NHS
Dorset
Clinical Commissioning Group

MEDICINES STANDARD B1:
MEDICINES RECONCILIATION IN PRIMARY CARE

The NICE Guidance [NG5] describes Medicines reconciliation as "*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.

GPs are responsible for ensuring that good quality data regarding a patient's medication accompanies the patient on admission to hospital for all planned admissions or is sent to the secondary care provider in a timely manner following a request for all unplanned/emergency admissions.

Secondary care services are responsible for ensuring that good quality data regarding a patient's medicines is sent to the patient's GP on discharge.

In circumstances where GP practices experience unreasonable delays in receiving discharge information from secondary care or if information received is found to be incomplete or inaccurate deeming it difficult for the GP to reconcile a patient's medicines effectively, a report must be made via the CCG's significant event reporting system to ensure the Clinical Governance team can address issues raised via quality monitoring systems.

Once a discharge summary is received by the GP practice, the information on changes to medication should be critically reviewed and incorporated into the GP's patient record, so that appropriate changes made to medicines during a patient's stay in hospital are continued as intended by the hospital prescriber. This process is central to reducing the risk of medication error; if not carried out, in more extreme cases, this could result in patients taking duplicate medicines or taking medicines that are incompatible, which increases the risk of complications.

Readmissions relating to medication may be due to issues like restarting medicines that have been discontinued, patients being unable to cope with their medication regime on discharge and the absence of a medicines support system for these patients.

STANDARDS

The supply of information should be secure, timely, and accurate.

Response to a request for information from secondary care about a patient's medicines should be made in a timely way, so as not to impede care of the patient in the hospital setting. This should occur within one working day of a direct request from the hospital or in circumstances where the admission to hospital is planned information regarding the patient's medicines should be forwarded to the hospital as part of the hospital referral process.

Information regarding a patient's medicines should be made available to the GP practice within 24 hours of their discharge. In circumstances where this is not the case the event must be recorded as an adverse incident via the CCG adverse incident reporting system.

Information received by the practice when the patient is discharged should be clinically reviewed by the patient's GP within two working days of receipt.

The required information can be supplied or received in a number of ways. NHS Dorset Clinical Commissioning Group encourages the use of agreed standard templates for the transfer of patient information between healthcare settings. The chosen method of transfer of the information (for example, written, fax, or electronic) can be decided locally.

The pharmacy department at Dorset County Hospital have an established a secure encrypted email address that GPs can use to forward information after a patient is admitted to hospital. The email address is drughistory@dchft.nhs.uk.

A standard template that practices may wish to use for provision of information to secondary care by email or by fax is shown at the end of the policy.

INFORMATION TO BE PROVIDED ON ADMISSION

To be able to reconcile medicines accurately, the following information must be provided, either in the referral letter *or* as a result of a request made by the hospital for all non-elective admissions:

- Complete patient details i.e. full name, date of birth, weight if under 16 yrs, NHS/unit number,
- Current and relevant past medical history
- A complete list of all the medicines prescribed for the patient
- Details of any medicines that the patient takes but that are not prescribed by the GP practice (e.g. clozapine)
- Dose, frequency, formulation & route for all of the medicines listed

- The intended duration of treatment for medicines where this is appropriate (e.g. antibiotics, short course corticosteroids, hypnotics)

Details of increasing, or decreasing dose regimens (e.g. insulin, warfarin, oral corticosteroids)

Known allergies and history of any drug interactions
Any additional information such as therapeutic drug monitoring schedules (etc)

This information should be clear, unambiguous and legible and should be made available as soon as possible.

This information should be available to the hospital within one working day of a patient's admission to hospital.

NFORMATION TO BE PROVIDED ON DISCHARGE

To be able to reconcile medicines accurately, the suggested minimum dataset should include:

- Complete patient details i.e. full name, date of birth, weight if under 16 yrs, NHS/unit number, consultant, ward, date of admission, date of discharge
- Current and relevant past medical history
- Procedures carried out during admission
- A complete list of all the medicines prescribed for the patient (all medicines should be included, not just those dispensed at the time of discharge)
- Dose, frequency, formulation & route for all of the medicines listed
- Details of medicines stopped and started during the admission, with a clear explanation for doing so
- The intended duration of treatment for medicines where this is appropriate (e.g. antibiotics, short course corticosteroids, hypnotics)
- Details of increasing, or decreasing dose regimens (e.g. insulin, warfarin, oral corticosteroids)
- Known allergies and history of any drug interactions
- Any additional patient information provided such as corticosteroid cards, anticoagulant booklets etc.

This information should be clear, unambiguous and legible and should be available within 24 hours of a patient's discharge.

MEDICINES RECONCILIATION IN GP PRACTICES

Information relating to the discharge of patients from hospital should be date stamped on receipt in the practice and clearly marked for the attention of the named GP or other healthcare professional responsible for care of the patient.

Discharge information should be clinically reviewed, processed into the patient's medical record as soon as possible after receipt, ideally within 24 hours of receipt, but not more than 2 working days.

The named GP or healthcare professional caring for the patient should reconcile discharge medicines with the information on the practice patient medical records (acute and repeat) and code any new diagnosis and/or medicines related issues.

If the discharge information is missing any of the information specified in the "Discharge Information" section above, then the GP practice should attempt to obtain it from the place of discharge to ensure that accurate reconciliation of the patient's medicines occurs as soon as possible after discharge, and to avoid any risk of adverse effects from medicines or medicines related re-admission to hospital.

Review the discharge information in a timely way. Ensure that any changes to the medicines made during the patient's hospital stay are documented, and any necessary changes to the patient's medication record in the practice are made.

A quick reference guide to using discharge information to assess if there have been any changes made to the patient's medicines, and whether any associated patient monitoring/recall is necessary is shown on the last page of this policy.

Significant changes in medication should trigger a review of medicines with the patient. To avoid discontinued medicines being taken in error, patients should be advised to return any discontinued / unwanted medication to their local pharmacy or the GP practice dispensary for destruction.

At this point, consider whether the patient would benefit from a medicines use review (MUR) or support through the New Medicine Service (NMS) via the patient's community pharmacy. If required contact the pharmacy to arrange.

When the discharge information has been reviewed, "read code" the patient under "medication review of medical notes". Add a recall date if necessary.

In the event that the patient's medicines are dispensed in a monitored dosage system (MDS) the relevant pharmacy/dispensary should be contacted and made aware of any changes that were made to the patient's medicines during their hospital stay.

REPORTING

If information is missing from the discharge summary, particularly where this leads to potential or actual harm to the patient (including a near miss), report this to the CCG using the adverse incident reporting process.

If a patient is readmitted within 30 days of discharge, report this to the CCG using the adverse incident reporting process.

DUTIES/RESPONSIBILITES AND ACCOUNTABILITY

The place of discharge is responsible for providing a sufficient level of information to the patients GP practice to allow accurate and timely reconciliation of medicines after discharge.

GP practices are responsible for ensuring that where a patient is transferred into another care setting (acute or community hospital, or care home) that accurate information regarding patient's medicines is available when the patient is transferred and that information regarding a patient's medicines on discharge is clinically reviewed and the patient's medical record in updated to reflect any changes that were made and communicated to all relevant healthcare professionals and the patient in a timely manner so not to impede patient care.

REFERENCES

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE guidelines [NG5] March 2015

Managing medicines in care homes NICE guidelines [SC1] March 2014

Keeping patients safe when they transfer between care providers – getting the medicines right (Royal Pharmaceutical Society, June 2012)

Medicines Reconciliation: A Guide to Implementation (National Prescribing Centre)

Managing patients medicines after discharge from hospital, (Care Quality Commission, October 2009)

Records Management: NHS Code of Practice

APPENDIX 1 **SUGGESTED FORM FOR TRANSFER OF A PATIENT'S DRUG HISTORY TO SECONDARY CARE BY EMAIL OR BY FAX**

Patient details

Full name of patient	
Address	
DOB	
NHS Number	
GP/Practice name	
Other relevant contacts e.g. Consultants name, usual community pharmacy, specialist nurse	
Weight (if under 16 years old)	
Allergy status or adverse reactions to medicines to include causative medicine, brief description of reaction, probability of occurrence	
Relevant medical history	

Current Medication
(Please list all medicines including inhalers, eye/ear drops, patches, injections)

Name of medicine Generic name (or brand name where relevant)	Form	Dose strength	Dose frequency/ time	Route	Reason for medication if known	Comments (e.g. intended duration)

Other relevant information

Additional information e.g. therapeutic monitoring arrangements, increasing/decreasing dosage regimens, Monitored Dosage System (MDS) etc

Details of any medicines that are not prescribed by the GP practice (e.g. clozapine):

Name, time, date, job title of person completing record	
Contact telephone number for queries	
Signature	

APPENDIX 2 MEDICINES RECONCILIATION ON DISCHARGE QUICK REFERENCE LIST

Allergy status Have there been any changes to the patient's allergy status?
Medical conditions Have any new health conditions been diagnosed? Have these been updated on practice records?
Changes to medicines Have any medicines been stopped? Why? Have any new medicines been added? Why? Have the doses of any medicines been changed? Have any formulations been changed? Has the frequency / timing of the dosing changed? Is there a clear explanation of the reasons for starting/stopping/dose changes to medication?
Medication recommendations Ongoing monitoring requirements? Advice on starting, discontinuing or changing medicines
Duration of treatment Are the newly prescribed medicines ongoing? Do any of the medicines need to be stopped in a given time frame? *Think about analgesics, benzodiazepines, antibiotics.*
Drug interactions Are there any possible interactions between the drugs the patient is taking? *Include any self medication with herbal / supplement preparations.*
High-risk drugs Was the patient started on a drug with a narrow therapeutic margin whilst in hospital? Is the patient on increasing or decreasing dose regimens? Does the patient need any additional monitoring? *Examples: insulin, warfarin and lithium.*
Identifying discrepancies Have there been any (un-explained) discrepancies identified between the discharge information and the information held in the practice? Have these been followed up with the place of discharge?
Repeat prescriptions Has the repeat prescription item list been updated? Do all the medicines need to be on repeat? Are some the medicines more appropriate as acute only?

Additional information for the patient Does the patient need any additional information provided such as a corticosteroid card, anticoagulant booklet?
Other considerations Were any signs of non-adherence identified whilst the patient was in hospital? Are there any clues that the patient might be intentionally or un-intentionally non-adherent with their medicines? Would the patient benefit from a medicines use review from the pharmacy to help ensure that their use of medicines is optimised? Would it be useful if the pharmacy assessed the patient for compliance aids under the Disability Discrimination Act? Where capacity, sensory or language barriers, how has all the necessary support information been given to authorised representative/carer If the patient has had medicines discontinued, do they still have supplies that need to be disposed of?