Western Health and Social Care Trust

Medicines reconciliation on admission and discharge from hospital policy

April 2013

Policy Title	Medicines reconciliation on admission and discharge from hospital policy
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Responsible Officer	Clinical Pharmacy Development Lead, WHSCT

Equality & Diversity Statement

Western Health and Social Care Trust (WHSCT) can no longer be reactive in its response to demographic changes within society. There is now a positive duty to be proactive and ensure that it provides services and develops policies that are accessible and appropriate to all sections of the community.

The development of this policy has undergone an Equality Impact Screening Assessment and does not warrant a full EQIA to be undertaken.

Acknowledgement

The WHSCT would like to acknowledge the medicines reconciliation policy template developed by the East and South East England Specialist Pharmacy Services October 2008 which underpins this policy**.** Barry Keenan, Senior Pharmacist, SWAH (Lead Author)

Introduction

Communicating clear and accurate information relating to a patient during transfer between care settings is a basic component of quality care. This must include accurate information about the patient's current medicines. At each transfer point health professionals collect, check and communicate information enabling timely, informed decisions to be made about medicine treatments. This "reconciliation" of medicines is a basic requirement for good patient care.

Medication errors represent a significant cause of harm to hospital inpatients. Errors occur most commonly on transfer between care settings and particularly at the time of admission. Two recent literature reviews reported unintentional variances of 30-70% between the medications patients were taking before admission and their prescriptions on admission[1].

Policy objectives

The objectives of this policy are to:

- define the medicines reconciliation (MR) approach for the WHSCT.
- define the roles and responsibilities of staff involved in this process.
- define information sources and requirements to be used when collecting information about a patient's medication.
- describe minimum data sets to be used when a patient's medication requirements are being communicated between care settings.
- provide an audit tool to assess the quality of medicines reconciliation processes.

Scope

This policy applies to all registered nursing, pharmacy and medical staff involved in the admission, transfer and discharge of patients within the Western Health and Social Care trust (WHSCT).

This policy also refers to and is formally linked with the following supporting documents and procedures:

- WHSCT Medicines Code incorporating section on management of patient's own drugs.
- WHSCT standard operating procedures for assessment of patient's own drugs for re-use and disposal of patient's own drugs.
- Northern Ireland Clinical Pharmacy Standards
- WHSCT Inter hospital transfer of patients and their files/records July 2008
- Guidelines on regional immediate discharge documentation for patients being discharged from secondary into primary care. GAIN June 2011

National Institute for Health and Clinical Excellence (NICE) recommendations

NICE and the National Patient Safety Agency (NPSA) have issued a 'Technical patient safety solution for medicines reconciliation on admission of adults to hospital'[1] which tasks health organisations that admit adult patients to develop policies for medicines reconciliation on admission. This applies to both elective and emergency adult admissions.

The safety solution also states that:

- pharmacists should be involved in the medicines reconciliation process as soon as possible after admission
- the responsibilities of pharmacists and other staff involved in medicines reconciliation are clearly defined and
- strategies are incorporated to obtain information about medications for people with communication difficulties

Definition of Medicines Reconciliation

Medicines reconciliation has been summarised by The National Prescribing Centre (NPC) as the process of the 3 Cs

- **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 (for example, GP repeat prescribing record supplemented by information from the patient and/or carer);

- **Checking:** this involves ensuring that the medicines and doses now prescribed are appropriate for the patient**.** This check may identify medicines which are clinically inappropriate or unintentional discrepancies which will need to be reviewed and rectified as appropriate.

- **Communicating:** any intentional changes to medicines are appropriately documented within the medical record and communicated, together with reasons for these changes, to the patient and other health professionals responsible for their care.

Medicines Reconciliation on admission

There are two discreet levels of medicines reconciliation (Levels one and two) and a third level that involves a full medication review:

LEVEL ONE: Basic reconciliation (Medication History)

Involves collecting and verifying a patient's current medicines list as it exists immediately prior to admission. The minimum dataset of information required to be gathered is outlined in appendix 1. The medication history must be collected using two or more information sources described within appendix 2 and be documented in the patients' clinical record (Trust Medicines Reconciliation Form) This documentation must also include any changes made to medicines as a result of the on-going treatment plan. Where level 1 has been completed by a prescriber the patient's medicine kardex must also be completed.
Circumstances relating to the patients inability to communicate effectively or the completeness of clinical information accompanying the patient may make it difficult to document an accurate medication history on admission. If this is the case the admitting doctor **must** document this and communicate any required follow up.

LEVEL TWO: Full reconciliation

Involves comparing the verified medication history (as gathered above) with the patient's medicines kardex to document intentional discrepancies (any changes in medicines with appropriate reasons) and to identify and rectify unintentional discrepancies. This ensures appropriate transcription of medicines has taken place and that therapies are clinically appropriate, in line with the current treatment plan. Again level 2 must be clearly documented in the patient's clinical record (Trust Medicines Reconciliation Form). All outstanding issues must be communicated and actioned appropriately.
Work pressures and human error can lead to transcription errors when documenting medicines which may cause medicines to be omitted or prescribed at the wrong dosage . It is therefore essential that whenever possible the initial level one reconciliation is backed up by level two medicines reconciliation.

LEVEL THREE: Medication review

This involves a structured critical examination of a patient's medicine with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste[2].
A medication review can only be conducted accurately once medicines reconciliation is complete. Medication review requires additional skills to those required for medicines reconciliation and for the purposes of this policy medication review is considered outside the scope of this policy.

Responsibilities of staff

Medicines reconciliation is the responsibility of **all** staff involved in the admission, medicine prescribing and administration, monitoring, transfer and discharge of patients requiring medicines. The responsibilities of healthcare staff are summarised below.

Level	Description	Patient Group	Responsible staff
1	Verifying the medication history i.e. confirming and documenting an accurate list of medicines and detailing a treatment plan which includes changes to prescribed medicines.	All patients ideally within 6-12 hours of admission	**Admitting doctor**. The admitting doctor should detail (in medical notes) a list of current medicines together with a treatment plan which may include changes to medicines as appropriate. These should then be prescribed on a medicines kardex allowing nursing staff to administer medicine treatments. Some defined admission wards may use other healthcare staff e.g pharmacists to facilitate the admitting doctor with this process but **overall responsibility lies with medical staff.**
2	Comparing the verified medication history to the patient's medicine kardex and treatment plan to: a. Resolve unintentional discrepancies b. Advise on pharmaceutical aspects of treatment.	All patients within 48 hours of admission	This process is primarily carried out by **pharmacists**. Pharmacists should verify the level 1 information and resolve any outstanding issues relating to medicines. If necessary they should inform the medical team immediately to resolve prescription problems which could potentially have an adverse effect on treatment. In completing the "Nursing Assessment and Plan of Care Adult In-Patients" **nursing staff** should document allergy information and discuss with patients if they take regular medicines and whether these have been brought into hospital. Nursing staff should bring to the attention of medical or ward based pharmacists any medicines issues which they have identified whilst providing care for patients. **Pharmacy technicians** will manage assessment of patients own medicines and support nursing staff in the timely supply of medicines to patients.

Medicines reconciliation on transfer or discharge.

In order for healthcare professionals to deliver high quality patient care they need to be fully informed with respect to ongoing treatment. This includes an accurate list of current medication together with complete information relating to medicines that have been stopped, started or altered and the reasons for these. The patient and/or carers must also be fully informed of these changes. Ensuring appropriate

communication will help to maximise the chances of adherence to treatment plans and reduce the likelihood of adverse events caused by failure to monitor on-going medicine treatments.

Medicines reconciliation roles and responsibilities of staff during transfer or discharge.

	Medical staff	**Pharmacy staff***	**Nursing staff**
At discharge or transfer	Responsible for completing accurate transfer letter or immediate discharge letter. The minimum data set relating to medicines is described in appendix 3	Validate discharge information relating to medicines by providing a clinical check*. Make arrangements to ensure ongoing supply of medications at discharge Counsel patient and or carers on ongoing medicine treatments at discharge * This is dependent on clinical area having a dedicated pharmacy service	As per "Nursing Assessment and Plan of Care Adult In-Patients" check discharge medicines against prescription and medicines kardex. Discuss medicines with carer or patient (if not already completed by pharmacist) return patients own medicines if appropriate.

Training

Clinical staff carrying out all level of medicines reconciliation should receive appropriate Trust medicines management training which is supported and led by the pharmacy. Training should be delivered either prior to staff commencing employment (final year QUB medical staff) or within the first couple of weeks of employment.
Training may be through a locally or regionally agreed training package.

Pharmacy staff should receive training on medicines reconciliation processes as part of their clinical induction training.

Audit Arrangements

All staff groups involved should undertake audits of the medicines reconciliation process including:

- Measuring the percentage of patients that have had their medicines reconciled (levels one and two) within 48 hours of admission. (excluding patients who were admitted and discharged within a 48 hour period.) This percentage should increase over the audit cycle period. Standard 95%

- Measuring the percentage of patients discharge prescriptions which contain full medicines reconciliation at discharge. (All changes to medications documented by clinician with appropriate verification and clinical check by pharmacist at ward level) Standard 95%

Appendix 1

Minimum dataset required for medicines reconciliation.
The information required below must be recorded in the patient's clinical record either within the admission pro-forma or on the trust approved medicines reconciliation form and then filed in patient patients' medical record. Most clinical areas have clerk in forms with this information tabulated to aid completion. **Documentation of a medication history solely on the medicines kardex is unacceptable.** This information is in addition to essential clinical information routinely recorded at the time of admission.

- Patient details (full name, date of birth, weight, NHS/unit/hospital number, GP, date and time of admission).
- Known allergies and nature of the reaction
- A complete list of all of the medicines currently being taken by the patient including dose, frequency, formulation and route
- Detail medication management in patients own home (include details of specific support)
- Document sources used to compile medicines history (minimum of 2 recommended)
- Document name and signature of practitioner carrying out medicines reconciliation together with the date and time of completion.
- Communicate any issues encountered whilst compiling history which require follow up and clarification.

Specific medications to ask about include:
Inhalers, eye drops, topical preparations, once weekly medication, injections, OTC medication, herbal preparations, oral contraceptives, hormone replacement therapy, insulin, nebuliser therapy and home oxygen. Additional information for specific drugs e.g. indication for medicines that are for short-term use only (antibiotics), day of week of administration for once weekly medication (bisphosphonates, methotrexate)

Patients / carers must be explicitly asked if they have on their possession or are taking medicines other than what the nurse has administered.

The following questions may help to identify specific medicines management problems:

- Does anyone help you with your medicines at home? If so, who? What do they do?
- Do you have any problems obtaining or ordering your repeat prescriptions (NB: relative / carer might help)
- Do you have a regular community pharmacy that you use?
- Do you have problems getting medicines out of their packages?
- Do you have problems reading the labels?
- Some people forget to take their medicines from time to time. Do you? What do you do to help you remember?

- Some people take more or less of a medicine depending on how they feel. Do you ever do this?
- Most medicines have side-effects. Do you have any from your medicines?
- Specific medication related questions such as; “Have any medicines been stopped recently or have any doses been changed recently?”

Patients who are unable to communicate appropriately or have a poor understanding of their medicines

These patients may be particularly vulnerable to errors arising from incomplete medicines reconciliation. When obtaining a medication history for these patients a minimum of two separate sources should be used with one of these being:

- an electronic GP record e.g. GP referral letter or emergency care summary
- medicines administration and review sheet (if patient in a care home facility)

These primary sources can then be backed up by appropriate communication with carers and family or via translator services if language is an issue.

APPENDIX 2

Sources of Information used for Medicines Reconciliation.

There are several varied sources which can be used to help complete medicines reconciliation on admission. None are full proof without associated communication with the patient or appropriate carer but some are considered more reliable than others. When completing medicines reconciliation the admitting doctor must document the sources used to compile the record. At least two sources of information should be used when compiling a list of current medicines. It is essential that the doctor also communicates within the medical record any outstanding issues which need to be addressed in relation to medicines e.g. further clarification of current therapy. A list of sources used for medicines reconciliation is listed in appendix 2

The following sources used to compile medication histories and aid medicines reconciliation are listed below in no order of preference, as reliability can vary according to the situation. It is recommended to use two or more sources to facilitate comprehensive medicines reconciliation.

• **The Coherent Patient**
− Always listen to the patient who in many situations will tell you exactly what medicines they may or may not take.
− Always try to establish how exactly a patient takes their medicines, as this could be very different from the formal records.

• **Patients Own Drugs (POD's)**
− Encourage patients to bring in their medicines from home.
− Discuss each medicine with the patient to establish what it is for, how long they have been taking it, and how frequently they take it.
− Do not assume that the dispensing label accurately reflects patient usage.
− Check the date of dispensing since some patients may bring all their medicines into hospital, including those that have been stopped.

Please note: When assessing patient's own drugs the Trust procedures for use and disposal of patient's own drugs must be followed. These are referred to in the Trust Medicines Code and are listed on the Trust Intranet. Contact the local pharmacy department for advice if required.

• **Relatives/carers/paid workers**
− Patients may have relatives, friends or carers who help them with their medicines.
− This is common with elderly patients or with patients where English is not their first language.
− Carers can be very helpful in establishing an accurate drug history and can also give an insight into how medicines are managed at home.
− Be mindful of maintaining confidentiality

• **Repeat prescriptions**
− Some patients keep copies of all their repeat prescriptions. Many of these may include medicines that have been stopped.

− The date of issue should always be checked and each item confirmed with the patient.
− If there is any doubt, the GP surgery should be contacted.

• **Electronic GP referral letter or Emergency Care Summary**
− These are normally a reliable source of medicines information but pay particular attention to the last prescription date of a medicine which may give a clue to whether or not it is currently being taken. Always check with patient/carer or GP surgery as appropriate.

• **Compliance aids**.
− These may be filled by the community pharmacist, relatives or patient. Remember many medicines will not fit into compliance aids so always refer to specific medicines as indicated in appendix one.

• **Medication reminder charts**
− The chart should be checked through with the patient and the date of issue noted.

• **Recent hospital immediate discharge letter.**
− Check whether any changes have been made by the GP since the patient's previous discharge from hospital.
− If the patient has been home for more than two weeks it is likely that they may have visited their GP and changes made.
• **Residential/Nursing home records** e.g. Medication Administration Record spreadsheets.
− Useful and accurate source for a drug history.
− Usually sent in with the patient.

In some cases it may be necessary to investigate additional sources to obtain a complete medication history. Examples of teams that may need to be contacted for further information include:

- Anticoagulant clinics
- Community pharmacists
- Specialist nurses e.g. heart failure/asthma nurse/Diabetes specialist nurse
- Drug and alcohol service
- Renal Dialysis unit
- Other hospitals for clinical trials/unlicensed medicines
- Residential, Nursing home data
    - Community Psychiatric nurse

Appendix 3

GAIN NI has recently produced guidance on the completion of immediate discharge documentation for patients being discharged from secondary to primary care.(ref) This document clearly details the responsibilities of the clinician with respect to communicating medicines reconciliation information to primary care.

The full document can be viewed at:

http://www.gain-ni.org/images/Uploads/Guidelines/Immediate-Discharge-secondary-into-primary.pdf

With respect to medicines information a comprehensive list of current medications should be documented including:

- Known allergies and the nature of the reaction (record if no known drug allergies NKDA)
- Drug name (written generically where appropriate)
- Route of administration
- Frequency
- Dose (approved units)
- Start and stop dates
- Drug started with brief reason
- Dose changed with brief reason
- Drug stopped with brief reason
- Indication if supply given to patient with appropriate documentation of quantity.

It is particularly important to document any follow up required in relation to monitoring the effects of medicines e.g. assessment of renal function, blood pressure, serum drug levels etc.

APPENDIX 4: WHSCT MEDICINES RECONCILIATION FORM (example)

Medicines managed by: **Self** □

Other (specify)……

Compliance aid used: □Yes □No

Filled/provided by……..

……..dispensing (e.g. weekly, daily, fortnightly etc.)

Repeat dispensing scheme: □Yes □No

Provided by:……

Other special requirements: (specify)……..……..

Allergies / Medicine Sensitivities

Drug (Generic) or allergen	Type of reaction
. ……	……
……	……
……	……

No Known Allergies □ (please tick)

Signature	Date	Designation

Source of history: (Use a minimum of 2 to compile list if possible)

□ GP phone call □ Patient □ Patients Own Drugs □ Medical notes □ Medication Card

□ GP referral letter □ Carer/Relative □ Repeat script □ Current kardex □ Fax

□ Community pharmacy □ Emergency Care Summary □ Patient Centre □ Diamond □ Emed

Record of telephone contact with:

Name of person spoken to:	Telephone No:	Contact (e.g. GP/carer)	Date	Time
……	…….. ..	……	……	……..

Medicines prior to admission (Include regular, PRN, oral and non-oral)		Medication review on admission				
Entry Date	Medicine name, route/form, dose and frequency	Please circle				Comments / Modifications (if medication held or discontinued) Altered – must be signed and dated
		Continue	Alter	Hold	Discontinue	
		Continue	Alter	Hold	Discontinue	
		Continue	Alter	Hold	Discontinue	
		Continue	Alter	Hold	Discontinue	
		Continue	Alter	Hold	Discontinue	
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		Continue	Alter	Hold	Discontinue	
		Continue	Alter	Hold	Discontinue	
		Continue	Alter	Hold	Discontinue	

Ask if the patient uses any of the following (list details above) None □

□ Inhalers □ Home Nebs □ Home O_2 □ Patches □ Injections e.g Insulin (include doses)

□ Clinical Trial Drugs □ Specialist medicines supplied from hospital □ Oral contraceptives/HRT

□ Eye/Ear drops □ Creams/Oints □ OTC/Herbal remedies

Further action required: (E.g. Contact GP/relative in morning)

Compiled by:	Date & Time: Bleep:	Verified by:	Date & Time: Bleep:

Additions or modifications to the above list must be signed and dated in the comments section.

REFERENCES

1.National Institute for Health and Clinical Excellence/ National Patient Safety Agency. Technical patient safety solutions for medicines reconciliation on admission of adults to hospital. Department of Health. December 2007.

2. Task force on Medicines Partnership and the National Collaborative Medicines Management Services Programme (2002). Room for Review. A guide to medication review: the agenda for patients, practitioners and managers.