**Community Pharmacy Safety in Practice (CP-SiP)**

**Change Package**

**Clinical Module - Medicines Reconciliation**

**2018-19**



**Background**

A key aim of the Safety in Practice programme is to work with Primary Health Care teams to reduce preventable patient harm from the care they receive. Adverse drug events (ADEs) are major causes of patient morbidity and mortality, and a source of significant costs for both organisations and patients.1

Medicines reconciliation is defined as the process to collect, compare, and communicate the most accurate list of medicines that a patient is taking, together with details of any allergies and adverse drug reactions (ADRs). This has the goal of providing the correct medicines for a given time period at all transition points.2

International studies show:

* Between 10 and 67% of medication histories have at least one error4
* Up to one-third of medication errors have the potential to cause patient harm5
* More than 50% of medication errors occur at transfers of care6
* Patients with one or more medicines missing from their discharge information are 2.3 times more likely to be readmitted to hospital than those with correct information on discharge7
* 85% of discrepancies in medication treatment originate from poor medication history taking.8

‘Implementing Medicines New Zealand 2015-2020’,3 emphasises that healthcare providers will need to work together to ensure medicine reconciliation happens consistently at each transition and involves the patient.

**Medicine reconciliation standards HQSC**

The recommended processes in this clinical module are based on the Medicine Reconciliation Standards developed by the Health, Quality & Safety Commission.2 This is summarised below:

* **Collect:** The healthcare practitioner collects the most accurate list of medicines, allergies, and adverse drug reactions (ADRs) using a minimum of two source types.
* **Compare:** The healthcare practitioner compares the collected medicines, allergies and ADR list against the prescribed information, identifying and documenting any discrepancies.
* **Communicate:** At each transfer point, all changes that have occurred to the patient’s medicines, allergies and ADR lists will be documented, dated, and communicated by the healthcare practitioners involved to ensure the care of the patient is continued.

A medicine discrepancy is categorised as ‘unintentional’ or ‘intentional’. Action is required to resolve the discrepancy and must be documented for accountability with a time, date and signature.2

**Clinical Module Aim**

By June 2019, all patients with non-GP\* generated prescriptions will have their medicines reconciled and follow-up actions completed at time of dispensing.

**\***Non-GP generated prescriptions include prescriptions that have the potential to change regular medicines such as hospital discharge and outpatient prescriptions. This excludes A&E and dental prescriptions, one-off or new specialist prescriptions.

# Measuring Reliability of Your Care

**Pharmacist Scope of Practice**

According to The Pharmacy Council of New Zealand, “The practice of pharmacy is necessarily broad and is wider than pharmacists working directly with patients, given that such roles influence clinical practice and public safety. In a clinical role, the pharmacist acts as a medicines manager, providing patient-centered medication therapy management, health improvement and disease prevention services, usually in a collaborative environment. Pharmacists ensure safe and quality use of medicines and optimise health outcomes by contributing to patient assessment and to the selection, prescribing, monitoring and evaluation of medicine therapy”.9

Good medicines management and patient education are core responsibilities of pharmacy practice. In conjunction with a Pharmacy Expert Group, we have developed process and outcome measures that we believe represent best practice for medicines reconciliation.

These measures indicate expectations of best practice for ‘every patient, every time’, for those at transitions of care.

It is best practice to document all interventions and recommendations made to evidence work that has been carried out. This is one way pharmacists can show all the work that they do, which is in line with Pharmacy Council of New Zealand Competence Standard O1.4.7. Therefore, the process measures relate to documented evidence that the best practice activities have been performed.

**“*Competence Standard O1.4.7****Supports and provides continuity of care with accurate and timely documentation of clinical and professional interventions and recommendations, using agreed handover protocols.”*

**Process and outcome measures**

The process measures assess whether there is documented evidence of the activity taking place. This information needs to be recorded in the patient file (Toniq or RxOne).

The outcome measures assess whether there is good continuity of care. Even if the ‘non-GP generated’ script has been reconciled, the next GP script may still have out-of-date medicines or doses. This step is to be completed when the next GP script has been received.

To assess your process, we require data from a random sample of 10 patients each month who have received a ‘non-GP generated’ script. Please do not include NHI or identifiable data, the information needs to be anonymous.

# Part 1: Process measures (Every patient, every time)

**Collect:**

**1a Is there evidence the prescription was reconciled with a minimum of 2 valid sources?**

* *Primary sources include: patient or carer, patient held medicine list (ie yellow card), patient’s own medicines as presented by the patient (noting date of supply and expiry dates).*
* *Secondary sources include: previous dispensing history, Testsafe, information from GP or other healthcare professional, aged residential care facility.*

**1b Is there evidence that the adverse drug reaction (ADR) status was checked?**

**1c Is there evidence that the allergy status was checked?**

**Compare:**

**2. If there were any unexplained discrepancies, is there evidence they were clarified with the prescriber?**

*Note: ‘unexplained’ is when there is no evidence that the medicine has intentionally changed in the discharge summary or other available documents, and the patient is unaware of such changes.*

**Communicate:**

**3a. Is there evidence the patient was educated about any changes, or that there have been no changes?**

**3b. Is there evidence the patient was given the opportunity to ask questions?**

**3c. Is there evidence the patient was offered an up-to-date list of their current medicines?**

(eg Yellow Card, patient medication list)

**Please note: If there is a change in medicines, even if you have contacted the GP, it is good practice to place an alert on your patient record so that when they next present with their regular GP script, you can check that the changes have been incorporated.**

**Part 2: Outcome measures – completed only if the next GP script is presented**

**4a Is there evidence that the next GP script was checked with the up-to-date medicines list in the pharmacy?**

**4b. If there are any discrepancies, have you clarified and documented these?**

(e.g. the GP practice was contacted to confirm the script is correct)

**Table 1: Measures and Rationale**

Is there documented evidence that the patient has received the following care when they presented a ‘non-GP generated’ prescription?

|  |  |  |
| --- | --- | --- |
| # | Measure | Rationale |
| 1.a  Collect  1b  1c | **Is there evidence the prescription was reconciled with a minimum of 2 valid sources?**  Yes □ No □    **Is there evidence that the adverse drug reaction status was checked?**  Yes □ No □  **Is there evidence that the allergy status was checked?**  Yes □ No □ | Medicines reconciliation standards2 require that:  The healthcare practitioner collects the most accurate list of medicines, allergies and ADRs based on a standardised data set using a minimum of two information source types.  Medicines reconciliation uses at least two sources. Using one source may not be accurate.  Removal of previously dispensed but uncollected repeat medication will help reduce the risk of incorrect medication being taken.  Patients should be encouraged to return unwanted or changed medicines back to their pharmacy for safe disposal.  ***NOTE:***  ***Primary sources include:*** *patient or carer, patient held medicine list (ie yellow card), patient’s own medicines as presented by the patient (noting date of supply and expiry dates).* ***Secondary sources include:*** *previous dispensing history, Testsafe, information from GP or other healthcare professional, aged residential care facility.*  **ADRs** (adverse drug reactions) are responses that are noxious and unintended and occur at ‘normal’ doses.2  When documenting, include:   * Medicine name and formulation * Status such as type, severity and date of onset. Document ‘no known allergies’ or ‘no known ADRs’ if they have none, or ‘unknown’ if status unknown. * Source of the allergy information eg patient, Centre of Adverse Reactions Monitoring (CARM), MedicAlert®.   **Allergies** are immune-mediated and can cause reactions ranging from mild to anaphylaxis. |
| 2.  Compare | **If there were any unexplained discrepancies, is there evidence they were clarified with the prescriber?**  Yes □ No □ N/A □ | Medicines reconciliation standards2 require that:  The healthcare practitioner *compares* the collected medicines information, allergies and ADR list against the prescribed information, identifying and documenting any discrepancies. If there is a discrepancy, clarify if this is intentional or unintentional.    N/A = no discrepancies |
| 3a.  Communicate  3b  3c | **Is there evidence the patient was educated about any changes, or that there have been no changes?**  Yes □ No □  **Is there evidence the patient was given the opportunity to ask questions?**  Yes □ No □  **Is there evidence the patient was offered an up-to-date list of their current medicines?**  Yes □ No □ | Medicines reconciliation standards2 require that:  At every transfer point, all changes that have occurred to the patient’s medicines, allergies and ADR list will be *communicated*, dated, and documented to ensure continuity of patient care.  Timely communication and accurate documentation at all transfer points is essential for reducing medication errors.  Full communication includes details of the sources of information, discrepancies identified, and reasons for changes.  A study of 100 patients’ understanding of medications at discharge found about 15% were unaware that a new medication had been prescribed, and only half understood specific information about their medications, including dosages, dosing schedule, and purpose.  Patients generally remember and understand less than half of what clinicians explain to them.  Record an accurate list of medicines so it is accessible or available for other users, and ask the patient or carer if they would like a print-out. This could also be in the form of a Yellow card.  An up-to-date medicines list is important for patients, carers and other health professionals to know which medicines they are taking and when.  Other relevant patient information may also be offered such as SafeRx® information sheets, consumer medicine information sheets or Self Care Cards. |

|  |  |  |
| --- | --- | --- |
| Outcome measures – completed only if next GP script is presented | | |
| 4a  4b | **Is there evidence that the next GP script has been checked with the up-to-date medicines list in the pharmacy?**  Yes □ No □  **If there are any discrepancies, have you clarified and documented these?**  Yes □ No □ N/A □ | Patients who have been discharged from hospital or have been to an outpatient clinic are generally given a prescription with a 1 month supply of medicines. Upon returning to their GP, they will receive a new prescription that may not have been reconciled with the changes made in hospital or at the outpatient appointment. It is important that this new GP script is carefully checked with the patient history and previous dispensings to make sure it is up-to-date.  Check the new script against the most up-to-date list you have on Toniq or RxOne  To check if the changes are intentional, contact the GP to let them know that the discharge or outpatient script was different. The GP may not have realised the medicines were changed in hospital (unintentional), or they may have decided to make further changes, or return to the previous medicine or dose (intentional). If the patient is fully aware the GP has intentionally changed the medicines and knows they are different to the discharge prescription, this can be considered a clarified discrepancy.  Yes = discrepancies have been clarified to determine if intentional or not  No = have not clarified with GP or patient  N/A = there were no discrepancies. |

**Randomising patients**

**For sample sizes up to 10**

Audit all 10 patients.

**For sample sizes of 11 - 28**

1. Select a random number between 1 and 10 by picking pieces of paper out of a hat.
2. If you select an odd number audit every other patient starting at 1 e.g. 1st, 3rd, 5th, 7th etc. If you select and even number audit every other patient starting with the second patient eg 2nd, 4th, 6th, 8th etc.

**For sample sizes 29+**

1. Select a random number between 1 and 10 by picking pieces of paper out of a hat.
2. Audit every other patient starting at this number eg if 6 is drawn audit the 6th, 8th, 10th patient etc.

# Data collection and submission

In order to assess your processes for medicines reconciliation, you will need to collect data from 10 random patients presenting a ‘non-GP generated’ prescription every month. As a team, you will then reflect on your results monthly and look for opportunities for improvement.

Note: We DO NOT require NHI or patient identifiable data, so please ensure it is anonymous.

* Documented evidence is required for compliance to Process Measures - please tick ‘No’ on the spreadsheet if the information has not been documented in the patient file.
* Outcome measures require follow up one month later to see if a GP script has been presented. If one of the 10 sample patients has not returned with a GP script, please note this in the data collection spreadsheet.

***Please note: we expect low scores for the baseline August 2018 data, where interventions occurred prior to the Safety in Practice programme beginning, so do not worry.***

# Getting your team ready for Safety in Practice

**Points to consider**

* Read through this document so you are familiar with the content
* Identify responsible leads to drive the programme in your pharmacy
* Organise a staff meeting to talk about Safety in Practice and what is involved
* Develop a process or an SOP document for locums and new staff
* Decide on how to create up-to-date medicines lists and make sure all staff know how to do this
* Decide how you will document any interventions and discussions with prescribers
* Decide how to document patient discussions in the patient file
* Discuss how to select the 10 patients per month for data collection
* Decide who will be responsible for completing the data collection sheet and submitting data
* Engage with your GPs regarding the CP SiP programme and discuss medicines reconciliation and the process you will be using
* Display posters in the pharmacy so patients are aware that you are a ‘Safety in Practice’ pharmacy

Creating change – getting started ****

Before you start the plan phase:

* Bring together your team – these people will work with you to plan and carry out the test of change
* Select the process you wish to change

As a team answer the 3 questions above:

1. What are we trying to accomplish? (write an objective for this PDSA cycle)
2. How will we know if a change is an improvement?
3. What changes can we make that will result in improvement?

# Plan stage

Plan how the changes will happen – ask yourselves and write down the following:

* What will we do?
* Who will carry out the plan?
* When will it take place?
* Where will it happen
* What data and information will we collect ie what will help us determine if the change is an improvement?
* Do we need training or materials?

Make predictions – what do you think will happen when you test the change and why?

Ask yourself:

* What do we hope to learn by testing the change?
* What will happen when we test the change?
* How will the change be carried out?

# Change Idea examples

|  |  |
| --- | --- |
| **General** | * Discuss results of baseline data collection together and include SiP as a regular agenda item at team meetings * Arrange education session for the pharmacy team about the medicines reconciliation process and the HQSC standards |
| **Clinical processes** | * As a team, identify barriers that will prevent you from adhering to the recommended medicines reconciliation process and look for ways of addressing them * Check repeats that are yet to be collected for patients presenting with a ‘non-GP generated’ prescription to make sure they are correct |
| **Documentation** | * Agree on how you will all document that medicines reconciliation has taken place * Decide on how you will all flag ‘non-GP generated’ prescriptions so you can be alerted when the next GP script is presented |
| **Discussion with patient** | * Use a consistent process to flag ‘non-GP generated’ dispensings so that a discussion with the patient occurs upon medicine collection * Involve the patient in the process so they are aware that there have been changes, or no changes to their regular medicines * Provide information to patients about any new medicines or conditions. See [www.healthnavigator.org.nz](http://www.healthnavigator.org.nz) for resources * Optimise use of Self Care Cards if applicable * Utilise SafeRx® patient information leaflets if applicable |

# Previous teams’ experiences

Some pharmacies found it useful to create a new medicine called ‘hospital’ so they could easily search for ‘non-GP generated’ prescriptions when searching for their 10 patients. This was also useful so everyone was aware that medicines may have changed, so they knew to carefully check the next GP script.

**Do**

* Prepare to test; gather resources
* Try out your change idea – it is usually best to try it out on a small sample. Starting on a small scale might mean 1 or 2 patients – that way if it doesn’t work it is easier to remove the step or process
* While you are testing keep track of what happens in real time – don’t wait to write it up

**Study**

Complete the analysis of the data.

Ask yourself:

* What has changed?
* Who was affected?
* Are the effects positive or negative?
* Are they worth keeping or removing, adapting or developing?

Compare the data to your predictions.

**Act**

* Summarise and reflect on what was learned
* Refine the change based on what was learned
* Are you going to adopt the change, adapt and retest, or abandon?
* Prepare a plan for your next PDSA cycle – back to the Plan step for your next cycle!

|  |
| --- |
| **Contacts**   * Questions, feedback or general enquiries: [info@safetyinpractice.co.nz](file:///E:\SiP\info@safetyinpractice.co.nz) * Submitting data: [audit@safetyinpractice.co.nz](mailto:audit@safetyinpractice.co.nz) * Website: [www.safetyinpractice.co.nz](http://www.safetyinpractice.co.nz) * Meet our team: <http://aucklandnc.safetyinpractice.co.nz/our-programme/meet-the-team/> |

**Glossary**

|  |  |
| --- | --- |
| Allergies | Immune-mediated and can cause reactions ranging from mild to anaphylaxis. |
| ADRs(adverse drug reactions) | Responses that are noxious and unintended and occur at ‘normal’ doses. |
| Discrepancy | Any medicine that is omitted, altered, added or substituted without documented explanation in the patient’s clinical record or other form of accepted communication. Any medicine difference which is undocumented, even if clinically indicated is called a discrepancy.2 |
| ‘non-GP generated’ prescriptions | Include hospital discharge, outpatient and specialist prescriptions. One-off or new specialist prescriptions are not included in this clinical module. |
| Medicines reconciliation | The process to collect, compare, and communicate the most accurate list of medicines that a patient is taking, together with details of any allergies and/or adverse drug reactions (ADRs) with the goal of providing correct medicines for a given time period at all transition points.2 |

**Resources**

* [Health Quality & Safety Commission 2010. Medicine Reconciliation Standards, Version 3. Wellington: Health Quality & Safety Commission.](Health%20Quality%20&%20Safety%20Commission%202010.%20Medicine%20Reconciliation%20Standards,%20Version%203.%20Wellington:%20Health%20Quality%20&%20Safety%20Commission.%20)  www.hqsc.govt.nz/assets/Medication-Safety/Med-Rec-PR/Medication\_Rec\_Standard\_v3.pdf (Accessed 17-08-18)
* Ministry of Health 2015. Implementing Medicines New Zealand 2015-2020. Wellington: Ministry of Health 2015. ISBN-978-0-478-44826-9. [www.psnz.org.nz/Folder?Action=View%20File&Folder\_id=86&File=ImplementingMedicinesNZ2015to2020June2015.pdf](http://www.psnz.org.nz/Folder?Action=View%20File&Folder_id=86&File=ImplementingMedicinesNZ2015to2020June2015.pdf) (Accessed 17-08-18)
* Health Quality & Safety Commission. Three steps to better health literacy – a guide for health professionals. [www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf](http://www.hqsc.govt.nz/assets/Consumer-Engagement/Resources/health-literacy-booklet-3-steps-Dec-2014.pdf) (Accessed 17-08-18)

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6. Sullivan C, Gleason KM, Rooney D, et al. 2005. Medication reconciliation in the acute care setting: opportunity and challenge for nursing. Journal of Nursing Care Quality 20: 95-98.
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8. Gleason KM, McDaniel MR, Feinglass J, et al. 2010. Results of the Medications At Transitions and Clinical Handoffs (MATCH) study: an analysis of medication reconciliation errors and risk factors at hospital admission. Journal of General Internal Medicine 25(5):441-447.
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**Appendix 1: Measures template**

**Feel free to adapt for use in your pharmacy**

**Community Pharmacy Safety in Practice – Medicines reconciliation checklist**

|  |  |
| --- | --- |
| Patient NHI/Name | Date |

**Collect**

Clinical Checks

**1a Is there evidence the prescription reconciled with a minimum of 2 valid sources?**

Yes □ No □

**1b Is there evidence that the adverse drug reaction status was checked?**

Yes □ No □

**1c Is there evidence that the allergy status was checked?**

Yes □ No □

**Compare**

**2 If there were any unexplained discrepancies, is there evidence they have been clarified with the prescriber?**

Yes □ No □ N/A □

**Communicate**

Patient Education

**3a Is there evidence the patient was educated about any changes or that there have been no changes?**

Yes □ No □

**3b Is there evidence the patient was given the opportunity to ask questions?**

Yes □ No □

**3c Is there evidence the patient was offered an up-to-date list of their current medicines?**

Yes □ No □

Outcome measures – if next GP script presented

**4a Is there evidence that the next GP script has been checked with the up-to-date medicines list in the pharmacy?**

Yes □ No □

**4b If there are any discrepancies, have you clarified and documented these?**

Yes □ No □ N/A □