

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Medicines Reconciliation Policy and Procedure for Adult and Paediatric Patients

Version No.:	2.0
Effective From:	15 March 2018
Expiry Date:	15 March 2021
Date Ratified:	17 January 2018
Ratified By:	Medicines Management and Governance Committee

1 Introduction

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 contains two action points.

- 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 ensure the Trust meets the requirements of this patient safety guidance. In 2014 the Newcastle upon Tyne NHS Hospital Trust made the decision to also include paediatric patients in the medication reconciliation policy.

2 Scope

This policy should be followed by all medical, nursing and pharmacy staff that have responsibility for ensuring the patient’s regular medicines are appropriately continued during their hospital admission. The profession of staff who lead the medicines reconciliation process and the percentage of medicines reconciliations carried out by each group will vary between ward areas.

3 Aims

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

4 Duties (Roles and responsibilities)

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 the Newcastle upon Tyne Hospitals NHS Foundation Trust is present on many wards; consequently in most directorates pharmacists will be involved in the medicines reconciliation process to some degree.

Currently the clinical pharmacy service is provided between the hours of 8.30am and 5pm Monday to Friday on base wards. A targeted clinical pharmacy service is provided from 9am to 5pm on Saturday and Sunday across the Trust and an extended hours pharmacist service runs from 7.30am to 10pm every day on the Assessment Suite.

In some areas, detailed medicines reconciliation will be carried out by a pharmacist, but in others the medical and nursing staff will be solely responsible. The use of e-record to create a task list of patients receiving high risk medication allows the clinical pharmacy team to prioritise patients in all areas to ensure those patients deemed to be most at risk are seen by a pharmacist. . Referral of complex patients to the directorate pharmacist, by nursing or medical staff, is also available in all areas

Each ward has an allocated clinical pharmacist and it is the responsibility of that pharmacist to identify and prioritise patients requiring medicines reconciliation. The pharmacist or a clinical technician must carry out detailed medicines reconciliation as soon as possible after admission in all patients where medicines reconciliation is deemed necessary. In lower priority patients the responsibility may fall solely to the medical staff who must carry out the process within 24 hours of admission. 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 at some point during the hospital admission (good practice).

5 Definitions

Medicines Reconciliation

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.

6 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. In the case of a neonate or very young infant, the parents/carers must be consulted.
- **Medical notes/Clinic letters.** The patient may have only recently been discharged from hospital and the paper/electronic patient record may contain copies of discharge prescriptions and/or inpatient medicine charts. It is important to always check "Patient Information/Visit list" in CERNER Powerchart for recent admissions as changes made to medicines may not yet have been communicated to or actioned by the GP and so may not appear on a list of medication from the GP. Professional judgement as to the validity of the information must always be exercised, especially if the prescription was not verified by a pharmacist. In adult patients anything produced within the previous three months could be a valuable source of information and should be considered. In paediatrics the individual patient should be considered including age, weight and stability of their condition. In most paediatric cases, where a document is older than one month, changes should be considered likely and hence records are unlikely to be accurate.
- **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. In paediatrics, labels may be inaccurate as weaning doses or instructions are sometimes given to parents/carers verbally in clinic, hence it is important to confirm with parents. Also, some parents/carers have a medication chart/ medication plan including useful information (i.e. rescue medications for epileptic children).
- **GP.** In adults the most accurate and up-to-date source of information is the repeat list from the GP as 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. A disadvantage of this source is that it may not list specialist medication the patient is prescribed, e.g. hospital only drugs, specialist psychiatric medication. Healthcare professional must be aware that the GP is not always the most up-to-date source in paediatrics; parents, patients own medications and clinic letters should be considered more appropriate
- **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/Summary Care Record.** If the patient has been referred to the hospital by their GP a detailed letter, including a list of medication, may accompany the patient.

7 Training

- **Medical staff** – Training will be provided to 3rd year medical students at Newcastle University. It is not routinely provided to 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 who require training

8 Equality and diversity

Considerations in carrying out medicines reconciliation

- Patients who are deaf or hard of hearing
- Patients with limited English
- Patients with a learning disability or autism
- Patients who are drunk / under the influence of drugs
- Patients with dementia or who are confused or agitated
- Patients who are unconscious

In these situations the patients relatives/carers may be a useful source of information, or the patient's GP can be contacted. The Trust provides a spoken language and British Sign Language interpreting service and the Learning Disability Liaison Nurse is available for consultation.

9 Monitoring compliance

Standard / process / issue	Monitoring and audit			
	Method	By	Committee	Frequency
Monitor implementation of policy	Internal medicines reconciliation audit	Pharmacy	Medicines Management Governance Committee	Annually

10 Consultation and review

The following people/areas have been consulted in drawing up this policy: Pharmacy, Medication Safety Working Group, Medicines Management Committee and the Children's Services Directorate.

This policy has been reviewed by: Lorna Clark, Assistant Director of Pharmacy, Steven Brice, Assistant Director of Pharmacy and Sinead Greener, Lead Clinical Pharmacist (Children's Services)

11 Implementation (including raising awareness)

The policy will be made available to all staff via the Trust intranet and web site.

12 References

“Technical patient safety solutions for medicines reconciliation on admission of adults to hospital” 2007, NICE/NPSA

Procedure for Medicines Reconciliation

1. Obtaining a medication history

- 1.1. A medication history should be obtained for all patients within 24 hours of admission.
- 1.2. The medication history may be taken by a doctor, pharmacist or suitably trained nurse, pharmacy technician or pre-registration pharmacist.
- 1.3. The patient must be identified and their name and other demographics recorded on documentation (if not already noted).
- 1.4. 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.
- 1.5. 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?
- 1.6. For each drug the name, strength, dose, frequency, formulation and if the medication is a special, 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, identify the route of administration (i.e. PEG) or preferences for certain formulations (i.e. liquids or tablets). If the patient's 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.
- 1.7. 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, clinic letter, community pharmacy. At least two sources of information, if available, should be used to create an accurate drug history. Documentation from any recent hospital admissions **MUST** be reviewed to ensure that changes not yet actioned by the GP have not been overlooked.

- 1.8 Medication for the treatment of addiction e.g. methadone must be verified by someone other than the patient.
- 1.9 The medication history must be signed and dated by the person completing it.

2. Medicines Reconciliation

- 2.1. 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.
- 2.2. 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.
- 2.3. 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.
- 2.4. 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.

Documentation of Drug History by the Pharmacy Team

When documenting the history in the notes:

Double check that the patient's identifiable details have been documented on the page and are correct.

The **text in bold** are the headings we use when documenting a history.

- Write the **date and time of entry** and place a green sticker in the margin
 - Use a title across the top : **Pharmacy Drug History by name**(printed) and **role**
 - **Sources used:** Usually two (ideally one being the patient/carer). Gp fax should be no older than ONE month. Very occasionally one source is appropriate- clinical judgment needed.
 - **Allergies and the reaction details:**
 - **Medications as follows:**
 - List all the medication a patient should be on. Include:
 - Generic name (and brand if important)
 - Strength,
 - Dose,
 - Frequency
 - Formulation (including strength of suspensions, tablets, opening capsules)
 - Method of supply (if potentially a homecare medication / special)
 - Route of administration (oral,ng, peg, pej)
 - Document if on HOME parenteral nutrition (PN)-(No further information is required re the PN just that they are on it and it will then be picked up by the home PN Pharmacist)
 - **Points to action:** – use bullet points
 - **note:** withheld medication and reason
 - Sign
 - Contact number
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- It is possible to annotate or amend the already documented history in the clerking or admission booklet only if it can be done neatly and it is clear to see the amendments made (i.e. Different handwriting).
 - ALL WRITING IN MEDICAL NOTES SHOULD BE LEGILBLE AND MADE WITH A BLACK PEN.

Equality Analysis Form A

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

PART 1

1. **Assessment Date:**
2. **Name of policy / strategy / service:**
3. **Name and designation of Author:**
4. **Names & designations of those involved in the impact analysis screening process:**
5. **Is this a:**

Policy	<input checked="" type="checkbox"/>	Strategy	<input type="checkbox"/>	Service	<input type="checkbox"/>
Is this:	New	Revised	<input checked="" type="checkbox"/>		
Who is affected	Employees	Service Users	<input checked="" type="checkbox"/>	Wider Community	<input type="checkbox"/>
6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*
7. **Does this policy, strategy, or service have any equality implications?** Yes No
- If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:**

8. Summary of evidence related to protected characteristics

Protected Characteristic	Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups	Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address <i>(by whom, completion date and review date)</i>	Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? <i>(by whom, completion date and review date)</i>
Race / Ethnic origin (including gypsies and travellers)	Staff are expected to comply with policy irrespective of their race / ethnic origin.	No	No
Sex (male/ female)	Staff are expected to comply with policy irrespective of their sex.	No	No
Religion and Belief	Staff are expected to comply with policy irrespective of their religion and belief.	No	No
Sexual orientation including lesbian, gay and bisexual people	Staff are expected to comply with policy irrespective of their sexual orientation.	No	No
Age	Staff are expected to comply with policy irrespective of their age.	No	No
Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section	Staff with physical disabilities will be expected to comply with policy. Staff with learning difficulties, sensory impairment and mental health may be excluded from being involved in the medicines reconciliation process. This is appropriate from a safety and security perspective.	Staff with learning difficulties, sensory impairment and mental health may be excluded from the policy; this is on the grounds of safety.	No
Gender Re-assignment	Staff who have had gender re-assignment are expected to comply with policy.	No	No
Marriage and Civil Partnership	Staff are expected to comply with policy whether they are married, in a civil partnership or single.	No	No
Maternity / Pregnancy	Staff are expected to comply with policy when pregnant.	No	No

9. Are there any gaps in the evidence outlined above? If 'yes' how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any

significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes No

- 11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)**

No.

PART 2

Name:

Lorna Clark

Date of completion:

22/2/18

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