East London NHS
NHS Foundation Trust

Policy for the Reconciliation of Medicines

Document Control Summary	
Title	Policy for the Reconciliation of Medicines
Purpose of document	To describe process for medicines reconciliation in East London NHS Foundation Trust
Status	Final
Version	6.0
Authors	Veena Shivnath, Clinical Lead Pharmacist Tsana Simmonds, Lead Pharmacist Lauren Christie–Jones, Clinical Pharmacist
Circulated to	Trust senior pharmacists Medicines Committee
Approved by	Jennifer Melville, Chief Pharmacist Raj Shergill, Deputy Chief Pharmacist Medicines Committee
First edition	March 2008
Second Edition	May 2010
Third Edition	February 2011
Fourth Edition	November 2011
Fifth Edition	September 2012
Sixth Edition	December 2016
Review date	December 2019
All comments and amendments to	Veena Shivnath, Clinical Lead Pharmacist

Version Control Summary		
Version	**Date**	**Comments / Changes**
1.0	April 2008	• Add scope. • Amend process- 2.3. • Reference documentation 5.1 • Add flowchart - appendix
2.0	May 2010	• Updated data collection form
3.0	Feb 2011	• Changed to reflect POMUK audit results: 50% patients reconciled within 24 hours.
4.0	November 2011	• Medicines Reconciliation form updated so aligned with CQUIN guide. Target completion rate changed.
5.0	September 2012	• Changed to reflect clinical pharmacy services: Acute wards: 72 hours, Forensic wards: 4 days and EHCC: 7 days • Updated Medicines Reconciliation form inserted in Appendix
6.0	December 2016	• New Medicines Reconciliation form uploaded in Appendix 1 • Updated the Aim • Amended processes 3.1 – 3.5 • Updated data collection 4.2 and 4.5 • Added 4.7 to data collection • Updated documentation 6.1 and 6.2 • Added new MEDR template (for RiO) (appendix 2) • Added example of completed new MEDR template (appendix 3) • Added the PDF document to be uploaded into clinical documentation until further notice (appendix 4) • Updated the process summary of medicines reconciliation (appendix 5) • Addition of Information Governance guidance on obtaining consent for SCR access.

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1. Aim

1.1. To outline the process and responsibilities for medicine reconciliation in East London Foundation Trust (ELFT).

2. Scope

2.1 This policy applies to all clinical pharmacists and accredited medicines management technicians working within ELFT and provides guidance as to how patients' medicines should be reconciled.

3. Process and Consent

3.1. Medicines reconciliation is the process of creating an accurate list of all medications a patient is taking. The list can then be compared to medicines prescribed at admission.

3.2. Details that should be recorded include; the name of the medicine(s), dosage, frequency and route of administration. For antibiotics, antivirals and antifungals, the indication and duration of therapy should also be recorded.

3.3. For all new patients, check the patient's electronic (RiO) or written notes for any details about their current medication. This could include discharge summaries, clinic letters relating to medicine list/changes, or details of depot administration.

3.4. The patients Summary Care Record (SCR) should be accessed and where the patient does not have an SCR, then the G.P. surgery should be contacted for information about the patient's current medication. Please see 3.5 regarding obtaining consent for SCR access. The information from the GP surgery could be taken verbally and documented in the patient's notes, or preferably, if the patient is on several medications a faxed copy should be requested from the GP. If there is documented evidence that this has been done and there are no discrepancies the pharmacist does not have to call the GP again.

3.5. **Obtaining consent** to access a patients SCR. The person accessing SCR needs to confirm one of three options:

1. That the patient has given consent for their record to be viewed or

2. That the patient consent cannot be obtained (e.g. the patient is unconscious) but that the clinician wishes to proceed or

3. The patient has not given consent and the clinician is withdrawing from the process. Therefore the SCR cannot be used as a source for the medication history process and an alternate source should be obtained.

Permission to proceed is either given verbally by the patient at the time of access or may be presumed from the Patient Information Sharing Consent form (also known as the permission to share form). Permission for non GP staff to view the GP record in SCR form may be withheld by the patient via their GP who, in turn, own the SCR process. This access is recorded and checked by the Privacy Officer of the organisation to ensure it is appropriate.

An audit trail is kept of access to the SCR by Smartcard used to gain access and the reason given. For further information on consent, please refer to the guidance on consent provided by the GPHC

3.6. Where possible, always ask the patient what medication they were taking before admission including medication bought from local community pharmacies or health food shops. Patients/carers should be encouraged to bring all of their current medicines into hospital. These medicines should be assessed for validity and re-use in accordance with the Trusts Patient's Own Drug Policy.

3.7. When it is not possible to ask the patient, information can be obtained from the relatives or carer. Exercise care and caution with regards to patient confidentiality. Refer to the NHS Code of Practice – Confidentiality.

3.8. Other resources that can be used to obtain an accurate history are:

- HIV Clinics
- Nursing/ care home records (e.g. a MAR chart)
- Repeat Prescription (FP10)
- Summary Care Record (SCR)
- Specialist addiction services
- Community Mental Health or Recovery Teams (CMHT/CRT)
- Clozapine Clinic
- Previous prescription charts

4. Data collection

The following information should be obtained for all patients:

4.1. Any drug allergies or adverse drug reactions. This should include the name of the causative agent and a brief description of the reaction if possible.

4.2. Whether the patient has been taking the medication as prescribed. It is important to identify if dose re-titration is needed e.g. clozapine, carbamazepine, lamotrigine, lithium.

4.3. Any over-the-counter or alternative medication that the patient is taking e.g. St John's wort.

4.4. Use of any illicit drugs e.g. cannabis.

4.5. If the patient is a smoker; as smoking can affect the pharmacokinetics of certain drugs. The average daily cigarette usage should be recorded to help aid the choice of smoking cessation therapy e.g. strength of nicotine patch to be used.

4.6. For current medication, information should be obtained about the name, strength, formulation, dose and indication of treatment.

4.7. For patients who obtain medication in a compliance aid, identification of the last supply date should be obtained from the community pharmacy. The pharmacy should be asked to refrain from dispensing any current cycles in case inpatient medication changes are made to the patient's medication. Documentation of the quantity the patient has at home should also be made.

5. Discrepancies

5.1. Check for any discrepancies between the list of medication obtained during medicine reconciliation and the medicines prescribed on admission or at point of transfer of care from another agency/unit.

5.2. Check if any changes or omissions are intentional. Sources that can be used are the patient, G.P, relative or carer, notes, or other healthcare professional involved in the patient's treatment.

5.3. Any discrepancies which cannot be explained should be resolved urgently with the doctor

6. Documentation

6.1. A record of all the information obtained should be entered in the patient's Rio progress notes using the format set out in the template in Appendix 1 or 2.

6.2. The form should be uploaded on to the patients RiO progress notes as soon as possible.

6.3. The 'Pharmaceutical care' section of the prescription chart should be completed by the pharmacist carrying out the final check of this MEDR process (date & signature). This does not apply to wards in Luton and Bedfordshire (who have different medication charts).

7. Responsibilities

7.1. The admitting Doctor is responsible for completing the prescription chart on admission. Information can be obtained from any of the sources detailed above, although if the patient is admitted when the patient's G.Ps surgery or other sources are closed, it may not be possible to obtain an accurate drug history at this point.

7.2. A pharmacist/pharmacy technician should be involved in medicines reconciliation for all patients as soon as possible after admission. The targets for medicines reconciliation completion are as follows:

Acute wards:	95% of patients have medicines reconciliation completed within 72 hours
Forensic wards:	95% of patients have medicines reconciliation completed within 4 days
EHCC/ Long-stay:	95% of patients have medicines reconciliation completed within 7 days

7.3. The pharmacist is responsible for ensuring that the initial drug history taken is verified and corresponds to the medication prescribed on the prescription chart.

7.4. A pharmacy technician who has been trained as competent can compile a list of the medication regime the patient was taking using the sources detailed above. This information should be detailed in the Pharmacy drug history proforma (Appendix 1 or 2) and given to the pharmacist with details of any discrepancies they have identified. If the technician has entered the medication history in the progress notes, the note should be validated by a pharmacist. The pharmacist still has overall responsibility for ensuring that the drug history is accurate.

7.5. Ward staff should ensure on discharge that details of the patient's current medication verified by a pharmacist are sent to the G.P, or transferred to the next centre of care.

8. Communication difficulties

8.1. For patients who cannot speak English or who have other communication difficulties, information should be obtained from other sources detailed above. Patient information leaflets about medicines in different languages are available on the intranet. In addition an interpreter can be booked to obtain further information from the patient and to explain any changes in medication to the patient.

9. Discharge

9.1. A pharmacist should ensure that medication prescribed on discharge corresponds to the medication the patient was taking in hospital. They should check that any medication that should have been stopped or reviewed before discharge has been done.

9.2. Details of the patient's medication at discharge should be sent or given to the patient, the patient's G.P., and the next unit involved in the care of the patient to ensure continuity of treatment. A copy should also be filed in, or uploaded to the patient's notes.

10. Audit

10.1 A medicine reconciliation audit will be carried out one year after implementation

11. References

- Technical patient safety solutions for medicines reconciliation on admission of adults to hospital. National Institute for health and clinical excellence. National Patient Safety Agency. December 2007. www.nice.org.uk/PSG001
- Admissions service. Policy and Procedure. Pharmacy Service. Leicestershire partnership NHS Trust. September 2007
- Standard and procedure for compiling a patient drug history. Barts and the London NHS Trust Clinical Pharmacy Focus January 2005
- Procedure for taking a drug history. Newham University NHS Trust Pharmacy Service. November 2006
- Nickless G, Davies R. How to take an accurate medication history, The Pharmaceutical Journal; February 2016 No 7886 vol 296

Appendix 1: Old MEDR Template

Patient Details			
Name		**Date of Birth**	
Ward		**RiO number**	
Date/time of admission		**Consultant**	
GP (name/ telephone no.)			

Source of drug history (minimum of 2)
☐ Patient/Carer
☐ GP
☐ SAU
☐ PODs
☐ CMHT/Clozapine Clinic:
☐ Other:

Allergy status/Adverse drug reaction and details (if none NKDA)		
Medication	**Allergy/Adverse reaction details**	**Source (e.g.patient GP)**

Medication						
Drug name, dose and form	**Frequency**	**Route**	**Prior to admission Y/N/NEW**	**Compliance Y/N**	**On Chart Y/N**	**Comments e.g** date of last script, discrepancies with chart?
Compliance aid? (Y/N)		**Community Pharmacy: name and telephone number**				

Medication counselling/ discussion at time of admission/ Action plan. Discussion between:			
Ward technician ☐ **Ward pharmacist** ☐ **Patient** ☐ **Carer** ☐ **Other** ☐:			
Smoking Y/N: (if Yes, how many cigarettes?:	**Interested in smoking cessation? Y/N**		**Alcohol Y/N:** (if Yes, how much?:
OTC medication:			
Herbal medication:			
Counselling offered Y/ N /NA: **Inhalers** **Lithium** **Clozapine** **Insulin device** **Warfarin** **Others**			

Completed by:				
Name	**Profession**	**Initiated:** date & time	**Completed:** date & time	**Validated by** (pharmacist)

Appendix 2: New MEDR template

RCODE MEDRC01: Medicines reconciliation completed

Medicines Reconciliation [Patient name, DoB]

Allergies:
Dossette box: Y/N
Community Pharmacy Name & Tel:

Drug History:
Sources used for DHx completion:

Regular medications:
[Medication name, strength, form: and dose]

Acute medications:
[Medication name, strength, form, dose and (date last supplied)]

Smoking: Y/N

OTC/herbal medications: Y/N

Other comments:

Appendix 3: Example of completed MEDR template

RCODE MEDRC01: Medicines reconciliation completed

Medicines Reconciliation [John SNOW, 01 Dec 1991]

Allergies: Penicillin (anaphylaxis); Amisulpride (Hives)
Dossette box: Y
Community Pharmacy Name & Tel: ABC Pharmacy, E18 8SP, T: 0208 223 8014

Drug History:
Sources used for DHx completion: Patient + GP (SCR) + PODs (Dossette box)

Regular medications:
Haloperidol tablets: 5mg MANE
Amlodipine tablets: 10mg MANE
Sodium Valproate MR "Epilim Chrono" tablets: 1g NOCTE
Haloperidol Decanoate IM injection: 150mg every 4/52 (next due 29/08/2016)
Salbutamol 100micrograms/dose evohaler: ONE to TWO puffs QDS PRN
Beclomethasone 100micrograms/dose evohaler: TWO puffs TWICE DAILY

Acute medications:
Senna tablets: 7.5mg NOCTE (Rxed 02/08/2016)
Paracetamol tablets: 1g QDS PRN (Rxed 09/08/2016)

Smoking: Y – 10 cigarettes/day

OTC/herbal medications: Y – "Wellmans" multivitamin: ONE tablet ONCE a day

Other comments:
*John wants to give up smoking, however he feels that he is very anxious and stressed at present, and so has agreed to have a further 1:1 surrounding smoking cessation once he is more settled on the ward. He will notify nursing staff when this occurs.

*John's community pharmacy confirmed that he was supplied with 4 weeks medication (in dossette boxes) on the 08/08/2016. John confirmed that this medication is at home.

Appendix 4: PDF document to be uploaded into clinical documentation until further notice.

The MEDICINES RECONCILLIATION for this patient has been completed And is in their RiO PROGRESS NOTES

Appendix 5: Process Summary of the Reconciliation of Medicines

Patient admitted to hospital

Admission clerking by doctors

Drug chart written up

Check the patients' notes to verify any regular or acute medication, allergies and any adverse drug reactions. Also check RiO progress notes for depot clinic entries

Obtain a list of medications from the patients SCR. Ascertain the patients' allergy status and any adverse drug events.

Ask the **patient/carer** the following:

- Allergy status
- Medication taken prior to admission
- Compliance
- Over-the-counter medication use
- Herbal/complementary medication use
- Smoking status
- Illicit drug use

Ask if medication can be brought in

Use other sources to supplement if necessary:

- Nursing home records
- Repeat prescription
- Community Pharmacist
- Clozapine clinic
- HIV/ TB clinic
- Specialist addiction services
- Community Mental Health Teams (CMHT)

Discuss any discrepancies with the prescriber

Amend the drug chart if necessary

Document the information obtained in the patients RiO progress notes and clinical documentation.