

Medicines Reconciliation Policy and Procedure

Effective: December 2008 Reviewed: March 2010 Review: March 2012

Summary

In December 2007 the National Institute for Clinical Effectiveness (NICE) and the National Patient Safety Agency (NPSA) published “Technical patient safety solutions for medicines reconciliation on admission of adults to hospital”. This document contained two action points, the first of which is to be implemented by Trusts by December 2008 and concerns medical, nursing and pharmacy staff.

Action 1.1 All healthcare organisations that admit adult inpatients should put policies in place for medicines reconciliation on admission. This includes mental health units, and applies to elective and emergency admissions.

Action 1.2 In addition to specifying standardised systems for collecting and documenting information about current medications, policies for medicines reconciliation on admission should ensure that:

- Pharmacists are involved in medicines reconciliation as soon as possible after admission.
- The responsibilities of pharmacists and other staff in the medicines reconciliation process are clearly defined; these responsibilities may differ between clinical areas
- Strategies are incorporated to obtain information about medications for people with communication difficulties.

This policy has been created in order to meet the requirements of this patient safety guidance.

Introduction

The aim of medicines reconciliation on admission to hospital is to ensure that medication prescribed on admission corresponds with what the patient was taking at home prior to admission.

The National Prescribing Centre defines medicines reconciliation as:

- Collecting information on medication history (prior to admission) using the most recent and accurate sources of information to create a full and current list of medicines.
- Checking or verifying this list against the current prescription chart in the hospital, ensuring any discrepancies are accounted for and actioned appropriately.
- Communicating through appropriate documentation, any changes, omissions and discrepancies.

Medication errors pose a threat of harm to hospital inpatients, leading to increased morbidity, mortality and economic burden to health services. Errors occur most commonly on transfer between care settings and particularly at the time of admission. Two recent literature reviews reported unintentional variances

of 30-70% between the medication patients were taking before admission and their prescriptions on admission.

Information sources available for medicines reconciliation.

- **Patient / Carer.** The patient and / or their carer may be a very good source of information about their current medication. Many carry very accurate lists of their medication. Care must be taken to ensure the patient is taking the medication as prescribed.
- **Medical notes.** The patient may have only recently been discharged from hospital and the notes may contain copies of discharge prescriptions and inpatient medicine charts previously verified by a pharmacist. Anything produced within the previous three months is a valuable source of information and should be considered to be accurate. Discharge letters may be used although care should be taken as these are quite often incomplete.
- **Patient's own drugs.** Many patients will bring their current medication into hospital, although some may not bring labelled boxes. This may reduce the value of this information source as it may not be possible to establish the correct directions for this medication or whether the medication was actually prescribed for that patient.
- **GP.** The most accurate and up-to-date source of information is the repeat list from the GP. This will show all acute and repeat prescriptions and when they were last issued. The receptionist will usually fax a copy on request. Again care must be taken to ensure the patient is taking medication as prescribed. The only disadvantage of this source is that it may not list specialist medication the patient is prescribed e.g. hospital only drugs, specialist psychiatric medication.
- **Community Pharmacy.** If the patient always uses the same community pharmacy they will be a valuable source of information. However if the patient does not have a regular community pharmacy the records may be incomplete.
- **GP referral letter.** If the patient has been referred to the hospital by their GP a detailed letter, including a list of medication, may accompany the patient.

Procedure for Medicines Reconciliation

1. Introduction

1.1 Purpose

This procedure aims to provide guidance to all healthcare professionals (medical, nursing and pharmacy staff) involved in the process of medicines reconciliation on wards and departments within Newcastle-upon-Tyne Hospitals NHS Foundation Trust.

1.2 Scope

This procedure is limited to providing guidance to medical, nursing and pharmacy staff involved in medicines reconciliation.

2. Obtaining a medication history

- 2.1 A medication history must be obtained for all patients within 24 hours of admission.
- 2.2 The medication history may be taken by a doctor, pharmacist or suitably trained nurse, pharmacy technician or pre-registration pharmacist.
- 2.3 The patient must be identified and their name and other demographics recorded on documentation (if not already noted).
- 2.4 The drug history may be recorded in the patient's notes or, for pharmacy staff, on a Pharmacy Assessed Medication History record sheet that will be filed in the notes at a later date.
- 2.5 The patient and / or carer should, where possible be interviewed to establish what medication they are currently taking. The patient must be asked the following questions:
 - Do you know what medication you are currently taking?
 - Do you have a list of current medication?
 - Do you use any other types of medication e.g. inhalers, injections, eye drops, creams, ointments?
 - Do you buy anything over the counter or use herbal or homeopathic medication?
 - Have you recently discontinued any medication or is there anything you are prescribed by your GP that you do not take?
 - Do you have any drug or non-drug allergies?
- 2.6 For each drug the name, strength, dose and frequency must be established. If the patient's own drugs are available the strength and frequency may be obtained from them. It is important to check with the patient that they take the medication as prescribed. If the patients own drugs are in a compliance aid any information on the compliance aid including the name of the community pharmacy responsible for filling it should be recorded.
- 2.7 There may be enough information gained from the patient and patient's own drugs to create an accurate drug history. If not other sources must be consulted e.g. hospital notes, GP surgery, GP referral letter, community pharmacy. At least two sources of information, if available, should be used to create an accurate drug history.
- 2.8 Medication for the treatment of addiction e.g. methadone must be verified by someone other than the patient.
- 2.9 The medication history must be signed and dated by the person completing it.

3. Medicines Reconciliation

- 3.1 To complete the medicines reconciliation process the list of drugs must be compared with the prescribed drugs on the inpatient chart. Allergies must be compared with those recorded on the front of the chart.
- 3.2 If a doctor has carried out medicines reconciliation it is their duty to ensure all allergy information and medication prescribed on the inpatient chart is correct and to discontinue or prescribe medication as appropriate. They may wish to discuss their decisions with a colleague.

- 3.3** If medicines reconciliation has been carried out by a nurse or member of pharmacy staff any discrepancies must be discussed with the prescriber or another doctor looking after that patient.
- 3.4** If the doctor is not available a communication note may be left, in accordance with local policy, for minor discrepancies. For serious discrepancies the prescriber or another doctor looking after the patient must be contacted and discrepancies rectified as soon as possible. Alternatively recommendations may be written in the patient's medical notes.

Medical Staff Responsibilities

In all areas doctors will be responsible for carrying out the initial medicines reconciliation. In many areas pharmacy staff will carry out more detailed medicines reconciliation after clerking.

Pharmacy Staff Responsibilities

The clinical pharmacy service within Newcastle-upon-Tyne Hospitals NHS Foundation Trust is undergoing a period of major change. As part of the clinical pharmacy strategy many new posts have been created and areas that previously had no clinical pharmacy service now have a service. Consequently in many directorates pharmacists will be involved in medicines reconciliation.

Currently the clinical pharmacy service is provided between the hours of 8.30am and 5pm Monday to Friday. There are plans to extend this service to provide late night and weekend working (summer 2009).

There is great variation between the clinical pharmacy services provided to individual directorates therefore in some areas detailed medicines reconciliation will be mainly carried out by a pharmacist but in others the medical and nursing staff will be solely responsible.

The following table details where clinical pharmacy services are available to carry out detailed medicines reconciliation

Directorate	Clinical pharmacy service in place
Internal medicine / A and E	Part
COTE	No
Surgical services	Yes
ENT / Head and Neck	No
Musculoskeletal	Yes
Renal Medicine	Yes
Urology	No
Neurosciences	Yes
Perioperative and Critical Care	Yes
Specialist Haematology	Yes
Cancer Services	Yes
Children's Services	Yes
Women's Services	No
Cardiothoracic Surgery	Yes

Cardiology	Yes
Plastics / Ophthalmology	Part
Dermatology	No

When a ward has a clinical pharmacy service it is the responsibility of that pharmacist to carry out detailed medicines reconciliation within one working day of admission. When the ward does not have a regular clinical pharmacy service the responsibility falls to the medical staff who must carry out the process within 24 hours of admission. If the ward does not have a dedicated clinical pharmacist or regular medical cover it is the responsibility of the nursing staff to ensure medicines reconciliation is carried out.

In the majority of cases if the initial medicines reconciliation has been carried out by a doctor the process will be repeated and the history confirmed by a member of pharmacy staff (good practice) in areas with pharmacy service.

Barriers to carrying out medicines reconciliation

- Deafness
- Learning difficulties
- Poor / no understanding of English
- Patient drunk / under the influence of drugs
- Confusion / agitation
- Patient unconscious

In these situations the patients relatives may be a useful source of information or the patient's GP can be contacted. The Trust does provide an interpreting service.

E-Record

When this major development is complete in summer 2009 there will access to all medication and allergy data from previous hospital admissions.

Training

- **Medical staff** – Training will be provided to 5th year medical students and F1s as part of the safe prescribing programme run by pharmacy.
- **Pharmacy staff** – An in-house programme has been developed to train those members of staff not already trained by other means.
- **Nursing staff** – The in-house pharmacy programme may also be used for nursing staff that require training.

Monitoring and review

The audit tool provided by the NPSA / NICE will be used to audit adherence to the policy at least once a year. The policy will be reviewed every two years.

Policy author: Assistant Director of Pharmacy – Clinical Services

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	Medicines Reconciliation Policy	Policy Author:	Assistant Director of Pharmacy – Clinical Services
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy does not discriminate against any individual or group in terms of race, ethnicity, nationality, gender, culture, religion, sexuality, age or disability.
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? (If “yes”, please answer sections 4(b) to 4(d)).	No	
4(b).	If so can the impact be avoided?	N/A	
4(c).	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
4(d)	Can we reduce the impact by taking different action?	N/A	

Comments:	Action Plan due (or Not Applicable): Not applicable
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Name and Designation of Person responsible for completion of this form: Assistant Director of Pharmacy – Clinical Services Date: 12 January 2009

Names & Designations of those involved in the impact assessment screening process: Drugs and Therapeutics Panel

If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)

For advice on answering the above questions please contact Helen Lamont, Director of Nursing, or, Christine Holland, Senior HR Manager. On completion this form must be forwarded electronically to Steven Stoker, Clinical Effectiveness Manager, (Ext. 24963) steven.stoker@nuth.nhs.uk together with the procedural document. If you have identified a potential discriminatory impact of this procedural document, please ensure that you arrange for a full consultation, with relevant stakeholders, to complete a Full Impact Assessment (Form B) and to develop an Action Plan to avoid/reduce this impact; both Form B and the Action Plan should also be sent electronically to Steven Stoker within six weeks of the completion of this form.