FREQUENTLY ASKED QUESTIONS

Question 1. What is medication reconciliation?

The process of collecting, confirming and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care the verified information is transferred to the next care provider. This process of medication reconciliation facilitates continuity of medication management and decreases the risk of medication-related harm.

Medication reconciliation involves four steps:

1. Collecting information to compile a list of each patient's current medications
    - This should include whenever possible a structured interview conducted at admission with the patient or patient's representative by an appropriately trained healthcare professional to obtain and document the patient's current pre-admission medications, including previous adverse drug reactions and allergies, and any recently ceased or changed medications.

2. Confirming the accuracy of the information collected to achieve a Best Possible Medication History (BPMH)
    - Using at least one additional source of medicines information to verify the information obtained.

3. Comparing the history with prescribed medicines at every transfer of care
    - Compare the patient's medication history with their prescribed inpatient treatment on admission, transfers between wards/units, transfers between hospitals and on discharge. Check that changes are clinically appropriate and explanation for changes documented.
    - Where there are discrepancies the clinician performing the reconciliation must ascertain whether discrepancies in therapy are intentional or unintentional and then document any resulting changes.

4. Supply accurate medicines information to the patient and next care provider
    - An accurate and complete list of the patient's medications is supplied to the patient and/or carer and the next care provider.
    - Information about any changes that have been made to medicines and any ongoing therapeutic plan for medicines is also supplied.

Question 2. Why introduce formal, systematic medication reconciliation processes?

It ensures that patients receive all intended medicines and that accurate, current and comprehensive medicine information follows them at all transfers of care. Unintentional changes to patients' medicines at transfers of care can result in considerable harm and have been linked to poorer health outcomes, increased hospital readmissions and mortality.

Question 3. Do all medication histories need to be confirmed?

Yes. To ensure accuracy and completeness of the medication history confirmation with at least one additional source is recommended. Examples of sources of medicines information include the patient's GP, community pharmacist and the patient's own medicines. This may not be possible in all cases but a concerted effort should be made.

Question 4. Who is responsible for completing the four steps of medication reconciliation?

Medication reconciliation is the responsibility of medical officers, nurses, and pharmacists. Each has a role in the process. Responsibility for each of the four steps may differ at each site, based on local resources and workflow.

Example on admission

For a patient admitted to the hospital via the emergency department, the ED pharmacist (or nurse trained in taking a structured medication history) takes the medication history and confirms it. The medical officer then makes and documents the decisions on which medicines to continue, adjust or cease and writes up the medication chart. With this information, a pharmacist or nurse can reconcile the medication history with the medication chart to ensure no unintentional omissions/discrepancies occur.

Example on transfer

For a patient transferred to another hospital, the referring medical team communicates the patient's current medications, changes that have been made together with a copy of the patient's medication history and any ongoing medication management plan. The medical officer accepting the patient compares the medication history with the patient's current medications and clarifies any changes and the ongoing plan with the referring team.

Example on discharge

For a patient discharged home, the pharmacist (or nurse trained in reconciling medications on discharge) compares the patient's medication history, the patient's medications at discharge, the discharge plan and the discharge medication list. Any discrepancies are clarified with the medical officer and the discharge medication list adjusted or an explanation for changes provided. The pharmacist (or nurse) provides the patient and/or carer with a discharge medication list with an explanation of changes in a format which can be easily understood.

Question 5. Where is the BPMH documented?

Ideally the BPMH should be documented so that it is at the point of care, accessible to all members of the health care team. A standardised form such as the *Medication Management Plan* (or electronic equivalent) that can be used to guide taking a medication history and can be kept with patients' active medication chart is recommended. Alternatively the dedicated section of the national inpatient medication chart may be used.

Question 6. How do you engage medical officers?

Medical officers are the members of the health care team who have responsibility for writing admission medication orders and discharge summaries. Include them in redesigning processes to minimise rework and streamline workflow. Apart from delivering safer patient care, benefits to medical officers include, having an accurate baseline of medications for treatment decisions, reduction in calls/pages from pharmacists needing to clarify initial medication orders and better access to information to complete the discharge summary.