Humber Teaching
NHS Foundation Trust

# MEDICINES RECONCILIATION GUIDELINE

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| **Author/Lead**<br>**Job Title** | Leanne Bloor<br>Chief Technician |
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**VALIDITY – Documents should be accessed via the Trust intranet to ensure the current version is used.**

**CHANGE RECORD**

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| *1.00* | *05.11.12* | *New guidance* |
| *1.01* | *29.11.12* | *Changes to the Medication Reconciliation Tool* |
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| *1.08* | *08.04.20* | *Included the addition of ePMA and removed reference to Medicines Reconciliation Tool*<br>*Guideline became version 2.0* |
| *2.1* | *01.05.22* | *Update wording in section 6*<br>*Addition of section 7.3*<br>*Addition of appendix 2*<br>*Updated intranet links throughout document* |
| *2.2* | *04.05.24* | *Reviewed. Updated contact details. Approved at Drug and Therapeutics Group (30 May 2024).* |
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## 1. INTRODUCTION

The aim of medicines reconciliation is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. Due attention should be given to the process and potential sources of error.

Details to be recorded include the name of the medicine(s), dosage, frequency, formulation, form, and route of administration.

Establishing these details may involve discussion with the patient and/or carers and the use of records from primary care.

The definition in NICE Guidance (NG5) is as follows:

Medicines reconciliation is 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.

**This does not include medicines review.**

All healthcare organisations that admit adult inpatients should put policies in place for medicines reconciliation on admission. This includes all units and wards and applies to elective and emergency admissions.

In addition to specifying standardised systems for collecting and documenting information about current medications, policies for medicines reconciliation on admission should ensure that:

- Pharmacists are involved in medicines reconciliation as soon as possible after admission.
- The pharmacist's role in medicines reconciliation is often in an advisory capacity, supervising pharmacy technicians or other trained staff.
- The responsibilities of pharmacists and other staff in the medicines reconciliation process are clearly defined; these responsibilities may differ between clinical areas.
- Strategies are incorporated to obtain information about medications for people with communication difficulties.

## 2. SCOPE

This guidance applies to all patients who are admitted to inpatient care within Humber Teaching NHS Foundation Trust (HTFT) and relates to all medicines.

This guidance should be followed by all Doctors, Non-Medical Prescribers (NMPs), Mental Health Practitioners (MHPs), Nurses, Pharmacists and Medicines Optimisation Technicians (MOTs) providing care to HTFT inpatients.

This guidance should be read in conjunction with the HTFT Safe and Secure Handling of Medicine Procedures (SSHMP).

## 3. STATEMENT

All patients admitted to Humber Teaching NHS Foundation Trust (HTFT) inpatient units will have their medication reconciled using the appropriate documentation within 24 hours of admission, using a minimum of two sources of information. In exceptional circumstances where it has not been possible to use a minimum of two sources of information, a detailed record of the reasons why must be made in the patient's notes.

## 4. EQUALITY AND DIVERSITY

This guidance aims to promote the needs of patients who are not able to communicate or voice their opinions for themselves due to impairment or language barriers. Patients may need extra support if they experience sensory or cognitive impairment, have a lack of access to family or carer support or experience language barriers.

## 5. MENTAL CAPACITY

Practitioners should consider that individuals with limited capacity may need support from an independent mental health advocate. When interviewing individuals about their medication history practitioners should presume capacity unless an assessment of capacity has deemed otherwise.

## 6. STANDARDS

**The medicines reconciliation process should be completed within 24hours of the patient being admitted to the ward/unit.**

### 6.1. Admissions from primary care

- Accurately list all of the patient's medicines (including prescribed, over the counter / internet / non-prescribed / illicit and complementary medicines) and carry out medicines reconciliation within 24 hours of the patient being admitted.
- On admission, all patients' prescribed medication will be checked with the patients Summary Care Record (if available)
- Evidence can be gained from a recent, up to date hard copy of the GP record and/or by telephoning the GP as soon as possible after admission to check for recent changes.
- Up to date GP records may also be obtained via System One.
- Any patient who has a non- HTFT Medicines Administration Record (MAR) Chart (e.g. patients supported in Care Homes) will have this checked against their prescribed medication.

### 6.2. Admissions from other healthcare providers (e.g. acute hospital, prison service, Care/Nursing home )

- All patients' medications will be checked with the discharge summary/ immediate discharge letter (IDL)/non-HTFT MAR provided.
- All patients admitted will have details of any Patients Own Drugs (PODs) recorded using the appropriate documentation.

### 6.3. Patients transferred from other HTFT units/wards

- If the medicines reconciliation process has been completed prior to transfer the process is deemed to be satisfactory.
- If the medicines reconciliation process has been partially completed, the information collected so far can be considered satisfactory and the process can proceed to completion.

### 6.4. All patients

- Any patient who brings in PODs will have these assessed and recorded on the using the appropriate documentation method within 24 hours of admission
- Within 24 hours of admission, all patients will be interviewed about their medication to ascertain if changes have been made to the regime held on record with the GP.
- Where the patient is not able to be interviewed the reasons should be documented and information should be sought from the patient's usual carer(s) or advocate when possible.
- If it is not possible to interview the patient within 24 hours of admission there may be benefits to interviewing the patient at a later time.
- The purpose of interviewing the patient is to highlight discrepancies between the healthcare record and the medication that the patient reports they are taking. Therefore, patients with limited capacity or considered to be unreliable historians should not necessarily be excluded but their information not relied on as a sole source for medicines reconciliation.
- Reasons that might be valid for not being interviewing might include where the patient:
  - Declines
  - Is agitated
  - Is cognitively impaired
  - Has limited capacity (e.g. not been responsible for own medication)
- Any other information about medication taken prior to admission and its source will be recorded on the appropriate documentation.

## 7. MEDICINES RECONCILIATION and RECORDING PODs

### 7.1. For in-patient units using Lorenzo ePMA

- Once the information has been gathered, if the medication(s) have not already been clerked, they should be clerked on to Lorenzo. The help guide for this is available here: ePMA - Inpatient Prescribing Medication clerking.pdf (humber.nhs.uk)
- If the medication(s) have already been clerked the sources and information recorded should be checked for accuracy.
- If additional information sources need to be added to the already clerked medication, please use this help guide: Adding New Sources of Information for Medication Already Clerked.pdf (humber.nhs.uk)
- If the patients has PODs which have been assessed and suitable to use on the ward, these should be entered on to Lorenzo using the help guide available here: Adding POD information to Clerked Medication.pdf (humber.nhs.uk)
- When a patient has been transferred internally, a second medicine reconciliation is not required for units/wards where ePMA modules are being used
- If there are any discrepancies or conflicts during the medicine reconciliation process that you cannot resolve, a clinical note should be distributed to the relevant staff members. A help guide for this is available here: Distribute a clinical note.pdf (humber.nhs.uk)

### 7.2. For community hospitals using SystmOne

- Use Appendix 1 to record PODs and other relevant information.
  Please note: only pharmacists should mark the PODs form as a final version.
- The technician or health care professional doing the initial medicine reconciliation should record that a medicine reconciliation or review level 1 has been completed on the medication chart or POD form as appropriate
- Any discrepancies found should be sent as a medication query via the task icon.
- A pharmacist will then review the information, record that a Medicine reconciliation or review level 2 has been completed on the medication chart or POD form as appropriate and finalise the POD form.

### 7.3. Granville Court

- Use appendix 2 to record details of medicines reconciliation and PODs
- Information and details recorded to be 2nd checked by a nurse.
- Any discrepancies are to be resolved prior to administering medication

## 8. ROLES AND RESPONSIBILITIES

### 8.1. Doctors, Nurses and Non-Medical Prescribers

Doctors, nurses and Non-Medical Prescribers will gather information about medicines reconciliation as soon as possible after admission. They will record any information received or obtained about medicines reconciliation on the appropriate documentation.

On an in-patient ward, the Prescriber (Medical or Non-Medical) will ensure that Medicines Reconciliation is completed within 24 hours of admission.

The practitioner will seek advice for discrepancies that are difficult to resolve.

### 8.2. Nurses

The nurse (or delegate i.e. ward clerk) will gather information about the medications the patient is taking. Sources to be used are:

- GP Record
- Summary Care Record (Information should always be verified with the GP at the earliest opportunity if appropriate)
- Immediate Discharge Letter (IDL)
- Non HTFT Medicines Administration Record Chart
- Patients Own Supply of Medication
- Patient or Carer Information
- Other Sources (may include)
  - CPN/ Intensive Home Care Teams/District Nurses/Long term Conditions or Specialist Nursing
  - Triage Documentation (Mental Health Act Assessment, A & E contact)
  - Letters/ correspondence in Notes
- The information obtained will be scanned into the patient's electronic record so that it is available to be viewed by the prescriber.
- The nurse (or delegate) will document the source(s) of information and date obtained on the appropriate documentation.

### 8.3. Prescriber

- The Prescriber must record the information gathered about the medications the patient is taking on the appropriate documentation, indicating the source(s) of the information.
- The information gathered should be used to compile a complete and accurate list of medicines and any discrepancies between the sources of information resolved before prescribing inpatient medication.
- Any discrepancies that cannot be resolved should be documented and advice sought before prescribing.
- Corroboration of information using multiple sources will improve the accuracy of the medicines reconciliation process.
- The medication recorded should include:-
  - Prescribed Medication
  - Over The Counter Medication
  - Herbal Remedies
  - Vitamins
  - Medication bought over the internet or bought from some other source
- The patient's allergy status should also be recorded:
  - Where Lorenzo is in use the allergy status should be updated using this guide. The allergy status should not be left as "none recorded".
  - Where SystmOne is in use the allergy status should be updated under allergies and sensitivities. If you are unsure how to do this you should use the F1 help key within SystmOne.

- Care should be taken when dealing with unfamiliar medicines and the current BNF consulted to clarify doses, potential interactions, and strengths of medications.
- Advice should be sought if needed by contacting Humber Teaching Foundation NHS Trust Pharmacy number is 01482 301732

### 8.4. Pharmacist

The Pharmacist will check the standard of the medicines reconciliation as soon as possible after admission and will indicate their involvement by

- Clinically verifying clerked items on Lorenzo
- Recording Level 2 Medicines Reconciliation on SystmOne on the electronic medicines chart or POD form as appropriate

The Pharmacist will highlight any discrepancies between the medications prescribed prior to and on admission to the prescriber using the task function in SystmOne or distributing a Medic Communication Note in Lorenzo

### 8.5. Pharmacy Technician

The Pharmacy Technician will assist the pharmacist in collating and verifying information on the appropriate documentation

If not already completed by unit staff, the Pharmacy Technician will access the patients Summary Care Record (SCR) if available. The Pharmacy Technician may contact the GP to request email or verbal verification of the medication prescribed prior to admission and details of any recorded adverse reactions if necessary.

## 9. POTENTIAL SOURCES OF INFORMATION

When admitting patients, various sources of information are available. The following details aim to draw attention to some of the benefits and potential drawbacks of these sources and outline how to record information on the appropriate

**GP Record**

- High reliability
- Reliability reduced if the patient may have had recent involvement from Intensive Home Treatment or Crisis Services
- Do not rely on if patient has had recent Acute Trust or consultant outpatient contact that has not yet been communicated to the GP
- Red and amber (specialist) medicines may not necessarily be on GP record
- Repeat medication list should be checked for indications on whether regular ordering has been recorded by looking at the last ordered date and usage (100%)
- Be aware that last acute medication may or may not also be on the list- check date of issue
- Often not available out of hours

**Non-HTFT Medicines Administration Record Chart**

- High reliability but the administration record should also be checked for '0' or other codes which may indicate that the medication has not been administered
- Can be brought in from home (when carers have been involved in administering medicines) or on admission from Acute Trust
- Accuracy should be verified with the GP in working hours at the earliest opportunity if admission from home

**Patients Own Supply of Medication**

- Moderate reliability
- Higher reliability if admitted with TTO from Acute care
- Check name of patient and take care if name appears in abbreviated form (e.g. Mr Brown or Mr J Brown)

- Check dispensing date and that the amount of medication remaining suggests that the medication is currently being taken
- Only accurate for medication which the patient has remembered to bring in e.g. depot medication and liquids- may not be stored with patient or medication may be left at home
- Accuracy should be verified with the GP in working hours at the earliest opportunity if admitted from home

**Patient or Carer Information**

- Reliability variable and should always be verified with the GP in working hours at the earliest opportunity if admitted from home
- Patient may not give reliable accounts if admission from Acute care due to not being familiar with changes made during acute admission
- Where possible use patients own supply to improve validity of information

**Other sources (record where information obtained from in appropriate column)**

**CPN/Intensive Home Care Teams/District Nurses/Long term Conditions or Specialist Nursing**

- Variable reliability as may not be complete for all medications but include details of specific medications
- May not have up to date history of all medications
- Often can advise date of last depot and date of next depot, date of B12 injections and changes to medication regimens not on GP records (e.g. insulin doses)

**Triage Documentation (Mental Health Act Assessment, A & E contact)**

- Variable reliability as may not be complete for all medications
- May not have details of all medication prescribed
- May have details of recent changes

**Immediate Discharge Letter (IDL)**

- High reliability
- Care needed to ascertain correctly dated IDL is used and that information on whether medication is to be continued or not is checked.

**Letters and other sources in Notes**

- Variable reliability as may not be complete for all medications
- Care needed to ensure dates of information are considered

**General Considerations**

- Corroboration of information using multiple sources will improve the accuracy of the medication reconciliation
- Information should always be verified with the GP in working hours at the earliest opportunity if appropriate
- Any discrepancies between the sources of information should be actioned to resolve and establish correct medication at point of admission
- Take care when dealing with medicines that you are unfamiliar with
- Check the current BNF for doses, potential interactions and strengths of medications
- Seek advice from Trust Pharmacy (01482 301732) if necessary

## 10. POTENTIAL SOURCES OF ERROR

- No access to the patient's prescription record from primary care.
- Discrepancies between the primary care prescription record and the medications the patient is taking.
    - Patient is no longer taking prescribed medications
    - They are taking medications they have obtained themselves (for example, over-the-counter medicines, herbal medicines or vitamins)
    - Doses have been adjusted by the GP, patient or by secondary care and the primary care record has not yet been updated
    - Patient is not taking medication as prescribed
- Difficulties in obtaining an accurate account of a patient's medication record.
    - May be caused by an acute condition
    - May be due to sensory or cognitive impairment
    - Lack of access to family or carer support
    - Language barriers.
- Errors in transcribing medication details to the hospital clinical record.
- Misinterpretation of information provided.

## 11. IMPLEMENTATION

This guidance will be implemented via a series of training sessions to all inpatient units, doctors and non-medical prescribers during a session delivered by Pharmacy. Information will be sent to all prescribers and units. Unit managers will highlight any issues with implementation to the Clinical Care Directors. Medicines Reconciliation will be completed as part of the admission process on all inpatient units within HTFT.

## 12. MONITORING AND AUDIT

Medicines Reconciliation will be monitored by Pharmacy and the Drug and Therapeutics Committee.

## 13. REFERENCES

NICE Medicines Optimisation Guideline NG5. March 2015.
Lorenzo help guides available on the intranet: Lorenzo Help Guides (humber.nhs.uk)
For SystmOne guidance please use the F1 key when in SystmOne.

## 14. DEFINITIONS, ABBREVIATIONS AND FURTHER DETAILS

**Amber drugs**- medicines that require specialist monitoring and supply and only supplied to patients from secondary care during the initiation phase. Until prescribing is accepted by the GP they may not be recorded on the GP record and picked up only from the Patients Own Drugs Supply, patient Interview or from information provided by secondary care.

**Medicines Administration Record Chart (MAR Chart)** - a record chart (not a legal prescription) the purpose of which forms a record of the prescribed medication and the doses taken or administered. These may be from a care home, used because the individual has formal or informal carers or is used by the individual themselves as an aid memoir or issued on discharge from the Acute Trust.

**Patients Own Drugs (PODs)** - patients own supply of medication that they bring into hospital. These may include items prescribed by the GP, secondary care specialist items, items purchased over the counter, vitamins or minerals, food supplements or herbal medicines. Care should be taken to ensure that items are not duplicated by the generic and trade name. The name of the patient should be checked carefully, especially if the full name of the patient does not appear. Patients may also not bring all their medication in and special care should be taken with monitored dosage systems (MDS) as not all medication is suitable to be put in them.

**Red Drugs** - medicines that require specialist monitoring and supply and only supplied to patients from secondary care. These may not be recorded on the GP record and picked up only from the Patients Own Drugs Supply, patient Interview or from information provided by secondary care.

**Repeat Medication Record** - A list of medication that the general practitioner allows a patient to reorder without face-to-face consultation with the general practitioner. It is usually in the form of a tear off slip attached to the GP prescription form. Depending on the system used by the general practitioner this may contain information on when an item was last issued (given as a date) and the usage (percentage- a high percentage indicates the patient is obtaining regular prescriptions at the frequency expected for the dose prescribed). Some repeat slips also include information on acute medications and allergies and this is usually clearly stated. However general practitioners sometimes leave medication on repeat while patients are switching over from one medication to another, in case a new medication doesn't suit and the patient has to revert back to the previous medication. Also information about newly prescribed medication from hospital appointments or discharge may take some time to be put on the repeat system.

## Appendix 1 – SystmOne Patient's Own Drugs (POD) Recording form

**Patient's Own Drugs (POD) Recording Form**

1 Patient Own Drugs and assessment for use

Rows

Add Row
Edit Row
Remove Row

| Medicine Name and Form | Dose and Directions | Date dispensed | Quantity | Expiry Date | Suitable for Use |
|---|---|---|---|---|---|

2 **Patient consented to use or disposal of own drugs**

- Yes
- No

3 **POD notes**

4 **Pharmacy technician discrepancies note**

5 **Pharmacist discrepancies note**

Next Section

## Appendix 2 – Medicines Reconciliation Tool Granville Court

Patient Name:
NHS Number:
(Addressograph)

Humber Teaching
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**Medicines Reconciliation Tool and POD Recording Form**

| Code | NURSE OR DELEGATE to complete this table on admission — Source of information | Date | Time | Obtained by (initial) | 2nd Checker (initial) |
|---|---|---|---|---|---|
| 1 | Patient /carer Information | | | | |
| 2 | Summary Care Record (SCR) | | | | |
| 3 | GP email or telephone call | | | | |
| 4 | Electronic Patient Record | | | | |
| 5 | Repeat prescription print out | | | | |
| 6 | Discharge letter | | | | |
| 7 | Non- HTFT Medicines Administration | | | | |
| 8 | Patient Own Drugs (POD) or MCA | | | | |
| 9 | Other (specify) | | | | |

| Patient Allergy Status (Medicines, intolerances and other sensitivities AND the nature of sensitivity where known) | Source (codes) |
|---|---|
| | |

| Consent to SCR Access (tick and sign) | | | |
|---|---|---|---|
| Recorded in Notes | | Best Interest | |
| Name | | Signature | Date |

| Multi-compartment Compliance Aid (MCA) | Usual supplier (name & telephone no) |
|---|---|
| | |

| Practitioner to complete this table on admission — Medicine Name and Form | Dose and Directions | Added to MAR (circle) | | Source (codes) | 2nd check Codes | Patient Own Drugs and assessment for use — Date Disp. | Qty. | Exp. Date | For use (circle) | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |
| | | Y | N | | | | | | Y | N |

**Notes** (If there are discrepancies that cannot be resolved, record details here and contact a prescriber for advice)

**Notes**

**Details of Practitioner completing Medicines Reconciliation**

Name | Signature

**Date:** | **Time:**

**Nurse Assessor Details**

Name & Signature

Date: | Time:

**Comments**

**Medicines Reconciliation checked by (2nd checker)**

| Name | Signature | Date | Time |
|---|---|---|---|
| | | | |

**2nd Check Codes**

- C = details confirmed
- A = amendment made (see Comments)
- O = Other (specify)

Version 1.07. Jul22 (V:\Corporate\Pharmacy\Pharmacy Team\Shared\Policy Procedure Protocol & Guideline\Guidelines\Medicines Reconciliation)