Wrightington, Wigan and Leigh Teaching Hospitals
NHS Foundation Trust

STANDARD OPERATING PROCEDURE:	**MEDICINES RECONCILIATION**
SOP NO:	**TW10-037 SOP 3**
VERSION NO:	**4**
APPROVING COMMITTEE:	**MMSB** **(Medicines Management Strategy Board)**
DATE THIS VERSION APPROVED:	**September 2020**
RATIFYING COMMITTEE:	**PARG** **(Policy Approval and Ratification Committee)**
DATE THIS VERSION RATIFIED:	**October 2020**
AUTHOR(S)	**Pharmacy SMG** **(Pharmacy Senior Management Group)**
DIVISION/DIRECTORATE	**MEDICINE/PHARMACY**
LINKS TO OTHER POLICIES, SOP'S, STRATEGIES ETC:	**TW10/037 Medicines Management Policy**
CONSULTED WITH	**MMSB Membership**

Date(s) previous version(s) approved (if known)**:**	**Version:2** **3**	**Date: July 2014** **December 2016**
DATE OF NEXT REVIEW:	**October 2023**	
Manager responsible for review *N.B. This should be the Author's line manager*	**Director of Pharmacy**	

The WWL Way

AT ALL TIMES, STAFF MUST TREAT EVERY INDIVIDUAL WITH RESPECT AND UPHOLD THEIR RIGHT TO PRIVACY AND DIGNITY

1 INTRODUCTION

1.1 The aim of medicines reconciliation on admission to hospital is to ensure that medicines prescribed during admission correlate with those that the patient was taking before admission unless deliberate changes have been made.

1.2 The purposes of this document are:-

1.2.1 To ensure each patient has their medication history confirmed and medicine reconciliation as soon as possible after admission to hospital (ideally within 24 hours).

1.2.2 To ensure the patient's medication is assessed, prescribed correctly and appropriately.

2 PROCEDURE STATEMENT

The procedure defines the responsibilities of prescribers (doctors, dentists and non-medical prescribers), pharmacists, medicines management technicians and other staff in the medicines reconciliation process.

3 KEY PRINCIPLES

3.1 The patient receives the correct medication on admission to the hospital, after transferring between wards and on discharge.

3.2 The patient's allergy status is recorded accurately from at least two reliable sources.

3.3 A medication history is established from at least two reliable sources. The primary source (where appropriate) should be the patient and with the patient's consent, the patient's GP medication records should always be used as a second source when obtaining a medicines reconciliation.

3.4 Medication history will be accurately recorded in the appropriate place. For the purposes of this SOP this will mean the "Medicines Reconciliation" document on HiS or where medicine charts are still in the use the corresponding section on the chart

3.5 Patients own medication (POD) is checked for validity and patient compliance.

3.6 That medicines prescribed are suitable and fit for purpose

3.7 Discrepancies between the medication history and the prescribed medication are documented and actioned correctly. This would usually involve discussion with the team but should also be recorded in an appropriate place (e.g. MDT section, patient notes, nursing plan)

4 MEDICINE RECONCILIATION PROCEDURE

Confirming a Medication History

Please could you refer to the appropriate section: prescribers or pharmacy:

4.1 Prescribers

4.1.1 Introduce yourself to the patient; explain who you are and that you want to confirm their medication history. Confirm the patient's ID, by checking three points of reference: Their full name, Date of Birth, checking the patient's unit number/NHS number & patient's wrist band (non-admitted patients may not have a wrist band e.g. A&E minors)

4.1.2 If they are able to answer, confirm with the patient if they have any drug allergies or are intolerant of any medications. This information must be documented in HiS using the allergies summaries tab or added to medicine charts where still in use. The entry must be signed and dated and include the following information if known:-

4.1.2.1 Causative agent,
4.1.2.2 Signs, symptoms and severity of reaction
4.1.2.3 Date the reaction occurred

4.1.3 Ask if they take any regular medication from either their GP or that they may buy over the counter e.g. (herbal remedies) and ask if they have brought their medication in with them.

4.1.3.1 If they have their medication with them, please refer to Section 6 and Appendix 1- how to assess PODs.
4.1.3.2 If the patient hasn't brought their medication in, but is aware of the medication they take and you are confident the information is accurate then complete a medication history, recording this in the "History of Home Medication" box within the Medical Assessment Document on the HIS system or paper notes where still in use.

4.1.4 Document if the patient is known to have or suspected to have any compliance issues.

4.1.5 If a repeat prescription is used to obtain the medication history, confirm that it is for the correct patient, it is in date (within 2 months of current date) and that the repeat prescriptions, if numbered, are all present.

4.1.6 Carers/relatives of the patient may be used as a source of information in the absence of PODs/suitable patient information.

4.1.6.1 The most appropriate sources should be consulted e.g. carers/relatives/GP surgery/EPR (previous discharge letters, consultant letters), Community Drug Team, Nursing home records – MAR sheets, community pharmacy. Please refer to section 5.
4.1.6.2 Summary Care Records (SCR) or Medical Interoperability Gateway (MIG) should be accessed for up to date medication lists held on GP surgery records wherever one exists. NB permission must be sought and granted by the patient before records are accessed.
4.1.6.3 If the patient is unconscious/otherwise unable to consent and a medication history is deemed in the patient's best interest, then the SCR/MIG can be accessed without permission of the patient – you will be asked to record a disclaimer on the SCR confirming this. The Information Governance Team will follow up on a proportion of these.

4.1.7 If the patient's takes no regular medications, please document this in the "History of Home Medication" box within the Medical Assessment Document on the HIS system or paper notes where still in use.

4.1.8 Refer to TW10/037 SOP4 - Prescription Chart Procedure for prescribing of medications for patients where prescription charts are still in use or you're his training materials for HIS prescribing.

4.2 Pharmacy

4.2.1 Locate the patient on the HIS system and check their "documents" section to see whether a medication history has already been completed. In areas where prescription charts are still in use, check the inside cover of the chart.

4.2.2 Introduce yourself to the patient; explain who you are and that you want to confirm their medication history.

4.2.3 Confirm the patient's ID, by checking three points of reference: Their full name, Date of Birth, checking the patient's unit number/NHS number & patient's wrist band (non-admitted patients may not have a wrist band e.g. A&E minors) Ask the patient for consent to access their medication history from their GP if needed.

4.2.4 If they are able to answer, confirm with the patient if they have any drug allergies or are intolerant of any medications. This information must be documented in HIS using the allergies summaries tab or added to medicine charts where still in use. The entry must be signed and dated and include the following information if known:-

4.2.4.1 Causative agent.
4.2.4.2 Signs, symptoms and severity of reaction.
4.2.4.3 Date the reaction occurred.

4.2.5 Ask if they take any regular medication from either their GP or that they may buy over the counter e.g. (herbal remedies) and ask if they have brought their medication in with them.

4.2.5.1 If they have their medication with them please refer to Section 6 and Appendix 1- how to assess POD's.
4.2.5.2 Ask the patient if they have further supplies of medication at home and clearly document this.
4.2.5.3 If they have any items that aren't stocked within the hospital, ask whether a representative can bring them in from home.

4.2.6 If the patient hasn't brought their medication in, but is aware of the medication they take and you are confident the information is accurate then complete a medication history, recording this in the "Medicines Reconciliation" document on HIS or where medicine charts are still in the use the corresponding section on the chart. Ask the patient if they have further supplies of medication at home and clearly document this.

4.2.7 For each medication from the history, document if the patient has any known compliance issues.

4.2.8 If a repeat prescription is used to obtain the medication history, confirm that it is for the correct patient, it is in date (within 2 months of current date) and that the repeat prescriptions, if numbered, are all present.

4.2.9 Even If the patient is able to confirm their medication history, another source must be used to establish the medication history.

4.2.10 The most appropriate source should be consulted e.g. carers/relatives/GP surgery/EPR (previous discharge letters, consultant letters), Community Drug Team, Nursing home records – MAR sheets, community pharmacy. Please refer to section 5.

4.2.10.1 Summary Care Records (SCR) or Medical Interoperability Gateway (MIG) should be accessed for up to date medication lists held on GP surgery records wherever one exists. NB permission must be sought and granted by the patient before records are accessed.

4.2.10.2 If the patient is unconscious and a medication history is deemed essential to prevent loss of life, then the SCR can be accessed without permission of the patient – you will be asked to record a disclaimer on the SCR confirming this and may be contacted by a member of the Information Governance team. Record that you have obtained consent in the speech bubble in the "Sources" section of the HIS medicines reconciliation document or add this information to the medicine chart where still in use.

4.2.11 If the patient takes no regular medication, this should be documented on in the Medicines Reconciliation note on the HIS system or on the prescription chart if still in use.

4.2.12 On completion of a clinical check, the pharmacist must sign, date and add time of verification to the Medicines Reconciliation Note on HIS.

4.2.13 For critical medicines the dose **and indication** must be clinically checked by the pharmacist

5 VALIDATION - RINGING DIFFERENT SOURCES TO GAIN INFORMATION

Guidance on seeking information regarding the patient's medication e.g. G.P. Surgery, nursing home, community pharmacy etc.

5.1 Have the patient's details to hand before ringing the appropriate person, including their full name, date of birth (DOB), residential address and NHS number.

5.2 Follow Information Governance procedures for ensuring that the number connected to is an appropriate and authorised source of information (as per SOP TW10/110 Secure Methods to Transfer Information).

5.3 On phoning the information source, inform the person answering the phone who you are and where you are calling from. Explain that you want a medication history for one of their patients or residents.

5.4 Confirm with the person providing the information, the patient's name and the DOB and the address of the patient to prevent misidentification e.g.: - duplication of the same name. Some sources will require NHS number so ensure that this is available.

5.5 Record full details of the patient's regular medication including directions, strengths and any specific brands.

5.6 Confirm that all items are current and or have been prescribed recently and also ask about acute items which do not form part of the regular prescription.

5.7 Confirm any allergies and intolerances the patient may have.

5.8 Some information sources will only email the information; in that case provide your NHS.NET email address so they can do so. If non NHS.NET email addresses are used at either end of the transfer then the message must be suitably encrypted.

5.9 Some information sources will ask for the telephone number to ring back, to confirm who they are talking to, others may also ask for a headed note paper fax, detailing all information required. Trust approved paperwork to be used.

5.10 Thank them for their assistance.

6 ASSESSING PATIENTS' OWN MEDICATION. (PODS)

6.1 Patients are encouraged to bring into hospital all currently prescribed and over the counter medication (OTC). On arrival to hospital a green patient's own medication bag should be used to consolidate the medicines and to identify the patient's medicines. Refer to the flowchart in Appendix 1.

6.2 Each POD must be assessed individually on admission for suitability.

6.3 The medicine must be in its original container and be in good condition, physically intact, dry, clean and uncontaminated. Blister strips should not be used.

6.4 The medication must contain a clear label showing:-

6.4.1 Correct patients name
6.4.2 Correct drug name
6.4.3 Correct drug strength
6.4.4 Expiry date and dispensing date (as below)
6.4.5 Confirm contents of box match the label.

6.5 Eye, Ear or Nose Drops may be used if they have been dispensed within the previous month and are in date. Opened creams and ointments and oral liquids may be re-used if they have been dispensed within the previous 3 months and are in date.

6.6 Patients' own controlled drugs may be reused. This must be logged in the patient own controlled drugs register and stored in the ward controlled drugs cupboard – Patient's own controlled drugs must **not** be stored in patient's bedside (OSD) lockers.

6.7 PODs that must be stored in the fridge can only be reused if the cold storage chain can be verified. **NB** unopened insulin that the patient has with them must be put in the fridge on admission. However, an opened vial/pen that they are using may be stored at room temperature in the bedside locker for up to 28 days after opening. (Actrapid vials can be used for up to 42 days)

6.8 Do not use any items that are in a dosette box/blister pack or other monitored dosage system (MDS) where medicines are mixed together so that identification of the medication cannot be determined. MDS should be stored in the POD locker. MDS containing controlled drugs must be stored in CD cupboard and entered into the patient's own CD Register. MDS may be reused for discharge if no changes are made to preadmission medication.

6.9 **NB**. (Pharmacy staff only): If the patient was admitted on a blister pack, this must be documented by ticking the "Compliance Aid" button in the Medication Reconciliation document on HIS or on the medicine chart in areas where these are still in use. Remember to add full contact details for the community pharmacy that provides the blister pack.

6.10 When Pharmacy is closed, nursing staff and doctors should refer to the Out of Hours Procedure in Appendix 2

6.11 No medication should be removed, destroyed or sent home until the full pharmacy medicines reconciliation has taken place and then only with the consent of the patient.

6.12 Remember, if in doubt, do not reuse.

7 RESPONSIBILITIES OF STAFF

It is the responsibility of all staff to ensure that:

7.1 PODs are only used when suitable.

7.2 PODs are used for the named patient only.

7.3 Patients own CD's are locked away in the CD cupboard and recorded in the patients' own CD book and not stored in the patient's bed-side locker.

7.4 Destruction of POD's must have patient's verbal consent and only be carried out by pharmacy teams.

8 LANGUAGE BARRIERS

Patients that don't speak English as their first language, should be assisted by using an interpreter if needed: - Telephone: #6888 or 0800 028 0073 (24hrs). Further information on interpreter/sign language services available can be found on the Trust intranet: http://intranet/Departments/Interpreter_Services/default.asp

9 DISCREPANCIES

9.1 Check the Medicines Reconciliation Note against the eMAR on HIS for any discrepancies between the medication history and the medication prescribed.

9.2 Check and confirm whether any changes or omissions are intentional.

9.3 Document any outstanding discrepancies whether intentional or not in the 'issues to be resolved' box in the Medicines Reconciliation Note or Pharmacy Progress Note in HiS as appropriate. Areas not on HIS should have this recorded on the prescription chart and in the notes.

9.4 Unintended critical medicines omissions must be corrected immediately

10 HUMAN RIGHTS ACT

Implications of the Human Rights Act have been taken into account in the formulation of this document and they have, where appropriate, been fully reflected in its wording.

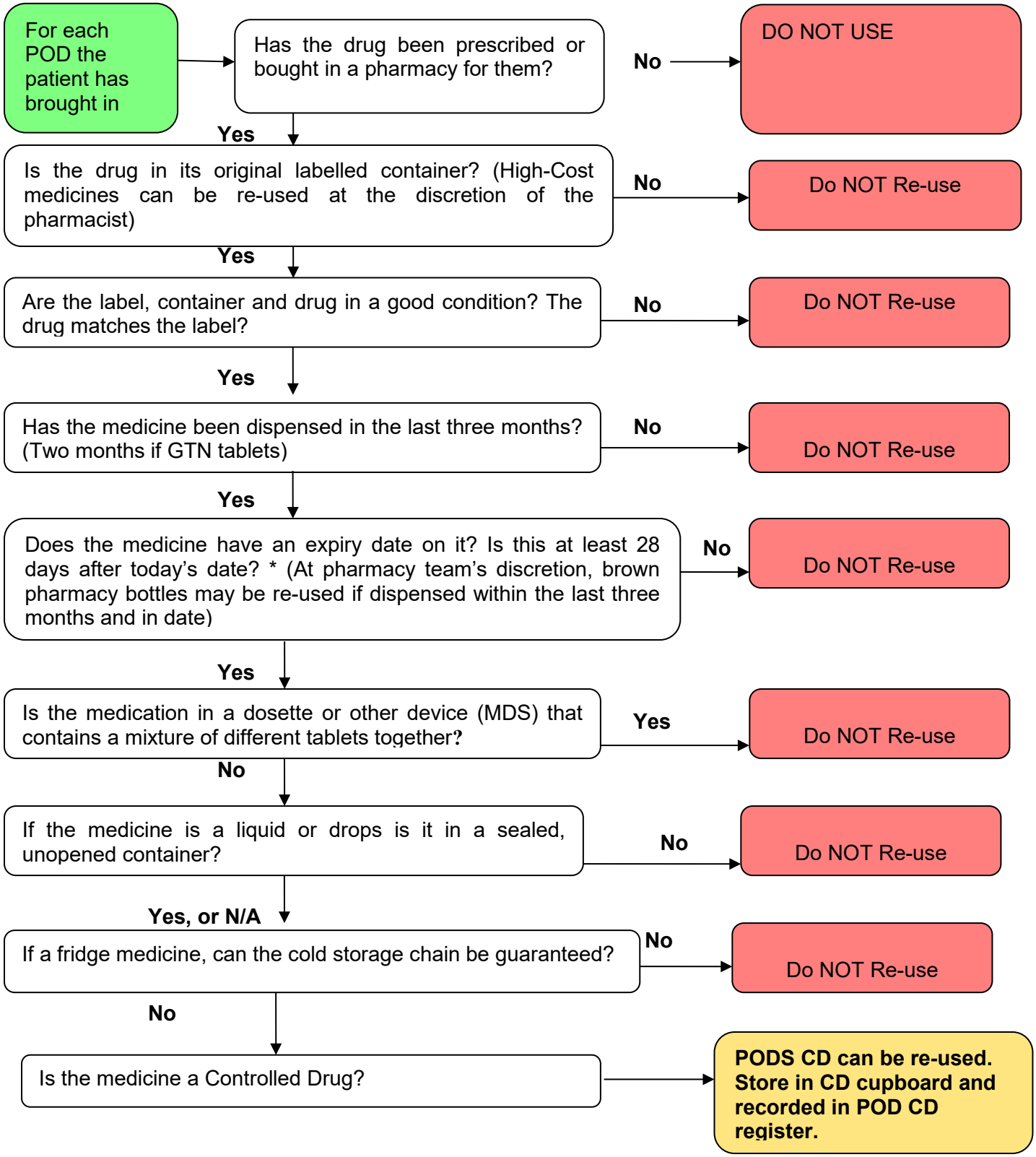
11 ACCESSIBILITY STATEMENT

This document can be made available in a range of alternative formats e.g. large print, Braille and audio cd.
For more details, please contact the HR department on 01942 77 3766 or email equalityanddiversity@wwl.nhs.uk

Appendix 1

Checklist for Suitability of PODS - Pharmacy

Use the following algorithm for each POD the patient has with them to see if OK to re-use



Appendix 2

Checklist for Suitability of PODS – Nurses and Doctors