Cheshire and Wirral Partnership
NHS Foundation Trust

Document level: Trustwide (TW)
Code: MP19
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Medicines reconciliation policy

Lead executive	Medical Director
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Type of document	Policy
Target audience	All clinical staff
Document purpose	Safer prescribing of medicines Compliance with NPSA/NICE guidance on medicines reconciliation

Approving meeting	Medicines Management Group	Date 16-Jun-16
Implementation date	16-Jun-16	

CWP documents to be read in conjunction with	
HR6	Mandatory Employee Learning (MEL) policy
MP1	Medicines policy
MP20	Policy for the resuse of patient's own drugs

Document change history	
What is different?	
Appendices / electronic forms	
What is the impact of change?	The document highlights the national directive that medicines reconciliation must be undertaken within 24 hours of admission

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

Document consultation	
Clinical Services	Clinical Pharmacy team
Corporate services	
External agencies	

Financial resource implications	None

External references
1. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes .NICE guidelines [NG5] Published date: March 2015

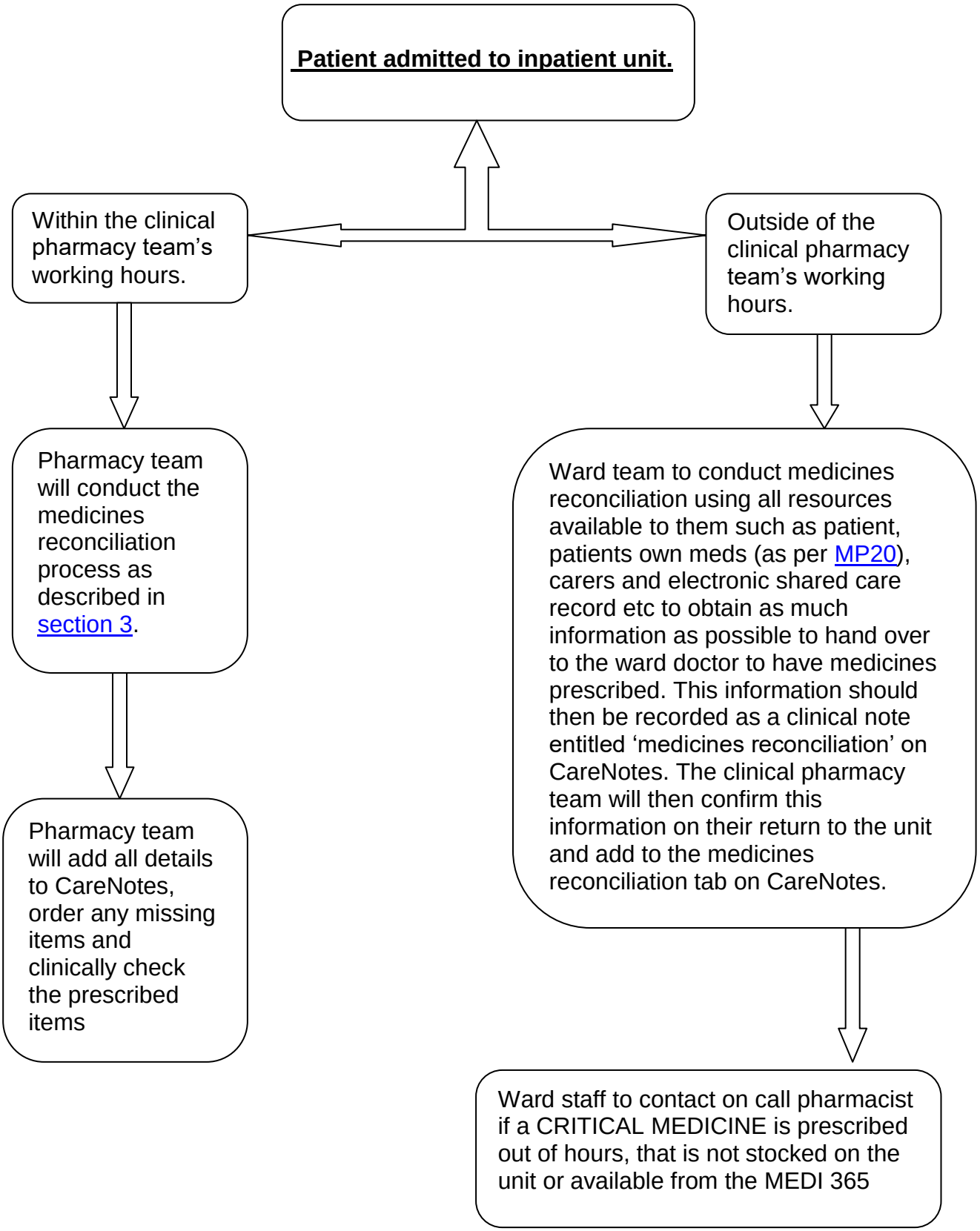
Equality Impact Assessment (EIA) - Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	

Equality Impact Assessment (EIA) - Initial assessment	Yes/No	Comments
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
N/A		
Is the impact of the document likely to be negative?	No	
- If so can the impact be avoided?	N/A	
- What alternatives are there to achieving the document without the impact?	N/A	
- Can we reduce the impact by taking different action?	N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

Contents

Quick reference flowchart

For quick reference the guide below is a summary of actions required.



1. Introduction

NICE Guideline NG5 entitled 'Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes' was released in March 2015.

Section 3.1 of this guidance 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 document made a number of new recommendations including the target that medicines reconciliation should be completed within 24 hours of admission and the continued involvement of pharmacy staff in this process. The document does acknowledge that the process will vary from setting to setting. In the Cheshire and Wirral Partnership NHS Foundation Trust all patients admitted between 08:30 and 16:30 Monday to Friday will have their medicines reconciliation conducted by a member of the clinical pharmacy team. Outside of these hours, clinicians receiving an admission should use the resources available to them (listed below) to conduct the medicines reconciliation. This information should be documented as a clinical note entitled 'medicines reconciliation' on CareNotes. This information will then be confirmed by the clinical pharmacy team on return to the unit.

This document describes the processes that should be followed by Trust staff in order to ensure the effective reconciliation of medicines on admission.

2. Definitions and Abbreviations

The definition of medicines reconciliation originates from the National Prescribing Centre. Medicines reconciliation includes:

- Collating 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 (for example,
- GP repeat prescribing record supplemented by information from the patient and/or carer).
- 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
- GP – General Practitioner
- MAR – Medication Administration Record, used by many nursing and residential homes. It is a record of the medication given to the patient.
- POD – Patient's Own Drug. This is any medication which is brought into hospital for a patient that is either prescribed for them by their doctor or purchased for their use.
- CPN – Community Psychiatric Nurse
- TTH – To Take Home or Discharge prescription
- PMH – Past Medical History
- PC – Presenting Complaint

3. Process for ensuring accuracy of prescription charts (Medicines reconciliation)

3.1 Collecting Information

Any member of clinical staff can commence information collection for medicines reconciliation. In order to obtain an accurate medicine history, more than one source of information is needed. A single source should only be used when no other sources are available, the source used must be reliable. All sources of information should be recent i.e. dated within the last month. Sources of information that may be used include:

- A computer print-out from a General Practitioner (GP) clinical records system (allergies, repeat and acute prescriptions)
- A patient's repeat prescription request form
- MAR (Medicine Administration Record) sheet from nursing/residential home
- Community pharmacy records
- Information from the patient, their family, or a carer
- Discharge prescription from a patient's previous admission to hospital
- Patients' Own Medicines (PODs) or compliance aids available at the time. There may be medicines missing or not included in the compliance aid.
- Local electronic shared care record. The system to be used will vary between inpatient units.

The medication history should be collected from the most recent and reliable source.

Remember that patients could be getting their medicines from more than one source e.g. clozapine, medication to treat dementia, methadone and depot injections are generally prescribed by the mental health services and the GP may not have a record of this. In the same way some medicines for medical conditions are prescribed by a hospital specialist e.g. Roaccutane (isotretinoin), chemotherapy.

The patient or carer may be able to provide additional information to the GP list on when and how the patient actually takes the medication. This can be different to the GP record e.g. time of day, frequency.

Information collected should include:

- Patient details i.e. full name and date of birth or NHS/ unit number or address
- A list of all the medicines currently prescribed and that are being taken by the patient
- A list of all the medicines bought or otherwise obtained (where this can be established)
- Dose, frequency, formulation and route of all the medicines listed
- Previous adverse drug reactions or allergies and details of the reaction

It is acknowledged that some patients may have certain communication difficulties. These may be, for example, language barriers, confusion or lack of capacity. Where barriers to communication exist it is advisable to use a second source of information that you consider to be a more accurate and reliable record of what medication the patient was taking prior to admission.

3.2 Recording information and communication

The staff member collecting the information should obtain a paper copy of the medicines list, where possible, to file in the patient's notes in the prescription section. This may be a fax or photocopy.

The medicines reconciliation form, (appendix 1), should only be completed by the clinical pharmacy team. This paper version should be used to begin the medicines reconciliation and the information then transcribed over to the electronic version. Entries on the form should be initialled and dated. See appendix 2 for instructions on how to complete the medicines reconciliation form.

Only when the medicines reconciliation has been completed by the clinical pharmacy team, should the 'Medication History' box on the front of the prescription chart be signed and dated

The sources of information used must be recorded on the form. Where there is a discrepancy between what the patient is prescribed and what the patient is actually taking this discrepancy and the reason should be recorded.

If medication is changed (stopped, withheld, dose changed, commenced) on admission this should be documented by the prescriber.

A CareNotes entry should be made with the title 'Medicines Reconciliation' and include the following information:

- Medicines reconciled with: (list ALL the sources used)
- Prior to admission patient prescribed:(list all the medicines including doses and freq)
- Allergies: either Nil Known or list of what patient is allergic to and reaction
- Prescribing discrepancies identified; (as a list)
- Action taken (as a list)

Once the medicines reconciliation is completed, all members of the pharmacy team are responsible for the completion of the electronic form which is located in the medicines tab on care notes.
On discharge the discharge prescription should be completed including a list of any medicines that have been stopped since admission and this should be sent electronically along with the other discharge paperwork to the GP.
When transferring a patient to another organisation a copy of the prescription chart or discharge letter should be sent with the patient. It is good practice to establish whether a supply of medication is required.

4. Monitoring of Policy

A twice yearly audit will be conducted to include the time taken for completion of medicines reconciliation, personnel involved and quality of information recorded.

Medicines reconciliation will be audited against the following standards:

- 100% of patients admitted to an in-patient will have their medicines reconciled within 24 hours by either pharmacy or clinical ward staff
- 100% of patients will have an allergy status recorded on their prescription chart on admission.
- 100% of patients will have their date of admission recorded on their prescription chart on admission.
- The medication history box on the prescription chart will be signed for 100% of patients for whom medicines reconciliation has been completed.

- 100% of medicines reconciliation completed by staff will be recorded on CareNotes as a clinical note.

5. Duties and Responsibilities

5.1 Medical Director, Compliance, Quality and Regulation/Chief Pharmacist

Responsible for overseeing the review of this policy in line with the Medicines Management Group business cycle, national guidance and changes in clinical practice.

5.2 Medicine Management Group (MMG)

- MMG is responsible for ratifying medicines management related polices.
- It is the responsibility of the Chair to ensure that the minutes of the meetings reflect the approval process and that all reviews of the policy are timetabled within the work programme.

5.3 Author

It is the responsibility of the author to seek appropriate consultation and approval via the MMG. Authors will agree review dates and are responsible for ensuring the development, implementation and monitoring of the policy.

5.4 Line managers

Line managers have the responsibility to highlight this policy and the information contained within to all members of staff who work on inpatient wards or Crisis Resolution and Home Treatment team.

5.5 Trust staff

It is the responsibility of Trust staff to keep up to date with this policy in relation to their working environment.
Medical and nursing staff should commence the medicines reconciliation process as per this policy when admitting a patient to an inpatient unit.

5.6 Pharmacy team

It is the responsibility of the pharmacy team to ensure that medicines reconciliation has been completed in accordance with the policy and to provide medicines reconciliation training as part of CWP induction and mandatory training in medicines management.

Appendix 1 Medicines Reconciliation Form

Medicines Reconciliation		
Patient name: NHS number: DOB: Ward: Consultant:	Allergy Status: Admission Date: Med Rec obtained from (circle) Patient GP MAR POD CPN Carer TTH Clinic Other:	GP Details

PMH	Antipsychotic High dosage Y / N	Compliance Requirements e.g. blister pack

Presenting Complaint

Clinical note entered on completion (tick)		Med Rec completed by: (sign & date)	Pharmacist check:(sign & date)	Consent to use*/destroy P.O.Ds documented (tick)	

Medication History on Admission

	Medicine name and form	Dose	Freq	Cont	Stop	Comments	P.O.D	
							Suitable for use (Y/N)	QTY
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

Additional Information

Appendix 2 - Completing the medicines reconciliation form

Gather all the information needed to complete medicines reconciliation using at least two sources of information as documented in the policy

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Complete the demographics and GP details from CareNotes

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PMH & PC include both medical and psychiatric history and document reason for admission

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An allergy status must be obtained for all patients and the reaction also recorded if known

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An allergy status must be obtained for all patients and the reaction also recorded if known

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For each medication the patient was taking prior to admission record the drug name, strength and frequency

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If the patient has a compliance aid such as a blisterpack the name of the supplying community pharmacy should be identified and recorded along with their telephone number

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Any other useful information should be recorded in the additional information section

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Once the prescription chart has been written up:

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Check that the following information is complete and accurate;

- Demographics
- Ward
- Consultant
- Admission date
- Allergy status
- Medicines history box
- Compliance aid

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Check each medication against the prescription chart and document any discrepancies in the comment section. All discrepancies should be accounted for; unintentional discrepancies should be highlighted to the doctor so they can amend the prescription chart accordingly.

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File form in prescription section of patient's notes (this will be superseded when the electronic version of the form becomes available) and make a clinical note on CareNotes.