The Royal Wolverhampton NHS Trust

Policy Number: MP03

Title of Policy: Medicines Reconciliation

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1.0 Policy Statement (Purpose / Objectives of the policy)

The purpose of this policy is to guide all clinical staff when carrying out medicines reconciliation processes for patients.

It also reduces the risk to patients of medicines errors and complies with the Medicines Reconciliation section of the March 2015 NICE guidance for Medicines Optimisation (1).

Admission to hospital provides an opportunity to make appropriate changes to medication, however the process of medicines review is beyond the scope of this policy.

The policy is intended to deliver the following objectives:

- Support continuity of treatment to ensure that patients get the right drug, in the right dose at the right time.
- Reduce the risk of medication errors when the patient moves from one care setting to another.
- Improve the timely availability of accurate medicines information – essential for prompt and appropriate treatment.
- Provide ongoing personalised medicines management care for each patient.
- Reduce confusion about patient's medication regimes (for both patients and staff).
- Improve service efficiency, reduce waste and duplication of effort.
- Improve record keeping.
- Reduce delays in medication and missed doses.
- Reduce the risk of re-admission and prolonged length of stay.
- Support the development of standards and procedures for managing the transfer of patient care and medicines information across the Trust.

In adhering to this Policy, all applicable aspects of the Conflicts of Interest Policy must be considered and addressed. In the case of any inconsistency, the Conflict of Interest Policy is to be considered the primary and overriding Policy.

2.0 Definitions

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. 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.

3.0 Accountabilities

Medical Director

The Medical Director has overall responsibility for implementation, monitoring and compliance with this policy.

Chief Nurse

The Chief Nurse is responsible for supporting the nursing staff in implementing and monitoring this policy**.**

Clinical Director of Pharmacy

The Clinical Director of Pharmacy is responsible for ensuring that this policy is implemented, complied with and monitored within pharmacy and ensuring staff within the division with specific responsibilities carry these out. The Clinical Director

of Pharmacy is responsible for liaising with colleagues in the community to engage their support for this process and for ensuring the policy is reviewed and updated as required.

Clinical Directors/Matrons/Assistant Director of Pharmacy-Clinical Services

This group will be responsible for day-to-day implementation of the policy and ensuring:

- All staff are aware of their role under the policy.
- Staff have received sufficient training and are competent to implement the policy.
- Incidents and issues are reported as specified.
- Monitoring audits and evaluations are carried out as specified.

Doctors, Pharmacists, Pharmacy Technicians and Nurses

This group are responsible for following this policy.

4.0 Policy Detail

4.1 Rationale for Medicines Reconciliation

Patients need to have a Medicines Reconciliation within 24 hours of admission as per NICE Medicines Optimisation Quality Statement 4, March 2016 'Medicines reconciliation in acute settings' (2).

Medicines errors pose a threat of harm to hospital in-patients, leading to increased morbidity, mortality and economic burden to health services. Over half of these incidents occur at the interfaces of care and most commonly at admission.

Errors may occur at a number of stages during the admission process, including when:

- Determining the medication the patient is currently taking, from written records or the accounts of the patient, their families or carers.
- Transcribing details of the patient's medication to the hospital clinical record
- Prescribing medication for the patient after admission.

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, with any intentional changes clearly documented.

Medicines reconciliation can occur when patients are admitted to hospital, transferred to other units within the hospital or on discharge from the hospital.

Factors that may contribute to medicines reconciliation errors include the following:

- No access to the patient's prescription list from primary care.
- Discrepancies between the primary care prescription list and the medications

the patient is taking.

- Lack of inclusion of non-prescription medicines, including over-the-counter herbal and recreational drugs.
- Difficulties in obtaining an accurate account of a patient's medication, which may be caused by an acute condition, sensory or cognitive impairment, lack of access to family or carer support or language barriers.

4.2 Information Sources

There are many potential sources of information about patients' medicines although no source is reliable unless it is up to date. In every case, the source of information must be documented, dated and, where practicable, verified.

Some common information sources:

- The patient: including confirmation of prescribed, purchased and complimentary medicines and how they are taken (confirm patient adherence).
- Patient's relatives or carers.
- Nursing homes.
- Patient's Own Drugs (PODS) brought into hospital.
- Clinical Web Portal information including clinic letters, past discharge letters, Portal Notes, previous medical notes and allergy status.
- Inter-hospital transfer notes and discharge letters from other Trusts.
- OHC Shared Care Record; contains GP prescription and allergy information and can be accessed via the link in Clinical Web Portal. If the OHC Shared Care Record is unavailable the national Summary of Care Record (SCR) can be accessed using a NHS Care Identity Smart Card.
- GP's, specialist nurses or consultants from other services
- Community pharmacy patient medication records (PMR)
- Monitored dose system (compliance aid//Dosette box)
- EPMA system
- Mental Health Liaison Service (MHLS). Medicines prescribed by the mental health team may not appear on the GP record, therefore the mental health team may need to be contacted.

Information sources with additional access requirements may be available on request; such as the e-MED Renal System), Chemocare, Badgernet (maternity/neonates), INR Star and records of medicines delivered to the patient's home via 'Homecare' companies.

4.3 How to Complete a Medicines Reconciliation

Stage 1 Reconciliation (admitting clinician)

The drug history will be taken by the admitting clinician within the first 24 hours of admission and involves taking a medication history and collecting other relevant information about the patient's medicines, including any allergies. The history must be taken from the most recent and reliable source and where possible cross–

checked and verified. A list of common sources is provided in section 4.2.

The history will be documented in the appropriate section of the patient's notes, signed, stamped with name and registration number, and dated with a record made of the sources of information used. Any intentional discrepancies between what the patient was taking pre-admission, and the in-patient prescription must be noted with the reasons for variations documented in the patient's notes and on the in-patient prescription/ePMA, including:

- Medication stopped and the reason.
- Medication started, the reason and intended duration e.g. for antibiotics, clopidogrel etc.
- Dose or frequency changes.

In the case of planned admissions some of the information will be undertaken at a pre-admission clinic, this will need to be confirmed on admission.

Errors are reported through the incident reporting system (Datix) in line with MP04.

Stage 2 Checking (Pharmacy Technician / Pharmacist)

The checking stage involves ensuring information obtained in Stage 1 of the medicines reconciliation process is correct. This will carried out by a pharmacy technician or a pharmacist as soon as possible after admission, as per the local pharmacy procedure. The pharmacy confirmed drug history will be documented in the ePMA 'Med Rec and Assessment' tab.

A suitable doctor, prescribing pharmacist or nurse independent prescriber will be informed of any unintentional discrepancies and will amend the prescription accordingly. A record of any amendments will be made in the patient's notes.

For wards not using ePMA the pharmacy technician / pharmacist will record the drug history and the source of information used in the pharmacy box on the paper chart. The pharmacy technician / pharmacist will sign, stamp with name and registration number and date the information. For regular medications prescribed on the chart, the pharmacy technician / pharmacist will tick the medication and make a note in the pharmacy box. i.e. (✓) = regular medication. The pharmacy technician / pharmacist will note down any medications which are missing or incorrect; if there is a reason for omission or change, that will be written in the pharmacy box. For any items which have been newly started, N will be written in the additional information box for the drug.

Medicines Reconciliation on Discharge

The discharging clinician will note any medicines changes made on the e-discharge summary, including details about:

- Medicines started.
- Stopped medicines.

- Dose changes.
- Date and time the last dose of any when required medicine was taken, including specific instructions to support their administration.
- Information about any medicine given less often than once a day - weekly or monthly medicines.
- Information given to the person, family members or carers.
- When the medicine should be reviewed or any monitoring.
- Any other relevant information, for example smoking status, alcohol intake.

The pharmacist (or pharmacy technician) will complete a medicines reconciliation check of the discharge letter before signing the pharmacy section of the e-discharge letter. Where this is not possible, for example if a pharmacy confirmed drug history has not been obtained at ward level and the patient is being reviewed remotely by the dispensary pharmacist at the point of discharge, the following note will be added to the discharge letter:
'Discharge medication was clinically checked by the dispensary pharmacist. It was not possible to undertake a full medicines reconciliation at the point of discharge'.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	Doe the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

6.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
√	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

7.0 Maintenance

This policy will be reviewed after 3 years or at any stage where there is a change to guidance.

8.0 Communication and Training

The policy will be available on the Intranet and will be circulated to all appropriate staff.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Percentage of Stage 2 Medicines Reconciliations completed within 24 hours of admission	Assistant Director of Pharmacy – Clinical Services	EPMA reporting	Monthly	Pharmacy Performance Meeting every month and MMG every 6 months.
Incidents of incorrect medicines reconciliation	Assistant Director of Pharmacy – Clinical Services/Medicines Optimisation	Continuous monitoring of Datix incidents and quarterly reporting in line with the Trust Policy for managements of drug errors MP04	Continuous	Medicines Management Group

10.0 References

1. Medicines Optimisation: The Safe and Effective Use of Medicines to Enable the Best Possible Outcomes: National Institute for Health and Clinical Excellence (NICE), published March 2015, available at: 1 Recommendations | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE

2. Quality Statement 4 'Medicines Reconciliation in Acute Settings: National Institute for Health and Clinical Excellence (NICE), March 2016, available at: Quality statement 4: Medicines reconciliation in acute settings | Medicines optimisation | Quality standards | NICE

3. CQC Guidance for Providers, Medicines Reconciliation, last updated 20/03/2023, Available at Medicines reconciliation - Care Quality Commission (cqc.org.uk)

4. CQC Single Assessment Framework, Medicines Optimisation, last updated 22/02/2024, available at Medicines optimisation - Care Quality Commission (cqc.org.uk)

Part A - Document Control

Policy number and Policy version: MP03 version 6.0	**Policy Title** Medicines Reconciliation	**Status:** Final		**Author:** Assistant Director of Pharmacy-Clinical Services **Chief Officer Sponsor:** Chief Medical Officer
Version / Amendment History	Version	Date	Author	Reason
	1	March 2010	Assistant Director of Pharmacy-Clinical Services	Introduction
	2	May 2012	Assistant Director of Pharmacy-Clinical Services	3 yearly Review
	3	January 2015	Assistant Director of Pharmacy-Clinical Services	3 yearly Review
	4	June 2018	Assistant Director of Pharmacy-Clinical Services	3 yearly Review
	5	July 2020	Assistant Director of Pharmacy-Clinical Services	3 yearly Review
	5.1	Sept 2023	Assistant Director of Pharmacy-Clinical Services	Extension
	6.0	June 2024	Assistant Director of Pharmacy-Clinical Services	Full review

Intended Recipients: This is a Trust wide policy for all healthcare professionals who have involvement with prescribing/administering/ dispensing medications to patients.	
Consultation Group / Role Titles and Date: Medicines Management Group 7th May 2024	
Name and date of Trust level group where reviewed	Trust Policy Group - June 2024
Name and date of final approval committee	Trust Management Committee - June 2024
Date of Policy issue	July 2024
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	June 2027
Training and Dissemination: The policy will be available on the Intranet and will be circulated to all appropriate staff.	
To be read in conjunction with: MP01	
Initial Equality Impact Assessment (all policies): Completed Yes **Impact assessment (as required): Completed Yes** If you require this document in an alternative format e.g., larger print please contact Policy Administrator 8904	
Monitoring arrangements and Committee	MMG would receive any monitoring reports which would be required as part of the policy.
Document summary/key issues covered. This policy indicates the key roles required by health professionals to ensure that medicines reconciliation is carried out on admission to hospital, which enables an accurate drug history to be obtained.	
Key words for intranet searching purposes	Medicines Reconciliation.