

WAMSG

INTRODUCTION TO WAMSG RESOURCES TO ACHIEVE THE BEST POSSIBLE MEDICATION HISTORIES IN WA HEALTH

KEY POINTS

- The best possible medication history should be recorded as early as possible in the episode of care.
- All hospitals and health services should have a formal process for recording medication histories.
- Recording the best possible medication history is facilitated by access to a patient's medications.
- Consumer should be encouraged to carry an up to date medication list, taking the medication list and their medications with them when they present to hospital and other HealthCare facilities.
- Consumers should be empowered to be active partners achieving safe use of medications with, responsibility for awareness of the medicines they use.

BACKGROUND

A complete and accurate medication history is recognised as a key component for the quality use of medicines. The SQuRe medication reconciliation module has highlighted the shortcomings of the current system and the need for more appropriate methods of taking and recording a medication history as well as the need for the recorded medication history to be verified and checked against the medication chart (medication reconciliation on admission). The principles of obtaining and recording an accurate and complete medication history are comprehensively covered in Guiding Principle 4 of the Guiding Principles to Achieve Continuity of Care in Medication Management (Australian Pharmaceutical Advisory Council, 2005). The intention is to document the best possible medication history (an initial medication history that is verified as early as practicable) so that it can be used throughout the episode of care to avoid duplication of recording and potential discrepancies between information sources. The medication history should be documented in a manner that allows it to be readily accessed and amended or updated as necessary when new information becomes available.

The guiding principles describe the roles and responsibilities of consumers and/or carers, health services and healthcare professionals together with the minimum data required as part of the medication history.

WAMSG Actions

WAMSG convened a Medication History working party

The working group agreed that

- While the process of medication reconciliation requires a multidisciplinary approach with the participation of doctors, pharmacists and nurses, the medication history is part of the general medical history and thus the primary responsibility lies with the medical officer overseeing care.
- Recording of an accurate medication history is facilitated by access to a patient's medications and/or medication list which can be used as vital supplementary information for the medication history interview. Ideally current medicines should accompany the patient to any hospital episode of care. This requires appropriately informing consumers and/or carers as well as ambulance transfer procedures that include bringing the consumers medicines to hospital with the consumer.
- Use of Patient's Own Medicines Bag (POMB) is recommended. These bags are self-sealing bags used to transport a patient's medicines to hospital by the ambulance service or store a patient's medicines on presentation to the hospital. The bags may also be used to securely store a patient's medicines (preferably at the patient bedside) during a hospital episode, and to transport a patient's medicines to home at the time of discharge.

The working group developed the following resources which were endorsed by WAMSG

- A template one-page information sheet which may be given to patients on presentation to ED, outpatients or preadmission clinics. The leaflet explains what information the hospital seeks about their medicines. This sheet is suitable to be modified and sent to pre-admission patients. The template form is appended. Health services may alter this document for local use.
(http://www.watag.org.au/wamsg/docs/Patient_Information_Form.pdf)
- A sample form for recording medication history that may be used as a template for individual health services (http://www.watag.org.au/wamsg/docs/Medication_History_Form.pdf). This template has been modified for use by several health services, and has usually formed a component of a medication reconciliation form.

FURTHER READING

Guiding Principles to Achieve Continuity in Medication Management, Commonwealth of Australia. (Australian Pharmaceutical Advisory Council 2005).

[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D900D825B95328DACA25705A00181F55/\\$File/guiding.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D900D825B95328DACA25705A00181F55/$File/guiding.pdf)

SQulRe Medication Reconciliation CPI Initiative Guidebook

www.safetyandquality.health.wa.gov.au/docs/squire/templates/70329_Med%20Safety_v7.pdf;

WA Process of Pharmaceutical Review Policy

www.safetyandquality.health.wa.gov.au/medication/pharmaceutical_review.cfm

FURTHER INFORMATION

The Medication History is a pre-requisite component of a comprehensive Medication Action Plan. Current work foreshadows development of standardised Medication Action Plans. Further information regarding proposed national Medication Action Plans will be disseminated as it becomes available.

Dr Margherita Veroni, Project Coordinator, WA Medication Safety Group margherita.veroni@health.wa.gov.au