# Medicines Reconciliation Guideline

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<tr>
<th>Document Reference</th>
<th>Medicines Reconciliation Guideline G358</th>
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</table>
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**Validity** – Documents should be accessed via the Trust intranet to ensure the current version is used.

<table>
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<th>Date</th>
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INTRODUCTION

The aim of medicines reconciliation on hospital admission is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission. Details to be recorded include the name of the medicine(s), dosage, frequency, and route of administration. Establishing these details may involve discussion with the patient and/or carers and the use of records from primary care.

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 mental health units, 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.

NICE/NPSA/2007/PSG001

SCOPE

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

STATEMENT

All adult patients admitted to Humber NHS Foundation Trust (HFT) inpatient units will have their medication reconciled using the Trust Medicines Reconciliation Tool within one working day, 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.

STANDARDS

4.1. Inpatient admissions from primary care

- All patients’ medication will be checked with the GP record using a recent up to date hard copy of the GP repeat medication record on admission 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 SystemOne.
- Any patient who has a non-HFT Medicines Administration Record (MAR) Chart (e.g. patients supported in Care Homes) will have this checked against their prescribed medication.

4.2. Inpatient admissions from other healthcare providers (e.g. acute hospital, prison service)

- All patients’ medications will be checked with the discharge summary/immediate discharge letter (IDL)/non-HFT MAR provided.

4.3. Patients transferred from other HFT units

- If the medicines reconciliation process has been completed 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.
• All patients’ current medications will be checked with the copy of the HFT MAR from the previous unit.

4.4. All patients
• Any patient who brings in Patients Own Drugs (POD) will have these recorded on the Trust Medicines Reconciliation Tool within 12 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 within 12 hours of admission.
• 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 12 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 Trust Medicines Reconciliation Tool.
  • Within all Mental Health and Learning Disability services the Trust Medicines Reconciliation Tool is part of the Inpatient Initial Assessment document.
  • Within all Community Services the Trust Medicines Reconciliation Tool is part of the Inpatient Core Assessment Pack.
• The completed Medicines Reconciliation Tool should remain in the medical notes and will be checked by Pharmacy Staff at their next routine visit.
• Any query should be noted on the form, the full details recorded in the notes and Pharmacy notified immediately.

5. RESPONSIBILITIES

5.1. Nursing, Medical and other Clinical Staff
Nursing, Medical and other Clinical staff will gather information about medicines reconciliation as soon as possible after admission. Nursing, Medical and other Clinical staff will record any information received or obtained about medicines reconciliation on the ‘Medicines Reconciliation Tool’. Medical staff will be responsible for resolving and actioning any discrepancies in medicines reconciliation and liaising with Pharmacy where discrepancies are difficult to resolve.

5.2. Pharmacist
The Pharmacist will be involved in medicines reconciliation as soon as possible after admission and will indicate their involvement by signing the ‘Pharmacy Use’ box of the ‘Medicines Reconciliation Tool’. The Pharmacist will highlight any discrepancies between the medications prescribed prior to and on admission to the medical team not yet identified by the nursing and medical team.

5.3. Pharmacy Technician
The Pharmacy Technician will assist the Pharmacist by collating and verifying information on the ‘Medicines Reconciliation Tool’. The Pharmacy Technician will contact the GP and request a fax and/or verbally verification of the medication prescribed prior to admission and details of any
recorded adverse reactions if necessary. The Pharmacy Technician will highlight all sources of information from the notes used to complete the form for the Pharmacist to review.

6. **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.

7. **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, support individuals to make their own decisions and respect their right to make seemingly eccentric or unwise decisions unless an assessment of capacity has deemed otherwise.

8. **IMPLEMENTATION**

This Guidance will be implemented will be via a series of training sessions to all inpatient units, psychiatrists, junior doctors and non-medical prescribers during a session delivered by Pharmacy. Information will be sent to all prescribers and units. The Medical Director and Non-Medical Prescribing Lead will be asked to highlight the issues to the relevant group of prescribers. Medicines Reconciliation will be implemented as part of the admission process on all inpatient units within HFT.

9. **MONITORING AND AUDIT**

The use of the Medicines Reconciliation Tool will be monitored by Pharmacy and the Drug and Therapeutics Committee. A suitable audit will be designed and carried out. The NICE ‘Audit tool for medicines reconciliation on admission of adults to hospital’ might be a suitable basis for such an audit.

10. **REFERENCES**

NICE/NPSA *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital 2007.*
11. GUIDANCE

The aim of medicines reconciliation on admission to hospital 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.

11.1. Medicines Reconciliation Process

- 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 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.

11.2. Medicines Reconciliation Potential Sources of Errors

- 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.
11.3. **Sources of Information for Medicines Reconciliation Tool**

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 Trust Medicines Reconciliation Tool.

Record the medication form and dose in the left hand columns and then tick in each column that information has been sourced from. Record any discrepancies and how these have been actioned on the form (See completed example P11)

**GP Record**
- High reliability
- Reliability reduced if the patient may have had recent involvement from Intensive Home Treatment or Crisis Services
- Do not rely if patient has had recent Acute Trust or consultant out patient 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 HFT 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 301724) if necessary
**Patient Name:**

**NHS Number:**

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**Medication Reconciliation Tool**

(Multi-professional use – unit staff and medical team to complete to standards for checking by pharmacy staff)

<table>
<thead>
<tr>
<th>Patient Allergy Status (medicines, intolerances and other sensitivities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP repeat medication record used? (please circle and attach to back of form)</td>
</tr>
<tr>
<td>Information obtained from System One?</td>
</tr>
<tr>
<td>GP Name:</td>
</tr>
</tbody>
</table>

If information on medication prescribed by GP not available, indicate reason (please tick below)

- GP unknown
- GP cannot be contacted
- Surgery unwilling to disclose information

<table>
<thead>
<tr>
<th>Medication name, strength, form Dose and directions</th>
<th>GP Record</th>
<th>Non HFT MAR or Discharge Letter</th>
<th>Patient/Carer</th>
<th>Other source</th>
<th>Patients own drugs and assessment for use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date Disp</td>
<td>Qty</td>
<td>Exp Date</td>
<td>For use-check condition and instructions (Y/N)</td>
<td></td>
</tr>
</tbody>
</table>

Name of person obtaining information

Designation / Band

Signature

Date:

Time:

Enter the name of the medication, strength, form, dose and directions. Place a tick or cross in the appropriate categories and add dates and quantities when necessary. After completing the record, if there are discrepancies that cannot be resolved, record details below and contact Pharmacy for advice.

<table>
<thead>
<tr>
<th>Pharmacy Use: Name</th>
<th>Signature</th>
<th>Date</th>
<th>Job Title</th>
</tr>
</thead>
</table>

**Query raised Y or N (record details below)**

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Humber NHS Foundation Trust
Medicines Reconciliation Guideline
Version 1.01, November 2012
Patient Name: [NHS Number:]

Medication Reconciliation Tool
(Multi-professional use – unit staff and medical team to complete to standards for checking by pharmacy staff)

<table>
<thead>
<tr>
<th>Patient Allergy Status (medicines, intolerances and other sensitivities)</th>
<th>None known</th>
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</thead>
<tbody>
<tr>
<td>GP repeat medication record used? (please circle and attach to back of form)</td>
<td>YES</td>
</tr>
<tr>
<td>Information obtained from System One?</td>
<td>YES</td>
</tr>
<tr>
<td>GP Name:</td>
<td></td>
</tr>
<tr>
<td>GP telephoned?</td>
<td>YES</td>
</tr>
<tr>
<td>Date</td>
<td>xx.xx.xx</td>
</tr>
<tr>
<td>Time</td>
<td>xx:xx</td>
</tr>
</tbody>
</table>

If information on medication prescribed by GP not available, indicate reason (please tick below)

- GP unknown
- GP cannot be contacted
- Surgery unwilling to disclose information

Enter the name of the medication, strength, form, dose and directions.
Place a tick or cross in the appropriate categories.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose and directions</th>
<th>GP Record</th>
<th>Non HFT Medication administration record</th>
<th>Chart</th>
<th>Patients own drugs</th>
<th>Date &amp; Quantity</th>
<th>Patient/ Carer</th>
<th>Other source Triage + date</th>
<th>Other source IDL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>75mg daily</td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>10mg od</td>
<td>√</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td>20mg od</td>
<td>X</td>
<td></td>
<td>√</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of person obtaining information: Any nurse or Doctor
Designation / Band: Nurse or Doctor
Signature: Any nurse or Doctor
Date: xx.xx.xx
Time: xx:xx

After completing the record, if there are discrepancies that cannot be resolved, record details below and contact Pharmacy for advice.

Pharmacy Use:

Name: ____________________________
Signature: ________________________
Job Title: _________________________

Query raised: Y or N (record details below)
Discrepancy between GP record and other sources for citalopram due to recent admission. Confirmed should be on citalopram 20mg daily.
12. 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.