Procedure for the Reconciliation of Medicines

Version number :	10.0
Consultation Groups	Medicines Committee
Approved by (Sponsor Group)	Medicines Committee
Ratified by:	Medicines Committee
Date ratified:	November 2011
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Services	Applicable
Trust wide	✔
Mental Health and LD (Luton & Bedfordshire Only)	
Community Health Services	

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.
7.0	May 2018 Lauren Christie-Jones	• Addition of MEDR crib sheet to appendix 6 • Updates to IG following GDPR changes by
8.0	June 2021 Shoheb Khan	• Updated process including use of HIE - 3.3 • Updated process of MEDR validation in Rio – 6.2 • Deletion of appendix 1 – old MEDR template • Deletion of appendix 4 – form to upload for completion of MEDR • Amendment of Appendix 4 crib sheet for MEDR • Addition of use of digital platforms – 8.2 • Addition of digital platforms to crib sheet – appendix 4
9.0	August 2021 Shoheb Khan	• Added section for Veteran status – 4-4.1 • Rearrangement of section numbering for inclusion of Veteran status • Addition of appendix 1 – Veteran status Crib sheet for Rio documentation • Rearrangement of Appendices for inclusion of Veteran status Crib sheet for Rio documentation

		• Addition of veteran status on MEDR template
10.0	October 2021 Shoheb Khan	• Update of Aims – 1.2 • Update of Scope – 2.1 • Addition of NICE definition for medicines reconciliation – 3.1 • Amendment to process; splitting into Level 1 and Level 2 medicines reconciliation • Amendment for time for MEDR completion as per NICE [QS120] – 3.4; 8.2 • Addition of branding – 3.5 • Addition of Luton ICE database – 3.6 • Deletion of obtaining information verbally from GP – 3.7 • Hyperlink to 'Your records and your leaflet' – 3.8 • Amendment to sources examples and clarification of minimum two sources – 3.10 • Addition of DMS process – 5.7; 10.4; Appendix 2 & 3 • Documentation of discrepancies – 6.2; 6.3 • Inclusion of electronic clinical records for all sites (Rio; EMIS; SystmOne) – 7.1; 7.2 • Amendment of responsibility for including Level 1; also appropriateness of contacting on-call – 8.1 • Hyperlink to Guidance of use of digital platforms protocol – 9.2 • Clarification of inpatient – 10.1 • Documentation in discharge summary – 10.2 • Update of template – Appendix 2 & 3 • Update of Process Summary of Reconciliation of Medicines to reflect Section 3 – Appendix 4 • Update of Crib Sheet – Appendix 5 • Update of references

1. Aim

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

1.2. To promote patient safety and reduce potential clinical risk/errors on admission

2. Scope

2.1 This policy applies to all medical practitioners, nurses, ACPs, 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 a process designed to ensure that all medication a service user is currently taking is correctly documented on admission. This can then be compared to medicines prescribed at admission to identify changes in medication regime and any discrepancies.

NICE defines medicines reconciliation as: '*the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The term 'medicines' also includes over-the-counter or complementary medicines, and any discrepancies should be resolved. The medicines reconciliation process will vary depending on the care setting that the person has just moved into – for example, from primary care into hospital, or from hospital to a care home.'*

3.2. Level 1 medicines reconciliation is completed for all newly admitted service users and should be conducted by the admitting Doctor, nurse or ACP during the clerking process. This involves recent and accurate sources information to create a full and current list of medicines. The list should be obtained from at least two reliable and up-to-date (< 3months) sources - see Appendix 5 MEDR Crib sheet for list of sources.

3.3. Level 2 medicines reconciliation is processed for all newly admitted services users and is completed by a Pharmacist, accredited Pharmacy Technician or appropriate medical professional, as soon as possible (see 3.4). This is more thorough procedure which is recorded using the template in Appendix 2 (Appendix 3 for completed example) to identify, document and escalate any discrepancies to what has been prescribed in the medication chart - or recorded during Level 1 medicines reconciliation.

3.4. NICE [QS120] recommends that medicines reconciliation should occur within 24 hours of admission – which is mandated for Level 1 medicines reconciliation. However, the Trust acknowledges this is not always possible for Level 2, hence in **exceptional cases** (e.g. admitted to the ward over the weekend), a Level 2 medicines reconciliation can

take place within 72 hours of admission.

3.5. Details that should be recorded include; the name of the medicine(s), brand if applicable (i.e. Concerta XL), dosage, frequency and route of administration. For antibiotics, antivirals and antifungals, the indication and duration of therapy should also be recorded.

3.6. For all new patients, check the patient's electronic or written notes for any details about their current medication. London sites have the Health Information Exchange (HIE), which compiles patient's data from various sources such as discharge summaries, clinic letters relating to medicine list/changes or medicines prescribed by Tertiary care, or details of depot administration. Luton and Bedford have a similar database named ICE. Both systems can be accessed via RiO

3.7. The patients Summary Care Record (SCR) should be accessed and where the patient does not have an SCR, the GP surgery should be contacted for information about the patient's current medication. Please see 3.8 for information on obtaining consent for SCR access. The information from the GP surgery should be requested to be sent via NHSMail. Once verified, this should be documented on patient's notes as appropriate. 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.

3.8. To access patients SCR, the patient must be made aware of the Trust's approach to using patient data set out in the *Your Records and Your* leaflet.

Please note if permission for non-GP staff to view the GP record in SCR form has been withheld by GP (who administers the SCR access) then the GP should be contacted and asked to enable SCR access. All episodes of access are recorded and subject to audit to ensure that access was legitimate.

3.9. 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 Trust's Patient's Own Drug Policy.

3.10. Minimum of two sources are required for a medicines reconciliation. Other resources that can be used to obtain an accurate history are:

- Verified discharge summaries from other care providers e.g. secondary or tertiary care/prisons/hospices etc.
- Clinics e.g. TB,HIV, Clozapine
- Nursing/ care home records (e.g. a MAR chart)
- Repeat Prescription (FP10)
- Summary Care Record (SCR)
- Specialist addiction services (e.g. CGL; Path to Recovery)

- Community Mental Health or Recovery Teams (CMHT/CRT)
- Previous prescription charts

4. Veteran status

4.1 As a routine part of the medicines reconciliation process, pharmacy staff should ensure that:

Service users who identify as veterans (or dependent on a veteran) are captured. This ensures veterans have access to the right support available to them.

NB This can be a sensitive question; please be mindful with how the question is phrased – i.e. 'have you served in the forces?' as opposed to 'are you a veteran?'. Asking which armed forces (i.e. Navy/Air force/ Marines etc) may also help with engagement.

- Pharmacists/Pharmacy Technicians to check that the veteran status is documented on the 'Additional Personal Information online form' on Rio if applicable. Please see Appendix 1 – 'Veteran Status Crib sheet for Rio documentation' for further guidance.

- Pharmacists/Pharmacy Technicians are expected to confirm the veteran status if it has not been documented already.

5. Data collection

The following information should be obtained for all patients:

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

5.2 For current medication, information should be obtained about the name, brand (if appropriate) strength, formulation, route (if applicable e.g. PEG/RIG), dose and indication of treatment.

5.3 Adherence to medication as prescribed. It is important to identify if dose re-titration is needed e.g. clozapine, carbamazepine, lamotrigine, lithium.

5.4 Any over-the-counter or alternative medication that the patient is taking e.g. St John's Wort, CBD oil, gingko biloba etc.

5.5 Use of any illicit substances e.g. cannabis.

5.6 Confirm smoking status; 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.

5.7 Discharge Medicines Service (DMS): As part of discharge counselling, service users on complex medications or the ones that have been initiated on medications but might benefit from extra guidance are referred to their nominated community pharmacy after discharge from hospital. Pharmacists and pharmacy technicians offering DMS must ensure that consent is obtained from the service user before referral.

5.8 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 advised to refrain from dispensing any current cycles in case inpatient medication changes are made. This communication should be documented on the patient's electronic clinical record. Documentation of the quantity the patient has at home should also be made.

6.0 Discrepancies

6.1 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.

6.2 Check if any changes or omissions are intentional. Sources that can be used are the patient, ward doctor, G.P, relative/carer, clinical system (e.g. Rio, EMIS. SystmOne), or other healthcare professional involved in the patient's care. Document to clarify as necessary.

6.3 Any discrepancies which cannot be explained should be documented in the patient's notes and resolved urgently with the doctor

7. Documentation

7.1 A record of all the information obtained should be entered in the patient's electronic clinical record (e.g. RiO progress notes, EMIS, SystmOne) using the format set out in the template in Appendices 2 or 3.

7.2 This should be recorded on to the electronic clinical record (e.g. RiO progress notes, EMIS, SystmOne) and validated within 72 hours of admission

7.3 If applicable, the 'Pharmaceutical care' section of the prescription chart should be completed by the pharmacist carrying out the final check of the MEDR process (date & signature).

8. Responsibilities

8.1 The admitting Clinician is responsible for completing Level 1 medicines reconciliation and prescribing as appropriate within the first 24 hours of admission. Information can be obtained from any of the sources detailed in Appendix 5. If the patient is admitted when his/her G.P surgery or other information sources are not available, it may not be possible to obtain an accurate drug history at this point. The

admitting Doctor can also contact Pharmacy to request an urgent Level 2 medicines reconciliation during working hours; or if out-of-hours, the on-call Pharmacist can be contacted to support with processing a Level 1 medicines reconciliation.

8.2 If applicable, pharmacist or accredited pharmacy technician should be involved in Level 2 medicines reconciliation for all patients as soon as possible after admission (see 3.4).

8.3 The pharmacist is responsible for ensuring an accurate drug history is taken verified and corresponds to the medication prescribed on the prescription chart.

8.4 A pharmacy technician who has been r=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 2 or 3) and given to the pharmacist with details of any discrepancies they have identified. A medicines reconciliation can be validated in the electronic clinical record (e.g. RiO progress notes, EMIS, Systm One) notes by an accredited pharmacy technician providing they are competent to do so.

8.5 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.

8.6 The Information Governance Manager should be contacted for any queries regarding the use of patient data.

9. Communication difficulties

9.1 For service users 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.

9.2 In the instance where face-to-face contact is not appropriate or a viable option, digital platforms can be utilised to facilitate a 1:1 discussion with the patient. Please refer to the SOP for 'Guidance on the use of Digital Platforms' for more information.

10. Discharge

10.1 For inpatient discharges, pharmacist should ensure that medication prescribed on discharges 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

10.2 All medication changes that occurred during patient's admission should be

documented fully in the discharge summary.

10.3 Details of the patient's medication on discharge should be sent or given to the patient, the patient's GP and the next unit involved in the care of the patient to ensure continuity of treatment. A copy should also be filled in or uploaded to the patient's notes.

10.4 Pharmacist/Pharmacy Technician to liaise with nominated community pharmacy in regarding Discharge Medicines Service (DMS) if applicable

11. Audit

11.1 A medicines reconciliation audit will need to be carried out under the guidance of directorate lead pharmacist to ensure that standards are adhered to.

12. 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

- Information on patient data: http://elftintranet/sites/common/private/search_quick21.aspx?q=patient%20data%20rio&orderby=0&url=ObjectInContext.Show(new%20ObjectInContextUrl(2%2C52882%2C1%2Cnull%2C970%2Cundefined%2Cundefined%2Cundefined%2Cundefined%2Cundefined))%3B

- Medicines optimisation [QS120]. Quality statement 4. National Institute for Health and Clinical Excellence. 24 March 2016. https://www.nice.org.uk/guidance/qs120/chapter/Quality-statement-4-Medicines-reconciliation-in-acute-settings

- Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes [NG5]. NICE guideline. National Institute for Health and Clinical Excellence. 04 March 2015. https://www.nice.org.uk/guidance/ng5/chapter/1-Recommendations

Appendix 1: Veteran status Crib sheet for Rio documentation

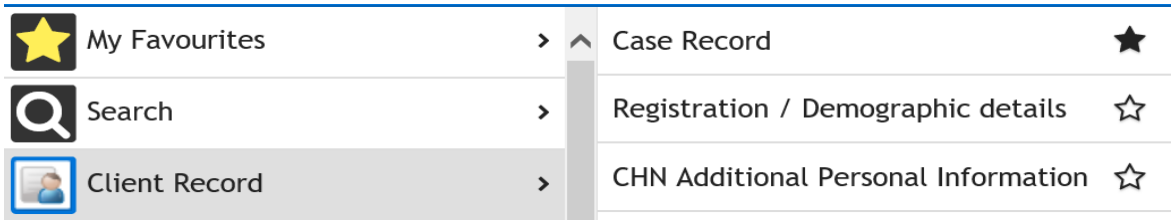
Recording Armed Forces Veterans

To record Veteran information

Accessing the Additional Personal Information form

Click 

icon



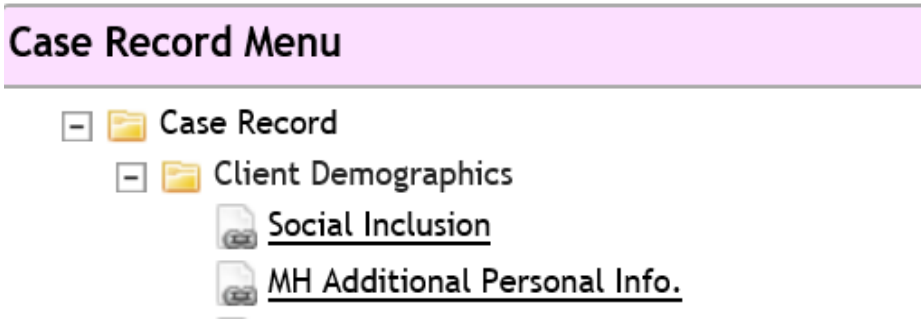
Click **Client Record** and select **Case Record** from the menu displayed.

The client/patient search screen is displayed.

Search for and select the client/patient in the usual way. If required provide an access reason.

The **Clinical Portal** page is displayed.

Expand the folder called **Client Demographics** and select **MH Additional Personal Info.**



Click **Add** at the bottom of the screen.

Complete all mandatory fields.

Scroll down to **British Armed Forces Indicator**

Select the correct option from the drop down list.

Ex-Services member

Not an ex-services member

Dependent of an ex-services member

Unknown

Known but not stated

Click Save at the bottom of the screen.

Appendix 2: MEDR template

RCODE MEDRC01: Medicines reconciliation completed

Patient name: **DOB:** **Ward:**

Allergies:

Community Pharmacy:

Community Pharmacy email:

Compliance aid:

Has the patient brought in POD's? Y/N

Compliance:

Sources:

Regular medications:

[Medication name, strength, form: and dose]

Acute Medications:

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

OTC/Herbal medication: Y/N

Tobacco smoker:

- **NRT offered: Y/N**
- **NRT accepted: Y/N**

Alcohol: Y/N

Illicit/ recreational drugs : Y/N

Seasonal Influenza Vaccine?

COVID-19 Vaccination?

Consent to DMS: Yes/No/NA

Contraception (where relevant)?

Veteran status completed on RiO: Yes/No/NA

Discrepancies:
Comments:
Plan: hand over to ward pharmacist/ medicines reconciliation complete

Initiated by:

Responsible Pharmacist:

Appendix 3: Example of completed MEDR template

RCODE MEDRC01: Medicines reconciliation completed

Patient name: Nessa Jenkins **DOB:** 06.12.1963 **Ward:** Ivory

Allergies: Penicillin (anaphylaxis); Amusulpride (Hives)

Community Pharmacy: Orite's Pharmacy, E18 8SP, T: 0208 123 4567

Community Pharmacy email: oritepharmacy@nhs.net

Compliance aid: Yes

Has the patient brought in POD's? Yes

Compliance: Stopped taking all medication 3 days ago

Sources: Patient; GP (SCR); PODs; ED summary 26.09.21; Orites Community Pharmacy; CGL;

Regular medications:

Espranor (buprenorphine) lyophilisates: 10mg MANE (last confirmed dose 27.09.21 – Community Pharmacy)

Amlodipine tablets: 10mg MANE

Sodium Valproate MR "Epilim Chrono" tablets: 1g NOCTE

Haloperidol Decanoate IM injection: 150mg every 4/52 (Last administered 09/09/2021)

Salbutamol 100micrograms/dose evohaler: ONE to TWO puffs QDS PRN

Beclomethasone 100micrograms/dose evohaler: TWO puffs TWICE a day

Acute medications:

Senna tablets: 7.5mg NOCTE (Rxed 02/08/2021)

Paracetamol tablets: 1g QDS PRN (Rxed 09/08/2021)

OTC/Herbal medication: Cod liver oil; AZ vitamins

Tobacco smoker: 40/day

- **NRT offered:** Yes
- **NRT accepted:** No

Alcohol: Yes – 1-2 cans Stella every 3 days

Illicit/ recreational drugs: No

Seasonal Influenza Vaccine: Yes – last 2020

COVID-19 Vaccination: Yes Pfizer 1st dose 06.04.21; Pfizer 2nd dose: 01.06.21

Consent to DMS: Yes

Contraception (where relevant): No

Veteran status completed on RiO: Yes

Discrepancies:

- Prescribed Haloperidol decanoate 100mg Monthly in the community Last administered on 07.10.21 but not charted
- Amlodipine 10mg OD on GP ScR but not charted
- Subutex S/L tablets prescribed instead of Espranor lyophilisates as per GP ScR

Comments:

- Community pharmacy confirmed that she was supplied with 4 weeks medication (compliance aid) on the 04/09/2021. Nessa confirmed that this medication is at home. Community Pharmacy informed to suspend dispensing of future compliance aids
- CGL confirmed Nessa under caseload. Key worker name: Stacey Corden. Confirmed Nessa is daily-supervised consumption. Informed of admission.
- Community pharmacy confirmed last administered dose of Espranor was 26.09.21 – Nessa also confirmed this. Informed Community Pharmacy of admission and request to cancel current prescription

Plan:

- Handover discrepancies to ward Pharmacist urgently

Initiated by: David Hassle – Pharmacy Technician

Responsible Pharmacist: Gavin Hoffman

Appendix 4: Process Summary of the Reconciliation of Medicines

Service user admitted to hospital

Admission clerking by doctors

Level 1 medicines reconciliation completed by admitting Doctor

Completed within 24 hours

Level 2 medicines reconciliation initiated by pharmacy

Completed within 24 hours (unless exceptional cases i.e. admitted over weekend - see 3.4)

-Initiate template (Appendix 2)
-Obtain a list of medications from the patient's reference sources. Rio document notes, GP ScR, HIE/ICE etc. (see 3.6)
- Ascertain the patients' allergy status and any adverse drug events.
-Check Rio progress for depot clinic entries

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 medications can be brought in

Use other sources to supplement if necessary (Appendix 5):-

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

-Document MEDR and any discrepancies.
-Discuss any discrepancies with the prescriber

-Amend the drug chart if necessary

-Document the information obtained in the patients RiO progress notes and validate

Medicines Reconcilliation

STEP ONE: DRUG HISTORY

Definition: a complete account of all prescribed and non-prescribed medications that a patient is currently taking.
The list of medications should be confirmed by a minimum of TWO sources.

SOURCES

THE PATIENT

Ask the patient
(Use of digital platforms if appropriate)

GP

GP RECORDS

1 Check SCR (see below)
or
2. Call the GP surgery

Community Pharmacy

PHARMACY

Contact the community pharmacy.
See SCR + PODS below.

RiO

1. Use Health Information Exchange Viewer to check TTAs and clinic letters from other Trusts.
2. Search progress notes for 'depot' to find relevant information.
3. Check 'Clinical Documentation' for recent NODFS

NHS Digital
SCR

Summary Care Records
Can be accessed here.
Use the NHS number to search for a patient's record.
See below for more information on SCR use

PODS

Patient Own Drugs
Be vigilant, call the community pharmacy.
Pharmacy contact details are on the medication label

SOURCES CONTINUED

FP10s/repeat

FP10/repeat prescriptions
Be vigilant, check the date & signature

RELATIVES/CARERS

Patient relatives/carers
Always seek patient consent before approaching. If consent cannot be sought, be vigilant about information you provide

DRUG CHARTS

If transferred from another Trust, check for a copy of the drug chart. Request it to be securely emailed (NHS.net) or faxed if not transferred with the patient

TERTIARY HEALTH CENTRES

Directly contact the centre such as; HIV clinics; TB clinics; Cancer care units; Neurosurgery units; Cardiac surgery units

NURSING/CARE HOMES

Request for the Medication Administration Records (MAR chart) to be faxed

ADDICTION SERVICES

Contact the patient's addiction service provider. Methadone scripts can be confirmed with the community pharmacy. Confirm date of last dose & get prescription **stopped**.

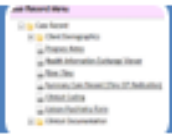
REMEMBER a *minimum* of TWO sources is required; however using MORE than two sources can only increase your confidence in ascertaining the most up to date list of a patient's medication.

Summary Care Records (SCR)

Definition: "an electronic record of important patient information, created from medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patients' direct care."

ACCESSING THE SCR

Via entering the following hyperlink into an internet browser
https://portal2.national.ncrs.nhs.uk/summarycarerecord

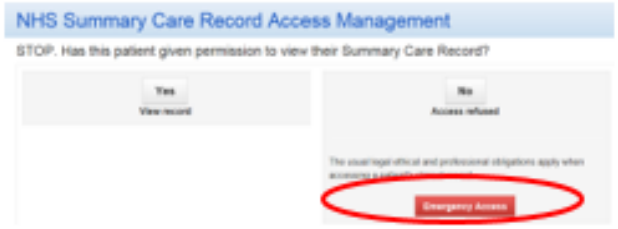


Via the Case Record Menu on patients RiO

Via the NHS Spine Portal located on all PC desktops

CONSENT

For ELFT patients, explicit consent does not need to be obtained from the patient prior to accessing their SCR. However, the patient must be made aware of the Trust's approach to using patient data set out in the Your Records and You leaflet found on the intranet. If the patient cannot be informed (e.g. patient may be unconscious), emergency access should be requested as below. **Please document any emergency access on RiO**



IF IN DOUBT...CONTACT YOUR WARD PHARMACIST!

IF OUT OF HOURS:

CONTACT THE ONCALL PHARMACIST

VIA THE DSN