Medication Reconciliation Workshops

Face-to-Face Education for Nursing & Midwifery Staff

Workshop 1

Introduction: the Case for Medication Reconciliation

Objectives

- Describe medication reconciliation (Med Rec)
- Identify why Med Rec is an effective approach to ensure continuity of medication management (CMM)
- Explore & discuss:
  - Look at current Med Rec practices

What is Medication Reconciliation?

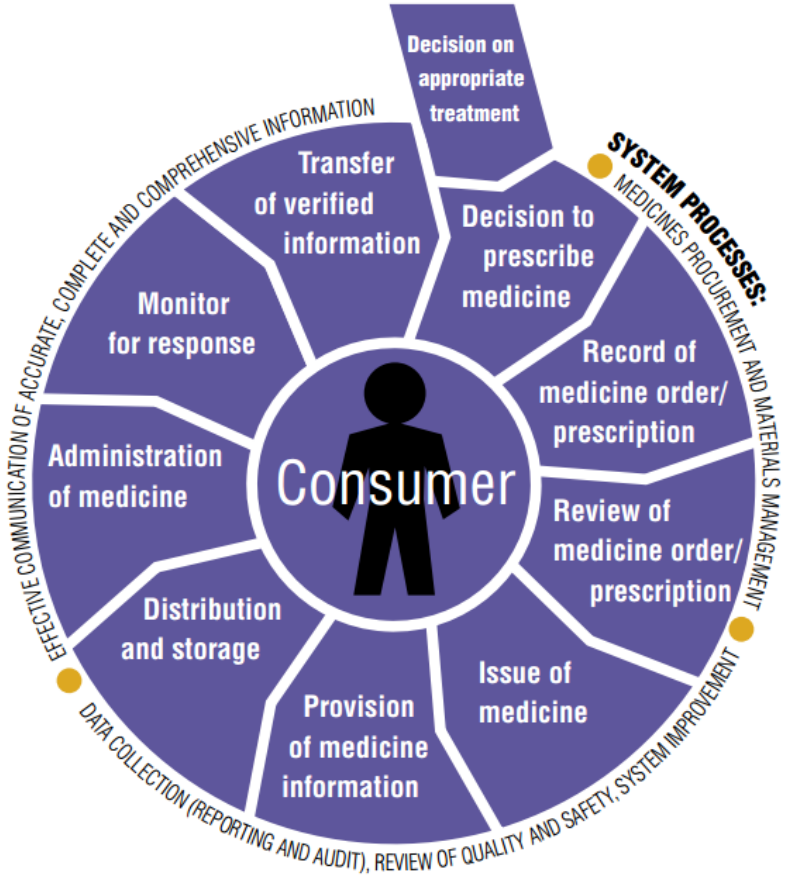
- A patient-centred, structured & standardised process
- Reduces adverse medication events by:
  - Ensuring patients receive all intended medications
  - Reducing transcription, omission, commission and duplication errors
  - Ensuring CMM
- A multidisciplinary process

Medication Reconciliation

1. Collect a comprehensive medication history
2. Confirm the accuracy of the history
3. Compare the history with prescribed medications
4. Supply accurate medication information

Continuity of Medication Management

‘CMM occurs when all components of the medication management cycle are completed and information is transferred to the next care setting’



The Medication Management Cycle
APAC Guiding principles to achieve continuity in medication management July 2005

So…Who's job is it to do medication reconciliation?

https://www.youtube.com/watch?v=U3qiZGB9yUg

Why is Med Rec important?
The evidence

- 10-67% of medication histories contain at least one error[1]
- Incomplete medication histories at the time of admission have been cited as the cause of at least 27% of prescribing errors in hospital[2]
- The most common error is the omission of a regularly used medication[3]
- Around half of the medication errors that happen in hospital occur on admission or discharge[4]
- 30% of these errors have the potential to cause harm[3,5]
- At hospital discharge, errors in medication documentation may occur at a rate of 2 errors per patient[6]

Examples of reported incidents in xxx LHD/SHN

Aspirin and clopidogrel ceased in ICU. Not recommenced when patient transferred to ward	Patient suffered sudden cardiac arrest resulting in death	May have contributed to patient's death
Patient prescribed ramipril 1.25mg daily, medication chart was re-written as ramipril 12.5mg daily	Patient suffered pre-syncopal episode, was transferred to HDU and required noradrenaline	Caused temporary harm and required intervention
Patient discharged home. Discharge summary listed insulin dose as 40 units at midday but the patient had been receiving 4 units at midday in hospital	Patient experienced seizures due to hypoglycaemia and was re-admitted	Caused temporary harm and required intervention

Why is Med Rec important?
Improving patient safety & quality

- Overall improvement in patient health outcomes
- Reduces unintentional harm due to medication error
- Complies with National Standards (ACSQHC)
- Complies with Australian Safety and Quality Goals for Health Care
- One of the ‘High 5’ World Health Organisation (WHO) patient safety solutions

Explore Current Practice

- Discuss what currently happens in your workplace:
  - What happens to medicines information as a patient moves through your facility?
  - Where is it documented? Who documents it and when?
  - What do you do when a charted medication is different to what the patient normally takes at home?
  - At which points in the process could a medication error occur?
- Use butchers paper to create a flowchart of each step:
  - Include ‘who’ does ‘what’ at each step, and ‘what’ and ‘where’ the information is documented

References

1. Tam V, Knowles SR, Cornish PL, Fine N, Marchesano R, Etchells EE. Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review. CMAJ 2005;173:510-5.
2. Dobrzanski S, Hammond I, Khan G, Holdsworth H. The nature of hospital prescribing errors. Br J Clin Govern 2002;7:187-93.
3. Cornish PL, Knowles SR, Marchesano R, Tam V, Shadowitz S, Juurlink DN, Etchells EE. Unintended medication discrepancies at the time of hospital admission. Arch Intern Med 2005;165:424-9.
4. Sullivan C, Gleason KM, Rooney D, Groszek JM, Barnard C. Medication reconciliation in the acute care setting: opportunity and challenge for nursing. J Nurs Care Qual 2005;20:95-8.
5. Vira T, Colquhoun M, Etchells EE. Reconcilable differences: correcting medication errors at hospital admission and discharge. Qual Saf Health Care 2006;15:122-6.
6. Roughead EE, Semple SJ, Rosenfeld E. The extent of medication errors and adverse drug reactions throughout the patient journey in acute care in Australia. Int J Evid Based Healthcare 2016; 14:113-22.

End of Workshop 1

If this is the last workshop you will complete today, please make sure you fill out a post-workshop survey before you leave and hand it to your facilitator