Shropshire Community Health NHS Trust

Medicines Policy Part 5: Medicines Reconciliation

Document Details	
Title	**Medicines Policy Part 5: Medicines Reconciliation**
Trust Ref No	1486-67062
Local Ref (optional)	
Main points the document covers	Legal and governance requirements when reconciling medicines at admission or transfer of care
Who is the document aimed at?	All clinical staff
Author	Medicines Management Team
Approval process	
Approved by (Committee/Director)	Quality and Safety Delivery Group
Approval Date	9th June 2021
Initial Equality Impact Screening	yes
Full Equality Impact Assessment	no
Lead Director	Director of Nursing and Operations
Category	Clinical
Sub Category	Medicines Management
Review date	30th June 2026
Distribution	
Who the policy will be distributed to	Available to all clinical staff
Method	Email notification of entry onto webpage
Document Links	
Required by CQC	yes
Required by NHLSA	yes
Other	

Amendments History		
No	Date	Amendment
1	June 2012	V1 Shropshire Community Health NHS Trust
2	November 2014	Scheduled review: Added reference to escript record
3	February 2018	Methotrexate amendment Level 2 review target change
4	May 2021	Scheduled Review – Greater clarification on types of medicines reconciliation

Shropshire Community Health NHS Trust

Medicines Policy
Part 5: Medicines Reconciliation

Contents **Page**

Appendices

1 DEFINITIONS

1.1 Medicines Reconciliation

Medicines reconciliation is a process designed to ensure that all the medication a patient is currently taking is correctly documented on admission and at each transfer of care primarily between in-patient settings. It encompasses:

- *Collection* of the medication history from a variety of sources (usually a minimum of 2 – see Appendix 3)
- *Checking* that medicines prescribed on admission for the patient are correct. The 'checking' step involves ensuring that the medicines and doses that are now prescribed for the patient accurately reflect the sources consulted. Discrepancies may be identified at this stage and these may be intentional or unintentional.
- *Communicating* any changes in medicines so that they are readily available to the next person(s) caring for the patient. Communication must include reasons for the change(s) and any follow-up requirements. Although the process and outcomes may be verbally discussed with other members of the healthcare team there must also be a written record in the patient's medical record and/or on the prescription chart as set out in Section 3.2

Medicines reconciliation should involve pharmacists. This means that systems to deliver medicines reconciliation in different areas of care should be supported by pharmacists and ideally involve pharmacy team members in a clearly defined process.

1.2 Medication review

Medication review has been defined as a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimizing the number of medication-related problems and reducing waste.

A medication review can only be accurately performed once an accurate list of what the patient is currently taking, i.e. medicines reconciliation, has been completed.

Medication review is a process requiring additional knowledge and skills to those required for medicines reconciliation and so the two processes have been separated for the purposes of this document. The detailed processes involved in medication review are considered beyond the scope of this policy.

1.3 Discrepancies

Part of the checking process includes the identification of any discrepancies. A discrepancy can be defined as any difference between the medicines the patient had been taking in their previous care setting and the medicines prescribed in their new care setting.

Discrepancies may be considered as:

- Intentional
- Unintentional

Intentional discrepancies can be defined as any difference between the medicines the patient was taking prior to admission and the medicines prescribed in their new care

setting that have been changed intentionally and agreed with the clinician(s) responsible for the patient's care.

Unintentional discrepancies (errors, omissions or unintentional additions) can be defined as any difference between the medicines the patient was taking prior to admission and the medicines prescribed in their new care setting that is not a conscious change.

1.4 Patient medical record

Within each setting, this is the main record in which the clinicians record the patient's diagnosis, treatment, test results, responses and ongoing management.

1.5 Prescription chart

This refers to the chart used to record the prescribing and administration of medicines during the inpatient stay.

1.6 Escript record

This is the record of medicines reconciliation and transactions on the computer system available in community hospitals.

2.0 LEVELS OF MEDICINES RECONCILIATION

2.1 Introduction

Medicines reconciliation (MR) is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer and discharge of patients requiring medicines. MR can be considered to occur at different stages or 'levels' which may in practice depend on the training and capability of the available staff, although ideally should be driven by the needs of the individual patient. The staff carrying out MR at any level must be appropriately trained.

2.2 Summary of levels of medicines reconciliation

Level	Brief description	Patient groups
Level zero	Admission or transfer-led by admitting clinician	All
Level 2	Pharmacy consolidation	All
Level 1	Continued pharmacy checks	All

2.3 Practical definitions

Following the transfer of a patient into the Community Hospital or the Prison service, an appropriately trained member of the nursing or medical staff will provide the first level (admission-led) medicines reconciliation as part of the admissions procedure.

(a) Level Zero - Admission-led

Patient group	By whom	Collection Method	Sources	Time frame
ALL adult admissions	- Admitting prescriber - Other healthcare professional (who has received appropriate training)	Using checklist as a reminder (Appendix 2), supported by appropriate training	Preferably at least 2 (Appendix 3)	Within 6 hours of admission

(b) Pharmacy Consolidation then First and Second Level Checks

Patient group	By whom	Collection Method	Sources	Time frame	Medicines Reconciliation Level
Agreed adult admissions	- Pharmacists - Accredited members of the pharmacy team (may include technicians and pre-registration pharmacists)*	Using checklist as a reminder (Appendix 2), supported by appropriate training.	At least 2, preferably 3	Pharmacy Team must ensure greater than 90% completion within 72 hours of admission	Medicines Reconciliation Level zero
Following consolidation at admission:					
By whom	**Sources to check**	**Purpose of Check**		**Frequency**	**Medicines Reconciliation Level**
Pharmacists only	Drug Chart eScript SCR	Medicines clinically appropriate & correct Ensure medicines optimised for patient		Once following admission	Medicines Reconciliation Level 2
Pharmacists - Accredited members of the pharmacy	Drug Chart eScript	Capture new medicines Order medicines		Each site visit	Medicines Reconciliation Level 1

team (may include technicians and pre-registration pharmacists)*		Capture dose changes Check drug chart following a re-write		

Although ideally all patients should receive Level 2 MR, it is acknowledged that this may not always be possible, therefore patients may have to be prioritised to receive this service.

3.0 PROCESS

3.1 Collection and Checking

Information shall be gained from the patient and/or carer using an agreed checklist and process (e.g. Appendix 1 & 2) and ideally corroborated by at least 2 reliable sources (Appendix 3). For patients with communication difficulties caused by their acute condition, sensory or cognitive impairment or language barriers, consideration may need to be given to accessing additional sources, depending upon the individual circumstances.

3.2 Communication

'Communicating' is the final step in the process, where any changes that have been made to the patient's prescription are documented and dated, ready to be communicated to the next person responsible for the medicines management care of that patient. Examples might include:

- When a medicine has been stopped, and for what reason
- When a medicine has been started, and for what reason
- The intended duration of treatment
- When a dose has been changed and for what reason
- When the route or formulation of the medicine has been changed, and for what reason
- When the frequency of the dose has changed and for what reason
- Monitoring and follow up requirements, when these need to be actioned and by whom
- The patient required support to take their medicines in a previous care setting which may need to be resumed or reviewed

(a) Communication following first level medicines reconciliation (admission led). ***This is the responsibility of the admitting clinician***

- Documentation should always be made in the patient medical record or communication notes as appropriate, noting sources used and dated and signed by the admitting practitioner
- Prescription chart (as list of medicines to be administered)
- Intentional medication changes should always be documented in the patient medical record or communication notes **and** on the drug chart giving reasons for the change

(b) Communication following second level medicines reconciliation (pharmacy consolidation). ***This is the responsibility of the pharmacist or pharmacy technician who carried out the MR.***

- Intentional medication changes not already documented should be recorded in the patient escript record and the doctor requested to document the reasons for the change
- Unintentional medication changes should be discussed with the prescriber and documented in the patient's escript record. The doctor will be asked to amend the prescription chart where clinically appropriate.

It is the responsibility of the person carrying out the second level medicines reconciliation to ensure that:

- Unintentional discrepancies highlighted by the MR are appropriately prioritised and resolved by referral to the clinical pharmacist, or to the responsible prescriber.
- Any future transfer requirements between care settings are appropriately documented in the patient escript record and where appropriate on the

prescription chart with any useful telephone numbers obtained on admission, as these may aid a smooth transfer between care settings

- To follow local trust policies on record keeping and documentation in the patient escript record. As a minimum, standard documentation in the patient escript record should include patient details, date, time, a summary of the actions as a result of the medicines reconciliation and name, signature of the individual carrying out the reconciliation (via log in details). Where changes have been made to the prescription chart these should also be appropriately documented.
- To ensure that medication changes and reasons for the changes are entered onto the escript system so that the electronic discharge letter is accurate

4.0 TRAINING AND ACCREDITATION

- Staff undertaking admission led medicines reconciliation will undertake a "prescriber induction" to attain competency in this field. Medicines Management Team will deliver this training to prescribers

- Staff undertaking Level 1 MR should receive appropriate training which is supported, delivered or led by the Medicines Management team. Face-to-face training should be delivered by pharmacists or pharmacy technicians.

- Staff undertaking Level 2 MR will be accredited through an agreed in-house competency assessment to carry out the service. Local standard operating procedures are in place to support activities.

5.0 AUDIT

Rates of medication reconciliation are monitored monthly to ensure targets are being met. These include:

Adult patients will have a Level 2 (pharmacy consolidation) MR carried out within a maximum of 72 hours STANDARD: 90%

6.0 CONSULTATION

The following people were consulted in the review of this policy:

David Young – Lead Pharmacist Community Hospitals and MIU

Susan Watkins – Chief Pharmacist

Medicines Management Team

Dani Cornford – Lead Pharmacist, Stoke Heath Integrated Care

Medicines Governance Group

APPENDIX 1. Checklist to support process of medicines reconciliation

It is **not** intended that this checklist be completed on paper and stored for every patient, rather that it underpins training around MR and practically supports the MR process and guides the documentation that must be added to the patient medical or escript record or the prescription chart.

Patient details (full name, date of birth, weight, NHS/unit/hospital number, GP, date of admission
The condition for which the patient was referred (or admitted) plus details of any co-morbidities
Known allergies (including non-drug allergies e.g. peanuts, beestings) and nature of the reaction. *Should be signed, dated with documentation of sources used*
A complete list of all of the medicines currently being taken by the patient
Dose, frequency, formulation and route of all the medicines listed
Specific medication to ask about include • Inhalers • Eye drops • Topical preparations • Once weekly medication (which day) • Steroids- e.g. maintenance / tapering dose • Nebules –does patient have a nebuliser at home? • Home Oxygen? • Herbal preparations/OTC/internet medicines • Insulin - check device • Any “when needed” medication • Anticoagulants - indication, duration • Analgesics including controlled drugs and patch formulations • Biologic injections - how to obtain further supplies • Apo-Go pens for Parkinsons Disease- how to obtain further supplies
Additional information for specific drugs e.g. indication for medicines that are for short-term use only including a stop date (antibiotics also require an indication),
Medication management in own home e.g. details of specific support from carers, dosette box, medication reminder charts
Sources used (minimum of 2) *Should be documented*
Name, signature and date of practitioner carrying out medicines reconciliation

APPENDIX 2. Collecting information for medicines reconciliation

The 'collecting' step involves taking a medication history and collecting other relevant information about the patient's medicines. The information may come from a range of different sources (some potentially more reliable than others). See Appendix 4.

The medication history should be collected from the most recent and reliable sources. Where possible, information should be cross-checked and verified. The person recording the information should always record the date that the information was obtained and the source of the information.

This section covers:

a. Taking a medication history
b. A checklist of questions that can support medicines reconciliation and help to identify any problems

A) TAKING A MEDICATION HISTORY

This process may not be applicable for patients with communication difficulties. If a carer or translator is not available, consideration should be given to relying solely on a variety of external sources. In such cases, the difficulties in obtaining the drug history, the sources used, and possible areas of uncertainty must be clearly documented.

- Introduce yourself to the patient and explain the purpose of your visit.
- Confirm with the patient whether they have any medication allergies or Adverse Drug Reactions (ADRs). Ask also about the nature of the reaction and document this information in the patient escript record and the drug allergy/hypersensitivity box on the medication record chart:
    - If the patient has no known drug allergies/hypersensitivities, then document as "*NKDA" or "none known"*
    - If the patient is unconscious/unavailable use other sources to determine allergy status where possible.
    - This information should be signed and dated and include details of the sources used
- Ask the patient if they have brought all their own medicines including OTC medicines and/or a list of their medicines into hospital.
- Ask the patient if they always take the medicines as prescribed by the doctor. If not, a medication review by pharmacist or doctor will be requested
- Ascertain what medicines the patient was using regularly at their previous care setting prior to admission (see Appendix 4 on Sources for Drug Histories).
- Ask the patient for details of medicine name, formulation, strength and frequency of administration for each medication.
- Where the patient has been transferred from another care setting you may need to check the medication history against the medication record chart or administration record from that setting. You may need to use your discretion and reconcile medicines from prior to admission to the previous care setting. This is especially important for patients admitted from A and E departments where drug charts at discharge are often incomplete.
- The first source of documentation of a medication history on admission should always be the patient summary care record with additional information (SCRai). If this is not available then the GP Summary may be used as an alternative
- In addition to asking the patient about regularly prescribed medicines, also check if the patient is using any of the medicines listed in Appendix 2 as these are often forgotten by patients.
- Ascertain the patient's adherence to their prescribed medication regime. Ask the patient/carer if they take/administer the medicines as labelled. Ask if they use a compliance aid.

Note: Some patients are confused on admission to hospital (especially the elderly) and claim not to be taking any medicines. In such instances alternative sources may define what medicines are prescribed and a view will need to be taken on whether the patient complies or not.

Specific information should be collected about the following drugs:

Inhalers

- It is important to confirm the name, strength and type of inhaler, and to get the patient to demonstrate their technique.

Warfarin

The following points should be recorded on the drug chart for patients taking warfarin:

- Indication, duration of treatment and target INR
- Patient's usual or most recent dose and INR result
    1. Tablet strengths held by the patient
    2. Whether patient has an anticoagulant "yellow" book

It is also important to take into consideration, diet and lifestyle changes, and possible drug interactions e.g. commencement of aspirin or heparins that may affect the INR.

DOACs

The following points must be recorded;

- Indication and duration
- Check the patient has a Patient Alert Card

Steroids

- It is important to obtain an accurate history particularly for patients with asthma or chronic obstructive pulmonary disease (COPD), irritable bowel disease (IBD) or arthritis.
- Ask about any recent courses (within past 6 months) and if so, how many and for how long (whether they were short 5-7 day courses or reducing courses).
- For those on long-term steroids this should be annotated on the drug chart so that treatment is not abruptly stopped. Clarify the maintenance dose
- Ensure the patient is in possession of a Steroid Emergency Card or Steroid Treatment Card (blue) where appropriate.

Insulin

- The type (human, bovine or pork), brand, administration device and dose should always be checked and annotated on the drug chart.
- For those patients that say that they have an insulin pen, clarify between the different presentations and strengths.
- Be aware that some insulins are available in different strengths e.g. glargine insulin and degludec insulin

Methotrexate

N.B. Methotrexate is managed like a controlled drug. Patient's stock is secured in the CD cabinet and the opening quantity is entered in a dedicated "Methotrexate Register". The running balance must be checked daily.

- It is prescribed once weekly so the day of administration, strength and number of tablets taken should be confirmed with the patient.
- Check that this is correct on the drug chart and that the six days of the week when the dose is not to be administered are crossed off.
- Any concomitant folic acid prescriptions should also be asked about.
- Ask to see the patients monitoring booklet.
- If the patient administers injections at home, ensure correct disposal via a hazardous waste bin is available
- Ensure that Trimethoprim is NOT co-prescribed with methotrexate

Bisphosphonates

- The day of administration for weekly dose forms should be confirmed with the patient and annotated on the drug chart.
- Check that this is correct on the drug chart and that the six days of the week when the dose is not to be administered are crossed off.
- Ask the patient whether they take calcium preparations and confirm which brand.
- Confirm the patient is aware of the specific dose timing requirement for bisphosphonates
- If initiating a bisphosphonate – ensure the patient is not already receiving a long-acting version e.g. denosumab

Opioids

- Confirm dose, brand, strength and colour of tablet
- Frequency of use, recent dose changes
- Ensure Oramorph (morphine sulphate oral liquid) dose is prescribed by both number of milligrams and number of millilitres (since two different strengths of solution are available)
- Confirm with hospital prescriber if concerns are raised

Methadone

- Check whether doses have been confirmed with the Drug Treatment Centre (DTC), patient's GP or community pharmacy
- Refer to local policies (e.g. urine screening)
- Contact the community pharmacist to alert them of the patient's admission and determine the normal dispensing schedule and when the patient last collected their methadone (daily supervised, weekly etc)
- Ensure methadone is prescribed by number of milligrams not number of millilitres (since two different strengths of solution are available)
- Patients do not usually get a supply of methadone on discharge.
- The GP, community pharmacist and DTC contact will need to be contacted pre-discharge to agree a plan of action.

Nebulisers

- Identify whether the patient has own nebuliser and nebules at home and document on the drug chart.

B) A CHECKLIST OF QUESTIONS TO SUPPORT MEDICINES RECONCILIATION AND HELP IDENTIFY ANY PROBLEMS

- Does anyone help you with your medicines at home? If so, who? What do they do?

- Do you have any problems obtaining or ordering your repeat prescriptions (NB: relative / carer might help)

- Do you have a regular community pharmacy that you use?

- Do you obtain medicines from internet pharmacies or OTC e.g health food shops?

- Do you have problems getting medicines out of their packages?

- Do you have problems reading the labels?

- Some people forget to take their medicines from time to time. Do you? What do you do to help you remember?

- Some people take more or less of a medicine depending on how they feel. Do you ever do this?

- Do you experience side effects or unwanted effects from any of your medicines?

- Specific medication related questions such as have any medicines been stopped recently or have any doses been changed recently?

Appendix 3. Sources of Medication Histories

The following sources of medication histories are listed below in no order of preference, as reliability can vary according to the situation. However, it is best practice that at least two or more sources are used to establish an accurate medication history.

The Patient

- This is an important source as the patient may be able to tell you exactly how they take their medicines.
- Always try to establish how exactly a patient takes their medicines, as this could be very different from the formal records.

Summary Care Record with additional information (SCRai)

- Viewing of the SCRai is only accessible by pre-authorised personnel. Where available it provides basic information such as allergy status, current medication (both acute and repeat) and contra-indications as documented on the GP practice computer.
- If SCRai is not available then request a copy of the patient's GP Summary

Recent hospital discharge summary

- Check whether any changes have been made by the GP since the patient's previous discharge from hospital.
- If the patient has been home for more than two weeks it is likely that they may have visited their GP and changes made.
- Discharge summaries that are more than one month old should not be used as a sole source for a drug history.

Patients Own Drugs (PODs)

- Encourage patients / carers to bring in their medicines from home.
- Discuss each medicine with the patient to establish what it is for, how long they have been taking it, and how frequently they take it.
- Do not assume that the dispensing label accurately reflects patient usage.
- Check the date of dispensing since some patients may bring all their medicines into hospital, including those stopped.

Compliance aids e.g. Dosette, Venalink, Medimax, Medipouch, Nomad, Pivotell machines

- These may be filled by the community pharmacist, carers or the patient.
- If dispensed by a community pharmacist, the device should be checked for dispensing labels which will provide the pharmacy contact details.
- The actual medicines in a compliance aid will not be used as a source of information, but the date of dispensing on the label should be checked bearing in mind that there is a possibility that medicines may have changed. The dispensing pharmacy can be contacted to clarify any issues.
- Remember to check for additional medicines e.g. 'when required' medicines and medicines that may not be suitable for compliance aids such as inhalers, eye drops, once weekly tablets etc.
- Contact the community pharmacist to inform them of the patient's admission, to prevent unnecessary repeat dispensing. They may also inform you of the number of compliance aids that have been filled, since these may still be at the patient's home.
- The community pharmacy's contact details should be documented on the drug chart.

GP surgery

- Ideally, a written list is preferable, especially if the receptionist appears to be having problems pronouncing the drug names.
- Be aware of 'acute medicines', 'repeat medicines' and 'past medicines' on the receptionist's screen.
- Always check when the item was last issued and the quantity issued.
- Specific questioning may be needed for different formulations, for example different types of inhalers (metered-dose, breath-actuated, turbohaler), different calcium preparations (Calcichew®, Calfovit D3®, Adcal D3®), or medicines which are brand specific (aminophylline, theophylline).
- It may be necessary for you to speak to the GP directly to clarify any discrepancies.
- Specifically ask whether there are any 'Screen messages'.
- Some medications are 'hospital only' and do not appear on the usual 'repeat list'.

Relatives/carers

- Patients may have relatives, friends or carers who help them with their medicines.
- This is common with elderly patients or with patients where English is not their first language.
- Carers can be very helpful in establishing an accurate drug history and can also give an insight into how medicines are managed at home.
- Be mindful of maintaining confidentiality

Repeat prescriptions

- Some patients keep copies of all their repeat prescriptions. Many of these may not be up to date and therefore incomplete e.g. some medicines may have been stopped or doses changed
- The date of issue should always be checked and each item confirmed with the patient.
- If there is any doubt, the GP surgery should be contacted.

GP Referral letters

- These are not always reliable.
- They are often written by the on-call doctor and may be illegible or incomplete.
- It may be necessary to double-check the drug history with the patient, relative/carer or GP surgery.

Medication reminder charts

- The chart should be checked through with the patient and the date of issue noted.

In some cases it maybe necessary to investigate additional sources to obtain a complete medication history. Examples of teams that may need to be contacted for further information include:

- Anticoagulant clinics
- Community pharmacists
- Specialist Nurses e.g. heart failure/asthma nurse
- Drug and alcohol service
- Renal Dialysis unit
- Other hospitals for clinical trials/unlicensed medicines
- Mental Health services
- Memory clinics

Where possible, also speak with the patient as to how he/she takes the medicines, as this may not be the same as on the prescription. It also engages the patient and allows questions on compliance and adherence as part of reconciliation.