Medicines Reconciliation in Hospital Policy

Written by:	**Medicines Governance Team, NHSGGC**
Approved by:	**Area Drug & Therapeutics Committee: Safer Use of Medicines Sub-Group, NHSGGC**
Approval date	**March 2025**
Review date:	**March 2028**

1. Introduction

Medicines are the most common intervention in the NHS and their safe use requires collective and collaborative effort between the multidisciplinary team and patients. Medicines reconciliation is a key step to ensuring that patients are prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation, and that avoidable harm from medicines is reduced. Accurate, timely medicines reconciliation on admission to, and discharge from, hospital is an integral part of clinical care and takes time to complete.

Medicines reconciliation on admission to hospital involves obtaining an up-to-date and accurate list of medication which the patient was taking pre-admission and documenting which medicines are to be continued, altered, with-held or stopped, in addition to documenting any known allergies the patient has. All medicines to be continued should then be prescribed (and allergies documented) on the appropriate prescribing system in use e.g. Hospital Electronic Prescribing and Medicines Administration (HEPMA) system. Medicines reconciliation at discharge involves obtaining an up-to-date and accurate list of medication the patient is taking at discharge and documenting on the Immediate Discharge Letter (IDL) which medicines are to be continued at home and which pre-admission medicines have been stopped or changed during this episode of care.

2. Aim of Policy

The policy describes the roles and responsibilities of staff groups, outlines key principles and signposts step by step guidance for completing the medicines reconciliation processes.

3. Scope

This policy applies to all clinical areas within NHSGGC hospital environments which admit and discharge in-patients and to all NHSGGC healthcare professionals working within these areas.

4. Responsibilities

Management and the multidisciplinary clinical team (MDCT) have a collective responsibility to ensure medicines reconciliation is reliably completed for each patient. It is important that the responsibilities of individual members of staff are clearly defined and understood by everyone in the MDCT. Patients and their relatives / carers are central to obtaining an accurate medication history and it is the responsibility of appropriate members of the MDCT to engage them in this process.

The responsibilities of individual disciplines are outlined below. The term ‘Prescribers’ applies to medical and non-medical prescribers where they have a defined role in the medicines reconciliation process.

Directors, Senior Managers and Clinical Directors

- Overall responsibility for ensuring there are safe, reliable, consistent processes for medicines reconciliation in place for patients within their service area.

Consultants

- provide clinical leadership to support safe, reliable, consistent implementation of medicines reconciliation processes for the patients under their care.
- supervise the performance of resident doctors, ensuring compliance with this policy and taking appropriate remedial action when practice does not comply with the policy.

Prescribers with responsibility for patients within a specific clinical area

- complete the medicines reconciliation process and produce a complete and accurate in-patient prescription for their patients within 24 hours of admission to hospital. (The medicines reconciliation and prescribing process on admission to hospital should be completed sequentially by the prescriber who is undertaking the initial patient assessment and clerk-in).
- maintain a complete and accurate prescription record during the patient's stay, including documenting reasons for changes in the clinical notes and/or on the appropriate prescribing system.
- complete the medicines reconciliation process at discharge, producing a complete and accurate Immediate Discharge Letter (IDL) which includes details of all medicine changes made during the patient's stay.

Pharmacists / Pharmacy technicians undertaking clinical roles

- verify the medicines reconciliation process has been completed by the prescriber and medicines accurately prescribed in the prescription record. This should be done as soon as possible during the patient admission.
- identify discrepancies (e.g. errors or omissions) in the prescription record or IDL and take appropriate corrective action (e.g. raise for review with the prescriber).
- where possible, IDLs will be reviewed by a pharmacist with knowledge of the patient and access to their prescription record and clinical notes. This enables verification that medicines have been correctly reconciled and information in the IDL, including reasons for changes, is complete and accurate.

Nurses:

- highlight to the prescriber any patients under their care (who they become aware of) who have not had medicines reconciliation completed within 24 hours of admission.
- flag discrepancies (errors or omissions) in the prescription record that they become aware of to the prescriber and agree appropriate corrective action.
- flag identified discrepancies (errors or omissions) in the IDL to the prescriber and agree appropriate corrective action.

5. Medicines Reconciliation Principles & Procedures

Medicines reconciliation primarily takes place on admission to hospital and at discharge home, but there is also a requirement to reliably communicate complete and accurate medicines information when patients are transferred between wards and hospitals.

In NHSGGC, medicines reconciliation on admission to hospital must be documented in an approved system / paperwork e.g. on Clinical Portal or in dedicated medicines reconciliation paperwork in notes. The PREFERRED METHOD is via the Clinical Portal two-step process of Medication History and Admission Review. Medicines reconciliation at discharge is also recorded on Clinical Portal as a Discharge Medication Review and is integrated within the IDL pathway. Full details on how to use this system can be accessed here.

The following principles should be adhered to when undertaking medicines reconciliation:

Admission to Hospital

- The medicines reconciliation process and an accurate prescription record must be completed within 24 hours of admission. For safety reasons this should be carried out by the prescriber undertaking the initial assessment and clerk-in of the patient.
- A minimum of **TWO** information sources must be used to obtain a list of medicines being taken by the patient and details of any medication allergies/sensitivities. The patient / carer should be involved in the medicines reconciliation process if at all possible. The process routinely starts with the most up to date and reliable source of information, which is usually the Emergency Care Summary (ECS), which should be verified with the patient or carer where possible. Dates on information sources must be carefully checked to ensure the information is up to date. Other useful sources are listed in Appendix 1. **Note:** In some circumstances there may only be one information source available. In this situation medicines reconciliation should still be completed, but a second source should be identified and checked at the earliest opportunity.
- The clinical appropriateness of each medicine, within the context of the patient's current clinical condition and reason for admission, should be considered before deciding which medicines are to be continued, withheld, amended or stopped.
- All medicines to be continued and details of medication allergy/sensitivities must be accurately transcribed to the prescribing record e.g. HEPMA.

During Stay/Transfer

- A complete, accurate and legible prescription record should be maintained during the patient's stay. If a medicine is started, amended, withheld or stopped then the reasons should be recorded in the patient's record.
- When a patient requires to be transferred to another ward or hospital the prescriber

should review the ongoing appropriateness of the medicine, within the context of the transfer, and update the prescription record accordingly

- Appropriate arrangements should be made to ensure medicine information is transferred when patients' transfer. If transferring to hospital areas outwith NHSGGC this will necessitate transfer letters or similar documentation.

Discharge from hospital

- The prescription record (e.g. current HEPMA record) must be reconciled with the last recorded medicines reconciliation (e.g. the Admission Review on clinical portal) to identify medication changes during the patient's stay.
- The clinical appropriateness of each medicine post discharge should be considered before deciding which medicines are to be continued, restarted or stopped. This should include reconsideration of any medicines withheld during the hospital admission.
- The following medicines information should be recorded in the IDL

  Continuing Medicines
  - Medicine name, dose, frequency, form/route
  - The duration/stop date if a medication is only to be continued for a fixed period of time e.g. course of antibiotics

  New Medicines
  - Medicine name, dose, frequency, form/route
  - The duration/stop date if a medication is only to be continued for a fixed period of time e.g. course of antibiotics
  - Indication/Reason for starting each new medicine

  Stopped Medicines
  - Medicine name, dose, frequency, form/route
  - Reason for stopping each medicine

- A final check of the medicines supplied to the patient must be carried out by the nurse discharging the patient by reconciling the IDL, prescription record, and medicines prior to the patient going home and the IDL being finally authorised. Identified discrepancies (errors or omissions) should be promptly resolved with the prescriber.

6. Education & Training

Clinical Directors and professional leads should ensure staff with responsibilities for medicines reconciliation are familiar with this policy and associated guidance. Medicines reconciliation training and policy awareness should be incorporated into induction training for all new staff with responsibilities for medicines reconciliation.

7. Policy Review

This policy will be reviewed every three years, unless the introduction of any new or amended legislation warrants an earlier review

Appendix 1: Information sources for Medicines Reconciliation

Patient/Carer

Emergency Care Summary

Patient's own medicines

GP letter

GP Practice print-out

GP repeat prescription order slip

Medicines Administration Record Sheet

GP phone call

Community pharmacist

Nursing home phone call

Case notes/previous IDL

Clinic letters

District nurse

Anticoagulant clinic

Mental Health Summary in clinical portal