
<td>10 units</td>
<td>breakfast, lunch &amp; dinner</td>
<td>Type 2 diabetes</td>
</tr>
<tr>
<td>Latanoprost (Xalatan) eye drops</td>
<td>1 drop each eye</td>
<td>at night</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Seretide 250/25 MDI</td>
<td>2 puffs</td>
<td>twice a day</td>
<td>Asthma (preventer)</td>
</tr>
<tr>
<td>Ventolin 100microg MDI</td>
<td>2 puffs</td>
<td>twice a day</td>
<td>Asthma (reliever)</td>
</tr>
<tr>
<td>Rabeprazole 20mg</td>
<td>1 tablet</td>
<td>night</td>
<td>Reflux</td>
</tr>
<tr>
<td>Paracetamol (Panadol Osteo) 665mg</td>
<td>2 tablets</td>
<td>three times a day</td>
<td>Pain</td>
</tr>
<tr>
<td>Buprenorphine (Norspan) 5microg/hr patch</td>
<td>1 patch</td>
<td>weekly on Mondays</td>
<td>Back pain</td>
</tr>
<tr>
<td>Calcium (Caltrate) 600mg</td>
<td>1 tablet</td>
<td>night</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Cholecalciferol (Ostelin) 1000 units</td>
<td>1 capsule</td>
<td>morning</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Risedronate (Actonel) 35mg</td>
<td>1 tablet</td>
<td>weekly on Sundays</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Blackmores glucosamine 1500mg</td>
<td>1 tablet</td>
<td>morning</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Blackmores Fish Oil 1000mg</td>
<td>2 capsules</td>
<td>morning</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Movicol sachets</td>
<td>2 sachets</td>
<td>when required (once or twice a week)</td>
<td>Constipation</td>
</tr>
</tbody>
</table>
WORKSHOP 3: DISCHARGE MEDICATION RECONCILIATION ACTIVITY
Discharge Medication Reconciliation Activity Facilitator Instructions

A discharge medication reconciliation activity has been included to allow participants to demonstrate skills in comparing a patient’s medication documentation on discharge, identifying and resolving discrepancies between these and supplying accurate medicines information to the patient (the last two steps of the medication reconciliation process). The activity can be adapted to suit the amount of time available and your local needs, for example you may like to include a patient medicines list template for participants to fill out for the patient.

Prior to the activity the facilitator should familiarise themselves with Jack Sparrow’s medication chart, admission medication history (contained on the MMP) and discharge summary as well as the information contained in the Discharge Medication Reconciliation Activity – Facilitator Prompt Sheet.

How to run the discharge medication reconciliation activity:

2. Read the scenario as a group and ask the group what information they will require to conduct a final check (slides 37-38).
3. Divide into pairs and provide the resources needed to complete this activity.
4. Give them approximately 5 minutes to review the information contained, discussing in pairs what concerns or issues that may need to be addressed with the doctor, and then secondly what they think should be communicated with the patient before discharge.
5. Bring the pairs together as a group again, and continue with slide 39 (refer to the Facilitator Prompt Sheet for more detailed information regarding the points for discussion). Once the group has identified all the relevant issues, proceed to slide 40.
6. Slide 40-41. Now it is the facilitator’s turn to act out the role of both the doctor and the patient for the scenario using the Facilitator Prompt Sheet to assist in providing the appropriate responses.
7. End the workshop using Slide 43 as a summary of what was addressed in Workshop 3.
Resources Required for the Discharge Medication Reconciliation Activity

Resources required for the discharge medication reconciliation activity include:

- A copy of the Discharge Medication Reconciliation Activity – Participant Handout for each participant (includes Jack Sparrow’s current medication chart, admission medication history and discharge summary).
- The Discharge Medication Reconciliation Activity Facilitator Prompt Sheet for the facilitator’s reference.
- If possible, the boxes/bottles of the medications that Jack Sparrow will be discharged home on:
  - Coumadin (warfarin) 1mg and 2mg tablets
  - Coversyl (perindopril) 2.5mg tablets
  - Diabex (metformin) XR 1g tablets
  - Crestor (rosuvastatin) 10mg tablets
  - Xalatan (latanoprost) eye drops
  - Vitamin D capsules
  - Alprim (trimethoprim) 300mg tablets
  - Movicol sachets
  - Panamax (paracetamol) 500mg tablets
- A patient medicines list template or form used within the facility to supply written medicines information to patients (if this part of the activity is chosen to be included).
Scenario Background

Mr Jack Sparrow, a 75 year old man, was recently admitted for a urinary tract infection with low-grade fever and loin pain. He was admitted on 10/9/16 and has improved since starting antibiotics. The VMO is happy with Jack’s recovery and has planned him for discharge today. The discharge summary has already been printed and placed in Jack’s file.

Prior to the activity the facilitator should familiarise themselves with Jack’s medicines information.

Ask the Group

What medicines information will you need to conduct a final check before discharge?

- Medication chart
- Admission medication history (BPMH)
- Discharge summary

Medicines Information to be given to Participants

- Jack’s current medication chart
- Completed Medication Management Plan (MMP)
- Discharge summary for Jack’s GP
- The boxes/bottles of the medications that Jack will be discharged home on (optional)

Activity

1. Divide the group into pairs (if possible)
2. Whilst looking through the sources of medicines information, consider prompting them with the following questions:
   - Do you have any concerns about the plan for Jack’s medications?
   - What do you think should be clarified or checked with the doctor before Jack goes home?
   - What information does Jack need to know before he goes home?
3. After some time of discussion in pairs, bring back the group to discuss:
   - What concerns or questions they wish to discuss with the VMO
   - What information would they like to provide Jack with before he goes home?
Concerns that should be identified

Here are some examples of the main concerns or questions that should be identified whilst discussing the case as a group.

**Antibiotics:** Will the Jack receive supply on discharge from the hospital or will he require a prescription? How many days’ supply does he need? (8 more doses to complete a 14 day course)

**Warfarin:** What dose should Jack go home with? When should he have a follow up INR? Documentation needs to be amended in the discharge summary so that the GP is aware to follow up INR and warfarin dose with Jack

**Pain relief:** Jack had some paracetamol charted and received 2-3 doses, should he continue taking this at home if he has pain?

**Movicol:** Was withheld during Jack’s admission. What should he do on discharge? Continue? Withhold? Is he experiencing any gastrointestinal side effects from antibiotic use? Does he need it?

NB: Some facilities may find prescribers intentionally withhold patient’s antihypertensive medications (e.g. perindopril) during their hospital admission when they are critically ill or unwell. If this is the case in your facility, any antihypertensive medication should also be reviewed upon discharge, with a plan of when to restart and what dose (and documented in the discharge summary for the GP to review).

As the facilitator, you will respond in the questioning as both the doctor and then later as Jack.

**As the Doctor**

*When asked about trimethoprim supply:* ‘Yes, I need to write a prescription for 8 more days. I was just about to do that!’

*Warfarin:* ‘The INR appears to be stable at 1mg. I would like Jack to continue with 1mg until he sees his GP for an INR check. The GP can continue to manage his warfarin. I’ll make sure I update the discharge summary regarding the plan for his GP to check Jack’s INR in 2 - 3 days.’

*Pain relief:* ‘Jack’s pain levels appear to be stable, so he shouldn’t require anything, but I am happy for him to take paracetamol if required, but no more than 4g (or 8 x 500mg tablets) in 24 hours.’

*Movicol:* ‘Jack experienced some diarrhoea yesterday. Perhaps we’ll explain to him two things: to refrain from using it whilst he is experiencing diarrhoea, but once he has finished the antibiotics, he could consider using it as required, just as he used to use it. But secondly, if the diarrhoea doesn’t settle or go away, he should inform his GP as soon as he can and make sure he keeps hydrated.’

**As Jack Sparrow**

The group now have an opportunity to speak with Jack regarding his medications. Encourage them to think about what kind of resources they may want to use e.g. medications, medicines list template, warfarin booklet, Consumer Medicines Information (CMI) and have some of these available.

Ideally the following information should be communicated to Jack:

**Trimethoprim:** When to take it, how long for and where he will get supply from.

**Warfarin:** What dose the doctor has changed it to, when he will need another INR test and the importance of seeing his GP in the next 2 - 3 days (ideally write the dose down in a warfarin booklet or medicines list).
Pain: What medication he can use for this (paracetamol) and the recommended dose.

Movicol: Advice that the doctor gave (withhold until diarrhoea settles and finishes antibiotics).

If the group is unsure of how to start the discussion, as the patient, you could initiate some of the questions. Some examples are below:

Trimethoprim: ‘When should I take it? How long do I need to take it for? Where can I get supply from?’

Warfarin: ‘What dose should I be taking? When do I need to get my INR checked? When should I see my GP next?’

Pain: ‘If I experience any pain, can I take my Panadol at home?’

Movicol: ‘Should I keep taking my Movicol now that I’m leaving hospital?’

General: ‘I’m not sure if I’ll remember everything you’ve told me about my medications. Do you have something written down that I can take with me?’

After this activity, there is one more slide in the workshop presentation which summarises the key points of Workshop 3
MEDICATION RECONCILIATION
FOLLOW UP DISCUSSION
Medication Reconciliation Follow Up Discussion

Facilitators should organise and facilitate a follow up discussion 3 - 6 months after the workshop/s to allow participants to discuss their experience with medication reconciliation processes. A Follow Up Discussion PowerPoint® presentation is provided for this purpose and can be adapted to suit the local context.

The discussion will allow participants to share their successes, learnings and challenges amongst their colleagues and is an opportunity to provide feedback to their local managers.

After the discussion, participants should be asked to complete a follow up survey.

To assist in keeping the Education Package relevant and useful the completed surveys should also be sent to the CEC CMM Program Lead.
OTHER RESOURCES
List of Useful Websites and Resources

National Prescribing Service (NPS)

- NPS MedicineWise smart phone app training video: https://vimeo.com/160958091

YouTube videos

- Medication Reconciliation Myth #2: It’s Not My Job: https://www.youtube.com/watch?v=U3qiZGB9yUg
- Australian Commission on Safety and Quality in Health Care: Get it right! Taking a Best Possible Medication History: https://www.youtube.com/watch?v=dc5jFuba6CI

CEC resources


Additional reading material
