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Good Practice Guidance for Residential and Nursing Homes

Medicines Reconciliation*
*Accurately listing a residents medicines

For prescribers and all staff responsible for medicines reconciliation in residential and *nursing homes.*

Definition

Medicines reconciliation is the process of identifying an accurate list of a person's current medicines **and** comparing them with the current list in use, recognising and resolving any discrepancies, **and** documenting any changes. The term 'medicines' also includes over-the-counter or complementary medicines. Any discrepancies should be resolved as soon as possible to ensure safe and effective patient care.

The information to compare with can be obtained from a variety of sources such as: GP surgery patient records, repeat prescription slips, hospital discharge letter, community pharmacy patient medication records and care home medicines administration record.

Background

A number of reports [1] have identified the high levels of medication errors that occur when people transfer between care settings. Older people, often taking multiple and complex regimens are some of the most vulnerable. When people move from one care setting to another, between 30% and 70% of patients have an error or unintentional change to their medicines[2].

The importance of medication reconciliation has been highlighted by the National Institute for Health and Clinical Excellence (NICE).

Why is medicines reconciliation important?[3]

- To avoid omission of medications
- Making sure critical medicines are not delayed, such as anticonvulsants, anticoagulants, antidiabetics, and for Parkinson's disease.
- To avoid errors in resident's receiving the wrong dose, strength, or formulation.
- To help avoid the risk of adverse drug reactions and interactions.

Purpose

- To ensure that care home residents receive **all intended** medication and **no unintended** medication following a transfer to and from the care home
- To provide a framework for staff to undertake Medicines Reconciliation for residents who are admitted to and discharged from the care home

What is the Medicines Reconciliation process?

Care homes should follow the three steps (3C's) to medicines reconciliation **(details in Appendix 1)**

1. **Collecting**
2. **Checking**
3. **Communicating**

Recommendations

Who should be involved with Medicines Reconciliation process?

Medicines reconciliation can be carried out by any healthcare professional[4], if they are competent to undertake reconciliation and have the skills and information, they need to carry out the task.

The following people should also be involved in medicines reconciliation.

- The resident and/or their family members/carer

- A pharmacist, other health and social care practitioners involved in managing medicines for the resident

What should care homes do to ensure Medicines Reconciliation process is safe?

- Have an up-to-date medicines policy that include written processes for accurately listing a resident's medicines[5] (medicines reconciliation)Refer to NICE Managing medicines in care homes SC1: 2014 accesses at www.nice.org.uk
- Establish who has responsibility for the process
- Ensure that the details of the person completing the medicines reconciliation (name, job title) and the date are recorded
- The person responsible for a resident's assessment for transfer into a care home should coordinate the accurate listing of all the resident's medicines as part of a full needs assessment and care plan and consider the resources needed for this to occur in a timely manner
- Consider completing a personalised Medicines Reconciliation Form (Appendix 2) as part of the reconciliation process

When should Medicines Reconciliation occur?

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

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

What Information should be available for Medicines Reconciliation?[6]

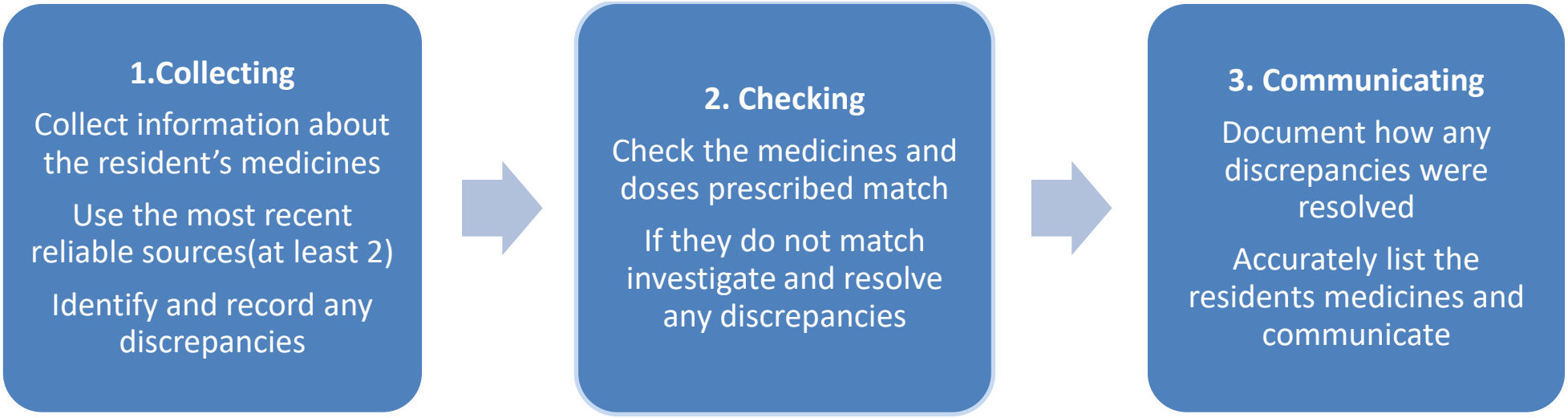
- Resident's details, including full name, date of birth, NHS number, address, and weight
- GP's details, current GP and old GP if recently changed GP
- Details of relevant contacts defined by the resident /carers (e.g. family members, consultant, regular pharmacist, specialist nurse, care home nurse lead for this individual)
- Known allergies and reactions to medicines or ingredients, and type of reaction experienced if known
- Current list of medicines, including name, strength, form, dose, timing and frequency, route of administration, and indication. This should include both prescribed medicines and those purchased over the counter
- Recent changes to medicines, including medicines started, stopped or dosage changed, and reason for change
- Date the last dose of any medicines was taken if given less often than once a day (includes 'when required', weekly, monthly, and quarterly medicines)
- Other information, for example when the medicine should be reviewed or monitored, any support the resident needs to carry on taking the medicine, e.g.
    - compliance aids
    - the consistency of thickened fluids needed for those with swallowing difficulties
    - details of flushes before and after medicines in PEG fed residents

References

1. NICE guidelines [NG5] Medicines optimisation March 2015 accesses at https://www.nice.org.uk/guidance/ng5
2. Keeping patients safe when they transfer between care providers – getting the medicines right LINK
3. Patient safety and Quality: An Evidence-Based Handbook for Nurses LINK
4. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes accesses at https://www.nice.org.uk/guidance/ng5/chapter/Key-priorities-for-implementation
5. NICE Managing medicines in care homes SC1: 2014 see LINK
6. Medicines reconciliation. LINK

Appendix 1: The Medicines Reconciliation Process (Accurately listing a residents medicines)

Care homes should follow the three steps (3C's) to medicines reconciliation (see below) - **Collecting, Checking and Communicating**.



***Sources of Information used in Reconciliation:**

Information for medicines reconciliation can be obtained from a variety of sources and at least two sources must be used

Examples of most reliable Information Sources	Examples of less reliable Information Sources
• Recent and dated computer print-out from a GP clinical records system • Recent and dated patient's repeat prescription request slip • Recent and dated hospital discharge summaries(check that all the patients medications are listed, not just those which were changed during the hospital stay) • Verbal information from the patient, their family, or a carer • Residents own drugs(check dispensing dates)	• Medicine administration record (MAR) sheets • Community pharmacy patient records • Care Plans • Care home managers • A monitored dose system(MDS) and other compliance aids • A medicines reminder
• *Residents consent is essential when obtaining information (refer to care homes Consent Policy).* • *If there are communication difficulties in obtaining information from the patient/carer, there should be more than one method of ensuring the accuracy of information. Alternative methods of communicating with the patient should be accessed e.g. interpreters, writing, sign language.* • *If using the Medicines Reconciliation Form record Information collected and the source on the form.* • *Any sources that are attempted to be accessed, but unavailable, should be documented.*	

Patient name:	☐ No known Allergies
Date of Birth:	☐ Allergies as follows
NHS no:	Describe reaction(if applicable)

Information source list(At the least 2 sources must be used)Tick which

Print-out from a GP clinical records system	
Repeat prescription request slip	
Hospital discharge summaries	
Resident/ client	
Family or carer	
Residents own drugs	
MAR charts	

Types of discrepancies

- Medicine is not currently prescribed
- Client no longer taking medicine
- Allergy to prescribed medicine
- Duplication of medicine
- Drug interaction
- Formulation incorrect or omitted
- Dose different
- Route different
- Frequency different
- Others (state e.g. illegible document)

Medications (This includes Prescription, Over the Counter and complementary medicines)	**Dose**	**Route**	**Frequency**	**Discrepancies Yes or No**	**Continue Yes or No**	**Comments and Who contacted**

Additional comments: e.g. explain where there are differences between information source list

Name:---------- Job title:---------- Signature:---------- Date:----------