journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Title: Medicines Reconciliation procedure

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Status: Approved
Document type: Procedure
Overarching policy: Medicines Overarching Policy

Contents

1 Introduction

Following this procedure will help the Trust to:

- Provide personalised care through effective use of medicines
- Manage risks with medicines through effective procedures for prescribing medication and handling information about the patient's medication at all points of care.
- To reduce medication errors occurring when patients transfer between care settings, particularly at the time of admission.

2 Purpose

The aim of medicines reconciliation is to ensure that the correct medicines are provided to the patient at all transition points between admission and discharge from hospital through a process of checking medicines prescribed against the most recently available lists from reliable sources of prescribing and supply.

For the majority of admissions, the pharmacy team will perform medicines reconciliation. However, when this is not possible to ensure patient safety non-pharmacy staff must undertake the medicines reconciliation process.

Following this procedure will help the Trust to:

- Specify standardised systems for collecting and documenting information about current medications
- Ensure the responsibilities of pharmacists and other staff in the medicine's reconciliation process are clearly defined
- Incorporate strategies to obtain information about medications for people with communication difficulties.
- Comply with NICE Guideline 5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes and NICE Quality Statement 4: Medicines Reconciliation in acute settings

2.1 Objectives

- To define the process for collecting and documenting information about current medications
- To identify relevant sources of information for medicines reconciliation and list data to be collected.
- To define when medicines reconciliation should occur
- To clarify responsibilities of pharmacists and other staff in the medicine's reconciliation process; these responsibilities may differ between clinical areas

3 Who this procedure applies to

This procedure applies to all staff involved in:

- the prescribing of medication to TEWV inpatients
    - On admission to a ward
    - Following a period of inpatient treatment at Acute trust
    - Following assessment at Accident + Emergency or attendance at outpatient appointment
    - For long stay patients following attendance at dentist where a prescription has been issued
    - At discharge from inpatient stay
- the detailed reconciliation of the medication the patient was taking on arrival at an inpatient facility, by the pharmacy team. This is usually part of the process to ensure all prescribed medication is available on the ward for the patient to take.

This procedure has been reviewed in consultation with the Pharmacy Leadership Team. The views of the professionals involved with medication in the multi-disciplinary team have been sought via the Locality Medicines Management Groups and the Drug and Therapeutics Committee

The procedure aligns to the Trust values of RESPECT and COMPASSION, as it involves the views of both patients (including carers or family) and the healthcare professionals to ensure that the correct medication is prescribed on admission to an inpatient ward in a safe and timely manner for every patient. There is consideration of the interfaces of care where medicines related processes can go wrong, and the other partners in the care system involved in the prescribing and supply of medication for our patients, such as General Practitioners, community pharmacists, and other care settings such as Care Homes

The procedure aligns to the Trust value of RESPONSIBILITY, in terms of complying with the NICE Clinical standard for Medicines Reconciliation and best practice. At all points in the process when a patient moves between care settings e.g. from inpatient ward back home under the care of the Mental Health Community Team and the GP, every care is taken to ensure information about medication is accurate and complete when shared between different professionals. The includes the learning that takes place if things go wrong or are not as good as possible so that the right people are informed and the process reviewed upon or reflected upon.

4 Related documents

This procedure describes what you need to do to implement the Medicines Reconciliation section of the Medicines Overarching Framework Policy.

The Medicines Reconciliation Procedure defines the compliance requirements for safe, secure and appropriate handling of medicines which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-
Admission, Transfer and Discharge Policy - link

Medicines Administration Record (MAR) chart – procedure for use link
Safe Transfer of Prescribing link
Medicines Safety Series 18 – Safe Transfer of Psychotropic Medication link
Medicines Safety Series 24 – Medicines Reconciliation on Admission link
Medicines Safety Series 17 – Critical Medicines link

5 Definitions

5.1 What is medicines reconciliation

NICE NG5 states the following: [1]

- Medicines reconciliation is the process of identifying an accurate list of a patient's current medicines – including the name, dosage, frequency, and route – and comparing them to the current list in use, recognising any discrepancies, and documenting any changes. This results in a complete list of medications, accurately communicated to all professionals involved in the patients care, in which any issues with medicines, such as wrong dosage or omission have been addressed.
- Medicines reconciliation should be undertaken whenever a patient moves between care settings. It is recognised that the process will vary depending on the care setting that the person has just moved into e.g. primary care into acute care setting, transfers between hospitals, prison to secure mental facility, hospital to primary care
- Medicines reconciliation applies to all inpatient admissions to mental health services.
- It is recommended that this occurs within 24 hours of admission, or sooner if clinically necessary, regardless of the time of admission or the day of the week.[2]
- Medicines-related patient safety incidents are more likely when medicines reconciliation happens more than 24 hours after a person is admitted to an acute setting.[2] Undertaking medicines reconciliation within 24 hours of admission enables early action to be taken when discrepancies between lists of medication are identified.[2]
- Medicines reconciliation may need to be carried out on more than one occasion during a hospital stay

5.2 When should medicines reconciliation occur?

For all in-patients in the following circumstances:

- On admission to hospital within 24 hours or sooner if clinically necessary
- Following transfer back to a TEWV from ward at another Trust

- Following outpatient review at another Trust
- At discharge from hospital

5.3 What is outside of the scope of this procedure?

5.3.1 Community mental health setting

When a patient is seen in a community setting, it is best practice whenever medication is reviewed or prescribed for a current list of the patient's medication to be established i.e. medicines reconciliation occurs. It is recognised this often only uses one source of information, usually list GP prescribed medication, and should be used with caution when only a single source of information is used.

For medication that cannot be transferred to the GP where the Trust continues to prescribe e.g. Clozapine processes are in place to ensure when the 6 month prescriptions are renewed or changed that a medicines reconciliation process takes place to ensure that there are no discrepancies. See separate guidance.

For psychotropic medication which is newly prescribed or amended during an inpatient admission, processes are in place after discharge to ensure the ongoing supply medication, which can include medicines reconciliation within the community team until prescribing is transferred to the GP.

Please refer to Safer Transfer of Prescribing link and Medicines Safety Series 18 – Safe Transfer of Psychotropic Medication link for more information.

5.3.2 Primary care

When patients are discharged from hospital into primary care, NICE Guideline 5 requires that medicines reconciliation should be completed before a prescription or new supply of medicines is issued and within 1 week of the GP practice receiving the information.[1] To support our colleagues in primary care attaining this target the Trust has its own discharge communication standards and process which includes information about medication on discharge, dose changes since admission, new and stopped medication (see Admission, Transfer and Discharge Framework link)

5.3.3 Transfers between wards in the Trust

For inpatients that are transferred between wards in the Trust, there is no requirement for medicines reconciliation to occur, as the current Inpatient Prescription and Administration Chart will transfer with the patient. It is expected, that for all internal transfers, any medication related issues are communicated on Paris and any outstanding issues or tasks highlighted to the pharmacy team of the receiving ward.

5.3.4 Medication review

Medicines reconciliation should not be confused with medication review. NICE Guideline 5 defines a medication reviews as 'a structured, critical examination of a person's medicines with the

objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste.

6 What is the process for medicines reconciliation?

6.1 Overview of medicines reconciliation on admission to hospital

Step 1 – during the admission Dr's clerking **Initial medicines reconciliation**	Prescriber ascertains the medication the patient is currently taking from Summary Care Record (or information from GP system / referral) AND information from patient (or family/carer) including patients own drugs; the Inpatient Prescription and Administration Chart is started. The prescriber must take into consideration the guidance in Medicines Safety Series number 24 – Medicines Reconciliation on Admission link when prescribing medication immediately following admission, especially out-of-hours or at weekends when the pharmacy team is not available to complete a detailed medicines reconciliation.
Step 2 – within 24 'working' hours since admission **Detailed medicines reconciliation**	A pharmacy technician will complete a detailed medicines reconciliation using multiple sources which is checked against the Inpatient Prescription and Administration Chart started in step 1. A pharmacist will clinically review the prescription along with any discrepancies and queries. (see section 6.5 overview pharmacy process)

6.2 Collecting information

This involves the collection of information about the medication from a variety of sources and should involve patients and their family members or carers where appropriate.

Accurately list all the person's medication, including prescribed, over the counter or complementary medicines.

Always record the date that the information was obtained and the source of the information.

Make a record of any discrepancy between what the patient is currently prescribed, and what the patient is taking with reasons for this variation if any can be established.

Sources of information:

- Summary Care Record or emailed print out from GP record
- Copy of a patient's repeat prescription or request
- Verbal information from the patient, their family, or a carer
- Medical notes or discharge summary from a patient's previous admission to hospital
- Take-home (i.e. discharge) prescription summaries

- Medical notes transferred from another ward or unit
- Patient's own drugs
- Medication Administration Records (MAR) from social and care home settings
- Community Pharmacy Patient Medication Records (PMR), repeat dispensing records and medicine use review records. (NB patients may use multiple pharmacies)
- Specialist nurse care and clinical management plans
- Monitored dosage systems and compliance aid

The minimum information available on admission should include:

- Complete patient details i.e. full name, date of birth, weight if under 16 years, NHS number, GP, date of admission
- Presenting condition plus co-morbidities
- A list of medicines currently prescribed, including those bought over the counter
- Dose frequency, formulation and route of the medicines listed
- An indication of medicines that are not intended to be continued
- Monitored dosage systems and compliance aid
- Known allergies and previous drug interactions

Health professionals should recognise that people's ability to understand the issue of medicines reconciliation may differ and this must be taken into account in discussions with the person (be it the patient, their family or carer). Some people may need additional support to understand the issue, for example, if English is not their first language or if they have communication or sensory difficulties.[2]

6.3 Checking information

This is the process of ensuring that the medications and doses that are now prescribed for the patient are correct.

This does not mean that they will be identical to those contained in the medication history – the doctor now caring for the patient may make some intentional changes.

It is recognised that the medicines reconciliation process can be complex and particular attention should be made to any critical medicines. Medication Safety Series 24 - Medicines Reconciliation on admission: Top tips and safety checks! link has been produced to support staff when completing medicines reconciliation

6.4 Documenting and communicating information

This 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 that sees them.

It includes documenting such things as:

- When a medicine has been stopped, and for what reason (including topical preparations)
- When a medicine has been initiated, and for what reason
- The intended duration of treatment (e.g. for antibiotics and hypnotics)
- When a dose has been changed or is planned to be changed for dose titrations
- When the route of the medicine has been changed
- When the frequency of the dose has changed intentionally
- Discrepancies and action take to rectify

All discrepancies identified MUST be recorded on Paris and include the action taken and outcome.

Where a discrepancy is potentially serious the prescriber must be informed and DATIX report of the error must be made.

All documentation of medicines reconciliation MUST be made on the patients Electronic Patient Record (EPR), within 24 hours of completion. This is usually done by using the *Paris Case note type Medicines reconciliation;* except for single source medicines reconciliation undertaken in the community and medicines reconciliation following admission or outpatient clinic review at an acute trust, where a case note should be used.

The *Paris Casenote type Medicines reconciliation* includes a list of medication which MUST reflect what the patient was taking at the point they were admitted to hospital, as verified from reliable source(s) i.e. prescribed, over-the-counter or herbal medication and non-prescribed medication obtained illicitly. NB this may not necessarily match what is prescribed on the drug chart.

6.5 Medicines Reconciliation at admission - pharmacy process

Identify	**Identify any new admissions** to the ward for whom medicines need to be reconciled. • Consider which patients are most urgent / complex when prioritising workload • *Return from acute trust – reconcile TEWV in-patient chart with discharge letter*
Data collection	**Collect information from at least two reliable sources** • GP medication information – Summary Care Record / email medication list / copy FP10 / MAR chart. • Patients Own Medication (POD). If patient has a compliance aid document details of compliance aid type and who fills it. **Think reuse of PODs** • Speak to patient (or family / carer -with consent if possible) to confirm current medication, **compliance** with prescribed regime and allergy history as soon as possible after admission. **Think OTC, herbals and illicitly acquired POMs, including borrowed medication, or drugs and abused medication e.g. laxatives** (If not appropriate or possible to speak to the patient document reasons on PARIS – consider when to return to speak to patient) • Access clinical care record to check for documents admission record and any recent out-patient appointment or crisis / liaison / community team input and changes to medication. For example, depot, acetylcholinesterase inhibitors. • Other sources can be used but need to consider reliability of these
Reconciliation	**Collate and review information to establish** what the patient was taking (or not) at admission. • Compare against the prescribed medication on the inpatient prescription and administration record. • **Beware allergy status** • **Think critical medicines.** Check for additional information needed for patients currently prescribed high-risk drugs: clozapine, lithium, anticoagulants, insulin, methotrexate, anti-epileptics, anti-infectives, anti-Parkinson drugs, methadone, and depot injection.
Chart endorsement	**Check and endorse the drug prescription and administration chart to ensure legible, safe, and clinically appropriate for the patient** • Highlight any CRITICAL MEDICATION in the comments section • Clarify items to order highlighting stock and PODs to minimise duplication and waste.
Discrepancies	**Identify any discrepancies. Take corrective action** • Either yourself (within your own medicines reconciliation competency) or discuss with the ward pharmacist and highlight any concerns or discrepancies found and corrected or unresolved • If the ward pharmacist is not immediately available and a serious issue (e.g. involving a critical medicines, potential prescribing error, or incorrect / blank allergy status) is identified. This should be highlighted to the medical staff on the ward or to another pharmacist. • Discuss with medical staff any un-accounted for discrepancies. Pharmacist, Non-Medical Prescribers can make amendments to discrepancies where they fall within their scope of practice. • Pharmacy technicians will refer any issues outside their competence to ward pharmacist
Record	**Add entry on PARIS** using case note type 'Medicines reconciliation' **within one working day of completion of task** and record activity i.e. time taken • Ensure appropriate significant alerts are in place e.g. warfarin, insulin, HDAT, lithium and allergies are documented on the drug chart and PARIS. Update the outcomes of any queries. • Complete the medicines optimisation page of the Prescription and Administration Record chard • Update the ward visual control board
Clinical check	**For every new admission the pharmacist will undertake a clinical check of the patients prescribed medication.** The completed medicines reconciliation will be used as part of the process. • **At admission think VTE assessment? Is RT prescribed? Is the patient now HDAT? Smoking status is NRT prescribed, effects on of other medication? Falls/Frailty risk? Physical health?** • When the pharmacist is satisfied that the prescribed medication is clinically appropriate, they will initial the individual drugs on the Prescription and administration record. • Outstanding queries are denoted using "Q" N.B. these must be followed up at the earliest opportunity • A more detailed clinical review of medication may be identified at admission

6.6 Admission to Respite, Residential or Day services

Patients admitted to a respite or community residential bed or accessing day services, where a Medicines Administration Record (MAR chart) is used, require medicines reconciliation to be completed at the first admission using two sources of information. For subsequent admissions medicines reconciliation should be carried out every 3 months or sooner if notified of changes. All service users must have annual medicines reconciliation against the MAR chart. (See Trust guidance link)

6.7 Transfers between ward external to the Trust

When patients are transferred back to the Trust from an acute hospital, medicines reconciliation should occur as soon as possible, using discharge letter / information or a copy of the acute inpatient drug chart, to ensure the Trust Inpatient Prescription and Administration Record is current and correct. (see Admission, Transfer and Discharge Framework link)

The Pharmacy team will use the front of the chart 'medicines reconciliation complete:' section to indicate this has occurred.

6.8 Discharge from hospital

At discharge from hospital, medicines reconciliation must occur to establish the changes to medication since admission. These need to be communicated, along with the reasons, to the GP as part of the inpatient GP discharge letter.

Sources of information:

- Record of admission medicines reconciliation on Paris. If not available go back to primary sources of medication at admission e.g. GP information
- Inpatient Prescription and Drug Administration Record includes information about changes to medication in the **Start Code** (N= new, A= amended, P = previous) and **Stop Code** boxes. The standards for prescription writing on the reverse of the chart give more guidance on the codes used.

At discharge the pharmacy team will check the accuracy of the medication that has been prescribed from the inpatient chart to ensure there are no unintentional discrepancies. This doesn't not constitute a medicines reconciliation at discharge described above.

For psychotropic medication which is newly prescribed or amended during an inpatient admission, processes are in place after discharge to ensure the ongoing supply medication, which can include medicines reconciliation within the community team until prescribing is transferred to the GP.

Please refer to Safer Transfer of Prescribing link and Medicines Safety Series number 18 – Safe Transfer of Psychotropic Medication link for more information.

7 Roles and responsibilities

Role	Responsibility
Chief Pharmacist and Deputy Chief Pharmacist – Clinical Services	• To implement this policy within the Pharmacy Service • To ensure the implementation of this policy is monitored
Pharmacists and pharmacy technicians	• To undertake the majority of detailed medicines reconciliations within the first 24 hours of admission to an inpatient bed (within agreed pharmacy service levels) • To undertake medicines reconciliation when patients are transferred externally to the Trust. • To support the medical staff undertaking medicines reconciliation at discharge • To provide training and support to non-pharmacy staff undertaking medicines reconciliation. • To work within the single pharmacy competency framework for medicines reconciliation
Medical staff (and Non-Medical prescribers)	• To undertake an initial medicines reconciliation at admission to enable the Inpatient Prescription and Administration chart to be completed safely. To be mindful that out of hours and weekends there is no pharmacy medicines reconciliation service and further guidance is available in Medicines Safety Series number 24 – Medicines Reconciliation on Admission link • To undertake medicines reconciliation when patients are transferred back to Trust from an acute hospital admission. • To provide information at discharge from hospital to the GP about medication changes and the reason, including newly stopped and started medication.
Nursing staff	• To undertake medicine reconciliations when pharmacy staff are not available especially out of hours or weekends where there is an urgent clinical need. (See Medicines Safety Series number 24 – Medicines Reconciliation on Admission link for further guidance)

8 How this procedure will be implemented

- This policy will be published on the Trust's intranet and external website.
- Induction training for all clinical pharmacists
- Competency based training for pharmacy technicians undertaking extended roles
- Induction training for all medical staff
- Communicating discharge medicines reconciliation covered in the Paris inpatient GP discharge letter training.

8.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
Medical staff	Induction medicines training Paris GP discharge letter training	1 hour 1 hour	At start of placement
Pharmacists	Induction – reading procedure and shadowing staff	3 hours depending on experience	During induction
Pharmacy technicians	National Medicines Management qualification medicines reconciliation	Study, portfolio and assessment	Refresher competency every 2 years
Nurses	Local induction	1 hour	At start of placement
Non-medical prescribers	Induction As part of mentored supervision on qualification	1 hour 1 hour	During induction

9 How the implementation of this procedure will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Medicines reconciliation rates (>95% of admissions) and time from admission (% undertaken in less than 24 hours)	Monthly Performance dashboard Locality Lead Pharmacist	Locality Pharmacy Leadership Teams Locality Medicines Management Group

10 References

1. NICE Guideline 5 Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes https://pathways.nice.org.uk/pathways/medicines-optimisation

2. NICE Quality Statement 4 Medicines Reconciliation in acute settings

https://www.nice.org.uk/guidance/QS120/chapter/Quality-statement-4-Medicines-reconciliation-in-acute-settings

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	23 September 2021	
Next review date:	01 October 2024	
This document replaces:	PHARM-0026- v4	
This document was approved by:	Name of committee/group	Date
	Drug & Therapeutics Committee	23 September 2021
This document was ratified by:	Name of committee/group	Date
	N/A	
An equality analysis was completed on this document on:	Standard pharmacy EA applies to this document	
Document type	Public	

Change record

Version	Date	Amendment details	Status

1.0	April 2008	New policy	Superseded
2.0	March 2011	Minor amendments	Superseded
3.0	April 2013	Reformatted	Superseded
4.0	November 2016	Change from CLIN0026 to PHARM 00026. Change from policy to procedure. Full revision in line with NICE guidance. Minor amendments throughout. Significant updates to section 4, 5, 6, 8, app 1, 2.	Superseded
5.0	September 2021	Minor amendments Replacement of appendix 4 by MSS24 Medicines reconciliation on admission Paris medicines reconciliation casenote recording guidance moved to Paris guides on intranet. Transferred to new template. (note - sent for publication 30/12/2021)	Approved

Appendix – Approval Checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Have training needs been considered?	Yes	
	Are training needs included in the document?	yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	General Pharmacy documents EA
	Have Equality and Diversity reviewed and approved the equality analysis?	n/a	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the document been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	