FREQUENTLY ASKED QUESTIONS

Medication Reconciliation Education Package (Nursing & Midwifery)

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.

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.[4] 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.[5-8]

References

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