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Royal Cornwall Hospitals NHS Trust

Medicines Reconciliation for Patients Admitted to Hospital Policy

V4.0

July 2019

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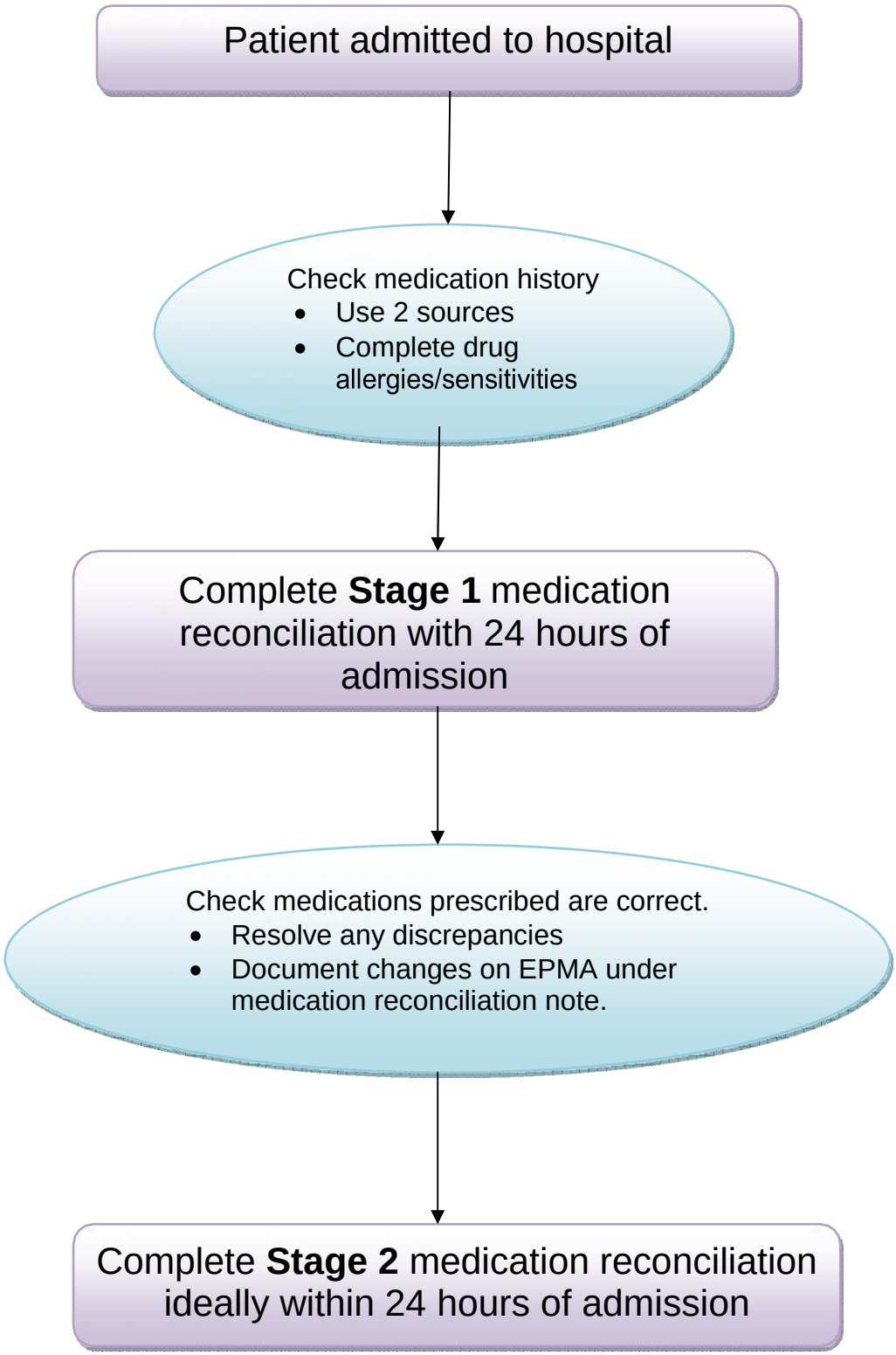
Summary


Patient admitted to hospital
Check medication history
• Use 2 sources
• Complete drug allergies/sensitivities
Complete **Stage 1** medication reconciliation with 24 hours of admission
Check medications prescribed are correct.
• Resolve any discrepancies
• Document changes on EPMA under medication reconciliation note.
Complete **Stage 2** medication reconciliation ideally within 24 hours of admission

1. Introduction

1.1 The National Institute for Health and Care Excellence (NICE) guidance 'Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes' (NG5, March 2015) provides recommendations for medicines reconciliation.

1.2. Medication errors pose a threat of harm to hospital inpatients and can lead to increased morbidity, mortality and economic burden to health services. Medication errors occur most frequently on transfer between care settings, particularly at the time of hospital admission.

1.3. This version supersedes any previous versions of this document.

1.4. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the 'information use framework policy', or contact the Information Governance Team rch-tr.infogov@nhs.net

2. Purpose of this Policy/Procedure

2.1. To reduce preventable medication errors on admission, on transfer between hospital units/wards or on discharge to primary care.

2.2. To ensure all the medicines a patient is currently taking are documented on admission and at each transfer of care including over-the-counter or complementary medicines.

2.3. To ensure any discrepancies identified in the process are resolved.

2.4. To ensure any changes that have been made on admission are documented, resulting in a complete list of medicines which can be accurately communicated on discharge.

2.5. To ensure that systems are in place to obtain information about medication for patients with communication difficulties.

2.6. To improve continuity of care when patients come into hospital and when

they are discharged or transferred. Any medicines whose effects may have contributed to their admission can be reviewed and any concordance issues can be addressed.

3. Scope

3.1. The following describes the process that should be followed in all adult and paediatric patients who are admitted to the Royal Cornwall Hospital NHS Trust, as soon as possible after admission.

3.2. This policy should be followed by all medical, nursing and pharmacy staff that have responsibility for ensuring that patients' regular medications are continued during hospital admission.

3.3. Pharmacy should be involved in medication reconciliation process as soon as possible following patient's admission to hospital.

4. Definitions / Glossary

4.1. Medicines reconciliation

Medicines reconciliation, as defined by the Institute for Healthcare Improvement, 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.

4.1.1. Basic reconciliation (Stage One)

Involves the collection and accurate identification of the medicines the patient was taking prior to admission i.e. medication history taking

4.1.2. Full reconciliation (Stage Two)

Builds on Stage One by comparing this information to the list of medicines prescribed on the drug chart, identifying any discrepancies, resolving them and recording the outcome.

4.2. Discrepancies

4.2.1. **Intentional discrepancies** involve any difference between the medicines the patient was taking prior to admission and the medicines prescribed on admission to hospital that have been changed intentionally by the doctors responsible for the patient's care.

4.2.2. **Unintentional discrepancies** involve any difference between the medicines the patient was taking prior to admission and the medicines prescribed on admission to hospital that were not intended e.g. errors, omissions, additions.

5. Ownership and Responsibilities

5.1. Medicines reconciliation is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer and discharge of patients requiring medicines.

5.2. Organisational responsibility for medicines reconciliation lies with the Chief Pharmacist

5.3. Role of the managers

Line managers are responsible for ensuring the policy is followed in their area

5.4. Role of the Medication Practice Committee

The Medication Practice Committee is responsible for:

- Monitoring the policy
- Reviewing the policy

5.5. Role of Doctors

- To ensure that a Stage One medicines reconciliation is initiated in the medical notes.
- Information from GURU or the Summary Care Record (SCR) should be used where available.
- To document the source of information
- To document whether any medicines were intentionally changed, initiated or stopped on admission and why.
- To resolve discrepancies identified by pharmacy staff and to document any decisions made.
- To refer any issues to the pharmacy team when necessary

5.6. Role of Nurses

- Where patients do not receive a medical clerking, to ensure that a Stage One medicines reconciliation is completed.
- Specialist nurses may be trained as Stage Two reconcilers and refer any queries to the supervising pharmacist.
- To collect and relay to prescribers or the pharmacy team information regarding medicines from patients and their carers
- To refer any issues to the pharmacy team when necessary

5.7. Role of Pharmacists

- To prioritise admissions areas and high risk patients and any patients referred to the pharmacy team
- To ensure Stage Two medicines reconciliation is completed for these patients.
- Resolve any issues identified by doctors, nurses or pharmacy technicians during Stage One medicines reconciliation.
- Document any discrepancies and actions taken as a ‘medicines reconciliation’ note on EPMA
- To ask for the patient’s agreement to send their medicines discharge information to their nominated community pharmacy and document this

5.8. Role of Pre-registration pharmacists

- Pre-registration pharmacists may undertake Stage One and Two medication reconciliation on completion of in-house training. Any queries should be referred to ward pharmacist.

5.9. Pharmacy Technicians

- Medicines optimisation technicians accredited with South West Medicines Management Module 4 to level 1 may undertake a Stage One medicines reconciliation and refer any queries onto the pharmacist.
- Medicines optimisation technicians accredited with South West Medicines Management Module 4 to level 2 may undertake a Stage Two medicines reconciliation and refer any queries onto the pharmacist.

6. Standards and Practice

6.1 All patients should receive a Stage One medicines reconciliation within 24hours of admission to hospital or sooner if clinically necessary.

6.2 Ideally all patients should receive Stage Two medicines reconciliation as early as possible within their patient stay.

Stage	Patients	Description	Staff involved	Timeframe	Referral
Stage One	All adult patients on admission	Allergy recording. Medicines taken prior to admission.	Admitting doctor or other healthcare professional who has received Stage One training (see 7.3)	Within 24hrs	Referral to Stage Two
Stage Two	Patients on high-risk medicines wards and patients referred from Stage One	Confirming accuracy of Stage One reconciliation. Identifying, resolving and documenting any discrepancies	Accredited members of the pharmacy team and other healthcare professionals who have received Stage Two training (see 7.3)	Ideally within 24hrs	

6.3 Medicines reconciliation should be carried out when a patient is transferred between wards within the hospital e.g. from critical care to another ward.

6.4 Process

6.4.1. Patients should be encouraged to bring their own medicines in to hospital and hand them to the admitting clinical staff, as these are a useful source of information

for medicines reconciliation.

6.4.2. Patients and their family members or carers, where appropriate, should be involved in the medicines reconciliation process.

6.4.3. The process of medicines reconciliation involves 4 steps: collection, checking, communicating, documentation.

STEP 1: Collecting the medication history from the most recent and reliable source.

- Information on medicines, dose, route and frequency and any allergies should be sought from the patient (or carer if necessary) and verified by another source. Medication for the treatment of addiction eg methadone must be verified by someone other than the patient.

- The date the information was obtained and the sources used should be documented in the medical notes or in the EPMA medicines reconciliation note. Documentation from recent hospital admissions must be reviewed to ensure that changes not yet actioned by the GP have not been overlooked.
- Sources of information include
- Information available from GURU or the Summary Care Record (SCR)
- A recent computer print-out from the GP's surgery or other confirmation of current medication prescribed by the GP
- Verbal information from the patient, carer or relative
- Referral letter
- Aria (for chemotherapy prescriptions)
- Vital data (for renal transplant patients and patients on haemodialysis)
- EPMA for any hospital out-patient prescriptions
- Current medication administration record (MAR) from nursing or residential home
- Latest supply of the patient's own medicines
- Information from the community pharmacist
- Information from Lloyds Out-patient dispensary
- Current inpatient chart from another hospital
- Patient held information cards e.g. lithium, anticoagulation, insulin passport

- A minimum of 2 sources must be used unless a medication reconciliation for the same admission has already been completed on a previous ward or the patient has been transferred from community hospital or nursing/residential home with current inpatient drug chart or medication administration chart.
- Patients must be asked about allergies or previous adverse effects from medicines and the clinical details of the reaction, any medicines that are supplied via hospital, homecare or other sources and any non-prescribed medicines they take.

STEP 2: Checking that the medicines prescribed on admission correspond to those that the patient was taking before admission.

Check to ensure the medicines, doses and formulations that are prescribed for the patient are correct. Any unintentional discrepancies which are identified must be resolved promptly by discussion with the doctor.

STEP 3: Communicating any changes in medicines

Any changes to medicines must be fully documented, with the reasons for the changes and any follow-up requirements. This must be recorded on the patients' medication reconciliation note on EPMA..

Any changes that have been made to the patient's prescription must be documented and dated.

This may include:

- When a medicine has been stopped and why
- When a medicine has been started and why
- The intended duration of treatment (eg antibiotics, hypnotics)
- When a dose, route or frequency has changed and why
- When a medicine is temporarily withheld and why

This information must be included in the discharge information to the GP either on the discharge summary text or entered as a 'Note to Appear on Discharge' on the EPMA system.

STEP 4: Communicating relevant pharmaceutical care information

Information regards the pharmaceutical care arrangements for the patient in the community should be documented in the medicines reconciliation note. This might refer to compliance aids or special collection arrangements that are in place for the patient, for example, the patient collects their medicines every 7 days due to opioid seeking behavior or suicide risk. If appropriate, this information should be recorded in the medical notes as well as the medicines reconciliation note to ensure the prescriber sees the information.

6.5 Patients with communication difficulties

6.5.1. It is recognised that obtaining a medication history from a patient can be difficult especially when patients have communication difficulties or are poor historians. Patients' immediate medical needs can also prevent the taking of a comprehensive medication history on admission. Special consideration should be given to patients who:

- are deaf or hard of hearing
- have learning disabilities or autism
- are drunk or under the influence of drugs
- have dementia or are confused/agitated
- are unconscious
- have limited understanding of the English language

6.5.2. If patients have difficulty communicating, practical measures must be used whenever this will enable communication e.g. seek advice from relatives, carer or specialist liaison team. If deemed in the patient's best interest, accessing their primary care record through GURU or SCR is permissible.

6.6 Discharge

Information gathered during the medicines reconciliation process and subsequent changes during the admission should be shared with the patient's

GP on discharge, using the 'Note to appear in discharge' function on EPMA or entering directly into the discharge summary text. EPMA information will also be shared with the patient's community pharmacist where agreement has been obtained to also provide this information to the patient's nominated community pharmacy.

7. Dissemination and Implementation

7.1 The document is available on the document library. Significant updates will be communicated via Trustwide email.

7.2 Implementation of the policy will be via Trustwide communication and supported by appropriate training for the relevant members of staff.

7.3 Training

- All staff accessing GURU & SCR will have undertaken the GURU and SCR e-learning programme
- All pharmacy technicians undertaking Stage 1 medicines reconciliation must have completed the South West Medicines Management Module 4 to level 1
- All pharmacy technicians undertaking Stage 2 medicines reconciliation must have completed the South West Medicines Management Module 4 to level 2
- All staff undertaking any stage of medicines reconciliation should be up to date in their mandatory medicines management training

8. Monitoring compliance and effectiveness

Element to be monitored	Completion of medicines reconciliation within specific time-frames
Lead	Lead Pharmacist for Patient Safety
Tool	A measurement tool will be used to calculate medicines reconciliation rate
Frequency	Snap shot measurement will take place on a minimum of a quarterly basis
Reporting arrangements	These results will be reported into the Pharmacy Governance Group and the Medication Practice Committee
Acting on recommendations and Lead(s)	The Pharmacy Governance Group and the Medication Practice Committee will lead on recommendations
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within the timeframe set out in the action plan. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders

9. Updating and Review

This policy will be reviewed every 3 years or sooner in the light of changes in legislation or practice. The policy review will be ratified by the Medicines Practice Committee when changes are substantial. For minor changes, the chair of the Medicines Practice Committee can approve and re-publish.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.2. The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Medicines Reconciliation for Patients Admitted to Hospital Policy V4.0				
Date Issued/Approved:	28 May 2019				
Date Valid From:	July 2019				
Date Valid To:	July 2022				
Directorate / Department responsible (author/owner):	Pharmacy Helen McClay Lead for Pharmacy Clinical Services				
Contact details:	01872 255997				
Brief summary of contents	Describes the process required to undertake medicines reconciliation on admission to hospital				
Suggested Keywords:	Medication reconciliation, Missed, Doses, Medicines, Delayed, Omitted				
Target Audience	RCHT	KCCG	CFT		
	✓				
Executive Director responsible for Policy:	Medical Director				
Date revised:	July 2019				
This document replaces (exact title of previous version):	Medicines Reconciliation on admission to hospital V3.0				
Approval route (names of committees)/consultation:	Medication Practice Comittee				
Care Group General Manager confirming approval processes	Robin Jones				
Name and Post Title of additional signatories	Not required				
Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings	Name: Kevin Wright				
Signature of Executive Director giving approval	Medical Director				
Publication Location (refer to Policy on Policies – Approvals and	Internet & Intranet	✓	Intranet Only		

Ratification):				
Document Library Folder/Sub Folder	Clinical/Pharmacy			
Links to key external standards	Care Quality Commission – Outcome 9 NICE Medicines Optimisation Guidance NHSLA medicines management requirements			
Related Documents:	Medicines Policy (EPMA Version) Procedure for allergies or Idiosyncrasies to Medicines and Food Mental Health Act 1983 Medicines Reconciliation: A Guide to implementation. National Prescribing Centre 2008.			
Training Need Identified?	Yes			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
12.12.08	V1.0	Final amendments approved: EIA completed; document published	Joanna Lawrence Education and Training Pharmacist
13.08.09	V2.0	Early review required; updates on templates and process	Joanna Lawrence Education and Training Pharmacist
13.06.11	V2.1	Change into new Trust format and amend dissemination and competency sections	Iain Davidson Chief Pharmacist
10.10.12	V2.2	Change into new Trust format and amend Standards and practice section to reflect electronic process	Joanna Lawrence Education and Training Pharmacist
3.05.16	V3.0	Review to include recommendations from NICE: Medicines Optimisation Guidance and flow chart included	Joanna Lawrence Education and Training Pharmacist

28.05.19	V4.0	General update Included learning from SI regards communicating information about specific pharmaceutical care arrangements in the community and the reasons for this e.g. a 7 day script due to suicide risks Review included addition of medication reconciliation for paediatric patients and patients with special needs	Iain Davidson- chief pharmacist Helen McClay- Deputy chief pharmacist.

Appendix 2. Initial Equality Impact Assessment Form

<table>
<tr><td colspan="6">Medicines Reconciliation for Patients Admitted to Hospital Policy V4.0</td></tr>
<tr><td colspan="3">Directorate and service area:
Pharmacy</td><td colspan="3">New or existing document:
Existing</td></tr>
<tr><td colspan="3">Name of individual completing assessment:
Helen McClay</td><td colspan="3">Telephone:
01872 255997</td></tr>
<tr><td>1. Policy Aim*
Who is the strategy / policy / proposal / service function aimed at?</td><td colspan="5">To reduce preventable medication errors on admission, on transfer between hospital wards/units or on discharge to primary care.</td></tr>
<tr><td>2. Policy Objectives*</td><td colspan="5">• To reduce preventable medication errors on admission, on transfer between hospital units/wards or on discharge to primary care.
• To ensure all the medicines a patient is currently taking are documented on admission and at each transfer of care including over-the-counter or complementary medicines.
• To ensure any discrepancies identified in the process are resolved.
• To ensure any changes that have been made on admission are documented, resulting in a complete list of medicines which can be accurately communicated on discharge.
• To improve continuity of care when patients come into hospital and when they are discharged or transferred. Any medicines whose effects may have contributed to their admission can be reviewed and any concordance issues can be addressed.</td></tr>
<tr><td>3. Policy – intended Outcomes*</td><td colspan="5">To reduce preventable medication errors during patient transfer</td></tr>
<tr><td>4. *How will you measure the outcome?</td><td colspan="5">Through annual audit
Referral to medication incident reports</td></tr>
<tr><td>5. Who is intended to benefit from the policy?</td><td colspan="5">Patients</td></tr>
<tr><td rowspan="3">6a Who did you consult with

b). Please identify the groups who have been consulted about this procedure.</td><td>Workforce</td><td>Patients</td><td>Local groups</td><td>External organisations</td><td>Other</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td colspan="5">Medication Practice Committee
Governance DMB, CSCS</td></tr>
<tr><td>What was the outcome of the consultation?</td><td colspan="5">Agreed</td></tr>
</table>

7. The Impact

Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		
Sex (male, female, trans-gender / gender reassignment)		**X**		
Race / Ethnic communities /groups		**X**		
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		
Religion / other beliefs		**X**		
Marriage and Civil partnership		**X**		
Pregnancy and maternity		**X**		
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked "Yes" in any column above and
- No consultation or evidence of there being consultation- this excludes any *policies* which have been identified as not requiring consultation**. or**
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.	**Yes**		**No**	**X**

9. If you are **not** recommending a Full Impact assessment please explain why.

Not indicated

Date of completion and submission	*24 07 19*	Members approving screening assessment	Policy Review Group (PRG) **APPROVED**

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust's web site.