Medication Reconciliation on Admission and Discharge Guideline

1. Guiding Principles

Admission to hospital, transfer between care areas and discharge from hospital to the community or another hospital are all recognised as key transition points for medication errors[1]. A correct and up-to-date medication list is vital to ensure continuity of medication management and safe prescribing while in hospital. Medication reconciliation is the formal process to ensure that the medicines the patient should be prescribed match those that are prescribed.

This document defines the process for medication reconciliation on admission and discharge at sites across WACHS Great Southern (WACHS GS).

2. Guideline

2.1 Medication reconciliation on admission

A Best Possible Medication History (BPMH) is to be taken by an appropriately credentialed health professional as early as possible in the patient's episode of care. Whenever practical, this should be performed before the End of the Next Calendar Day (ENCD) after admission.

Where a clinical pharmacist is available, ideally this pharmacist takes and records the BPMH and reconciliation. At regional sites or at Albany Health Campus (AHC) where no clinical pharmacist is available (including weekends and public holidays), this BPMH should be performed and reconciled with the medication chart by either a nurse or the admitting doctor.

This BPMH should be documented on a MR170.1 Medication Management Plan or the front of the patient's MR170A or MR171 WA Hospital Medication Chart (WA HMC). Use of the MR170.1 is the preferred option across WACHS GS. It should be documented on the appropriate area of the WA HMC that the MR170.1 has been initiated for the patient, and the MR170.1 form must then remain with the patient's current medication chart at all times during the admission.

Information must be sought and documented on all medications, including non-oral medications such as inhalers and eyedrops, over the counter and complementary medicines, and any medicines recently changed or ceased. A checklist is available on page 1 of the MR170.1 Medication Management Plan to guide this.

Medication history should generally be confirmed with at least two information sources. Sources used are to be documented in the appropriate section on page 2 of the MR170.1 Medication Management Plan. Ideally one of these sources should be the individual responsible for medication management in the community (patient or carer). Appropriate second sources of information can include the patient's regular community pharmacy, General Practitioner (GP) or My Health Record (MHR). The health

professional conducting the BPMH should always attempt to obtain patient or carer consent before requesting patient specific information from other health care providers.

In some circumstances a second source may be considered unnecessary, such as patients on nil regular medications or those transferred from residential aged care facilities (RACFs) with copies of current medication charts provided. If a second source is deemed unnecessary this is to be documented on the MR170.1 Medication Management Plan by the person completing the BPMH.

The BPMH must then be reconciled against current medication orders on the patient's WA HMC(s), taking into consideration the doctor's notes and plan, to identify any discrepancies.

Medication discrepancies or issues identified during medication reconciliation should be documented in the appropriate area on page 1 of the MR170.1 Medication Management Plan and/or in the patient's integrated progress notes for review. Where a clinically urgent discrepancy is noted, the prescriber should also be contacted by more direct means (e.g. telephone) to review the order.

2.2 Prioritisation of clinical pharmacy services for admission reconciliation

Where medication reconciliation cannot be conducted by a clinical pharmacist before the ENCD after admission, a risk assessment must be undertaken by an appropriately credentialed health professional to determine the priority of service by clinical acuity or risk of medication misadventure.

This risk assessment is best performed by a clinical pharmacist based on information available to them. Nursing or medical staff may also identify patients they believe are high risk and refer to the pharmacist for prioritisation.

In line with the WA Medication Review Policy, risk factors may include:

- Polypharmacy, with the prescription of five or more medications
- Multiple co-morbidities
- Prescription of high risk medications (such as anticoagulants or immunosuppressing medications)
- Prescription of a medication which has a narrow therapeutic index or requires therapeutic drug monitoring
- Patients with a presenting complaint or symptoms which may indicate a medication-related admission
- Where there are concerns about medication management or compliance
- Prescription of medications which are restricted or not available on either state or local formulary.

2.3 Medication Reconciliation on discharge or transfer

On discharge or transfer a complete, accurate and reconciled medication list must be provided to the patient's GP or receiving hospital/RACF.

It is preferred that this list is documented in Notifications and Clinical Summaries (NaCS) as part of a complete discharge summary. Ideally a clinical pharmacist will be involved in the preparation of this medication list. The pharmacist should be contacted as soon as possible to inform them of the planned discharge, preferably at least the day prior, to allow this to be completed. Where no pharmacist is available to complete this list, it should be prepared by a member of the patient's medical team.

A discharge medication reconciliation should be performed using the patient's MR170.1 Medication Management Plan before preparing the medication list. This reconciliation will confirm medications prescribed for discharge match those the patient is currently using. Where a pre-admission medication has been changed or stopped during admission, the medication list must clearly communicate the reason. Where a medication is to be temporarily withheld on discharge, the medication list must clearly outline the plan for recommencement or follow up.

Once the discharge reconciliation and medication list are complete, the patient (and/or carer responsible for medication management where required) should receive discharge medication counselling. The provision of this counselling should be documented either on the appropriate section of the patient's MR170.1 or in the patient's integrated progress notes. Discharge prescriptions should then be provided to the patient or carer for dispensing in the community.

If a dose administration aid is to be prepared for the patient on discharge, the staff member completing discharge reconciliation is to liaise with the relevant community pharmacy, including providing copies of the discharge medication list and discharge prescriptions.

If the clinical pharmacist and/or treating team are of the opinion that the patient would benefit from a Home Medicines Review (HMR), then this should also be conveyed to the patients GP in the NaCS discharge summary.

Any patient's own medications are to be returned to the patient on discharge. After reconciling, the staff member can offer to safely dispose of any ceased medications (with the patient's permission). If there are safety concerns regarding the return of patient's own medications, contact your clinical pharmacist or the Pharmacy Department for advice. When medications are returned, this should be documented on the patient's MR170.1 or inpatient notes.

When patients are transferring to another ward or regional hospital, red 'Ward Transfer – Inpatient Medication' bags should be used to transfer a supply of their current medications. This will ensure continuity of treatment until the area can source further supply of items not readily available in the clinical area from the Pharmacy Department. For transfers to regional hospitals this period may be a number of days - confirm with the hospital or Pharmacy Department the period required if unsure. If the transfer is to another hospital a copy of the current medication chart(s), a copy of the patient's MR170.1 and an up to date medication list as described above must be provided to the receiving site. Medications supplied in 'Ward Transfer – Inpatient Medication' bags are hospital stock, are not labelled for appropriately for patient self-administration and must not be given to the patient on discharge.

3. Definitions

Best Possible Medication History (BPMH)	A list of all medicines a patient is taking prior to admission. The list should include prescribed, 'over the counter' and complementary medicines and in most cases should be compiled and confirmed using at least two appropriate sources of information.
Dose Administration Aid (DAA)	A device or packaging system which organises tablets and capsules according to the time of administration.
Medication Management Plan	The standardised medication reconciliation form used during hospital admission (MR170.1)
Medication Reconciliation	The process of confirming that the medications prescribed for a patient on admission or discharge match those that the patient is currently taking.
Over the Counter (OTC) medications	Medications which can be purchased without a prescription from pharmacies or other retailers.

4. Roles and Responsibilities

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

Clinical pharmacists are to lead medication reconciliation, review and counselling services as described in this procedure in areas where there is clinical pharmacy resourcing.

Medical and nursing staff are to understand the process of medication reconciliation. In areas with clinical pharmacy resourcing, they are to aid in the identification of patients at high risk of medication misadventure to ensure they are prioritised for review. They are also to ensure the clinical pharmacist is alerted to planned discharges in a timely manner. In areas without clinical pharmacy resourcing they are to lead medication reconciliation, review and counselling services as described in this procedure.

5. Compliance

This guideline is a mandatory requirement under the *Medicines and Poisons Act (2014)*

Guidelines are designed to provide staff with evidence-based recommendations to support appropriate actions in specific settings and circumstances. As such, WACHS guidelines should be followed in the first instance. In the clinical context, where a patient's management should vary from an endorsed WACHS guideline, this variation and the clinical opinion as to reasons for variation must be documented in accordance with the Documentation Clinical Practice Standard.

6. Records Management

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

Monitoring of compliance with this document is to be carried out by the WACHS GS Pharmacy Department every 6 months using the following means or tools:

- Medication Reconciliation Audit

Results from this audit will be tabled at the Regional Medication Safety Group meeting and Regional Drugs and Therapeutics meeting.

8. Standards

National Safety and Quality Health Service Standards – 4.1, 4.3, 4.5, 4.6, 4.10, 4.12

9. Legislation

Medicines and Poisons Act (2014) (WA)
Medicines and Poisons Regulations (2016) (WA)

10. References

1. Western Australian Department of Health [Internet] MP0104/19 Medication Review Policy 2019 [Accessed 15 March 2022]
2. Western Australian Department of Health [Internet] Best Practice Principles for Medication Review: Guidance Document 2018 [Accessed 15 March 2022]
3. Australian Commission on Safety and Quality in Healthcare [Internet] Medication Reconciliation 2022 [Accessed 15 March 2022]

11. Related Forms

WA Medication History and Management Plan

12. Related Policy Documents

WACHS Medication Prescribing and Administration Policy

13. Related WA Health System Policies

MP0104/19 Medication Review Policy
Supporting information: Best Practice Principles for Medication Review: Guidance Document

14. Policy Framework

Clinical Governance, Safety and Quality

15. Appendix

Appendix 1: Medication Reconciliation on Admission Flowchart
Appendix 2: Medication Reconciliation on Discharge Flowchart

This document can be made available in alternative formats on request for a person with a disability

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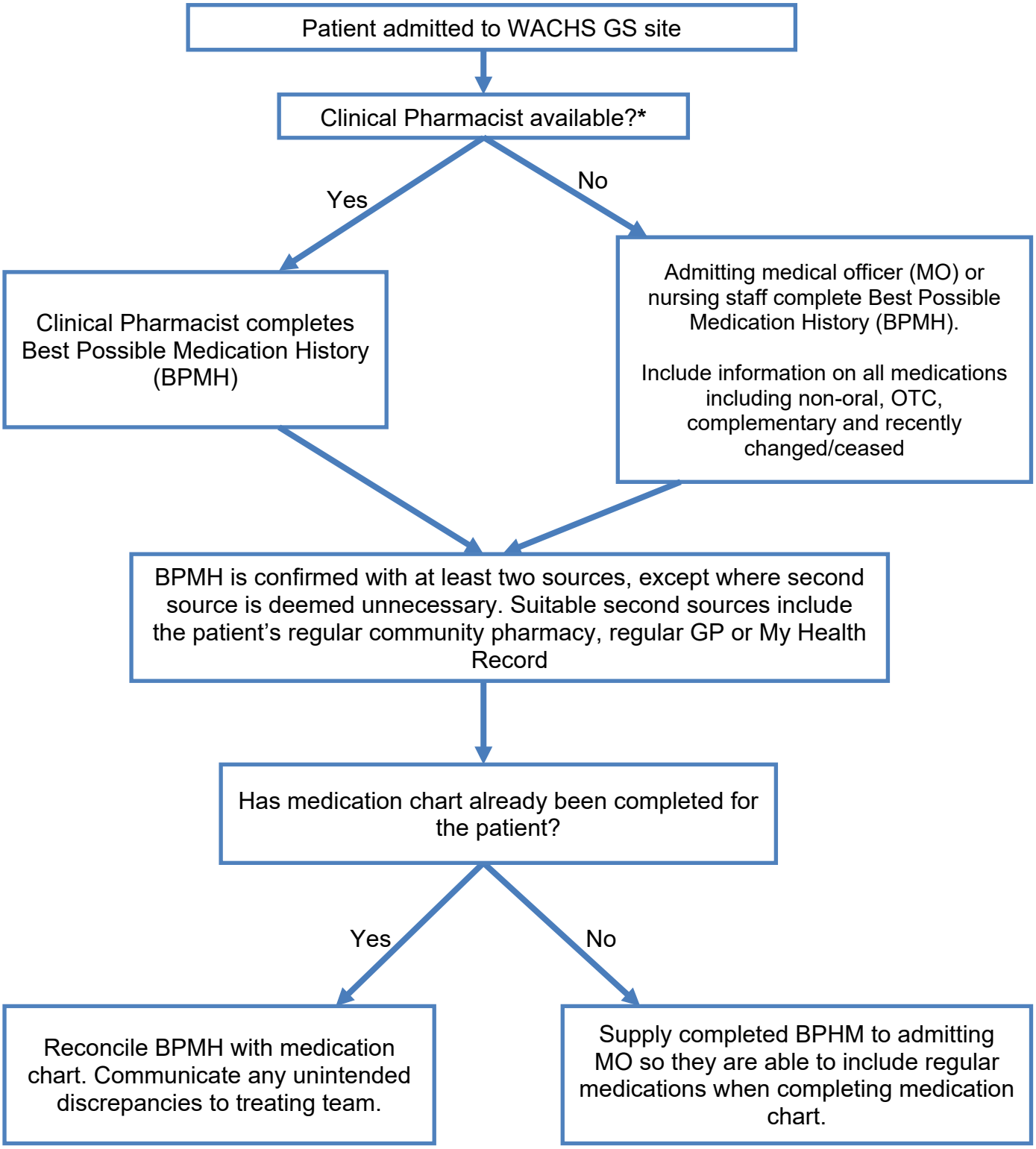
Appendix 1: Medication Reconciliation on Admission Flowchart



***** Where clinical pharmacist is available but unable to review all patients, prioritise service as per Section 2.2.

Appendix 2: Medication Reconciliation on Discharge Flowchart