## Committee Brief Template

## Purpose

To highlight patient safety risks associated with discontinuity of medication management and to recommend that the committee takes a lead role in governance of improvement activities to address these risks.

## Background

* 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.
* Discontinuity of medication management affects health systems around the world, and addressing this issue is a World Health Organisation patient safety priority.
* The Australian Commission on Safety and Quality in Health Care, National Safety and Quality Health Service Standards requires all health services to introduce medication reconciliation processes to improve patient care and minimise harm.
* Implementation of medication reconciliation processes across a health service can be complex; a key element of successful international implementation programs is the use of quality improvement methodology.

## Issues

(Select issues below relevant to your health service and where possible insert local data from incident reports or audits to support the case for change)

* Currently the service does not have in place policies, procedures and/or protocols on reconciling medicines.
* There is no consistency on the way medication histories are obtained or documented in the medical record. Often histories are taken by multiple clinicians, documented in various areas of the medical record and often not corresponding.
* A recent audit showed that only (insert percentage of patients) had a clear medication history documented that had been verified for accuracy in some way i.e. at least two sources of medicines information where used.
* Incident reports demonstrate that patients are experiencing harm from unintentionally changing or not recommencing important preadmission medicines e.g. (insert examples)
* An audit of discharge summaries found that only (insert percentage of discharge summaries) had an accurate medication list, and only (insert percentage of discharge summaries) included the reason/s for any change that occurred.
* Medicines information was interspersed throughout the medical record making it difficult and time consuming to determine the plan for medication management on discharge.

## Recommendations

That this committee notes the patient safety risks highlighted and contributes to the improvement activities by: (list actions required of this committee, see list below for examples)

* Identifying stakeholders
* Establishing reporting and approval processes
* Identifying areas (wards/units) of the health service to initiate the improvement process
* Supporting the formation of a multidisciplinary quality improvement project team to:
  + Evaluate current medication reconciliation processes
  + Identify and enlist clinical champions
  + Establish general goals
  + Develop, implement and evaluate improvement strategies
  + Disseminate results and findings.
* Assist with overcoming barriers to implementation

**Contact:** (insert name of person co-ordinating the improvement activities)

**Phone: Date:**