MEDICINE RECONCILIATION STANDARDS

SAFE MEDICATION MANAGEMENT PROGRAMME
ACKNOWLEDGEMENTS

The Chair of the Safe Medication Management (SMM) Programme would like to acknowledge the assistance of the 20 District Health Boards (DHBs) throughout New Zealand and the many stakeholders from across the health and disability sector who are engaged in the SMM Programme.

We particularly acknowledge the assistance of the SMM medicine reconciliation working group and the eight DHB pilots for their input into these standards.

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INTRODUCTION

Medicine reconciliation is an evidence-based process, which has been demonstrated to significantly reduce medication errors caused by incomplete or insufficient documentation of medicine related information. These standards provide a medicine reconciliation framework for implementation into the New Zealand (NZ) health and disability sector.

Medicine reconciliation has been 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/or adverse drug reactions (ADRs) with the goal of providing correct medicines for a given time period at all transition points.

Overarching principles

Vision

To ensure that the medicine reconciliation process becomes integrated into daily routine for all healthcare practitioners at all transition points of patient care and is understood by staff and patients as a process to facilitate the optimal use of medicines and reduce errors, as detailed in the New Zealand Medicines Strategy.¹

Goal

The medicine reconciliation process is completed for all patients at each transition point within 24 hours of admission, transfer, and discharge to and from the NZ health and disability sector.

Impact

Reduce all discrepancies that have the potential to become medication errors and / or result in medicine related harm to the patient.

Outcome

Patients receive the correct medicines i.e. the right medicine in the right dose to the right patient by the right route at the right time.
**Scope of application**

These standards apply to any person or organisation that provides medicine reconciliation within the NZ health and disability sector. Medicine reconciliation is a multidisciplinary process and a key to its success lies in communication (verbal and written) between the disciplines.

**Review period**

It is intended that the standards for medicine reconciliation continue to reflect the challenges and changes experienced by the healthcare sector. In order to achieve this, the document will be reviewed every two years.

**Explanation of terminology**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Standard</td>
<td>The reference point against which the medicine reconciliation service provision can be evaluated. The standard should be read in conjunction with the guidance.</td>
</tr>
<tr>
<td>Outcome</td>
<td>The outcome is the overall goal of each standard.</td>
</tr>
<tr>
<td>Criteria</td>
<td>The criteria are the components that are required to be in place in order to achieve the outcome of the standard.</td>
</tr>
<tr>
<td>Guidance</td>
<td>The guidance provides extra information to assist the implementation of the standard.</td>
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SUMMARY OF STANDARDS FOR MEDICINE RECONCILIATION

The standards for medicine reconciliation consist of four key areas.

- Accountabilities and responsibilities
- Process
- Documentation
- Measuring and reporting

Each key area has required criteria to achieve the standard. In order to ensure understanding of some of the criteria, guidance is included. These are intended to expand on the criteria and reduce any ambiguity.

In summary, the standards are detailed as follows.

1. ACCOUNTABILITIES AND RESPONSIBILITIES

Standard 1.1  Personal

All registered health practitioners involved in medicine reconciliation are responsible and accountable for the accuracy and quality of information provided to support the medicine reconciliation process at a given point in time.

Standard 1.2  Personal

Only registered health practitioners undertake medicine reconciliation.

Standard 1.3  Organisational

Each organisation ensures that each health practitioner involved in the medicine reconciliation process is able to undertake their role and responsibilities competently.

2. PROCESS

Standard 2.1  Collect

The health practitioner collects the most accurate list of medicines, allergies, and adverse drug reactions (ADRs) using a minimum of two source types.

Standard 2.2  Compare

The health practitioner compares the collected medicines, allergies and ADR list against the prescribed information, such as the medication chart, identifying and documenting any discrepancies.

Standard 2.3  Communicate
At each transition point, all changes that have occurred to the patient’s medicines, allergies and ADR lists will be documented, dated, and communicated to ensure the care of the patient is continued.

3. DOCUMENTATION MANAGEMENT

Standard 3.1 Documentation

Any information associated with medicine reconciliation is complete, accurate, relevant and current.

4. MEASURING AND REPORTING

Standard 4.1 Measures

Medicine reconciliation process, impact and balance measures are undertaken at regular intervals for learning and improvement using a continuous quality improvement cycle e.g. Plan – Do – Study – Act (PDSA) cycle².

Standard 4.2 Evaluation

Learnings from the measures are incorporated into ongoing medicine reconciliation process implementation and education and training requirements.

Standard 4.3 Reporting

Each organisation ensures reporting requirements are met to local and national requirements, for example, certification.
Guidance considerations to achieve these standards include:

**G1.1**

(a) The medicine reconciliation process is a collaborative process with every step in the process requiring clear ownership by the health practitioner according to their scope of practice.

(b) The responsibility for prescribing medicines as a result of the medicine reconciliation process lies with the prescribing health practitioner.

(c) Health practitioners who can be responsible for any part of the medicine reconciliation process include:
   - medical practitioner
   - pharmacist
   - nurse
   - midwife

(d) Other healthcare workers such as pharmacy technicians and enrolled nurses can participate in the medicine reconciliation process under the supervision of a registered health practitioner. Responsibility falls to the registered health practitioner.

(e) The responsibility for prescribing medicines as a result of the medicine reconciliation process lies with the prescribing health practitioner.

(f) All persons involved in the medicine reconciliation process are clearly documented on the medicine reconciliation form and/or in the clinical record to ensure a safe and monitored level of care. This includes the health practitioner’s family and given name, signature, date and time.

**G1.2**

(a) The organisation ensures that annual practising certificates and any notifications of the health practitioner’s scope of practice are sighted annually by the manager (or person with delegated authority).

(b) The health practitioner will also:
   - comply with the requirements of the Health Information Privacy Code revised edition (2008) and any subsequent revisions
   - comply with their organisation’s policies and procedures on medicine reconciliation and medicines management e.g. prescribing, administration
   - comply with the Māori health key principles of protection, partnership, and participation
   - work in partnership with the patient including communicating the reason for the collection of the information and the sources used, such as their general practitioner (GP), pharmacy, and rest home (when appropriate)
   - assume responsibility to ensure that the transfer of information occurs appropriately i.e. to GP, pharmacy and rest homes at discharge.
1. ACCOUNTABILITIES AND RESPONSIBILITIES

Outcome Health practitioners are informed and educated on their accountabilities and responsibilities for medicine reconciliation.

PERSONAL

Standard 1.1 All registered health practitioners involved in medicine reconciliation are responsible and accountable for the accuracy and quality of information provided to support the medicine reconciliation process at a given point in time.

Criteria The criteria required to achieve this outcome include:

1.1.1 Health practitioners clearly communicate and document all parts of the medicine reconciliation process that each health practitioner has been involved in.

1.1.2 Local policy on medicine reconciliation and/or medicine management clearly outlines accountability and responsibility lines in the organisation.

Standard 1.2 Only registered health practitioners undertake medicine reconciliation.

Criteria The criteria required to achieve this outcome include:

1.2.1 Health practitioners hold a current New Zealand practising certificate for the profession.

1.2.2 Health practitioners practise within their current scope of practice.
Guidance considerations to achieve this standard include:

**G1.3**

(a) The medicine reconciliation toolkit available on [www.safemedication.org.nz](http://www.safemedication.org.nz) provides guidance on the education and training requirements with examples. The main focus will be on understanding the purpose and impact of medicine reconciliation, the process and responsibilities involved, and medication history-taking.

(b) A train-the-trainer approach is suggested with 'hands on experience' to help facilitate the dissemination of medicine reconciliation practice.

(c) Health practitioners may require varying frequency for education and training e.g. doctors rotate on a more frequent basis. Medicine reconciliation should be included as part of induction and orientation programmes followed by one on one training.

(d) Peer review or competency assessment on a regular basis.
ORGANISATIONAL

Standard 1.3 Each organisation ensures that each health practitioner involved in the medicine reconciliation process is able to undertake their role and responsibilities competently.

Criteria The criteria required to achieve this outcome include:

1.3.1 The organisation ensures that there is a current local medicine reconciliation policy that outlines the requirements in line with the standards for:

- accountability and responsibility lines
- standard operating procedure e.g. instructions on how each health practitioner is expected to undertake the medicine reconciliation process
- education and training
- measuring and reporting

1.3.2 The organisation ensures that all health practitioners involved in the medicine reconciliation process are given adequate induction and orientation to enable them to undertake their roles and responsibilities competently.

1.3.3 The organisation ensures that education and training strategies are implemented, reviewed, and monitored for the medicine reconciliation process including ongoing appropriate professional development on a regular basis.

1.3.4 The organisation will have a quality assurance assessment conducted regularly for all health practitioners and any healthcare workers, e.g. pharmacy technicians and enrolled nurses participating in the medicine reconciliation process for the aspects of the process they are involved within.
Guidance considerations to achieve this standard include:

G2  The medicine reconciliation process is clear, consistent and able to be replicated for any patient in the course of their treatment by any health practitioner.

G2.1  (a) Sources of information can be electronic or paper based.

(b) Primary sources include:
- verbal information from the patient, patient’s family/caregiver
- patient held medication list, such as a yellow card
- patient’s own medicines as presented by the patient (noting date of supply and expiry date).

(c) Secondary sources include:
- general practitioner’s information
- community pharmacy’s information
- community mental health team information
- non government organisations (NGOs)
- rest homes
- lead maternity carers
- any other appropriate community health team, such as diabetes clinic.

(d) Tertiary sources of information include:
- clinical notes
- current medication chart
- transfer letters
- hospital pharmacy records
- admission medicines, allergies and ADR reconciliation documentation
- transfer medicines, allergies and ADR reconciliation documentation
- discharge medicines, allergies and ADR reconciliation documentation.

(e) Sources of information should not be older than three months and cover at least a period of six weeks to the present day.

(f) All collected lists should account for any changes to medicines (start, stop, continue or change), allergies and ADR status and be documented.
2. MEDICINE RECONCILIATION PROCESS

Outcome  Patients receive the correct medicines, that is, the right medicine in the right dose, to the right patient by the right route at the right time.

COLLECT

Standard 2.1  The health practitioner collects the most accurate list of medicines, allergies, and adverse drug reactions (ADRs) using a minimum of two source types.

Criteria  The criteria required to achieve this outcome include:

2.1.1  On admission, transfer and discharge, the health practitioner collects the most accurate list of medicines, allergies and ADRs from a minimum of two source types.

2.1.2  A primary source should be one of the two sources used where possible. Consult and confirm with the patient first when possible (or family or caregivers) prior to utilising secondary sources.

2.1.3  For transfer and discharge, the health practitioner can use the most accurate list of medicines, allergies and ADRs obtained at admission e.g. admission medicine reconciliation list as one of the sources of information.

2.1.4  Ensure the currency of the information sources used is valid, that is, the information sourced is not older than three months.

2.1.5  Use the National Medical Warning system, local patient alert databases or records within the organisation as sources of information for allergies and ADR information.

2.1.6  Ensure the source information includes name, role, contact details, date and time contacted.
Guidance considerations to achieve this standard include:

G2.1A Patient identification errors are a significant patient safety risk. A patient sticker can be used once all the patient details have been verified.

G2.1A.1 The NHI number is the unique lifetime identifier for all New Zealanders. The NHI number takes precedence over all other identifiers for consumers of health services in New Zealand.\(^5\)

G2.1A.2 The family name is also known as the surname.\(^5\)

G2.1A.3 The given name(s) must be accurately matching the details on the patient’s NHI number and written before the patient’s family name.\(^5\)

G2.1A.4 The gender of the patient and should be registered as male, female, or undetermined.\(^5\)

G2.1A.5 The date of birth will be documented in the format day/month/year e.g. 02/07/1974.\(^5\)

G2.1A.6 Allergies are immune-mediated and can cause reactions ranging from mild to anaphylaxis.\(^6\)
- medicine name and formulation
- type of reaction they experience or state unknown if unknown
- date or year of the reaction or state unknown if unknown
- source of ADR information e.g. patient, CARM, medic alert bracelet
- date, full name and signature of the person who records the information.

G2.1A.7 Adverse drug reactions (ADRs) are intolerances to medicines administered in their usual doses.\(^6\)
- medicine name and formulation
- type of reaction they experience or state unknown if unknown
- date or year of the reaction or state unknown if unknown
- source of ADR information e.g. patient, CARM, medic alert bracelet
- date, full name and signature of the person who records the information.
PATIENT IDENTIFICATION DETAILS

Standard 2.1A  The patient’s personal identification information will be collected and clearly documented.

Criteria  The criteria required to achieve this outcome include the collection and documentation of the:

2.1A.1  Patient’s National Health Index (NHI) number

2.1A.2  Patient’s family name

2.1A.3  Patient’s given name(s)

2.1A.4  Patient’s gender

2.1A.5  Patient’s date of birth

2.1A.6  Patient’s allergies

2.1A.7  Patient’s adverse drug reactions (ADRs)
Guidance considerations to achieve these standards include:

G2.1B Supplemental information may be necessary to aid decision-making processes such as:
- indications for use
- over the counter, alternative, complementary, rongoā medicines or therapies are part of the patient's medication history even if they can not be reconciled.
- new and/or recently discontinued medicines
- reasons for any medicine change e.g. form, dose, frequency
- PHARMAC details e.g. special authority numbers
- special care requirement, e.g. breastfeeding, pregnancy, renal and hepatic impairment
- chemical information e.g. tobacco, alcohol, recreational drugs
- adherence assessment outcome
- last medicine dose and time taken
- date of last dispensed medicines

G2.1.B.1 The medicine name will be written in non-abbreviated terms using the generic name unless there are safety reasons that require the addition of the trade/brand name next to the generic name e.g. oxycodone. Chemical abbreviations for medicine names are to be avoided e.g. KCl to be written as potassium chloride or EPO to be written as erythropoietin or evening primrose oil. Avoid the use of unapproved abbreviations. Refer to http://www.safeuseofmedicines.co.nz for guidance on current abbreviations.

G2.1.B.2 The medicine dose and units describe the measurement of the medicine. The use of abbreviations, decimal points with leading or trailing zeros, and ranges such as 10 – 20 mg are to be avoided. Refer to http://www.safeuseofmedicines.co.nz for guidance on current abbreviations.

G2.1.B.3 The frequency describes how often the medicine can be administered to the patient. Avoid the use of unapproved abbreviations. Refer to http://www.safeuseofmedicines.co.nz for guidance on current abbreviations.

G2.1.B.4 The route describes the means by which the medicine is to be administered to the patient. Avoid the use of unapproved abbreviations. Refer to http://www.safeuseofmedicines.co.nz for guidance on current abbreviations.

G2.1.B.5 This applies to medicines that are to be administered at a specific time such as for Parkinson's treatment. The time is to be recorded in hour(s)/minute(s) 24-hour format.
PATIENT MEDICINE DETAILS

Standard 2.1B  The patient’s current medicine information will be collected and clearly documented.

Criteria  The minimum criteria required to achieve this outcome include:

2.1B.1 Medicine name

2.1B.2 Medicine dose and units

2.1B.3 Frequency of administration

2.1B.4 Route of administration

2.1B.5 Specified individualised time for the medicine to be administered.
Guidance considerations to achieve this standard include:

**G2.2.1** (a) Admission medicine reconciliation occurs when any patient admitted to specialities, physical areas and/or hospital locations within the same organisation and inpatient episode of care.7

(b) Transfer medicine reconciliation occurs when any patient is transferred between specialities, physical areas and/or hospital locations within the same organisation7.

(c) Discharge medicine reconciliation occurs when any patient discharged from an inpatient episode of care to a new inpatient episode of care within same organisation e.g. ward to GP7.

**G2.2.2** Discrepancies - any medicine that is omitted, altered, added or substituted on the patient's medication chart without documented explanation in the patient’s clinical record or other form of accepted communication and can be:

- intentional (intended i.e. deliberate decision by prescriber at time of prescribing)
- unintentional (unintended i.e. unaware or unknown to prescriber at time of prescribing)

**G2.2.3** Reference made to ‘collecting’ rather than ‘reconciling’ allergies and ADR information as unable to verify quality of allergy and ADR information. Differences found presented to prescriber for an appropriate clinical decision and documentation.
COMPARE

Standard 2.2  The health practitioner compares the collected medicines, allergies and ADR list against the prescribed information, such as the medication chart, identifying and documenting any discrepancies.

Criteria  The criteria required to achieve this outcome include:

2.2.1  Compare the collected medicines, allergies and ADR list to the prescribed medicines, allergies and ADRs at admission, transfer and discharge to identify any differences. In general practice, the discharge medicines, allergies and ADR list is compared to the current patient’s medicines list (prescribed GP list).

2.2.2  Review the clinical notes or accepted documentation to identify any documented explanation for differences found. Any differences found not documented, even if clinically indicated, are a discrepancy.

2.2.3  Differences in allergies and ADR information found will be presented to the prescribing health practitioner for an appropriate clinical decision and documentation as unable to verify the quality of allergy and ADR information.
Guidance considerations to achieve these standards include:

G2.3.1 Communication should include:

- Patient details
- Date and time medicine reconciliation started
- Date and time medicine reconciliation completed
- Sources of information used and contact details e.g. the given and family name(s) of the person contacted at the general practice and/or community pharmacy including the telephone number
- Collected medicines, allergy and ADR list
- Discrepancies identified that require reconciliation by the prescriber
- Prescriber’s reconciliation (unintentional or intentional and reasons for changes)
- Details of the health professionals involved in the medicine reconciliation process e.g. full name and signature.

G2.3.2 A system for notifying prescribers that action is required to reconcile discrepancies is required. Where reconciliation is urgent, prescriber should be contacted immediately to discuss and rectify situation. Within 24 hours, prescriber will:

- Reconcile individually by indicating whether discrepancy is unintentional or intentional
- Sign, date and time to indicate reconciliation completed for each discrepancy
- Update relevant patient records e.g. medication chart, discharge summary, clinical notes.

G2.3.3 An accurate medicines, allergies and ADR list should be made accessible to other systems involved in medicines management.
COMMUNICATE

Standard 2.3  At each transition point, all changes that have occurred to the patient’s medicines, allergies and ADR list will be communicated, dated, and documented to ensure the care of the patient is continued.

Criteria  The criteria required to achieve this outcome include:

2.3.1 Each health practitioner involved in patient care should recognise that the accurate communication of changes to a patient’s medicines, allergies and ADR list is essential in reducing medication errors.

2.3.2 The communication step involves reconciling to complete the process. A combination of verbal and written communications will be used when reconciling discrepancies, acknowledging local policies and procedure requirements.

2.3.3 An accurate medicines, allergies and ADR list at any transition point includes information on medicines started, stopped and continued including any changes to dose, route and frequency and reasons for these decisions.

2.3.4 An accurate medicines, allergies and ADR list will be provided at discharge to:
   • patient or patient’s family/caregiver
   • GP
   • community pharmacy
   • lead midwifery carers
   • other lead carers as appropriate
   • rest homes
   • nurse practitioners
**Guidance considerations to achieve this standard include:**

| G3.1.1  | All health practitioners involved in medicine reconciliation are responsible and accountable for the accuracy and quality of information provided at all transition points to support the medicine reconciliation process. |
| G3.1.2  | Medicine reconciliation forms will be incorporated as part of the patient's record. When designing a local form (paper or electronic) for the medicine reconciliation process, the contents of the form comply with the criteria detailed in these standards. |
| G3.1.3  | To ensure quality of the information, regulate the development, approval, issue, change, distribution, maintenance, use, storage, security, and disposal of documents. Old documentation should be archived on a documentation management server, which users have access to. User access rights that reflect security considerations should be set up on a per user basis. |
| G3.1.4  | Policies and procedures are reviewed according to timelines but also when learnings are significant to warrant documentation change. |
3. DOCUMENTATION

Outcome Documentation for medicine reconciliation is complete, accurate, relevant and current.

DOCUMENTATION

Standard 3.1 Any information associated with medicine reconciliation is complete, accurate, relevant and current.

Criteria The criteria required to achieve this outcome include:

3.1.1 Information is kept up-to-date.

3.1.2 Information is in a form that can be used by relevant people.

3.1.3 Information is retained in accordance to current legislative requirements and good practice guidelines

3.1.4 Information is documented in accordance to organisation policy and contains the requirements that meet the standards.

3.1.5 Information is presented in language that can be understood and is relevant to the user.
Guidance considerations to achieve this standard include:

G4.1  (a) The Plan-Do-Study-Act (PDSA) cycle (also known as the Deming cycle), is a model for continuous improvement of quality\(^9\). The PDSA cycle is shorthand for testing a change by:
- planning the change
- implementing the change
- studying the results
- acting on what is learned.

(b) The PDSA cycle enables measurement for improvement to:
- identify areas where improvement could be achieved
- demonstrate that improvement is being achieved
- demonstrate that improvement is being sustained

(c) The Institute for Healthcare Improvement (IHI) provides methodology for tracking safety improvements made to medication systems\(^9\). The structure in the SMM measuring and reporting framework\(^7\) has been aligned to the IHI system and includes three types of measures.
- Process - how well are we implementing the proposed changes i.e. are we meeting our target within 24 hours?
- Impact - are we actually achieving improvement i.e. reducing discrepancies?
- Balance - are the changes to improve this part of the system causing new problems in other parts of the system i.e. delays in patients receiving their medicines?

G4.2  (a) The organisation will identify a process owner and therefore a line of reporting e.g. Chief Medical Officer, Director of Nursing or Chief Pharmacist.

(b) Measuring without regular reporting to staff involved in medicine reconciliation of the learnings will result in no improvement i.e. the PDSA cycle must be completed.

(c) Presenting the measures within a report identifies evidence to where improvement is most required and clear learnings from the PDSA cycle. This will enable new knowledge to be brought into daily practice.
4. MEASURING AND REPORTING

Outcome To demonstrate that medicine reconciliation has resulted in a reduction in discrepancies that have the potential to become medication errors or result in medication related harm to the patient.

MEASURING

Standard 4.1 Medicine reconciliation process, impact and balance measures are undertaken at regular intervals for learning and improvement using a continuous quality improvement cycle e.g. Plan – Do – Study – Act (PDSA) cycle.

Criteria The criteria required to achieve this outcome include:

4.1.1 identify the person/team/department responsible for measuring

4.1.2 determine the measures to be undertaken and set a timeframe cycle

4.1.3 collect measures and learnings according to set timeframes

4.1.4 incorporate measures and learnings into part of ongoing medicine reconciliation educational support and training within the organisation

Standard 4.2 Learnings from the measures are incorporated into ongoing medicine reconciliation process implementation and education and training requirements

Criteria The criteria required to achieve this outcome include:

4.2.1 evaluate the measuring and reporting to determine points of merit, worth, and significance

4.2.2 stabilise the biases from test to test

4.2.3 incorporate the learnings into ongoing medicine reconciliation educational support and training within the organisation
REPORTING

Standard 4.3   Each organisation ensures reporting requirements meet local and national requirements, such as certification.

Criteria   The criteria required to achieve this outcome include:

4.3.1   identify the person/team/department responsible for reporting locally and nationally if required

4.3.2   report measures and learnings to appropriate staff, clinical, quality, governance and management teams regularly
## APPENDIX A – DEFINITIONS

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>Authorised prescriber</td>
<td>A registered medical practitioner, midwife, dentist, nurse or optometrist, who has the rights to prescribe specified prescription medicines as set out in Section 2(1) of the Medicines Act 1981 and Medicines Regulations 2005 relating to scope of practice in New Zealand.</td>
</tr>
<tr>
<td>Certification</td>
<td>A mandatory requirement by the Ministry of Health, introduced under the Health and Disability Services (Safety) Act 2001, to replace the old system of hospital licensing. The requirements are based on the Health and Disability Sector Standards, which have established the minimum level of care that should be expected of any health care provider within New Zealand.</td>
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<tr>
<td>Discrepancy</td>
<td>A difference between the collected medicines list during the medicine reconciliation process and the prescribed medicines on the medication chart that is not documented in the clinical record, even if clinically appropriate.</td>
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<tr>
<td>Health practitioner</td>
<td>A person who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession.</td>
</tr>
<tr>
<td>Intentional</td>
<td>Describes a medicine discrepancy that was a deliberate decision by the prescriber at the time of prescribing, but not documented.</td>
</tr>
<tr>
<td>Medicine</td>
<td>Any substance or article, other than a medical device, that is manufactured, imported, sold, or supplied wholly or principally: (a) For administering to one or more human beings for a therapeutic purpose; or (b) For use as an ingredient in the preparation of any substance or article that is to be administered to one or more human beings for a therapeutic purpose.</td>
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<tr>
<td>Medicine Reconciliation -</td>
<td>Collect, compare and communicate has occurred.</td>
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<td>initiated</td>
<td></td>
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<tr>
<td>Medicine Reconciliation -</td>
<td>Collect, compare, communicate and reconcile has occurred.</td>
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<tr>
<td>completed</td>
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<td>Prescribe</td>
<td>In medical practice, the act of authorising an order to supply or administer a substance used or capable of being used to prevent, treat, or palliate a disease, or the symptoms or effects of a disease for the purpose of clinical treatment of a patient under the authorising person’s care.</td>
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Reconciled	Describes a medicine discrepancy that has been individually categorised by the prescriber as unintentional or intentional and action has been undertaken to resolve the medicine discrepancy. As part of action undertaken, each individual medicine discrepancy must have a time, date and signature documented for accountability.

Unintentional	Describes a medicine discrepancy that was unknown to the prescriber at the time of prescribing.
APPENDIX B – REFERENCES


11. Medicines Regulation 2005

12. Health and Disability Services (Safety) Act 2001