TRUST POLICY FOR MEDICINES RECONCILIATION

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	3	2023		referen	d nomenclature & ce to System One as tion source.
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to other staff via the c To be read in conjur			<u>qr</u>		
In consultation with Clinical Guidelines Gr Pharmacy Governanc	oup, Medi	cines Safe and Risk (Group, Clinical Pha	-	
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MEDICINES RECONCILIATION

1. <u>Introduction</u>

Medicines play a crucial role in maintaining health, preventing illness, managing chronic conditions and curing disease. Medicines use is often sub-optimal; only 16% of patients who are prescribed a new medicine take it as prescribed and ten days after starting a medicine, almost a third of patients are already non-adherent

- of these 55% don't realise they are not taking their medicines correctly, whilst 45% are intentionally non-adherent¹.

Medicines reconciliation, as defined by the Institute for Healthcare Improvement, is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated². NICE guidance suggests that:

- In an acute setting, accurately list all of the person's medicines (including prescribed, over-the-counter and complementary medicines) and carry out medicines reconciliation within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital
- Recognise that medicines reconciliation may need to be carried out on more than one occasion during a hospital stay for example, when the person is admitted, transferred between wards or discharged

The term 'medicines' also includes over-the-counter or complementary medicines, and any discrepancies should be resolved. The medicines reconciliation process will vary depending on the care setting that the person has just moved into – for example, from primary care into hospital, or from hospital to a care home.

2. <u>Purpose and Outcomes</u>

The aim of medicines reconciliation is to:

- ensure that medicines prescribed on admission correspond to those that the patient was taking before admission, unless deemed clinically inappropriate or documented as intentional changes
- make sure the right patient gets the right drug, in the right dose and at the right time
- reduce the risk of medication errors occurring when the care of a patient is passed from one care setting to another
- reduce confusion about patients' medication regimens (for both healthcare professionals as well as for patients).

An accurate account of a patient's medication history/allergies is essential on admission to hospital for a number of reasons:

- To allow medicines to continue during the patient's stay in hospital
- These may include critical medicines (e.g. anticoagulants) or life-sustaining medicines (e.g. insulins in type 1 diabetes or steroids in those at risk of adrenal insufficiency) which must be identified and prescribed promptly on admission

- To identify drug related adverse effects which may or may not have contributed to admission
- To ensure medications the patient is allergic to are not prescribed during their stay
- To ensure appropriate monitoring is carried out
- To allow medication review and ensure the patient is receiving optimum treatment for their condition(s)
- To ensure concordance/compliance and educate the patient regarding their medication.

The procedure meets the requirements for medicines reconciliation set down by the National Institute for Health and Care Excellence (NICE).

3. <u>Definitions Used</u>

Medicines Reconciliation: The process of identifying the most accurate list of a patient's current medicines on admission and comparing them to the current prescription chart (in hospital) enabling any discrepancies to be recognised and changes documented.

Patients Own Drugs (PODs): Medicines that the patient brings into hospital with them.

4. Key Responsibilities/Duties

Reconciliation should ideally take place within 24 hours of admission

Prescribers

- It is the responsibility of the admitting prescriber to ensure that complete and accurate information regarding the patient's usual medicines is collected and documented in the medical notes
- Any omissions/changes in medication should be communicated to the team responsible for that patient's ongoing care so that they can be followed up any discrepancies identified through medicines reconciliation should be reviewed
- All changes to medicines should be clearly documented in the patient's medical record and communicated to the GP on discharge via documentation on the TTO. It is the responsibility of the medical team caring for a patient to check the discharge prescription against the drug history on admission and inform the GP of all changes in medication including the reasons for those changes.

Nursing staff

- It is the responsibility of the patient's nurse to be alert to the possibility of unintentional changes to drug therapy
- Patients own drugs should be reviewed carefully against the prescription before administration
- Any omissions or discrepancies should be communicated to the relevant professional (prescriber and/or pharmacist/ward pharmacy technician).

Pharmacists/MMTs/Trainee Pharmacists

- It is the responsibility of the pharmacist/MMT/Trainee Pharmacist to perform medicines reconciliation
- They should ensure that any discrepancies are identified, reconciled and clearly documented in the appropriate place on the relevant e-prescribing system & medical records
- The pharmacy-led reconciliation should be carried out within 24 hours of admission, where possible.

5. <u>Medicines Reconciliation Process</u>

5.1 COLLECT

Confirmation of a patient's current medication list and allergy status may be obtained from a number of sources. Ideally at least two information sources should be used to increase the likelihood that the information obtained is complete and accurate. One of these sources should be the patient or their carer as information regarding how the patient actually takes their medication is essential.

For patients with communication difficulties, two information sources (other than the patient themselves) MUST be used. Possible information sources are listed in the table below:

Information	Advantages	Disadvantages
Source		
Patient (Verbal)	 Should be the primary source if at all possible and the patient has capacity Often the best source of information as some patients are aware of all aspects of their medication Patients can describe both their prescribed and OTC/ herbal medications. Patients can describe medicines prescribed by a specialist or other care provider (outside of GP). Compliance issues can be picked up Often aware of recent changes that may not have registered on the GPs computer system yet Aware of exactly how they take their medication rather than how they are supposed to take them May carry alert cards or bracelets relating to life sustaining medicines and allergies 	 The patient may be too unwell or confused to give an accurate history. May forget certain details e.g. strength of medicines, doses. frequencies The patient may not be the one managing their own medicines at home

Definite! O			The lobal instructions do not
Patients' Own Drugs (Non-	Allows an in-depth conversation with the patient of how they		The label instructions do not always accurately reflect patient
verbal)	actually take their medicines		usage.
verbal)	\square Compliance issues may be	П	Check the date of dispensing -
	discovered e.g. full boxes from		some patients bring all of their
	previous months.		medicines into hospital including
	Dispensing errors can be picke	1	those no longer taken.
	– up		Patients may not bring all of their
	Can include medicines		medication in to hospital Patients may have brought in other
	obtained from different sources		family members' medication by
	e.g. GP, hospital clinic etc.		mistake – check that the medication
			belongs to the patient.
Summary	□ SCRs contain details of		All patients must be consented
Care Record	patients key health information		before the SCR is accessed
	including medications, allergies	П	Not all patients have a SCR May
	and adverse drug reactions		not always be completely up- to-
	Lists current repeat and acute		date as relies on GP surgery to
	medicines being prescribed by		upload the SCR. Check the
	the GP & may include		date/time stamp on the top of
	medicines prescribed by		the page to check if recently
	specialist.		updated No information about OTC
	Accessible to authorised healthcare staff treating		medicines which patient might be
	patients in an emergency		taking or medicines not obtained
	patiente in an emergeney		from the GP . May not include
			medicines prescribed by a specialist
System One	Advantages: Shared record		Disadvantages- All patients must be
	database from multiple care		consented before SystmOne is
	providers		accessed.
	\Box Contains care records for the		Not all patients have a SystmOne
	patient- including medicine		record
	information from multiple care		No information about OTC
	providers		medicines which patient might be
	Accessible to authorised staff		taking or medicines not obtained
	treating patients.		from the GP
			May not always be completely up-
			to-date as relies on individual care
			providers to input data.
			Patient may not give access for all
Demost			care providers to see information.
Repeat	Will often show all medication on repeat (only if it is the most		Just because the medication is on
prescription	on repeat (only if it is the most up to date list).		the repeat list does not mean that the patient has been taking it. Has
requests (Non-			the medication been issued at all?
verbal)	state how many		Repeats do not show acute recent
	packs/tablets issued e.g.		items.
	for short course antibiotics	П	Patients may be carrying old/ out of
			date repeats. Check the date on
			the top of the repeat slip.
			Pages may be missing.
			Won't show changes that the GP
			might have verbally asked the
			patient to make
			No information about OTC
			medicines which the patient might
			be taking or medicines not
			obtained from the GP
		1	

GP receptionist (Verbal)	 A complete list of prescribed medicines can be obtained if the correct questions are asked A fax containing a medication list can be requested & obtained 	 Often acute / recently started medicines are missed from the list. Medicines that have not been requested by the patient for months will still appear on the list and may be restarted in error. Can misinterpret what the person is saying over the phone e.g. pronunciation, difficulty saying a drug name. No information about OTC medicines which the patient might be taking or medicines not obtained from the GP
GP referral letter (Nonverbal)	Computer print outs often have a complete medication list with both repeats/ acute	 Handwritten letters are often difficult to read and incomplete. No information about OTC medicines which the patient might be taking or medicines not obtained from the GP GP may not have all the necessary information for a patient if they are not the regular GP, e.g. out of hours
Patient's carer, relative (verbal)	Carers can often help establish a medication history and give an insight into how medicines are managed at home	Carer/relative may not know the full list of medicines taken or have limited information about drug doses/frequencies
Medicines Administration Record (MAR) sheets (Non- verbal)	 The most up to date list should be sent into hospital with the patient Can be more up to date than the GP list, due to verbal orders/changes made by GP – not always easy to tell by GP drug list alone e.g. stopping a drug 	 These are often in the format of drug charts. It is vital that they are read completely and correctly. Recent medication alterations are often overlooked. Check for the correct patient. Sometimes MARS sheets get filed in the wrong set of notes. Pages may be missing. MAR sheets may sometimes be handwritten and can be unclear. Extra caution should be taken if items are handwritten on a MAR sheet

Compliance Aid (Non-verbal) Do NOT rely on the labels as being correct – ALWAYS check the number of medicines in the device	 Current compliance aid will provide a complete list of oral tablets Easy to read, as they are usually typed Compliance aids may not provide a complete list i.e. stills the need to check for inhalers, eye drops, liquids etc. Need to ensure most up to date compliance aid is used No information about OTC medicines which the patient might be taking or medicines not obtained from the GP
Hospital old TTOs (Non- verbal)	 Very useful if the patient has been in hospital recently & a full drug history had been carried out prior to the TTO being written. I.e. last month. A "Pharmacy Checked" TTO is of better quality, than one that has not had this check These must be viewed with caution as changes may have been made in the interim May not be an accurate list if a full drug history was not checked before the TTO was written. TTO not had this check a drug history had been carried out or if anything was unintentionally missed off the TTO.
Hospital clinic letter	 May include 'hospital only'/shared care medication which might not be recorded on the GP clinical system May include information about changes to medicines which the GP might not have yet acknowledged Consider reliability of any medication lists that appear on the letters, as they may be out of date or could include mistakes Recent Betters may contain instructions for GPs that have not yet been action e.g. dose changes
Community Pharmacist (Verbal)	 Useful source of information when GP surgery closed. Useful for methadone/ buprenorphine for addiction dose confirmations. Useful to confirm compliance aid dispensing – last date dispensed, delivery dates, any recent changes to medicines, any medicines dispensed out of the blister pack e.g. eye drops, inhalers Useful source of information dose difficult to establish contact details. It can be difficult to establish contact details. It can be hard to determine if the medication list is complete e.g. GP may have issued a prescription but the patient has not had it dispensed, patient taken their prescription to a different community pharmacy.
National Alert cards / Apps / Booklets and Medication 'Passports'.	 Help to identify some critical and life-sustaining medications for prescribing at the earliest opportunity e.g. warfarin, methotrexate, lithium, insulin passport, Steroid Treatment Cards (Blue) and Steroid Alert Cards (Red) Useful source of information about current doses for these high risk drugs. Some, such as Steroid Emergency Card provide emergency treatment protocols to consider in acutely unwell patients.

e-Prescribing system alerts	 Alerts may have been created in the clinical/prescribing systems. May include: steroid dependence / chemotherapy patient / drug-seeking behavior etc Alerts will continue to be seen under the relevant icons for any future episode of care until removed. Alert icon in Lorenzo: Special Indicator in Meditech: 	 These may not be up-to-date; consider them as a prompt to investigate further rather than confirmation of current status May require update depending on assessment on current admission

Information should be obtained about all medication that the patient is currently taking on a regular and as required basis. This should include:

- Oral medication, inhalers/nebulisers, eye drops/ointment, injections, topical medication, sprays or patches
- Medication being prescribed by a specialist e.g. hospital only medication
- Weekly, monthly or 3 monthly medication should include the date the medicine was last taken/given and when it is next due. NB always ensure these medicines are prescribed clearly
- Contraception or hormone replacement therapy (HRT)
- Herbal products, complimentary medicines, vitamins and supplements
 Over the counter products
- As required medication clarify how often the patient normally takes it
- Defined courses of treatment (including those that have recently stopped) e.g. antibiotics, steroids or chemotherapy.

As a minimum the drug name, form, strength, dose and frequency should be confirmed for each medication taken. It may be appropriate to ascertain the indication and date started for certain medicines particularly if there is concern about adverse effects.

Patients taking warfarin, methotrexate, lithium or insulin should always have their dosing booklet checked.

Note on Steroids:

All patients with primary adrenal insufficiency (AI), such as those with Addison's disease, are steroid dependent. Additionally, some patients who take oral, injectable, inhaled or topical steroids for other medical conditions may develop secondary adrenal insufficiency and may become steroid dependent. There are trust guidelines on koha available to help clinical staff determine if a patient is at <u>Risk of Adrenal Insufficiency</u> from Prescribed Steroids

For all patients on current or recent (within 12 months) steroids:

- Check with the patient if they carry (or are aware they should carry) a Steroid Emergency Card if they do not, check if the patient's current therapy meets the threshold for issuing a Steroid Emergency Card (see guidelines if in doubt).
- Issue a card for all patients at risk of AI who do not already have a card in their possession
- For all patients at risk of AI ensure a 'Steroid Dependant' Clinical Alert is present or entered on the prescribing system – <u>Process for adding the alerts</u> <u>here.</u>

A complete list of the patient's current medication should be recorded in the health record as part of the admission clerking/medical notes. The healthcare professional taking the medication history should also record the source of such information and the date that the information was obtained along with their signature. This prevents duplication.

If the medication information is incomplete for whatever reason this must be clearly documented in the admission clerking/medical notes so that it can be followed up e.g. GP needs contacting after the weekend to confirm current medication, or relative to bring in patient's own medicines from home. Any subsequent additions or changes to the medication history must be clearly documented in the admission clerking/medical notes with the date, source of information and the signature of the individual making the changes. Pharmacy staff will usually document any discrepancies in the relevant eprescribing system (See appendices). To highlight these discrepancies to the medicines management checklist in order for them to action.

The patient's allergy status should also be documented in the admission clerking/medical notes. If the patient has no drug allergies then this should be recorded the allergy section of the relevant e-prescribing system. For all known allergies, the drug and reaction (if known) should be recorded. Staff should check that patients with an allergy are wearing a red wristband. The healthcare professional checking & documenting the allergy status should also record the source of such information and the date that the information was obtained along with their signature by completing the 'Allergy Box' in the relevant section of the medical notes.

5.2 CHECK

Once the medication history has been confirmed, this should be compared to the list of medications currently prescribed for the patient and any discrepancies noted.

If any medication is altered on admission this must be clearly documented in the medical notes with the reason for such changes, to ensure that this information is communicated to the GP when the patient is discharged from hospital. Please refer to appendices for how discrepancies are dealt with within each e-prescribing system.

5.3 COMMUNICATE

Please refer to the appendices for how completion of medicines reconciliation should be documented within each e-prescribing system.

Major errors and omissions (especially those involving critical drugs) must be discussed with the prescriber/ward pharmacist. These should also be documented in the patients' health record (AND the relevant process in the e-prescribing system) along with the sources of information with a note for the prescribers to review e.g.

"Date/time

Re: Medication history

The medication history for (patient name) was confirmed with (sources of information). The following discrepancies were noted:

Please review and prescribe as appropriate or document reasons for changes in medication. Thanks

(name, designation, signature, bleep)"

When the TTO is written, the prescriber responsible for the patient's care should compare the documented drug history on admission with the current medication and ensure all changes are communicated to the GP along with reasons for those changes and any monitoring required. This should be documented in the appropriate section of the TTO.

5.4 FOLLOW-UP

The team responsible for the care of the patient should ensure that any discrepancies in medication histories are reviewed as soon as possible

Ward pharmacists should also follow up on any discrepancies that have been documented on admission to ensure that these have been reviewed by the team looking after the patient and that reasons for any changes to medication are documented in the patient notes.

5.5 TRAINING REQUIREMENTS

- a. All foundation year doctors should be trained on medicines reconciliation as part of their foundation year programme and on induction. This is part of the Safe Prescribing e-learning package which is undertaken within the first 2 months of starting their foundation year.
- b. Newly qualified nursing staff will complete the training package and competency for medicines management
- c. All pharmacists, trainee pharmacists undergoing clinical placements and suitably experienced medicines management technicians will complete the medication history taking training and validation programme as part of their clinical induction

d. Specialist pre-clerking unit staff will complete a scope document regarding medication history taking

See appendices for individual processes with ePMA systems

6. Monitoring Compliance and Effectiveness

rtequirement .	Monthly monitoring of pharmacy compliance with the NICE standard of medicines reconciliation within 24hours of admission Monitoring of standards of medicines reconciliation
Monitoring Method:	Ongoing pharmacy metric for % medicines reconciliations completed with 24 hours of admission Bi-annual audit of medicines reconciliation standards Three yearly review of this procedure
Report Prepared by:	Deputy Chief Pharmacist
Monitoring Report presented to:	Clinical Pharmacy Team / Pharmacy Governance, Quality and Risk
of Frequency Report	Bi-annually

7. <u>References</u>

Source of data	Date of publication/ issue	Detail of requirement
¹ Royal	May, 2013	Medicines Optimisation: Helping patients to make the most of medicines.
Pharmaceuitcal Scoiety ² National Institute		Medicines optimisation: the safe and effective use
for Health and		

a = "		
Care Excellence	March 2015	of medicines to enable the best possible outcomes
		I. I

Appendix A

Process with Meditech (QHB, SRP and SJ)

Medicines Reconciliation Process

After seeing the new patient and using appropriate sources to complete a drug history, open up the EMR tab on Meditech and go into the summary screen. Identify any discrepancies between what is prescribed and the drug history.

6		C ecil 2/04/1945 20 BH20-02	194lb 0.11oz 8	cm BSA: 2.00m2 8kg BMI: 30.4kg/ wn allergies Adv:		B10000	1260	
-	of 2 Sele		aw)					
-		tient Activity Revi	Date-Time 10/11-1433	New: No know	Detail Detail			
		nsfer	10/11-1450	From: BH30-04				
Ξ	Quer	es						Patient Lists
	Critical Pharma Medicat MDS (M Bioequi Pharma	ion to access pt's GP record med? cist Interventions ion assistance at discharge onitored Dosage System) or valent note? cy supply comment cy supply note		Patient				Select Patient
0	of 1 Sele						\sim	Enter Orders
-		Orders with Activity	Review	Instructions	Status 🔺	Source	ę	Edit Orders
		digoxin 125mcg tablet QH0052690 MED TTO	digoxin 125 mc 10/11 14 10BH20		Active	OM Salisbury, Heidi		Rx Audit 🐼
			- Time User		Source			Progress Notes 📝
		New Order 10/11/2	2 - 1439 SALH.SNO	OP				Billing
C		1 12/04/1945 BH20 BH20-02	Allergy/Adv:	BSA:2.00m ² BN No known aller(hics)(Diagnose			0001260	Atient Lists Next Patient
								Find Patient
		Special Indicator	Las	st Edited By	Last Edit Dt/Tm			Select Visits
								Refresh EMR
		Allergy/AdvReac		Severity	Reaction	Status	Date	Summary 🗎
	•	-	Allergy			Verified	10/11/2	Review Visit 🔎
	••	Active Medication Digoxin [Digoxin]		Freq Start	/22 Yes			Problem List Image: Clinical Panels
	GG	Home Medication		Last s Taken (OD Unknown 1	Last Confirmed Rx			Vital Signs Medications
	Ğ	lansoprazole		OM Unknown 1				Microbiology 🥘
1		Dationt Pharman	▼ [Edit]					Blood Bank 🛞 Reports 🧷
		Patient Pharmacy						Patient Care 📩
(ED In	formation Exchange	▼ Rpt Date					Notes 🔄 Consultant Eps
								Orders 🖳 TTO Review
						0		Mar 🖸 Dociment 🖌
						-		Clinical Data
<			Archive	External		1	>	?@@@=!
				Application			Clinical Data	
						>		
		Ar	chive Externa Applicati			6	? @ @ (these

discrepancies into the Home Medication section on the summary screen

• Click on the document tab and

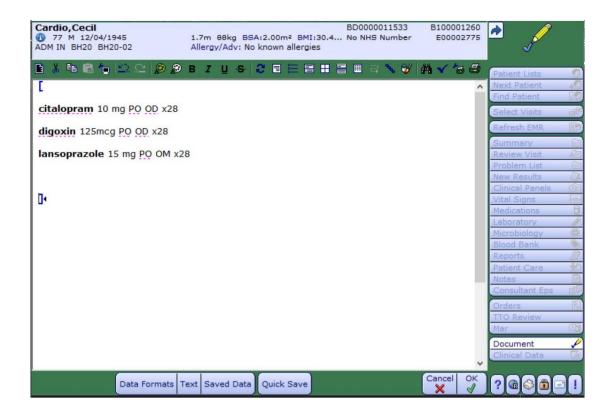
 \square Select the Medicines Reconciliation Pharm note

Cardio,Cecil 77 M 12/04/1945 ADM IN BH20 BH20-02	1.7m 88kg BSA:2.00m² BMI Allergy/Adv: No known allergi	:30.4	BD0000011533 No NHS Number	B100001260 E00002775	* 🖌	
	Document Clinical Pharmacy Medicines Reconciliation Pharm	Type V Note			Patient Lists Next Patient Find Patient	0.0
	OPAT Team Documentation Pharmacy PharmOutcomes Referral	Note Note Note			Select Visits	÷
	Tobacco Dependency Assessment GP Discharge Summary (QH)*		ļ		Refresh EMR Summary	
					Review Visit Problem List New Results	
					Clinical Panels Vital Signs	©= -^-

- Fill in the Medication Reconciliation screen appropriately; SCR access will already be filled in if the patient has been in previously, however this can be updated if needed.□
- Annotate if a patient uses a MDS if appropriate in the MDS on admission section.□
- Select the sources used in the Meds Reconciled Against section- can utilise the comments box to add further information to support the source.

	Allergy/Adv: No known allergie		HS Number	B100001260 E00002775	
n) (Crit Meds)					
💽 Medicines Reconciliation Pharm					
edicines Reconciliation				Patient Lists	
Medication Reconcilation Issues:				Next Patient	
Permission to access pt's GP record (SCR)?	(Agreed by Patient)	Unable to ask/respond	Declined by Parent/Guard.	Find Patient	- 9
(SCR)? MDS (Monitored Dosage System) on	MAR sheet	Agreed by Parent/Guardian Monitored Dose System	MDS and MAR sheet	Select Visits	d
admission?	MAK sneet	Monitored Dose System	MDS and MAR sneet	Refresh EMR	[
*Meds Reconciled Against	Ambulance Note	No Reply from Email GP	On-Call GP Note	Summary	1
Heds Reconcileo Against	(All) Chemist	GP Repeat Rx Slip/Info	Patient Own Medications	Review Visit	
	Compliance Aid	Health Profession Not GP	Prison Records	Problem List	(
	Clinic letter	Long Stay No MM on Adm	Patient Verbal Info	New Results Clinical Pane	ls C
	Carer's Record	Medical Notes Unconfirmed	Patient Written Info	Vital Signs	is c
	Discharge Letter	Med Order History	Summary Care Record	Medications	
	Drug Chart	Not Available	SystmOne	Laboratory	
	Email Request Sent to GP	Inappropriate Clinically	597 - 1997 - 1997	Microbiology	
*Permission to access SystmOne	Agreed by Patient Decline by	Patient Emergency Access Not Ap	pplicable	Blood Bank Reports	
record? (This visit only)	\sim			Patient Care	Ť
Medication Reconciliation	<entered></entered>			 Notes 	
Pharmacy supply note				 Consultant E 	ps 🗧
Ward		Comment:		Orders	
Pharmacy role	Play nacist	Pharmacy Technician	Trainee Pharmacist	TTO Review	
Comment	/			Mar	C
				Document	

- □ Click on the Medication Reconciliation section, this should pull over all the active medication and the items listed in Home Medicines from the summary screen.□
- Delete any items that were not part of the medicine's reconciliation.
- Remove the headings that are pulled over to create one list of medication.
- Add any quantities seen to the appropriate medication or if the medication is in an MDS, add "In MDS" at end of medication line.□



- Once satisfied that the report accurately depicts the patient's medication history, fill in the supply note to annotate the home supply
- Click to confirm to whether permission was gained to access SystmOne- If SystmOne wasn't used, select "Not applicable"□
- Enter the ward the patient was seen on and select your role.

critical medicines have been prescribed, annotate this on the Critical Medications tab and document the drug name in the comments section.

• Once this is completed, click view/save and enter your pin.

L									
Γ	Cardio,Cecil 77 M 12/04/1949 ADM IN BH20 BH20-1		1.7m 88kg BSA:2.00m² BM Allergy/Adv: No known allerg		BD000001153 No NHS Numbe		B100001260 E00002775	* 🥖	
□ lf any	- Medicines Re	cines Reconciliation Pharm						Patient Lists	9
	Permission (SCR)?	n to access pt's GP record	Agreed by Patient	Unable to ask/respond Agreed by Parent/Guardia		Declined by Parent/Guard.		Find Patient	
		itored Dosage System) on	MAR sheet	Monitored Dose System		IDS and MAR sheet		Select Visits	di
Cardio,Cecil 77 M 12/04/1945 ADM IN BH20 BH20-02	HDS (HON	1.7m 88kg BSA:2.00m² BM Allergy/Adv: No known allerg	I:30.4kg/m ² No NHS	0011533 5 Number		ns)Ç		Refresh EMR Summary Review Visit	
Recon Crit Meds								Problem List New Results	
🕞 🕞 Medicines Recon	ciliation Pharm							Clinical Panels	0
Critical Medications								Vital Signs Medications	145
Critical Medication					-	Patient Lists		Laboratory	
Critical med?		antiCoagulant meds	antiDiabetic meds	Thrombolysis meds		Next Patient		Microbiology	0
	All	antiEpileptic meds	Steroids (parenteral or long term)	IV anti-arrythmics		Select Visits		Blood Bank	1
		antiParkinson meds	Thyroid meds	Anticoagulant reversal				Reports	3
		antiPsychotic meds	antiDementia meds	Full blood count required		Refresh EMR		Patient Care	*
		antiInfective meds	Opioids (dosing)	HIV medications		Summary 💼 Review Visit 🖉 changes	-	Notes Consultant Eps	10
		Insulin	Immunosuppressive meds	Other critical meds		Review Visit 🔑 changes Problem List 📄	required		
Comment						New Results		Orders TTO Review	<u>IR</u>
Comment						Clinical Panels 💁		Mar	(C)
						Medications		Document	-
						Laboratory		Clinical Data	C.F
						Microbiology 🥥			
						Blood Bank			
						Reports 🗾 Patient Care 扰			
						Notes			
	Docume	nt being auto-saved						2020	

TRUST POLICY FOR MEDICINES RECONCILIATION V3 / March 2023

• If any amendments need to be made, this will need to be done as an addendum. To do this click on the note, press amend, enter the amendment then press ok and enter your pin.□

Appendix B Process for Lorenzo

Medicines Reconciliation on Lorenzo Clerked

Medicines (Enter Drug History)

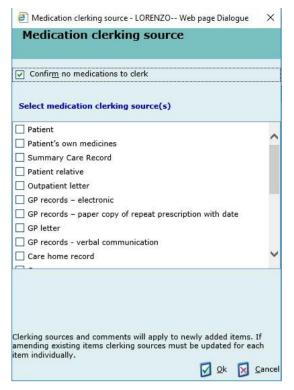
1. Open the patient record and select the Medication Tab (if not your default tab when opening a patient.

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2. Click on the "Medication Clerking" Link

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3. Select sources used. If the patient takes no medicines then select "Confirm no medicines to clerk" box and this ends here. If you are changing from nil drug history to adding medicines you will need to remove the tick from the "Confirm no medicines to clerk" box.



4. You can now enter the drug history. To copy medication already prescribed as an inpatient click the green arrow next to the relevant line.

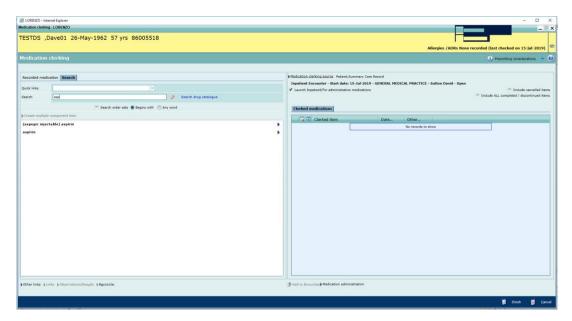
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Tip:

If you used a previous Derby sites discharge or outpatient as a source you can copy medicines from those encounters as well by selecting the blue arrow on the side of the screen then selecting the appropriate encounter and medication type.

Other members of the MDT may have already done this so it won't always be empty.

5. To enter medication manually click the search tab (highlighted above) and enter at least three characters of the medication you are searching for.



6. Select the appropriate drug and select the pre-configured dose or click "Other".

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7. Once details have been entered click "Ok".

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- 8. Repeat steps 4-7 for as many medications as necessary. The list in the right hand pane will be the finished "Clerked Medication" list that is available to all prescribers.
- 9. Remove the tick from the box "Launch Inpatient/for administration medications" to stop the system from taking you to the inpatient prescribing screen.

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10. Once you have entered the drug history click "Finish".

Medication Management Checklist (Enter Additional Information)

1. From the Clinical Indicators view click the bars in the "Pharm" column for the patient you have reconciled.

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Tip:

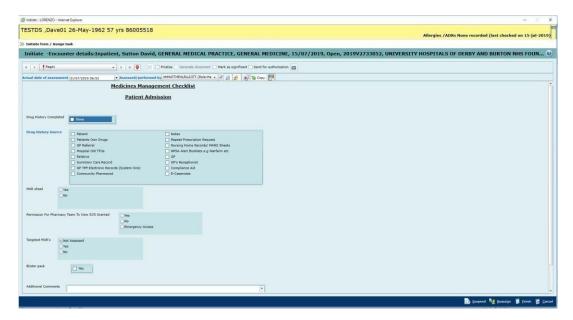
The colours of the bars mean;

Red = Form not completed and over 24hours since

admission Amber = Form not completed and 1624hours

since admission Green = Form already completed.

2. If there has already been a form completed the information already put in will be displayed. Add or edit information as required.



NB This form will be changing to remove some of the duplication and have a link to Meds Clerking directly to streamline workflow. Expected August to September 2019

3. Once complete, click "Finish"