Chapter 1: Medication Reconciliation

INTRODUCTION

Medication reconciliation is a formal process intended to prevent medication errors and medicines-related problems at transition points in patient care. It is an essential element of medication management. Medication reconciliation should occur at all points of transition between episodes of care. Medication reconciliation is consistent with the concept of continuity of medication management across the continuum of care as required by the *Guiding Principles to Achieve Continuity in Medication Management* and includes Guiding principle 4: accurate medication history.[1]

Failure to reconcile medications at transitions of care accounts for many preventable adverse events.[2] Poor communication of medical information at points of transition was responsible for up to 50% of medication errors and up to 20% of adverse medicine events.[3]

OBJECTIVE AND DEFINITION

Objective

The purpose of medication reconciliation is to ensure patients receive all intended medicines and to avoid errors of transcription, omission, duplication of therapy, and drug–drug and drug–disease interactions. The procedure for each organisation should be standardised. Ideally, the medication reconciliation process should commence as soon as possible on presentation or admission and a documented, confirmed medicines list be available before medicines are prescribed.

Definition

Medication reconciliation is the standardised process of obtaining a patient's best possible medication history and comparing it to presentation, transfer or discharge medication orders in the context of the patient's medication management plan (MMP).[4-6] See *Chapter 4: Medication management plan.*

Medication reconciliation also involves documenting discrepancies identified between the medication history and current medication orders and how these discrepancies were resolved.

EXTENT AND OPERATION

Medication reconciliation should be undertaken on:[4]

- presentation or admission to a health service organisation
- transfer between wards and care settings within an organisation
- discharge or transfer from the health service organisation to the community or other organisations
- transfer between community-based providers.

All patients should have their medication reconciled as soon as possible after admission or presentation. See Figure 1. If medication reconciliation cannot be completed for all patients, prioritise patients most likely to obtain maximum benefit. Patients most at risk of medicines-related problems include those who:

- have medication misadventure as the known or suspected reason for their presentation or admission to the health service organisation
- are aged 65 years or older
- take 5 or more medicines
- take more than 12 doses of medicines per day
- take a medicine that requires therapeutic monitoring or is a high-risk medicine
- have clinically significant changes to their medicines or treatment plan within the last 3 months
- have suboptimal response to treatment with medicines
- have difficulty managing their medicines because of literacy or language difficulties, dexterity problems, impaired sight, confusion/dementia or other cognitive difficulties
- have impaired renal or hepatic function
- have problems using medication delivery devices or require an adherence aid
- are suspected or known to be non-adherent with their medicines
- have multiple prescribers for their medicines
- have been discharged within the last 4 weeks from or have had multiple admissions to a health service organisation.

For patients who attend a health service organisation as a day patient or for ambulatory care (e.g. chemotherapy, renal dialysis, radiotherapy), medication reconciliation should be completed at the first episode of care and then every 6 to 12 months, following a recent admission or when there is a change in their treatment plan. See Figure 1.

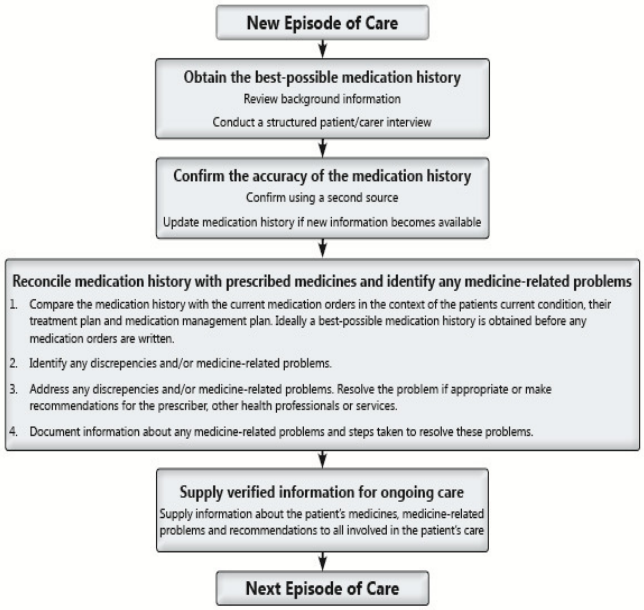

Figure 1. Medication reconciliation pathway.

Medication reconciliation is a four-step process and involves:

1. obtaining and documenting the best possible medication history
2. confirming the accuracy of the medication history
3. comparing the medication history with the prescribed medicines and follow-up discrepancies
4. supplying verified information for ongoing care.

Medication reconciliation requires an interdisciplinary approach that includes doctors, nurses, pharmacists and patients/carers across the continuum of care.[2] Although accurate medication histories are important for optimal patient care, obtaining them can be complex and time consuming. Evidence suggests this task is poorly done by those not focused on medication management and that pharmacists obtain more accurate medication histories than other health professionals.[7-10] Pharmacists have demonstrated that they are skilled and accurate in undertaking this task, and is valued by doctors.[7,11,12] Pharmacist-obtained medication histories have also been shown to be more accurate than patient-completed medication histories.[13]

Health service organisations need a reliable and robust medication reconciliation process that clearly articulates the steps involved and who is responsible for each step.

POLICY AND PROCEDURE

Obtain the Best Possible Medication History

A medication history is a record of all the medicines actually taken by the patient in the period before admission or presentation for the episode of care and includes information about previous adverse drug reactions (ADRs), adverse medicines events and allergies and recently ceased or changed medicines.[1] Obtaining a best possible medication history involves:

- reviewing background information
- conducting a patient/carer medication history interview.

Review Background Information

Before conducting an interview, review known patient-specific information. Use appropriate sources for background information, e.g. ward handover sheet, health records, transfer summaries, laboratory results, other health professionals. Some information may not be available from these sources and will need to be obtained during the face-to-face interview.

A combination of information sources can be used to compile or confirm the medication history. Alternative sources of information must be used if the patient does not manage their own medicines or if a reliable medication history cannot be obtained from the patient/carer.

Reviewing background information before the face-to-face interview allows patients to be prioritised and identifies issues to focus on during the interview. See Table 1.1.

Conduct Patient/Carer Medication History Interview

The critical component of obtaining a best possible medication history is a structured face-to-face interview with the patient/carer, preferably before admission, within 24 hours of presentation or admission, or at least before the end of the next working day after admission.[1] Pharmacists in the emergency department, medical assessment unit or preadmission clinic are ideally placed to obtain a medication history on admission.[14]

Interviewing the patient/carer to obtain a medication history is a key clinical activity performed by pharmacists. Medication history interviews provide opportunities for pharmacists to:

- establish rapport with the patient/carer and to explain their role in the patient's care
- commence preliminary education regarding the patient's medicines and any changes to their medicines
- use the information obtained to develop a MMP
- initiate plans for discharge and follow-up.

The medication history checklist on the *National Medication Management Plan* is a useful tool to use during the medication history interview.[15] See Table 1.2.

Table 1.1. Background patient information

The following information about the patient is useful:
•age, consider the ability to metabolise or excrete medicines, and the implications for appropriate selection of medicine and dosage
•gender, consider impact of gender on medicine selection
•height and weight
•pregnancy or lactation status
•immunisation status
•ethnic background or religion, consider implications for medicine selection including pharmacogenetic factors
•social background, consider the impact on patient's ability to manage their medicines
•details of regular GP, community pharmacy or other health professional as appropriate
•details of medication use, e.g. self-administering, nurse administers from dose administration aid, medicines crushed
•ability to communicate, e.g. cognitive function, language barriers, alertness, mental acuity, psychological state, and requirements for communication aids, e.g. glasses, hearing aids, need for interpreter service
•ability to take medicines as prescribed, e.g. cognition, dexterity, swallowing ability
•presenting condition, consider the possibility of adverse drug reactions, poor adherence, inadequate dosing, inappropriate therapy as a contributor to hospital presentation/morbidity
•working diagnosis, consider appropriate evidence-based therapy
•previous medical history, identify potential medicine and/or disease contraindications and ensure that management of the presenting complaint does not compromise a prior condition. Consider therapies for prior conditions that may have been omitted
•relevant laboratory or other findings (if available), focus on findings that will affect decisions regarding medicines, such as: -renal function -electrolytes -liver function -full blood count -cardiac markers -general observations -relevant previous therapeutic drug monitoring results.
Use appropriate sources to obtain information, such as:
•patient/carer
•patient's own medicines and/or medication list
•previous prescriptions (community pharmacy, discharge/ outpatient)
•preadmission clinic records
•GP referral letter/other correspondence, e.g. ambulance service notes
•GP medication list
•adherence aids
•transfer information from another health service organisation, e.g. nursing home, hospital, hostel
•electronic records, e.g. pharmacy dispensing system, discharge medication records
•current medication chart/administration records.

Table 1.2 Detailed instructions for conducting a patient/carer medication history interview

The nature of the interview will depend on the patient. Determine the specific goals of the interview and tailor the questions and discussion to obtain the necessary information. Questions must be relevant, as exhaustive interviews may be counter productive.

Conduct the interview in a location that allows privacy and minimises the risk of interruption and distraction. After determining the ability of the patient to communicate, choose an appropriate location and adopt a suitable position to enable the interview to take place comfortably and effectively.

1. Interview technique

•Greet patient and establish their identity.

•Ideally, use the AIDET framework:[16] **A**cknowledge the patient by name; **I**ntroduce yourself by name and profession and tell the patient how you can help them; tell them how long you will be talking to them (**D**uration); **E**xplain what you are doing and **T**hank the patient at the conclusion of the interview.

•Confirm that the time is convenient.

•Respect patient's right to decline an interview.

•Identify and attempt to overcome any communication barriers.

•Establish rapport with patient to support ongoing communication.

•Explain purpose of the interview (other health professionals may have already performed a medication history, so it may be necessary to explain the reason for a pharmacist-obtained medication history).

•Determine who is responsible for administering and managing the patient's medicines at home.

•Use an appropriate interview manner, avoid appearing rushed, be polite, attentive, maintain eye contact, avoid interrupting the patient, be non-judgemental, and communicate clearly and effectively. Use appropriate techniques, begin the medication history interview with open-ended questions to encourage the patient to explain and elaborate and move to close-ended questions to systematically minimise omissions. Use a structured and systematic approach to obtain a comprehensive medication history:
-ask patient/carer about their medicines using a logical and systematic method to ensure all relevant information is obtained and to avoid omitting relevant details
-consider using a written/mental checklist to ensure all patients/carers are asked pertinent questions regarding the patient's medicines.
-consider using the medication management plan to structure the interview and use as a guide to the information that is required.

2. Allergy and ADR history

•Confirm and document an accurate and comprehensive allergy and ADR history:
-confirm with patient/carer details of allergies or previous ADRs to any medicines (including CAM).
-if an allergy/ADR is known, document the medicine, reaction and date of reaction (if known) on the medication chart and any associated document
-if patient reports no history of ADR/allergy, tick the 'nil known' box on the medication chart
-if the ADR history cannot be established, tick the 'unknown' box on the medication chart
-sign and date the entry and print your name
-follow institutional policy regarding documentation of allergy and ADR history in the patient's health record.

3. Prescription and non-prescription medicines

•Ask patient/carer about their use of prescription and non-prescription medicines:
-ask which medicines were taken immediately prior to admission, specifically name (active ingredient and brand), dose, frequency and duration of current therapy
-locate and review patient's own medicines, if available, and consider appropriateness in view of current clinical details
-ask who is the usual prescriber for each medicine
-determine what they perceive the indications for each medicine are
-determine details of any adverse effects or allergies associated with current medicines
-determine the need for further supply of medicines on discharge
-ask about recently ceased/changed medicines and the reasons for the changes
-ask if they use adherence aids
-ask how they store their medicines at home
-ask if they use recreational substances, including alcohol, nicotine and illicit drugs, and the frequency of use.

•Ask patient/carer about their use of complementary and alternative medicines (CAMs):
-ask which CAM they are taking including herbal, vitamin and naturopathic medicines (specifically name, dose, frequency and duration of current therapy).
-ask their reason for taking the CAM.

4. Adherence assessment

This will be an ongoing process during the episode of care and assists in developing a medication management plan, facilitating discharge or transfer and ongoing care. See *Chapter 4: Medication management plan* and *Chapter 6: Facilitating continuity of medication management on transition between care settings.*

•Undertake a structured adherence assessment including patient's understanding and experience of taking their medicines:
-assess patient's understanding of their illness and determine if they need further education about their illness and refer to medical staff if required.

•Assess patient's understanding and attitude to current and previous medication therapy including:
-indication
-perceived effectiveness
-perceived problems attributed to medicines
-current monitoring
-reasons for changes to medicines.

•Assess patient's ability to use medicines as prescribed, e.g. do they have swallowing difficulties?

Table 1.2 Detailed instructions for conducting a patient/carer medication history interview (contd)
•Assess whether there are factors preventing adherence, such as: -insufficient knowledge of medicines -confusion -cost issues -personal or cultural beliefs or attitudes -physical limitations, e.g. poor vision, lack of strength or coordination.
•Assess patient's adherence by asking questions such as: 'People often have difficulty taking their medicines for one reason or another. Have you had any difficulty taking your medicines?' 'About how often would you say you miss taking your medicines?'
•Use a non-judgmental, empathetic approach and open-ended questions.
•Where possible, supplement self-reported adherence with objective measures, e.g. dispensing records.
•Inform medical staff if significant areas of poor adherence are identified.
•Identify strategies to address poor adherence.
•Assess how medicines were managed before presentation: -determine level of supervision/assistance needed for safe medicine administration at home, e.g. Was another person responsible for obtaining and/or assisting with medicine administration? Was an adherence aid being used? If so, who packed it?
•Assess patient's ability with respect to literacy, visual impairment, physical dexterity, cognition/memory and other disabilities.
•Assess need for additional adherence aids, e.g. large print, written information provided in a language other than English.

Obtain Patient's Consent

Where appropriate, obtain the patient's consent before requesting patient-specific information from other health professionals. Also:

- explain the need to contact other health professionals
- request permission to obtain patient-specific information from other health professionals
- obtain the patient's consent before discussing medication details with their carer or the person managing their medicines.

Summarise Interview

Allow the patient/carer to ask questions about their medicines during and at the conclusion of the interview. At the conclusion of the interview:

- advise the patient/carer when a pharmacist will next visit and what to do if they have further questions
- summarise the important information and describe the expected plan for their medication management, e.g. medicines-related issues that need to be resolved, different brands of medicine used.

Document Medication History

The information obtained in patient interviews should be accurately documented and readily available to other healthcare providers involved in the care of the patient. See Table 1.3

Table 1.3 Documenting medication reconciliation
A medication history should include:[1]
•patient details •date •name, designation and contact details of person documenting the medication history •information sources •list of medicines (prescription, non-prescription, CAMs, recreational, recently ceased, taken intermittently). For each medicine include: generic and brand name, strength, dose form, dose, route, administration schedule, duration of therapy/when medicine started, perceived indication (according to the patient) •adverse drug reactions and allergies.

Information may be gathered over several interviews as the patient/carer recall their medicines. It is important that the medication history documentation is easy to access and update when new information becomes available. Address issues identified when taking the medication history as soon as possible.[1]

Details of the medication history may be entered on the National Inpatient Medication Chart (NIMC).[17] However, the NIMC may be moved from the bedside when a new chart is commenced and there is insufficient space to record all the details required for a comprehensive history. A comprehensive medication history can be documented in a MMP, in paper or electronic format according to local policy. If the review is done in outpatients or a clinic then the MMP or local equivalent rather than the NIMC should be used. The medication history must then form part of the patient's permanent health record.

Planned Admissions

Ideally, all preadmission clinics will have a pharmacist present and all patients admitted for elective admissions will have their medication history taken and documented by a pharmacist.

Patient-completed questionnaires used for preadmission assessment are often inaccurate.[18] Encourage patients/carers to bring to the preadmission clinic:

- all their medicines (prescription, non-prescription, herbal and dietary supplements)
- medicines lists and repeat prescriptions
- any other information that could help accurately record what they have been taking, e.g. ADR card.

Advise patient/carer on:

- continuing current medicines regimen until their admission
- medicines that must be withheld and for how long before the admission
- medicines that are contraindicated or may interact with their planned treatment
- pre-medications required before admission.

Pharmacists should clearly document the plan for ceasing medicines before procedures and the plan for restarting them after the procedure.

On admission:

- check if there have been changes to their medicines since the preadmission clinic appointment
- document and flag medicines-related problems to be addressed before discharge, e.g. adherence.[1]

As not all elective admissions have preadmission processes, e.g. medical admissions, complete and document the medication history within 24 hours of presentation or admission, or at least before the end of the next working day after admission.

Confirm Accuracy of the Medication History

Determine if the medication history obtained from the patient/carer requires confirmation with alternative sources. Confirmation from a further source is required if:

- the patient is not responsible for administration of their own medicines
- a reliable medication history cannot be obtained from the patient/carer
- elements of the medication history are unknown
- the medication history is complex
- the medication history includes high-risk medicines.

Review the documented medication history and update if new information becomes available during the episode of care. Appropriate sources to confirm accuracy of the medication history include:

- patient's relative/carer responsible for supervising medicine administration
- dispensing history from previous hospital admissions and/or community pharmacies
- administration records from residential care or other health service organisations
- other health professionals, e.g. GP, community nurse
- patient's electronic health record
- patient's medicines or medicines list
- patient's prescriptions (community pharmacy, discharge/outpatient).

If unable to confirm what medicines the patient was taking before presentation or admission, then document that the medication history details obtained have not been confirmed.

Reconcile History with Prescribed Medicines

Medication reconciliation should:

- occur each time a patient is transferred from one episode of care to another and when new medication orders are written. Transfer may be within the organisation, on discharge or between providers of care
- include review of the previous medication orders alongside new orders and the care plan
- include review and resolution of discrepancies as they arise as well as available information to determine if discrepancies are intentional or non-intentional
- include communication with the prescriber to resolve medicines-related problems.

On Admission or Presentation

Compare the best possible medication history with the current medication orders in the context of the admission plan and the MMP and identify any discrepancies. Ensure that the patient has not been prescribed a medicine to which they have experienced an ADR/allergy. Medicine-related problems with the patient's current medicines regimen may be identified at this stage, see *Chapter 2: Assessment of current medication management* and *Chapter 3: Clinical review, therapeutic drug monitoring and ADR management*.

All medication reconciliation information should be documented in the patient's MMP as part of their active health record so that it is available to all healthcare providers involved in the patient's care. See *Chapter 13: Documenting clinical activities*.

The MMP should remain with the patient's active medication chart for the duration of the admission. It is then filed in the health record along with the medication chart on discharge. If the MMP is documented electronically it should be readily available in the patient's health record. Information technology can facilitate medication reconciliation if it is devised to support a well-designed process.[2] Minimum requirements for documenting medication reconciliation on a purpose-designed form are listed in Table 1.4.

Table 1.4 Minimum requirements for medication reconciliation recording form

Sources of information and contact details (where applicable):[15]
•carers/family •nursing home •community pharmacist •GP •community nurse •patient's own medicines •previous hospital records •medication list.
General information:
•who manages the patient's medicines •location of the patient's own medicines •immunisation status •contact information for GP, community pharmacist and residential aged care facility (if applicable).
Documented evidence:
•indicate that each medicine in the patient's medication history has been reconciled on admission and discharge •indicate variances in medication orders •explain action taken to reconcile discrepancies in medication orders.
Other useful details:[15,17]
•prescriber's plan for continuing/discontinuing medication for this episode of care •medicines that the patient has existing supplies of •medicines to supply on discharge •administration and/or adherence aids used prior to presentation •relevant information from adherence assessment •consent given by patient to contact other health professionals •relevant information regarding patient understanding of their medicines •presenting complaint •past medical history •admission weight and height •relevant biochemical data •risk assessment: level of independence and patient assessment •home visit or HMR referral recommended •follow-up medical review via ambulatory or outreach clinic recommended •discharge tasks documented and signed for including: medication counselling, CMI provided, discharge medication record provided, discharge medication supplied, administration aid supplied, community liaison pharmacist referral, discharge summary provided and where it has been sent.

Wherever medication reconciliation is performed, the MMP or equivalent should be filed in the patient's permanent health record for future access.

During Inpatient Stay

Check that the best possible medication history and current medicines are accurately transcribed for every transition the patient makes from one episode of care to another or when a new medication chart is written.

On Discharge/Transfer

Check that the discharge/transfer medication orders match current medication orders, the medicines supplied at discharge and the discharge plan. Check that there is a plan for recommencing medications withheld on admission and any changes noted.

The medication history should be listed in the discharge summary including the reasons for any changes between admission and discharge. Ensure that the details are included in the patient's electronic health record.

Reconcile the patient's own medicines with discharge/transfer medication orders and discuss changes to medicines during the episode of care and expected changes for discharge/transfer. Discuss with the patient what medicines will be required on discharge to ensure continued supply. Obtain permission from the patient to supply required medicines and remove ceased medicines for destruction. See *Chapter 6: Facilitating continuity of medication management on transition between care settings.*

Supply Verified Information for Ongoing Care

Ensure that verified information about the patient's medicines is received by all involved in the patient's care (including the patient) on discharge. Ensure information is included in the patient's electronic health record. Obtain patient consent before sharing any information with other healthcare providers in line with privacy and confidentiality legislation.

If the patient is being transferred to another episode of care, supply comprehensive information to the health professionals responsible for continuing the patient's medication management. Also provide relevant information to the patient in accordance with their MMP. *See Chapter 5: Providing medicines information* and *Chapter 6: Facilitating continuity of medication management on transition between care settings.*

Provide the following verified information:

- any medicines issued at discharge/transfer and the source for further supply
- discharge or transfer medicines list (complete and accurate list of all current medicines)
- explanation of the changes to therapy during the episode of care.

The method of information delivery should be timely and mutually agreed among healthcare providers. If required create a current list of medicines.

Encourage patients/carers to have a current list of medicines and to bring the list with them to each health service organisation or health professional that they attend.[17]

Table 1.5 lists the competencies and accreditation frameworks that are relevant to this chapter.

References

1. Australian Pharmaceutical Advisory Council. Guiding principles to achieve continuity in medication management. Canberra: The Council; 2005.
2. Poon EG. Medication reconciliation: whose job is it? Rockville: Agency for Healthcare Research and Quality. Morbidity and mortality rounds on the web; 2007. Available from <webmm.ahrq.gov/case.aspx?caseID=158>.
3. How-to guide: prevent adverse drug events (medication reconciliation). Cambridge: Institute for Healthcare Improvement; 2011. Available from <www.ihi.org>.
4. Institute for Safe Medication Practices. Medication safety self assessment for Australian hospitals. Sydney: Clinical Excellence Commission; 2007.
5. Institute for Safe Medication Practices. Building a case for medication reconciliation. ISMP Med Saf Alert 2005; 21 April.
6. Department of Human Services Victoria. Safer systems—saving lives. Preventing adverse drug events. Melbourne: The Department; 2005.
7. Carter MK, Allin DM, Scott LA, Grauer D. Pharmacist-acquired medication histories in a university hospital emergency department. Am J Health Syst Pharm 2006; 63: 2500-3.
8. Reeder TA, Mutnick A. Pharmacist-versus physician-obtained medication histories. Am J Health Syst Pharm 1008; 65: 857-60.
9. Tan VC, Knowles SR, Cornish PL, Fine N, Marchesano R, Etchells EE. Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review. CMAJ 2005; 173: 510-15.
10. De Winter S, Spreit I, Indevuyst C, Vanbrabant P, Desruelles D, Sabbe M, et al. Pharmacist-versus physician acquired medication history: a prospective study at the emergency department. Qual Saf Health Care 2010; 19: 371-5.
11. Stowasser DA, Collins DM, Stowasser M. A randomised controlled trial of medication liaison services-patient outcomes. J Pharm Pract Res 2002; 32: 133-40.
12. Taylor SE, Thompson B, Garrett K, et al. Comprehensive evaluation of the role of a clinical pharmacist in the emergency department. Quality Improvement Funding Final Report. Melbourne: Department of Human Services; 2003.
13. Dooley MJ, Van de Vreede M, Tan E. Patient-completed medication histories versus those obtained by a pharmacist in a pre-admission clinic. J Pharm Pract Res 2008; 38: 216-18.
14. Society of Hospital Pharmacists of Australia. Committee of Specialty Practice in Emergency Medicine. SHPA standards of practice in emergency medicine pharmacy practice. J Pharm Pract Res 2006; 36: 139-42.
15. Australian Commission on Safety and Quality in Health Care. National medication management plan. Sydney: The Commission.
16. AIDET: acknowledge, introduce, duration, explanation and thank you. Gulf Breeze: Struder Group. Available from <www.studergroup.com/aidet>.
17. Australian Commission of Safety and Quality in Health Care. National inpatient medication chart. Sydney: The Commission; 2009.
18. Blennerhassett J, Graudins L. Medication safety and patient participation: pharmacist, emergency department and beyond [letter]. J Pharm Pract Res 2005; 35: 244.
19. Society of Hospital Pharmacists of Australia. Clinical competency assessment tool (shpaclinCAT version 2). In: SHPA standards of practice for clinical pharmacy services. J Pharm Pract Res 2013; 43 (suppl): S50-S67.
20. Australian Pharmacy Profession Consultative Forum. National competency standards framework for pharmacists in Australia. Deakin: Pharmaceutical Society of Australia; 2010.
21. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney: The Commission; 2011.

Table 1.5 Competencies and accreditation frameworks

Relevant national competencies and accreditation standards and shpaclinCAT competencies
shpaclinCAT[19]
Competency unit 1.1 Medication history 1.1.1 Relevant patient background 1.1.2 Introduction to consultation 1.1.3 Questioning technique 1.1.4 Patient consent 1.1.5 Allergy and adverse drug reaction review 1.1.6 Accurate medication details 1.1.7 Patient's understanding of illness 1.1.8 Patient's experience of medicines use 1.1.9 Documentation of medication history 1.1.10 Confirmation of medication history 1.1.11 Adherence assessment
Competency unit 1.2 Assessment of current medication management and clinical review 1.2.1 Medication reconciliation
Competency unit 1.3 Identification, prioritisation and resolution of medicines-related problems 1.3.2 Identification of medicines-related problems 1.3.3 Prioritisation of medicines-related problems 1.3.4 Resolution of medicines-related problems 1.3.5 Documentation of medicines-related problems
Competency unit 1.5 Discharge/transfer facilitation 1.5.1 Reconciliation of medicines on transition between care settings
Competency unit 2.1 Problem solving 2.1.2 Access information 2.1.3 Abstract information 2.1.4 Evaluation and application of information
Competency unit 2.4 Communication 2.4.1 Patient and carer 2.4.2 Pharmacy staff 2.4.3 Prescribing staff 2.4.4 Nursing staff 2.4.5 Other health professionals
Competency unit 2.5 Personal effectiveness 2.5.1 Prioritisation 2.5.3 Efficiency 2.5.4 Logic 2.5.5 Assertiveness 2.5.6 Negotiation 2.5.7 Confidence

Competency unit 2.6 Team work 2.6.2 Interdisciplinary team
Competency unit 2.7 Professional qualities 2.7.2 Confidentiality 2.7.4 Responsibility for patient care
National competency standards framework for pharmacists[20]
Standard 1.1 Practise legally 3 Respect and protect the consumer's right to privacy and confidentiality 4 Support and assist consumer consent
Standard 2.1 Communicate effectively 1 Adopt sound principles for communication 2 Adapt communication for cultural and linguistic diversity 3 Manage the communication process 4 Apply communication skills in negotiation
Standard 2.2 Work to resolve problems 1 Analyse the problem/potential problem 2 Act to resolve the problem/potential problem
Standard 4.2 Consider the appropriateness of prescribed medicines 1 Gather relevant information
Standard 6.1 Assess primary health care needs 1 Elicit relevant clinical information
Standard 7.1 Contribute to therapeutic decision-making 1 Obtain accurate medication history
National safety and quality health service standards[21]
Standard 4 Medication safety: documentation of patient information 4.6 Accurate medication history 4.7 Documentation of adverse drug reactions 4.8 Review and reconciliation on admission and transfer
Standard 4 Medication safety: continuity of medication management 4.12 Current comprehensive list of medicines and the reason for change
Standard 4 Medication safety: communicating with patients and carers 4.15 Current medicines information