Somerset Partnership NHS
NHS Foundation Trust

MEDICINES RECONCILIATION ON ADMISSION TO IN-PATIENT WARDS POLICY

(to be read in conjunction with Trust Medicines Policy)

Version:	3
Ratified by:	Senior Managers Operational Group
Date ratified:	August 20115
Title of originator/author:	Head of Medicines Management
Title of responsible committee/group:	Clinical Governance Group
Date issued:	**August 2015**
Review date:	**July 2018**
Relevant Staff Groups:	All clinical staff involved in the reconciliation of medicines on in-patient wards

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DOCUMENT CONTROL

Reference	**Version** 3	**Status** Final	**Author** Head of Medicines Management
Amendments	Amended to reflect the acquisition of Somerset Community Health and changes to the Trusts governance structure.		
Document objectives: This policy sets out the procedures for the reconciliation of medicines on admission to in-patient units.			
Intended recipients: All clinical staff involved in the reconciliation of medicines on admission to in-patient units.			
Committee/Group Consulted: Reviewed by members of Drugs and Therapeutics group, Medicines Management Group and Clinical Policy Review Group.			
Monitoring arrangements and indicators: See relevant section.			
Training/resource implications: See relevant section			
Approving body and date	Clinical Governance Group	Date: August 2015	
Formal Impact Assessment	Part One	Date: July 2015	
Clinical Audit Standards	NO	Date: N/A	
Ratification Body and date	Senior Managers Operational Group	Date: August 2015	
Date of issue	**August 2015**		
Review date	**July 2018**		
Contact for review	Head of Medicines Management		
Lead Director	Medical Director		

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1. INTRODUCTION

1.1 Medication errors have the potential to cause harm to patients and hence present a serious clinical and financial risk to healthcare organisations. Errors commonly occur on transfer between care settings and particularly at the time of admission.

1.2 Medicines Reconciliation is a safety check designed to prevent unintentional changes being made to a person's medicines when they are transferred from one care environment to another. It involves compiling an accurate list of an individual's medicines immediately prior to admission, assessing a patient's compliance with prescribed medication, comparing the list with the prescription chart written for that individual after admission and documenting the reason for any changes.

1.3 The benefits of reconciliation include:

- Reducing prescribing errors
- Reducing hospital admissions and re-admissions due to harm from medicines
- Reducing the number of missed doses
- Improving the quality and timeliness of information available to clinicians, leading to improved therapeutic outcomes
- Increasing patient involvement in their own care promoting better concordance and reducing waste

2. PURPOSE & SCOPE

2.1 All inpatient services must have appropriate medicines reconciliation processes in place. This policy outlines how Somerset Partnership NHS Foundation Trust will implement medicines reconciliation within the constraints of existing clinical pharmacy resources.

2.2 The purpose of the policy is to define and standardise the medicines reconciliation process for all adult in-patients and by doing this, to improve the safety of patients by reducing preventable medication errors on admission and on transfer between hospital units.

2.3 The policy applies to all clinical staff involved in the reconciliation of medicines on in-patient units.

3. DUTIES AND RESPONSIBLITIES

3.1 The **Chief Executive** is ultimately responsible for ensuring the Trust complies with legal requirements and national recommendations for medicines management.

3.2 The **Trust Board** has a responsibility to ensure training and competency assessment is available to all relevant staff.

3.3 The **Medical Director** is the Executive Lead responsible for this policy and for ensuring medical staff comply with the policy and are competent to

undertake this role.

3.4 The **Director of Nursing and Patient Safety** is responsible for ensuring that nursing staff and non-medical prescribers comply with this policy and are competent to undertake this role.

3.5 The **Head of Medicines Management** is responsible for the on-going monitoring of compliance with this policy.

3.6 **Each registered healthcare professional** is accountable for his/her own practice and will be aware of their legal and professional responsibilities relating to their competence in the ordering, prescribing, administering, monitoring, dispensing and supplying of medicines whichever is within their scope of practice; and work within the Code of practice of their professional body.

- must acquaint themselves with this policy and other related policies
- will be aware of the action that should be taken if their practice or their patients safety is compromised
- will be aware of their limitations and seek advice or support from appropriate health professionals when in doubt

3.7 **Line Managers** are responsible for ensuring all staff are conversant with this policy and that they are competent to undertake this role. Line managers are responsible for ensuring that staff attend mandatory training in line with the Staff Mandatory Training Matrix.

3.8 **The Clinical Governance Group** is responsible for approving this policy and will ensure it is reviewed at least every three years or sooner in line with local and/or national requirements.

3.9 **The Learning and Development Department** is responsible for entering all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and reporting non-attendance to Local Managers.

4. Explanation of Terms Used

Medicines Reconciliation – is a structured approach to establishing and maintaining an accurate list of all the medicines that a patient is taking (including the name, dosage, frequency and route), identifying, resolving and documenting any discrepancies found; recording any changes made and the reasons for the changes; resulting in a complete list of medications, which can be accurately communicated at all stages from admission, through transfer and at discharge back to primary care.

Registered Practitioner – for the purpose of this policy this will usually mean a registered nurse or a medical or non-medical prescriber but may include, where appropriate, other registered professionals such as

registered physiotherapist, registered occupational therapist, registered pharmacist or pharmacy technician.

5. POLICY

5.1 Medicines reconciliation will be undertaken for all patients below. The process should be carried out within 24 hours of admission to the in-patient ward.

- Collecting Information – using two sources where available bearing in mind limitations of each source

- For each medication note the following in the appropriate section of electronic patient record:
    - Drug name
    - Formulation
    - Route
    - Dose
    - Frequency/ timing

- Check if there is any evidence to suggest the individual is not taking their medication(s) as prescribed and document any discrepancies.

- Resolve any discrepancies identified and document outcome.

5.2 Medicines reconciliation will be carried out by registered practitioners.

5.3 Prescribing medication following medicines reconciliation is the responsibility of a registered prescriber.

5.3 Medicines reconciliation documentation will be held in the designated part of patients' clinical notes to provide a clear record of:

- The sources of medicines information compared
- Any discrepancies found in the medication information
- Any changes to medication subsequently made

6. TRAINING REQUIREMENTS

6.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Training Matrix. Training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.

- Medicines Management Training – annual mandatory training for all medical and nursing staff

7. EQUALITY IMPACT ASSESSMENT

7.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected

characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

8. MONITORING COMPLIANCE

8.1 Monitoring arrangements for compliance

Overall monitoring of compliance with the policy will be the responsibility of the Drugs and Therapeutics Group.

Performance on wards of medicines reconciliation procedure will be monitored by members of the medicines management team but they will not be responsible for checking the accuracy of all medicines reconciliations.

Reports presented to the Drugs and Therapeutics Group will also be shared with the appropriate clinical groups and managers.

8.2 Monitoring arrangements for compliance with training

The Drugs and Therapeutics Group will be responsible for monitoring compliance with the training requirements outlined in this policy.

9. COUNTER FRAUD

9.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to occur and what action should be taken in such circumstances during the development of this procedural document.

10. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

10.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), the fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 12:	Safe care and treatment
Regulation 17:	Good governance

10.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 18:	Notification of other incidents

10.3 Detailed guidance on meeting the requirements can be found at http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20

providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf

11. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

References:

Technical patient safety solutions for medicines reconciliation on admission of adults to hospital. NPSA/NICE joint publication (2007). Accessed online at http://www.nice.org.uk/guidance/index.jsp?action=byId&o=11897

Medicines Reconciliation: A Guide to Implementation. National Prescribing Centre (2008)

Keeping patients safe – getting the medicines right RPS (2013)

Medicines: Ethics & Practice RPS (2014)

Good practice in prescribing and managing medicines and devices GMC (2013)

Drug history taking – avoiding the common pitfalls. Hospital Pharmacist 2006 (13) 98-100

How to take an accurate medication history when a patient is admitted Clinical Pharmacist 2009 (1) 31-32

Cross reference to other procedural documents

Development & Management of Procedural Documents
Learning Development and Mandatory Training Policy
Mandatory Training Matrix (Training Needs Analysis)
Medicines Policy
Record Keeping and Record Management Policy
Recovery Care Programme Approach Policy
Untoward Event Reporting Policy and procedure

All current policies and procedures are accessible to all staff on the Trust intranet.

12. APPENDICES

12.1 For the avoidance of doubt, appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A	Components of medicines reconciliation
Appendix B	Summary – Types of Information for Medicines Reconciliation
Appendix C	Sources of Medication Information and their limitations

COMPONENTS OF MEDICINES RECONCILIATION

1. Medicines reconciliation has four components described below. The process should be carried out within 24 hours of admission to the in-patient ward. Information is documented in the designated part of the electronic patient record.

1.1 Collecting Information

Information is collected on:

- Allergy/ adverse drug reaction status of the patient
- Current medication prescribed / taken by the patient immediately before or on admission

This information may be gathered by any member of staff involved in the admission process eg by phone or fax from GP surgery.

Find **two** sources of information where available, bearing in mind limitations of each source (see Appendix B for summary and Appendix C for more detail)

1.2 Recording Information

- For each medication note the following in the appropriate section of electronic patient record:
    - Drug name
    - Formulation
    - Route
    - Dose
    - Frequency/ timing

- The information must be entered by a registered practitioner.
- Where only one source of information was available this must be noted.

ALL medication should be included in the reconciliation process including external preparations, inhalers, herbal or homeopathic preparations, non-prescribed & over the counter medications, dietary supplements, recreational and illicit drugs (including 'legal highs').

NB Medication for the treatment of addiction e.g. methadone **must** be verified by someone other than the patient.

1.3 Checking what and how the patient takes their medication

Check if the patient was taking the medication(s) listed in stage 2 as prescribed.

- Is there evidence to suggest the individual may not be taking the medicines as stated?
- Document any discrepancies identified in the appropriate part of the electronic patient record.

1.4 Resolving Discrepancies and Prescribing

- Resolve any discrepancies identified in stage 3 and document outcome. This provides essential information on discharge for the next stage of reconciliation.

- Consider if any amendments to the patients medications are required in view of the clinical condition or reason for admission

- Document in the patient medical record any medicines intentionally withheld or discontinued, or new drugs added past this stage

2. High Risk Drugs

Every effort must be made to use **two independent** sources of information when reconciling high risk drugs including lithium, warfarin, methotrexate, opiates, insulin, clozapine, low molecular weight heparin and oral anti-cancer drugs.

Methotrexate	Dose, formulation, day of week dose taken
Warfarin	INR, dose, indication
Opiates	Recent dose, formulation, frequency of administration, any other analgesic preparations
Insulin	Dose, specific device & preparation
Oral anti-cancer drugs	Dose, frequency, start date, duration, stop date in current cancer treatment plan
Low molecular weight heparin	Dose, indication, intended length of course
Midazolam	Dose, form & strength
Injectable medication	Name, dose, frequency, route, formulation
Oxygen	Indication for therapy

Please refer to the trust intranet for information available on individual agents: http://intranet.sompar.nhs.uk/services/specialist_services/pharmacy__meds_mgmt_service/high_risk_drugs__processes.aspx

Appendix B

Summary – Types of Information sources for Medicines Reconciliation

Patient origin	**Notes**
Patient	Forgets
Relative or carer	Incomplete information
Medicines origin	
Medicines from patient's residence (PODs): dispensed (including compliance aids), and OTC, herbal, homeopathic, Chinese, etc.	May include discontinued medicines, changes in instructions to GP records
Primary care origin	
Contact Community pharmacy - PMR	Person may use more than one pharmacy
GP surgery – PMR	Not always up to date. 'Red drugs' may not be recorded
Printed GP summary	As above
Hand written GP referral letter	May not be complete with all meds
Summary Care Record	Not always updated
Nursing/residential home MAR	
FP10 / Repeat side of FP10	
Secondary Care origin	
Hospital MAR – most recent pre transfer	May not include medicines for all conditions
Discharge script – dated immediately pre transfer	As above
Discharge letter	As above
Discharge medicines	May not include all meds prescribed if PODs in use on wards
Patient notes (paper or RiO) including outpatient letters, specialist recommendations	
Electronic Prescribing Records	

Sources of Medication Histories and their limitations Appendix C

	Comment	Advantages	Disadvantages
The patient	This is an important source as the patient will tell you exactly how they take their medicines.	• Patients know a lot about their medication • Patients can tell you about recent changes that may not register on the GP's computer system yet • Patients can tell you how they actually take their medicines rather than how they are supposed to take them • Can help to identify compliance issues and gives the patient a chance to discuss any problems they are having with you • Best source of information on non-prescribed medication taken	• Not all patients can recall any or all of their medication details • Not all patients will want to talk to you or will be forthcoming • There may be communication difficulties eg o Deafness o Learning difficulties o Poor / no understanding of English o Patient drunk / under the influence of drugs o Confusion / agitation o Patient unconscious
Relative/ carers	Patients may have friends or relatives who help them with their medicines	• Carers can be very helpful in establishing an accurate drug history and give an insight into how medicines are managed at home.	• Be mindful of confidentiality
Ring GP surgery	Need to ask specifically for repeat and acute medicines	• A good source for allergies • Information on the last repeats a patient has had • May have further information on any recent consultations that the patient has had with their doctor	• Often talking to someone not trained about drugs so you may need to tease the information out. A faxed list may be preferable if the reception appears to be having problems pronouncing the drug names • Doesn't always have information about recent verbal dose changes • The patient may not comply • May not have a record of specialist drugs prescribed in hospitals and clinics
GP summary	May be sent by GP when admitting	• This gives more details than a repeat prescription slip: information on acute and repeat medication • Can give information on recent consultations that have been had with the patient (sometimes detailing dose changes or why drugs were stopped) • Should contain a record on drug allergies	• Drugs may have been discontinued or the patient stopped taking them • They may not be compliant • Doses may have been altered over the phone by the GP

	Comment	**Advantages**	**Disadvantages**
Patients' own drugs	Encourage patients to bring in their medicines from home eg using the Green Bag scheme Show the patient each medicine and discuss how the patient is taking it, what it is for and how long they have been taking it Do not assume that the label accurately reflects how the patient takes their medicine Check the date dispensed as some patients may bring all their medicines into hospital, including those stopped. Check the name is correct and is not a relatives medication	• Acts as a prompt for the patient who may not be able to tell you that they take two ramipril 5mg a day but can tell you that they take two red and white ones in the morning for their heart • Gives you evidence of what the patient is taking at home/immediately before admission	• Instructions may have changed since the drugs were prescribed • Patients may not have brought everything in with them • Patients may have brought things in with them that they no longer take • Medication may not be labelled • • • **Compliance aids:** • May be filled incorrectly by relative/carer/ nurse • Do not contain PRN medicines or eye drops, inhalers, once weekly tablets, warfarin, insulin, etc.
SCR	Summary Care Records allows allergy status, acute, repeat and discontinued medication to be viewed Need to obtain patient consent prior to viewing	• Accessible 24/7	• Patient has not always given permission for SCR to be updated. • Other disadvantages as for other GP records
FP10 / Repeat side of FP10	This shows all acute and repeat prescriptions and when they were last issued. Ensure the FP10 was issued to the patient and not a relative. Always check date of issue and confirm each item with the patient Ensure the patient has brought in their most recent script Prescriptions issued for 7 days at a time suggest the patient uses a		• Patients may not bring this in • Patients may be taking things that are not on the repeat • Drugs may have been discontinued or the patient stopped taking them • The patient may not comply • Doses may have been altered by the GP and not changed on the script • May not have a record of specialist drugs

	compliance aid.		prescribed in hospitals and clinics • Often have parts of the information cut off by the printer • If patient has several items on repeat there will be several sheets of paper – patient may not bring them all in • Sometimes items on the 'acute' list are repeated frequently
Recent Hospital MAR including additional drug charts eg insulin, warfarin	Check whether any changes have been made by the GP since the patient's previous discharge (if not transferred straight from another hospital)		• Bear in mind that the patients medicines may not have been reconciled at the point of admission to the previous hospital
Discharge script	Discharge prescriptions should not be used as a single source for a drug history		
Discharge letter	Discharge letters may be used with care as these are quite often incomplete		
Nursing home and Residential Home MAR		• Equivalent to drug charts used in nursing homes so should be an accurate account of the medicines that the patient has been receiving • Often the drugs are prepared in an MDS system for the nursing home along with administration sheets • Good if patient can't communicate with you • Should be a very current record of what the patient is taking. Check the last date of administration	

Hand written referral letter from GP		• If the doctor is the patient's own GP they should have a good idea of what the patient is taking	• Referring GPs may not be the patient's usual GPs so don't always know what the patient is taking • Referrals may be done from home visits where the GP doesn't have his/her computer with the list of drugs on and therefore has to do the best they can
RiO	RiO may be unreliable as a sole source for medicines reconciliation.		• Many different places exist where medication may be recorded and information often incomplete: o RiO Progress Notes o RiO Documents o RiO Care Plans. o RiO Core Assessments > Physical Health & Medication > Medication
Community pharmacy		• Particularly useful for determining brands and formulation that have been dispensed • Information on the last repeats a patient has had	• May not be able to find out which pharmacy the patient uses • The patient may not regularly use a specific pharmacy • Within a pharmacy, patient medication records can be fragmented i.e. one patient may have two or three records in one pharmacy • Doesn't always have information about recent verbal dose changes • The patient may not comply • May not have a record of specialist drugs prescribed in hospitals and clinics