Good Practice Guidance: Medicines Reconciliation

NHS Frimley Clinical Commissioning Group

Introduction

Medicines reconciliation is the process of identifying an accurate list of the actual medicines a person is taking on admission and at each transfer of care and comparing it with the current list in use to identify any potential discrepancies.

Medicines reconciliation is most effective when the person and/or their families are actively involved in the process where appropriate. They can provide up-to-date information about the medications they take and how they take them; they may not be being taken as prescribed.
Medicines reconciliation is time sensitive and should be completed as soon as possible on admission and/or at any transfer of care setting. Medication errors can and do take place during transfer of care such as discharge from hospital and transfer between care homes, including that between nursing and residential care.

Prescribed medications, over the counter medicines for self-care including complementary medicines, herbal, homeopathic and recreational substances should all be reviewed during the reconciliation process.

The process includes:

- Collecting information about the person's medication history
- Comparing the list of medications with the medicines the person is taking/using and how they are taking them. This includes reviewing all prescribed medications, over the counter medicines, complementary medicines, herbal, homeopathic and recreational substances
- Checking this information for both intentional and unintentional differences
- Communicating discrepancies with resident and prescribers.
- The resident (or family members/ carers) should be involved in this process to establish adherence to their medication regimen, e.g. is the person taking their medicines as prescribed or in a different way?
- Resolution of discrepancies should occur as soon as possible using clinical judgement to ensure safe and effective person-centred care. All changes should be clearly documented

Policies and procedures

The care home medicines policy should include information about medicines reconciliation and cover:

- Who is responsible for coordinating medicines reconciliation
- Who to involve in the process
- Information to be available and included in the medicines reconciliation process
- Information given to the person and/or their family or carers
- Training and the skills necessary for effective medicines reconciliation
- Record keeping

When should Medicines Reconciliation occur?

Medicines should be reconciled within 48 hours at each transfer of care including:

- New admission into residential/nursing home
- Hospital admission (planned and emergency)
- Hospital discharge
- Transfer from another care home
- Transfer within the same care home
    - e.g. from one unit to another, residential unit to nursing or nursing to residential care
- Discharge from care home to community

What are the benefits of completing Medicines Reconciliation?

Completion of thorough medicines reconciliation can reduce some of the avoidable risks of patients experiencing harm from their medication. It also ensures:

- records are kept up to date
- better patient centred care where the resident is part of the process and can communicate any difficulties with their medications to the team
- fewer chances of delayed doses or omitted medication if reconciliation is done at the right time
- reduction in prescribing errors and adverse drug events
- reduced hospital admissions

Who should be involved with the Medicines Reconciliation process?

Trained and competent staff should carry out medicines reconciliation. Staff will need to ensure they are up to date with the appropriate training, knowledge, skills and expertise including:

- effective communication and consultation skills
- technical knowledge of processes for managing medicines
- therapeutic knowledge of medicines' use.

Trained and competent staff need to possess these skills so that they can effectively consult with other healthcare professionals in carrying out medicines reconciliation. Other healthcare professionals can include GPs, Pharmacists, nurses (including discharge or specialist nurses), paramedics, dietitians and Speech and Language Therapists (SaLT).
It is good practice for care homes to ensure at least 2 members of staff are trained to carry out medicines reconciliation to account for leave and sickness.

Information to include in Medicines Reconciliation (Appendix 1)

- Person's details:
  - full name, date of birth and address
  - weight and height
- GP's details
- Details of other relevant contacts e.g. consultant, community pharmacist or specialist nurse
- Details of the person conducting the medicines reconciliation
- Known allergies and reactions to medicines or ingredients and the type of reaction
- Current medicines including:
  - name
  - strength
  - form
  - dose, timing and frequency
  - route
  - indication
- Changes to medicines and reasons for change, including medicines started, stopped or dosage changes
- Date and time the last dose of any 'when required' (PRN) medicine was taken. Establish how often the resident usually takes their PRN medication. Include specific instructions to support the administration of PRN. This information helps with the PRN protocol, e.g. signs and symptoms of needing the PRN.
  Any maximum daily doses of PRN medicines should be included.
- How and when the person prefers to or usually takes their medicine. This should include an assessment for self-administration where appropriate
- Information about any medication taken less often than once a day:
  - weekly
  - monthly
  - infrequently e.g. injections such as hydroxocobalamin or denosumab.

  Record when the last dose was administered and when the next dose is due to be given.
- Any medicine that has specific administration times such as medication for Parkinson's disease.
  Record when the last dose was administered and when the next dose is due to be given.
- Other relevant information to include:
  - OTC medications taken or used (see Good Practice Guidance: The Use of Over the Counter (OTC) medicines and Homely Remedies)
  - self-care products (see Good Practice Guidance: Supporting people to self-care in care homes)
  - catheters and related products: type, size, frequency, and date of last change
  - PEG/ NG feeds
  - dressings: type, size
  - when the medicine should be reviewed
  - any monitoring required for the medication
  - any support needed for the person to administer the medicine themselves
  - any compliance or dexterity issues that need to be highlighted
  - information given to the person, family members or carers
  - consistency of thickened fluids advised for those with swallowing difficulties
  - details of flushes before and after medicines administration in PEG-fed residents.

Sources that can be used for medicines reconciliation

Two or more sources (wherever possible) should be used to be sure the information is accurate and up to date. The following sources can be used to complete a medicines reconciliation:

- Verbal/ written information from the resident, family or carer
- Recent and dated summary of medication from the GP medication record
- Recent GP repeat prescription slip
- The most recent discharge letter from the hospital that lists current medications in use and/or the Connected Care record
- Patient's own medications/drugs ('PODs'). If medicines are in individual boxes, the information can be checked against the label, provided it has been dispensed recently (within 6 months)
- Compliance aids (if dispensed recently)
- Community pharmacy records/ Summary Care Record (SCR)
- District Nurse records
- Any clinic letters such as anticoagulant clinic, mental health clinic etc.
- Specialised medication charts, e.g. End of Life (EOL), PEG administration chart
- Nursing or residential care home Medicines Administration Record (MAR) charts

Be cautious and vigilant. Current medication records may not be up to date if the person has had a recent event such as hospital admission, out-of-hours visit, paramedic call out.
For such residents highlight medications which have been:

- recently stopped or started by the hospital
- where the dose has been changed (include the reason for the change).

Record keeping

Record the information from medicines reconciliation in the care plan. Make sure to record:

- details of the person completing the medicines reconciliation (name, job title)
- the date of the medicines reconciliation
- source(s) of information used to reconcile the medicines
- any changes to medications

Check the MAR chart to make sure it is accurate and up to date.

Governance

Medicines reconciliation is part of a full needs assessment and care plan. This should be carried out by the care home manager or the staff member responsible for a person's transfer into a care home. The governance process should be determined locally and include:

- organisational responsibilities
- responsibilities of health and social care practitioners involved in the process
- who those health and social care practitioners are accountable to
- individual training and competency needs
- resources needed to ensure that medicines reconciliation occurs in a timely manner.

Monitor the effectiveness of the processes and review them regularly.

Medications to be aware of when carrying out medicines reconciliation

- **Parkinson's medicines:** it is important to note the exact prescribed administration times so that these timings can be continued. Some residents may have a Parkinson's passport.
- **Analgesic patches:** often have set administration instructions, e.g. fentanyl patches should be applied every 72 hours. Establish when the last patch was administered and the location of the patch so the site can be altered as directed.
- **Warfarin:** Establish if there is a recent INR or if there is an updated anticoagulant record book. The current dose and time of administration should be recorded; it is useful to record the contact details of any anticoagulant clinic the resident attends.
- **Insulin:** it is important to identify the type of insulin, device used, the most recent insulin dose and information about managing hypo- or hyper-glycaemic episodes.
- **Methotrexate:** double check methotrexate doses - these are administered **weekly**.
  Check and record which day of the week it should be administered.
  Check the day of the week for folic acid - ensure both are not administered on the same day.
- **Depot long-acting injectable (LAI) antipsychotic:** identify the LAI antipsychotic and the frequency of administration. Some have similar sounding names and can be given at different dosing intervals. Staff must have the necessary knowledge, skills and competency to safely administer depot antipsychotic injections by deep intramuscular injection.
- **Lithium:** brands are **NOT** interchangeable. Prescriptions should always state the brand. It is important to continue to administer the same brand of lithium. If a change in formulation is required seek specialist advice. If a liquid preparation is prescribed it is important BOTH strength and volume are specified. Hot weather, infections, diarrhoea and vomiting can all result in higher lithium levels. Many medicines interact with lithium and can affect lithium levels.
- **Short courses of medication:** information on when to give the last dose should be obtained.
- **Other medications**: eye drops, ear drops, inhalers, creams, ointments.
- **Non-prescribed medications and products:** over the counter (OTC), multivitamins, supplements, herbal, homeopathic, preparations bought over the internet.

References

- WHO Assuring Medication Accuracy at Transitions in Care: Medicines Reconciliation
  Standard Implementation Protocol for Medication Reconciliation (who.int)
- NICE NG5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes
  Overview | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE
- CQC Medicines Reconciliation
  Medicines reconciliation (how to check you have the right medicines) | Care Quality Commission (cqc.org.uk)
- Specialist Pharmacy Service: Medicines Reconciliation Best Practice Resource and Toolkit
  Medicines Reconciliation: Best Practice Resource and Toolkit – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- NICE NG67: Managing medicines for adults receiving social care in the community
  Overview | Managing medicines for adults receiving social care in the community | Guidance | NICE
- Prescribing Arrangements for Lithium in Berkshire
  NHS (frimleyccg.nhs.uk)
- Prescribing Arrangements for Patients Prescribed Long Acting Injectable (LAI) Antipsychotics
  Long Acting Injectable (LAI) Antipsychotics (frimleyccg.nhs.uk)
- Frimley Clinical Commissioning Group: Good Practice Guidance for Care Homes
  Care Homes (frimleyccg.nhs.uk)

Appendix 1

Medicines Reconciliation Form

Resident name:	**Allergies and reactions:**
DOB:	Address:
NHS no:	
GP Details:	

Sources used (please tick). At least two sources should be used

Resident		Repeat prescription order slip	
Carer/Family/Next of kin		GP summary **FAX NOT ALLOWED**	
Discharge letter		Community Pharmacy	
Resident's own medicines		Other (specify)	

Medication name, strength and form	Dose	Route	Frequency	no. of days needed to sync with monthly cycle	Discrepancies (Y/N)	Comments and follow up *e.g.* Not taking/ No longer needs Recently stopped/ started in hospital

Medication name, strength and form	Dose	Route	Frequency	no. of days needed to sync with monthly cycle	Discrepancies (Y/N)	Comments and follow up *e.g.* Not taking/ No longer needs Recently stopped/ started in hospital

Medication name, strength and form	Dose	Route	Frequency	no. of days needed to sync with monthly cycle	Discrepancies (Y/N)	Comments and follow up *e.g.* Not taking/ No longer needs Recently stopped/ started in hospital

Warfarin	Dose on admission and time dose taken		Strengths kept	0.5mg	
				1mg	
	Anticoagulation clinic contact details			3mg	
				5mg	
Insulin	Insulin Name Device used (pen, vial, cartridge etc)		Number of units on admission and time dose taken/given		

Medication Needs Assessment

Lifestyle considerations	Communication Concerns (visual, language, hearing etc)	Medication Compliance Aids used?

Additional information:			
Date form completed:	Name of staff completing form	PRINT NAME: SIGNATURE:	
Date form checked:	Name of staff checking form	PRINT NAME: SIGNATURE:	