



Medicines Reconciliation In Hospital

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1. Introduction

Medicines are the most common intervention in the NHS and their safe use requires collective and collaborative effort between the multidisciplinary team and patients. Medicines reconciliation is a key step to ensuring that patients are prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation and that avoidable harm from medicines is reduced. Accurate, timely medicines reconciliation on admission to, and discharge from, hospital is an integral part of clinical care and takes time to complete.

The Scottish Government Chief Medical Officer letter (SGHD/CMO(2013)18)¹ sets out the national definition, goals, measures and best practice for medicines reconciliation as part of the Scottish Patient Safety Programme. NHSGG&C is required to implement this guidance and demonstrate compliance through monitoring.

2. Aims of Policy

The policy aims to describe:

- how medicines reconciliation is undertaken and documented within NHSGG&C
- the roles and responsibilities of staff associated with the process
- monitoring and reporting arrangements regarding policy compliance

3. Scope

This policy applies to all clinical areas within the hospital environment which admit and discharge in- patients and to all NHSGG&C employees working within these areas.

4. Responsibilities

Management and the multidisciplinary clinical team have a collective responsibility to ensure medicines reconciliation is reliably completed for each patient. It is important that the responsibilities of individual members of staff are clearly defined and understood by everyone in the clinical team. Patients and their relatives/carers are central to obtaining an accurate medication history and it is the responsibility of appropriate members of the clinical team to engage them in this process.

The responsibilities of the various disciplines are outlined below. The term 'Prescribers' applies to medical and non-medical prescribers where they have a defined role in the medicines reconciliation process.

Directors, Senior Managers and Clinical Directors:

- Overall responsibility for ensuring there are safe, reliable processes for medicines reconciliation in place for patients within their service area

Consultants:

- provide clinical leadership in support of safe, reliable implementation of medicines reconciliation processes for the patients under their care
- supervise junior doctors, taking appropriate action when they do not comply with medicines reconciliation procedures

Prescribers with responsibility for patients within a specific clinical area:

- complete the medicines reconciliation process and produce a complete and accurate medicine prescription chart for their patients within 24hrs of admission to hospital
- maintain a complete and accurate medicine prescription chart during the patient's stay, including documenting reasons for changes and comply with medicines reconciliation processes when patients are transferred to and from their care
- complete the medicines reconciliation process at discharge, producing a complete and accurate Immediate Discharge Letter (IDL) which includes details of all medicine changes made during the patient's stay

Pharmacists:

- verify the medicines reconciliation process has been completed by the prescriber and medicines accurately transcribed into the medicine prescription chart. This should be done as soon as possible during the patient admission.
- where possible, IDLs will be reviewed by a pharmacist with knowledge of the patient and access to their prescription chart and medical notes. This enables verification that medicines have been correctly reconciled and information in the IDL, including reasons for changes, is complete and accurate'
- flag discrepancies (errors or omissions) identified in the medicine prescription chart or IDL to the prescriber and agree appropriate corrective action

Nurses:

- highlight to the prescriber any patients under their care who have not had medicines reconciliation completed within 24hrs of admission
- flag discrepancies (errors or omissions) in the medicine prescription chart, identified during the medicine round, to the prescriber and agree appropriate corrective action
- flag discrepancies (errors or omissions) in the IDL, identified at the final check and authorisation, to the prescriber and agree appropriate corrective action.

5. Medicines Reconciliation Procedures

Medicines reconciliation primarily takes place on admission to hospital and at discharge home, but there is also a requirement to reliably communicate complete and accurate medicines information when patients are transferred between wards and hospitals. Medicines reconciliation involves a three step process of:

1. **Collect** the information about a patient's medication
2. **Confirm** that the information is accurate by comparing it with at least one other reliable source
3. **Communicate** (via documentation) this accurate list to all other health professionals involved in the patient's care

It is acknowledged that some flexibility is required to enable clinical areas to develop a medicines reconciliation process which can be reliably integrated within local systems and workflows. In doing so, the following principles must be adhered to:

Admission to Hospital

- The medicines reconciliation process and an accurate medicine prescription chart are completed within 24hrs of admission
- A minimum of 2 information sources are used to obtain a list of medicines being taken by the patient and details of any medication allergies/sensitivities. The process should start with the Emergency Care Summary, which should be verified with the patient or carer where possible. Other useful sources are listed in Appendix 1
- The clinical appropriateness of each medicine, within the context of the admission, is considered before deciding which medicines are to be continued, withheld or stopped
- The medicines reconciliation process should be documented using the NHSGGC Medicines Reconciliation eForm (eMR). This is linked to the patient's Emergency Care Summary (ECS) and is part of the Electronic Patient Record (EPR). The following fields are mandatory:
 - Hospital ward and specialty
 - Consultant's name
 - Patient's consent
 - Sources of medicines information
 - Medicine name, dose, frequency, formulation/route
 - Decision on whether each medicine is to be continued, amended, stopped or withheld and a brief reason for every change or medicine withheld
 - Prescriber's name
- All medicines to be continued and details of medication allergy/sensitivities must be accurately transcribed to the medicine prescription chart. For each medicine, complete the box in the medicine prescription chart to indicate if it was being taken before admission or is new/changed.

- The name of the pharmacist verifying the medicines reconciliation process should be recorded in the NHSGGC medicine reconciliation eForm. Any discrepancies (errors or omissions) should be promptly flagged to the prescriber and corrective action agreed.

During Stay/Transfer

- A complete, accurate and legible medicine prescription chart should be maintained during the patient's admission. If a medicine is started then the indication should be recorded in the patient's record. If a medicine is withheld or stopped, the reason should be clearly written on the prescription chart
- When a patient requires to be transferred to another ward or hospital the prescriber should review the ongoing appropriateness of the medicine, within the context of the transfer, and update the medicine prescription chart accordingly
- Transferred patients should be accompanied by their medicine prescription chart. Where this cannot happen, a copy of the chart should be supplied.

Discharge from hospital

- The medicines reconciliation process and an accurate IDL are completed prior to the patient being discharged from hospital
- The medicine prescription chart is reconciled with the medicines reconciliation eForm, completed on admission, to identify medication changes during the admission. Further information can be found in the patient's record
- The clinical appropriateness of each medicine post discharge is considered before deciding which medicines are to be continued or stopped. This should include reconsideration of any medicines withheld during the hospital admission.
- The following medicines information is mandatory in the IDL

Continuing Medicines

- Medicine name, dose, frequency, form/route
- The duration/stop date if a medication is only to be continued for a fixed period of time e.g. course of antibiotics

New Medicines

- Medicine name, dose, frequency, form/route
- The duration/stop date if a medication is only to be continued for a fixed period of time e.g. course of antibiotics
- Indication/Reason for starting each new medicine

Stopped Medicines

- Medicine name, dose, frequency, form/route
- Reason for stopping each medicine

Allergies

- Known medicine allergies/sensitivities/adverse drug reactions
- Where possible, IDLs will be reviewed by a pharmacist with knowledge of the patient and access to their prescription chart and medical notes. Any discrepancies (errors or omissions) should be promptly resolved with the prescriber.
- A final check of the medicines supplied to the patient is made against the IDL and prescription chart by the nurse prior to the patient going home and the IDL being authorised and sent to the GP practice. Identified discrepancies (errors or omissions) should be promptly resolved with the prescriber.
- The pharmacist/pharmacy technician will obtain patient consent and share the IDL with their nominated community pharmacy. The role of the community pharmacist is to follow up any care issues identified, support the patient and carer with additional information which will assist them in taking the medication and to prevent any inadvertent re-prescribing of medication which was discontinued for good clinical reason during the hospital admission.

6. Education & Training

Clinical Directors and professional leads should ensure staff with responsibilities for medicines reconciliation are familiar with this policy and competent to undertake the process. Medicines reconciliation training and policy awareness should be incorporated into induction training for all new staff and locums with responsibilities for medicines reconciliation.

Clinical pharmacists will advise and support locally organised training sessions delivered in partnership with medical and/or nursing leads. In addition there are two online resources:

- NHS Education Scotland: Medicines Reconciliation module (available via LearnPro)
- NHSGGC: Online induction for junior doctors. <http://glasgow-nhs.clinical-induction.co.uk>

7. Monitoring & Reporting

A measurement plan is in place as part of the Scottish Patient Safety Programme work to improve the quality and reliability of medicines reconciliation processes within NHSGG&C. This defines the goals, measures, data collection and reporting arrangements which will support the monitoring of this policy. Regular progress reports are given to the Acute Division Clinical Governance Forum as part of reporting arrangements for the Scottish Patient Safety Programme.

The reporting and investigation of medication incidents as per NHSGG&C Significant Clinical Incident policy provides an opportunity to learn about the effectiveness of established medicines reconciliation processes and potential areas of improvement.

8. Policy Review

This policy will be reviewed every three years, unless the introduction of any new or amended legislation warrants an earlier review

References

1. Safer Use of Medicines, Medicines Reconciliation: Revised Definition, Goals and Measures and Recommended Practice Statements for the Scottish Patient Safety Programme. Scottish Government Health Department/ CMO(2013)18

Appendix 1

Information sources for medicines reconciliation

Patient/Carer

Emergency Care Summary

Patient's own medicines

GP letter

GP Practice print-out

GP repeat prescription order slip

Medicines Administration Record Sheet

GP phone call

Community pharmacist

Nursing home phone call

Case notes/previous discharge letter/prescription

Clinic letters

District nurse

Anticoagulant clinic

Mental Health Summary in clinical portal