Approved by Quality & Patient Care Committee
19/10/17

MEDICATION – MEDICINES RECONCILIATION AND ADVERSE DRUG REACTIONS

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- To ensure safe and effective medicines reconciliation on admission and discharge.
- To ensure adverse drug reactions are documented and reported as and when they occur.

2. PATIENT

- All women and neonates

3. STAFF

- Medical, midwifery, nursing and pharmacy staff

4. EQUIPMENT

- Nil

5. CLINICAL PRACTICE

- Document medicines reconciliation on admission and discharge- see educational notes below.
- Document adverse drug reactions- see educational notes

6. DOCUMENTATION

- Integrated Clinical Notes or electronic equivalent
- National Inpatient Medication Chart (NIMC) or electronic equivalent

7. EDUCATIONAL NOTES

Medication reconciliation is a process that ensures the correct medications are prescribed and communicated at all transition points.

Medication reconciliation is intended to identify and resolve discrepancies – it is a process of comparing the medications a patient is taking (and should be taking) with newly ordered medications.

There is evidence that medication discrepancies can adversely affect patient outcomes.
This policy explains the process for medication reconciliation and defines the guidelines for documentation of medication reconciliation.

Medication histories are documented in the '*Medication List'* tab in the patient's electronic medical record (eMR). This is used for all obstetric, gynaecology and gynaeoncology patients who are non day stay admissions. Gynaecology and gynae-oncology patients are prioritised for medicines reconciliation due to multiple co-morbidities and increased age.

Referrals for Pharmacy to undertake medicines reconciliation in outpatient settings e.g. pre-op clinic can be made by calling the Pharmacy Department (ext 26716). Patients who may require referral include those on five or more medicines, those on high risk medicines or those with poor compliance.

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Reconciliation Responsibilities

Medical Officer	**Pharmacists**
All Medical Officers and Pharmacists have the responsibility to ensure that patient's medications are reconciled within 24 hours of admission.	
- Perform a Best Possible Medication History (BPMH) - Perform medication reconciliation - Identify and resolve discrepancies - Document changes made to a patient's medication regimen during their admission on eMR - Reconcile medications on discharge and communicate to the patient (or carer) and next health care provider an accurate list of medications the patient should be taking on discharge - The Medical Officer of the admitting team has ultimate responsibility to ensure that all essential medications are prescribed for the patient's stay in hospital.	- Perform a BPMH, - Perform medication reconciliation - Identify and resolve discrepancies - Document changes made to a patient's medication regimen during their admission on eMR. - Reconcile medications on discharge - Ongoing training to all healthcare professionals (HCP) in BPMH and medication reconciliation - Assist Medical Officer in communicating an accurate list of medications to the patient and community pharmacy on discharge when appropriate.
Registered Nurse or Midwife	
- Identify and document discrepancies and bring discrepancies to the attention of appropriate team/prescribing officer - Perform medication reconciliation - Assist with documentation of recently ceased or recent changes to medicines, risk identification and medication history and discharge checklists.	

Taking a Best Possible Medication History (BPMH)

See Appendix 1

Responsibilities: Medical Officer, Pharmacist, Registered Nurse or Midwife

1) **Interview** the patient or carer.

Where possible one of the two sources used to complete the BPMH should be a patient/carer interview.

2) **Confirm medication history** with a second source.

This may include:

- Community pharmacist
- Patient's Own medicines
- Patient's medication list
- General practitioner
- Nursing home
- Community nurse
- Previous admission

Medications brought into hospital by the patient/carer should not be returned home until the medication reconciliation process has been completed.

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3) **Document the BPMH** in *'Medications List'* tab *'Document Medication by Hx'* in eMR. This should include:

- Medication name
- Dose, route and frequency
- Indication and duration of treatment (where applicable)

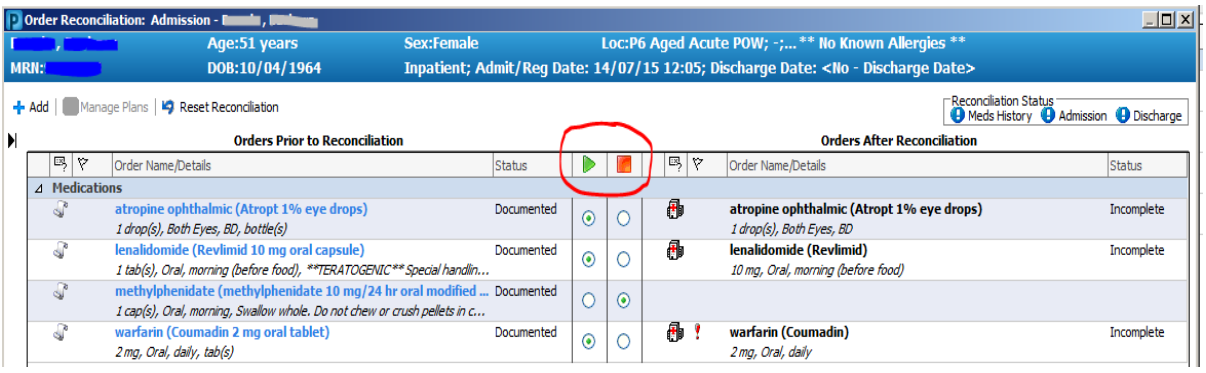
– If the patient does not take any regular medications this can be selected as an option.
– Once the history has been entered for all medications click '*Document History'* and enter your password in the authorising signature window.

4) **Document the source(s)** used above in the '*Compliance*' tab under '*Information Source'*. Choose from the drop down e.g. '*Patient or career/own medications'*. If the source is not available in the drop down list, it can be entered manually into the '*Compliance Comments'* tab.

Documenting a BPMH can be performed by a Pharmacist, Dr, Nurse or Midwife however the reconciliation can only be performed by a Doctor.

5) **Document the reconciliation on admission** by clicking on '*Medication List'* in the menu then '*Reconciliation- admission'*.
The '*Orders Prior to Reconciliation: Admission*' screen then opens.
The left side shows the '*Orders (medication) prior to reconciliation'* and the right side shows the '*Orders (medication) after reconciliation'*

- The Dr needs to reconcile each medication where possible.
- Click on the green arrow if the medication is to be converted to an inpatient medication OR click on the red square if it is not to be converted on admission.



When finished reconciling, click on '*Reconcile and sign'* entering your authorising password.

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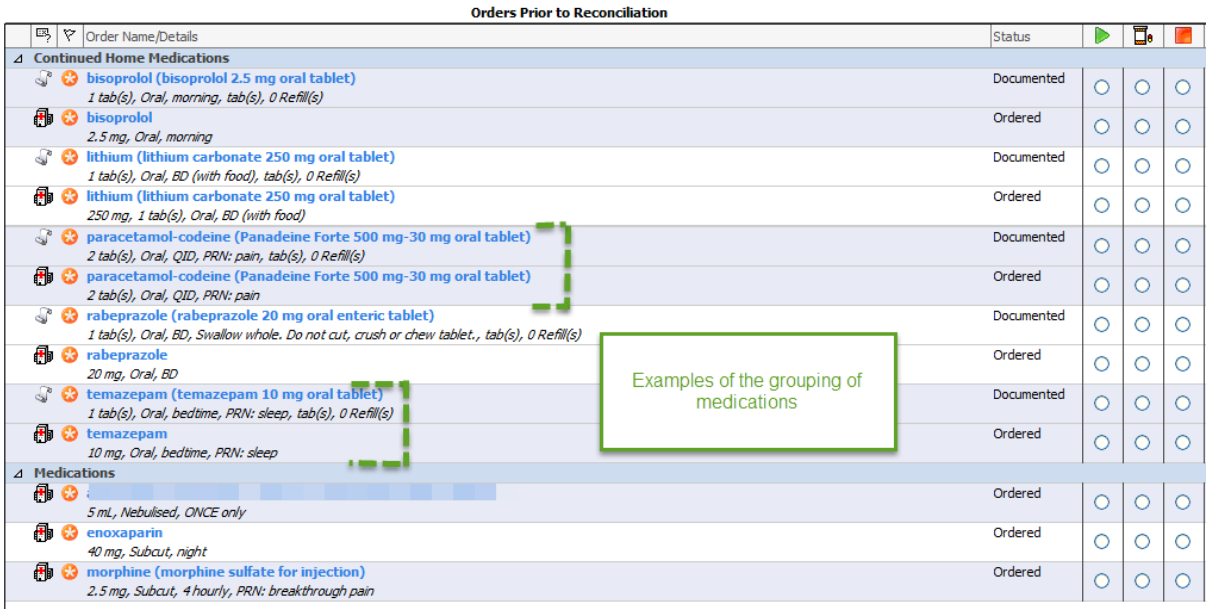
On Discharge

Discharge reconciliation is when the Dr determines what medications the patient will continue taking at home and what will not be continued on discharge (had any home medications not continued during the hospital admission). The Discharge Reconciliation will create the list of medications that will be printed as part of the patient's electronic discharge summary. The discharge summary will be used by the hospital pharmacy to supply medications to the patient on discharge (gynae-oncology patients only).

- Click on '*Medication list'* in the patient's menu.
- Click on '*Reconciliation- Discharge'*.
- The Dr must reconcile each medication to get a green tick for the Discharge Reconciliation process. This then allows the Dr to 'pull' the medications into the Discharge Summary. This list brings up the medications on admission (highlighted by a scroll icon) AND the medications currently charted (highlighted by the inpatient medication icon). For ease of viewing the duplicate orders are grouped together.



- Click on the green arrow to continue a medication on discharge
- Click on the red square to cease a medication on discharge
- When reconciliation is finished click '*Reconcile and sign'*
- Ignore the pill bottle as this functionality is currently on available

ALLERGIES AND ADVERSE DRUG REACTIONS

An adverse drug reaction (ADR) is defined as an appreciably harmful or unpleasant reaction, resulting from the use of a medication, which predicts hazard from future administration and warrants prevention or specific treatment, or alteration of the dosage regimen, or withdrawal of the product.

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Procedure:

1. Prior to administration of a new medication, the patient's known allergies documented on the NIMC or electronic equivalent must be checked.
    - If an allergy to the medication is identified, the medication must not be administered and the medical officer must be contacted.
2. The person administering a medication should be aware of potential side-effects prior to administration.
3. If an adverse drug reaction is observed when administering a medication to the patient the medical officer must be contacted immediately and, if possible, the medication must be stopped.
    - The type of reaction, intervention and outcome must be documented in the patient's health care record. In the case of emergency the RHW emergency procedures protocol i.e. PACE notification and Code BLUE must be followed.
4. Following the reaction, the medication and reaction/type/date must be updated in the "Allergies and Adverse Drug Reaction (ADR)" box on the NIMC or electronic equivalent and entered into eMR and iPM. Staff must report probable adverse events in IIMS.
    - In the event of an ADR the 'Report of Suspected Adverse Reaction to Drugs or vaccines' form (also known as the 'Blue card) must be completed and forwarded to the Advisory Committee on the Safety of Medicines (ACSOM) at the Therapeutic Goods Administration (TGA). A copy of the 'Blue card' must also be forwarded to the Pharmacy department to be reported at the RHW medication safety meeting.The "Blue Card" can be obtained from the TGA website http://www.tga.gov.au/adr/bluecard.htm, or electronically using TGA eBusiness Services at https://www.ebs.tga.gov.au/ebs/ADRS/ADRSRepo.nsf. A separate copy must be forwarded to the Pharmacy Department if using the electronic submission service.
5. All suspected adverse reactions to vaccines must also be reported to the local Public Health Unit (ext 28333). Failure to report an ADR is considered an incident, which must be reported to the Clinical Practice Improvement Unit via the IIMS reporting system.

Documentation

- Medical officers, nursing staff and/or pharmacists are required to complete the "Allergies and Adverse Drug Reaction (ADR)" details on all relevant medication charts or electronic equivalents, including eMR and iPM. (N.B. *patients may be more familiar with the term allergy, than ADR, so this may be a better prompt*).
- Once the allergy status or drug name and symptoms or reaction have been documented, the person documenting the information must sign, print their name and date the entry.

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Medication- Administration
- Medication- Prescribing

MEDICATION – MEDICINES RECONCILIATION AND ADVERSE DRUG REACTIONS cont'd

9. RISK RATING

- Low

10. NATIONAL STANDARD

- Medication Safety

11. REFERENCES

- Cornish PL, Knowles SR, Marchesano R, et al. Unintended medication discrepancies at the time of hospital admission. Arch Intern Med. 2005;165: 424-429.
- National Medication Management Plan User Guide, Australian Commission on safety and quality in healthcare November 2013.
- Ministry of Health Policy Directive 2013_043 Medication Handling in New South Wales Public Health Facilities

REVISION & APPROVAL HISTORY
Reviewed and endorsed Therapeutic & Drug Utilisation Committee 3/10/17
Approved Quality & Patient Safety Committee 21/8/14
Minor amendment February 2016
Therapeutic & Drug Utilisation Committee 12/8/14

FOR REVIEW : OCTOBER 2022

…/Appendix 1

APPENDIX 1: Obtaining a Best Possible Medication History

The medication history should be obtained from the most recent and reliable sources available.

More reliable sources

- Patient interview
- Carer interview
- Patient's own medications (remember to check dispensing date)
- Community pharmacy record (request a faxed list of previous 6 months dispensing if possible)
- Patient's repeat prescriptions
- Discharge summary from a recent previous hospital admission
- Nursing home charts (care with ceased medications)

Less reliable sources

- GP record system (check for ceased medications – often not removed from record)
- Family member interview
- Medical notes from another hospital (care if medications were started in hospital or truly pre-admission)
- Patient's medication lists (dose and strength often not recorded, not always up to date)

Blister Packs: remember not all medications are packed (e.g. warfarin, inhalers, liquids) and that patient may have more than one pack. Always check with community pharmacy responsible for packing blister.

Remember to always prompt for other medications such as

- Inhalers, sprays
- "When required" medications
- Over-the-counter medications
- Complementary medications or supplements
- Topical medications e.g. patches, creams
- Eye drops
- Intermittent medications e.g. weekly, monthly

Cross check all sources to ensure you have the most accurate list of what the patient was taking.

Record any recently completed courses of medications such as antibiotics or any recent changes made to medications in the electronic record in eMR.
To aid in discharge planning, record the name and contact details of the community pharmacy, LMO or residential care facilities on the eMR.