NHS University Hospitals of Derby and Burton NHS Foundation Trust

TRUST POLICY FOR MEDICINES RECONCILIATION

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<tr><td>Reference Number

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3</td><td colspan="2">Status

Final</td><td>Author: Sam Malton

Job Title: Deputy Chief Pharmacist</td></tr>
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<tr><td></td><td>3</td><td>2023</td><td colspan="2">D Moore</td><td colspan="2">Updated nomenclature & reference to System One as information source.</td></tr>
<tr><td colspan="7">Intended Recipients: All Clinical Staff involved in the prescribing, review and administration at ward level, including (but not restricted to), doctors, pharmacists, pharmacy technicians, advanced clinical practitioners and midwives. This includes all students of the aforementioned professions.</td></tr>
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<tr><td colspan="7">To be read in conjunction with: N/A</td></tr>
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Clinical Guidelines Group, Medicines Safety Group

Pharmacy Governance, Quality and Risk Group, Clinical Pharmacy Team</td></tr>
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<tr><td colspan="3">Contact for Review</td><td colspan="4">Deputy Chief Pharmacist</td></tr>
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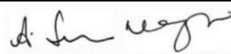
Executive Lead Signature	

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1. Introduction

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-adherent[1].

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 communicated[2]. 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. Purpose and Outcomes

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. Definitions Used

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. Medicines Reconciliation Process

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:

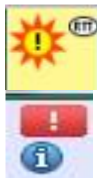
Information Source	Advantages	Disadvantages
Patient (Verbal)	• Should be the primary source if at all possible and the patient has capacity • Often the best source of information as some patients are aware of all aspects of their medication • Patients can describe both their prescribed and OTC/ herbal 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

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

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 Pharmacy checked must be reconciled against the old, corresponding drug chart – check if 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 - letters 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	- 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 Risk of Adrenal Insufficiency 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 – Process for adding the alerts here.

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 prescriber an entry will be placed in the patient's medical notes referring them 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

Monitoring Requirement :	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
Frequency of Report	Bi-annually

7. References

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

Care Excellence	March 2015	of medicines to enable the best possible outcomes

Appendix A

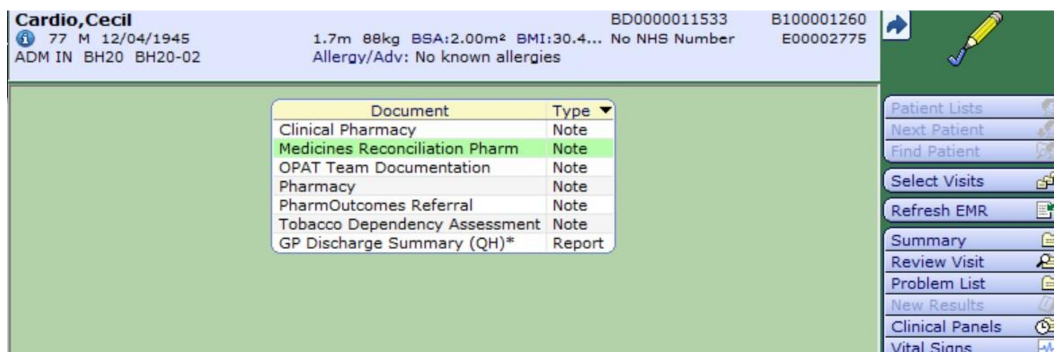
Process with Meditech (QHB, SRP and SJ)

Medicines Reconciliation Process

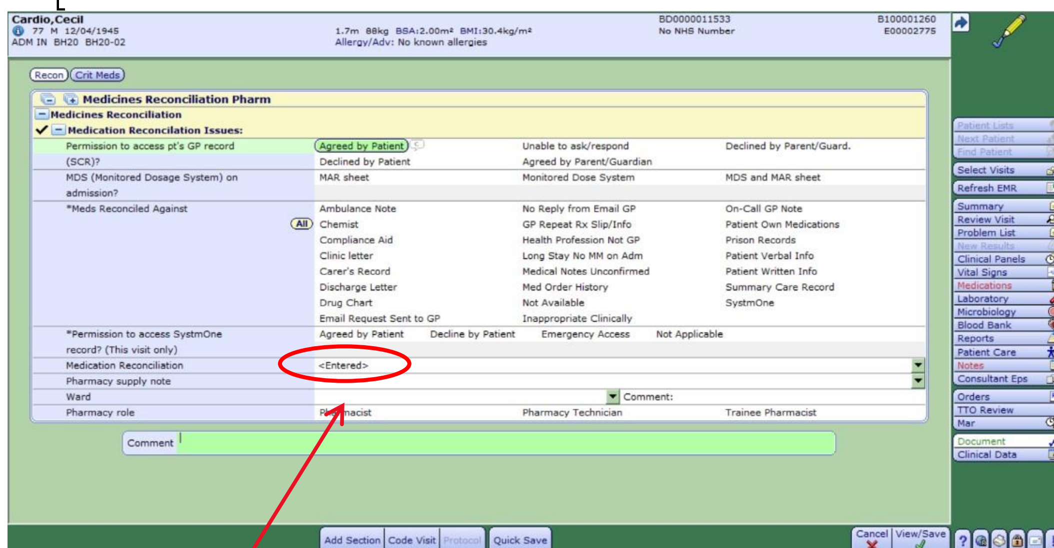
After seeing the new patient and using appropriate sources to complete a drug history, open up the EMR tab on Meditech and go into the summary screen. Identify any discrepancies between what is prescribed and the drug history.

- Enter all of these discrepancies into the Home Medication section on the summary screen
- Click on the document tab and

Select the Medicines Reconciliation Pharm note

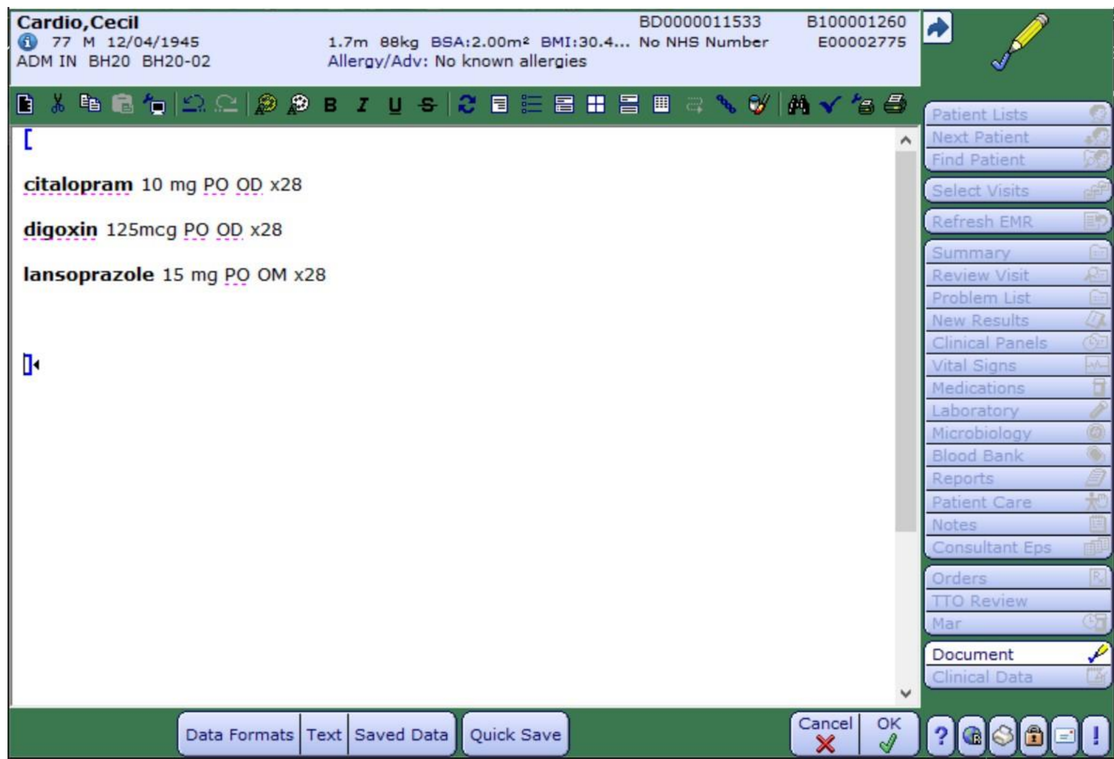


- Fill in the Medication Reconciliation screen appropriately; SCR access will already be filled in if the patient has been in previously, however this can be updated if needed.
- Annotate if a patient uses a MDS if appropriate in the MDS on admission section.
- Select the sources used in the Meds Reconciled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



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.

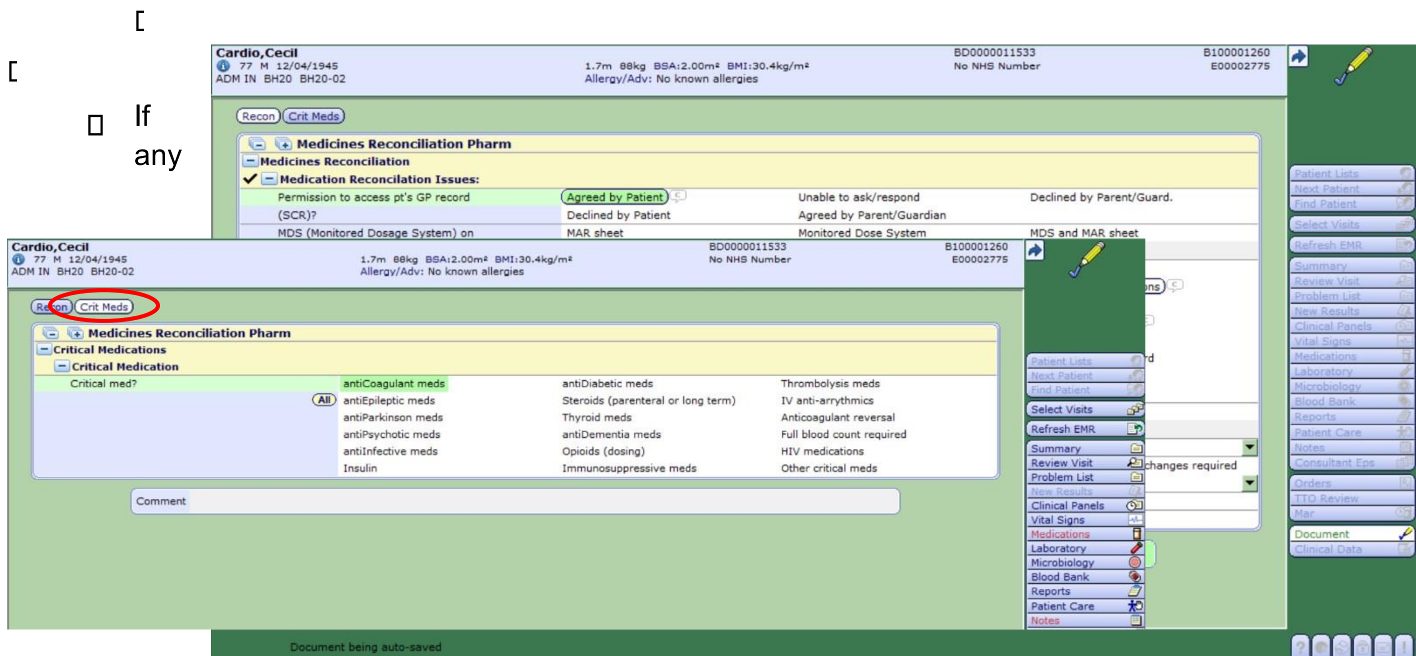
critical medicines have been prescribed, annotate this on the Critical Medications tab and document the drug name in the comments section.

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

[

[

If any



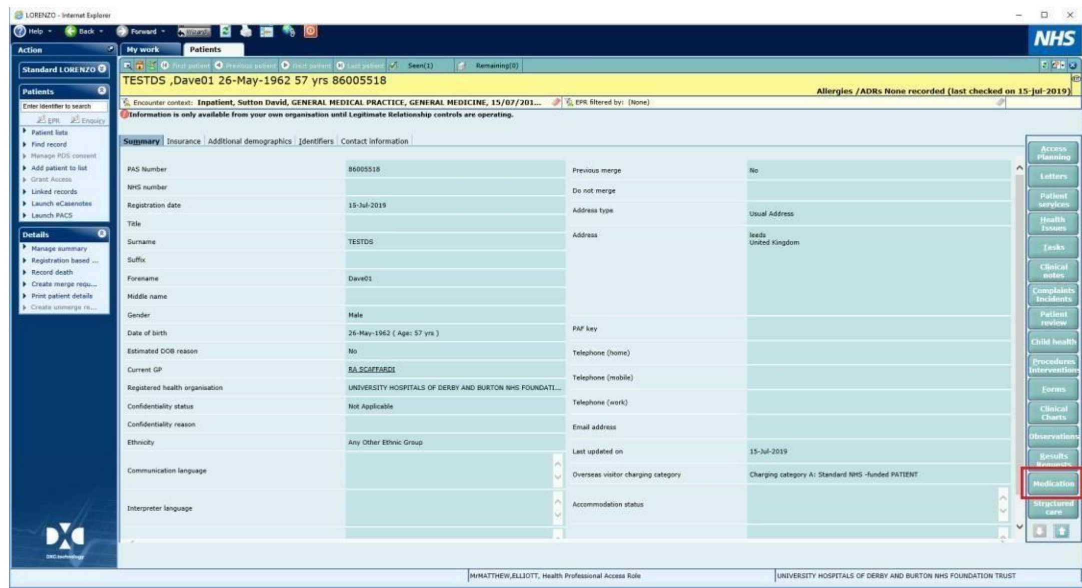
- If any amendments need to be made, this will need to be done as an addendum. To do this click on the note, press amend, enter the amendment then press ok and enter your pin.

Appendix B Process for Lorenzo

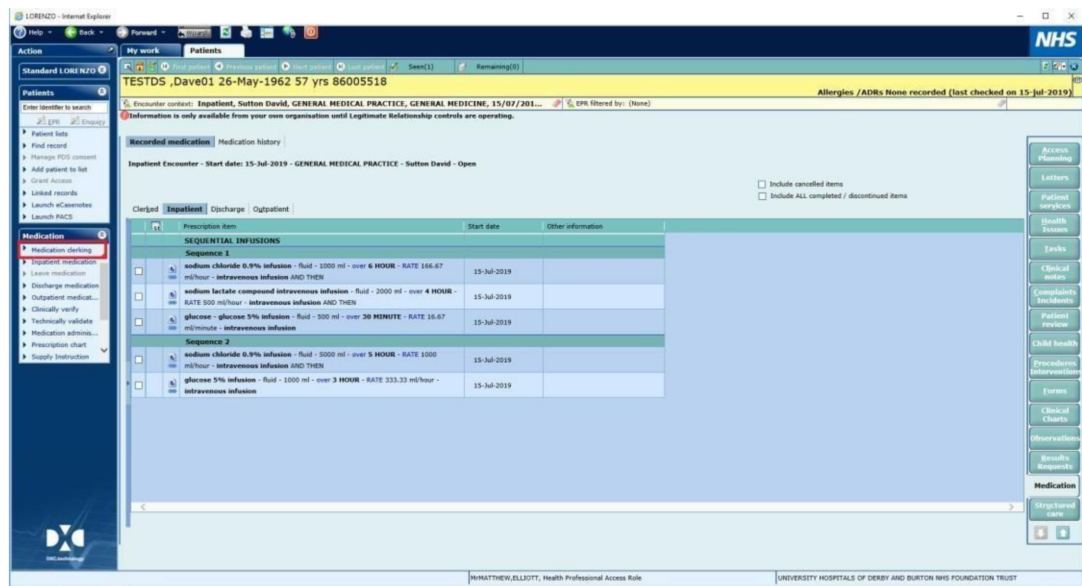
Medicines Reconciliation on Lorenzo Clerked

Medicines (Enter Drug History)

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



2. Click on the “Medication Clerking” Link



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.

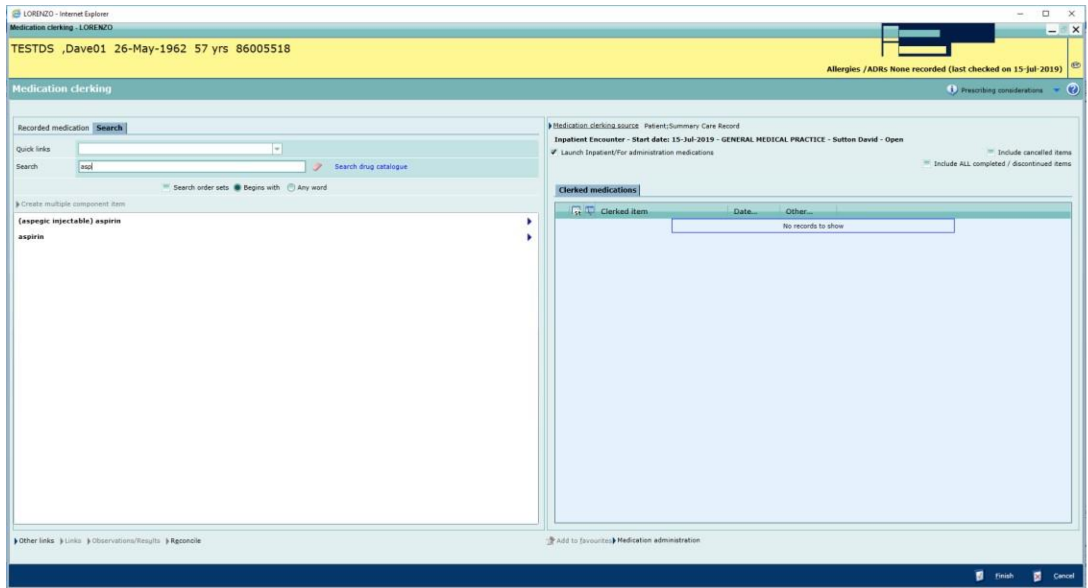
4. You can now enter the drug history. To copy medication already prescribed as an inpatient click the green arrow next to the relevant line.

Tip:

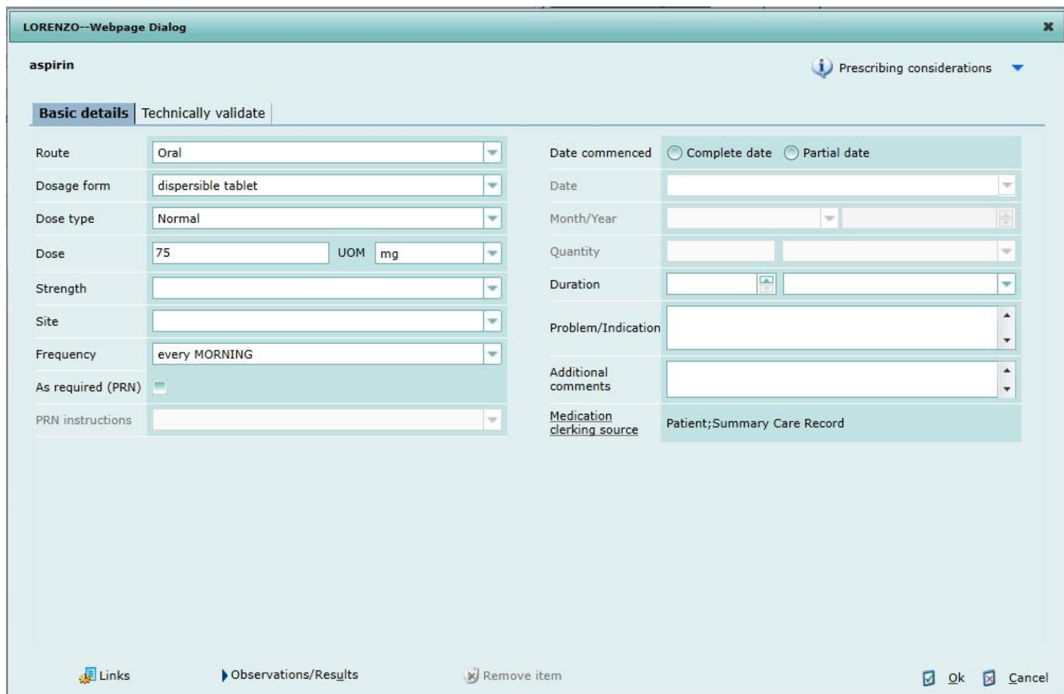
If you used a previous Derby sites discharge or outpatient as a source you can copy medicines from those encounters as well by selecting the blue arrow on the side of the screen then selecting the appropriate encounter and medication type.

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

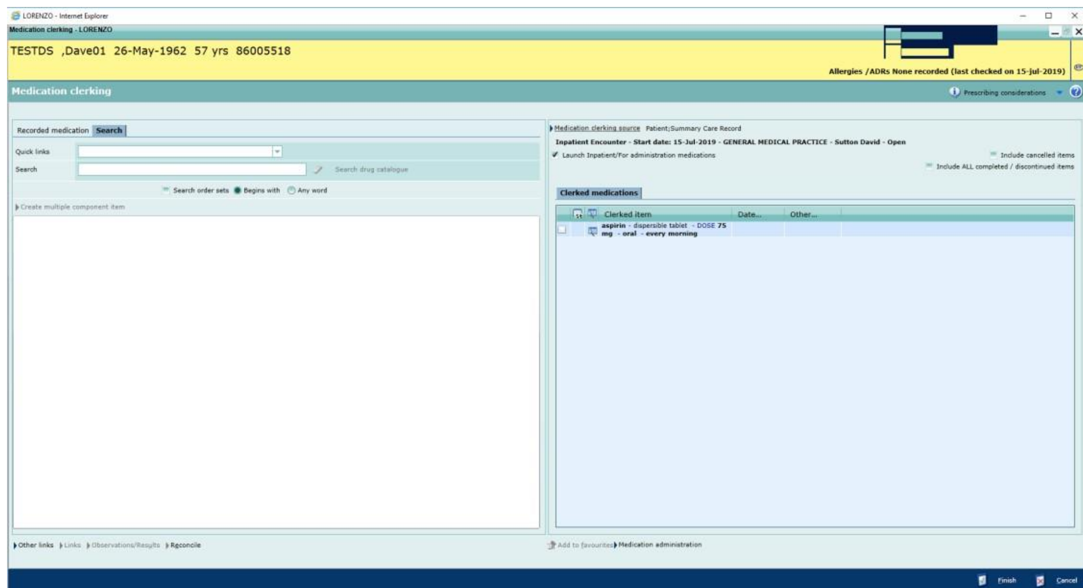
5. To enter medication manually click the search tab (highlighted above) and enter at least three characters of the medication you are searching for.



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

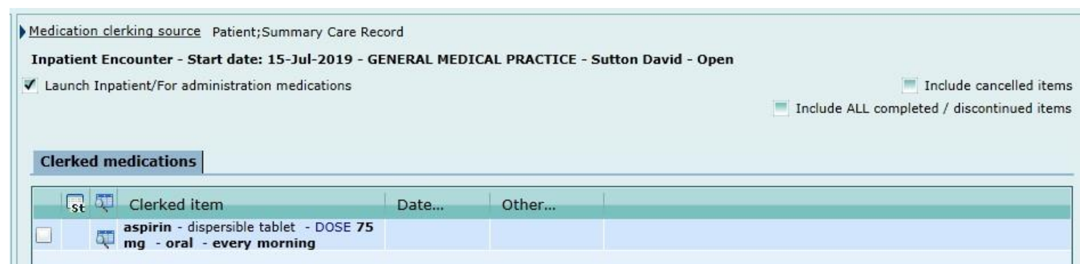


7. Once details have been entered click “Ok”.



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.

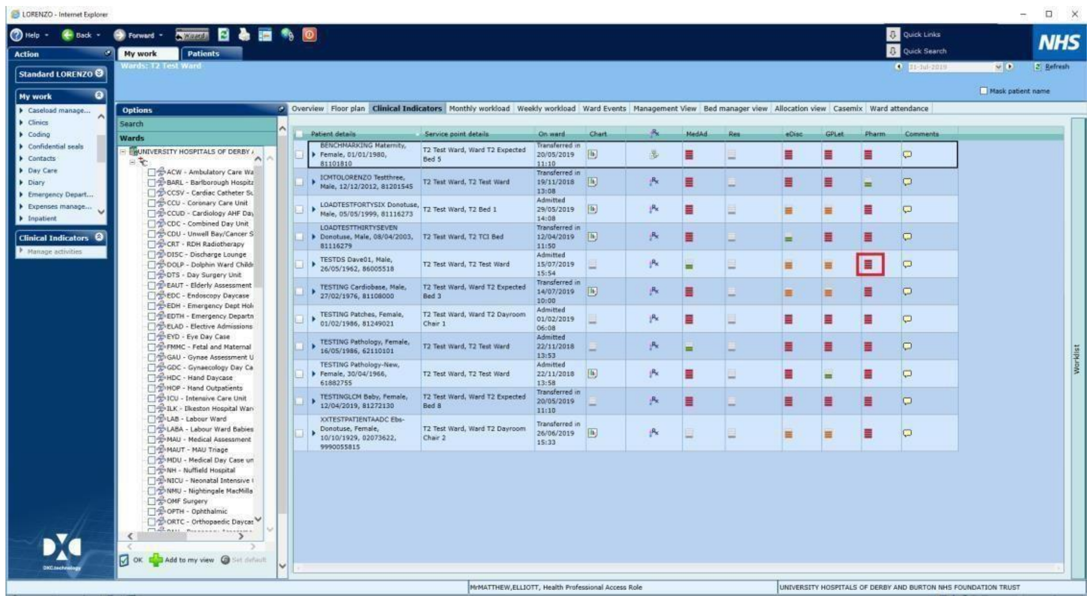
9. Remove the tick from the box “Launch Inpatient/for administration medications” to stop the system from taking you to the inpatient prescribing screen.



10. Once you have entered the drug history click “Finish”.

<u>Medication Management Checklist</u> (Enter Additional Information)

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



Tip:

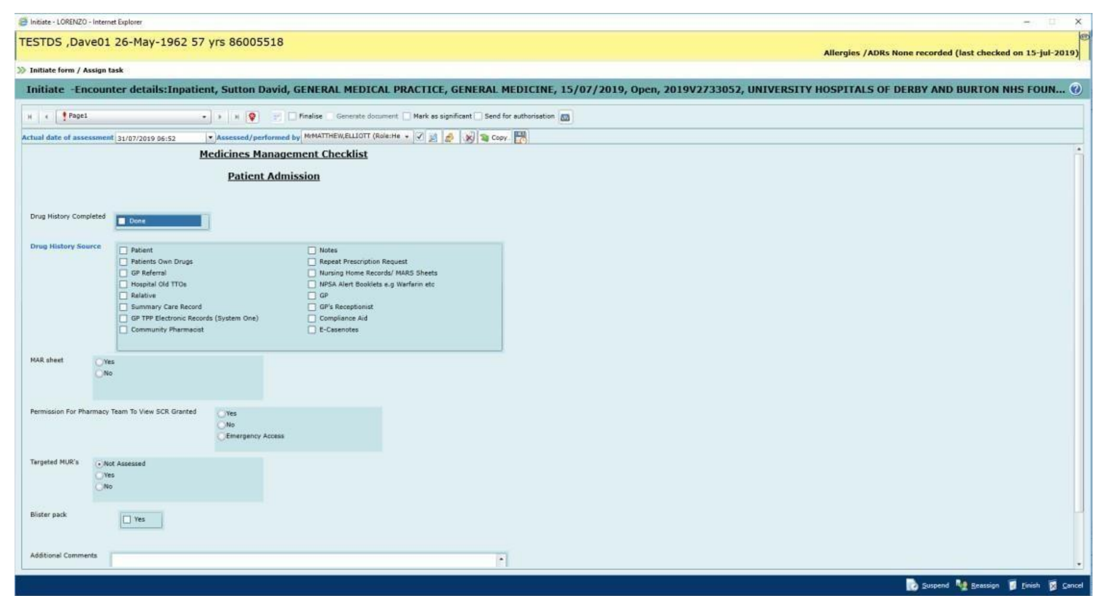
The colours of the bars mean;

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”