Kent and Medway CCG

Medicines Reconciliation

Best Practice Guidance

Approved by KMMOC and Clinical Cabinet
Approval Date: Ratified by Clinical Cabinet May 2022
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What is medicines reconciliation?

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

Why is medicines reconciliation important?

Up to 70% of patients transferring between care settings experience an unintentional medication change or error[1].

The Care Quality Commission (CQC) in Outcome 9: Management of Medicines states:

- The need for safe and appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines.
- Patients are to have, where possible, information about prescribed medication made available to them or to people who act on their behalf.
- Patients are to have their medicines at the times they need them, and in a safe way.

In order to minimise risk and ensure patient safety, accurate medicines reconciliations must be undertaken in a timely manner to deliver these standards.

Who is responsible?

It is the responsibility of the care home manager or the listed responsible person to reconcile all patient medications as part of a full needs assessment and care plan. Those carrying out medicines reconciliation must be suitably trained and competent to do so.

Patients and/or family members or carers, pharmacists and other health and social care practitioners as agreed locally e.g. nurses and end-of-life facilitators involved in managing medicines for the resident should be involved in medicines reconciliation where possible.

When should medicines reconciliation be done?

As soon as possible, for new and returning residents, following admission/readmission into the care home, from home, hospital or another care setting.

When a treatment has changed, ideally before the first dose is given or as soon as possible afterwards.

What should be included in medicines reconciliation on admission to a care home?

- Patient’s details including full name, date of birth

- GP's details, details of other relevant contacts defined by the resident/family/carers (e.g. the consultant, regular dispensing pharmacist, specialist nurse).

- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced (e.g. rash, sickness, anaphylaxis).

- Any medicines currently being taken including name, strength, form, dose, timing and frequency and indication, if known.
- Specific times of doses for time specific medicine such as Parkinson's medications.
- Date and time the last dose of any 'when required' medicine was taken, if known.
- Date and time of any medicine given less often than once a day (weekly or monthly medicines), if known.
- Other information including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support) e.g. a spacer device for certain inhalers.

How do I reconcile a patient's medication?

See Appendix 1 for a flowchart of the stages involved in medicines reconciliation. Registered managers must use a minimum of **TWO** **RELIABLE** sources of information to reconcile medicines. Examples of suitable sources include:

- Printed discharge summary
- Patient's own labelled medication
- GP Summary
- MAR chart
- Resident/carer/relative interview
- Discharge prescription or copy of repeat prescription – check the date on prescription to make sure it is a current list.

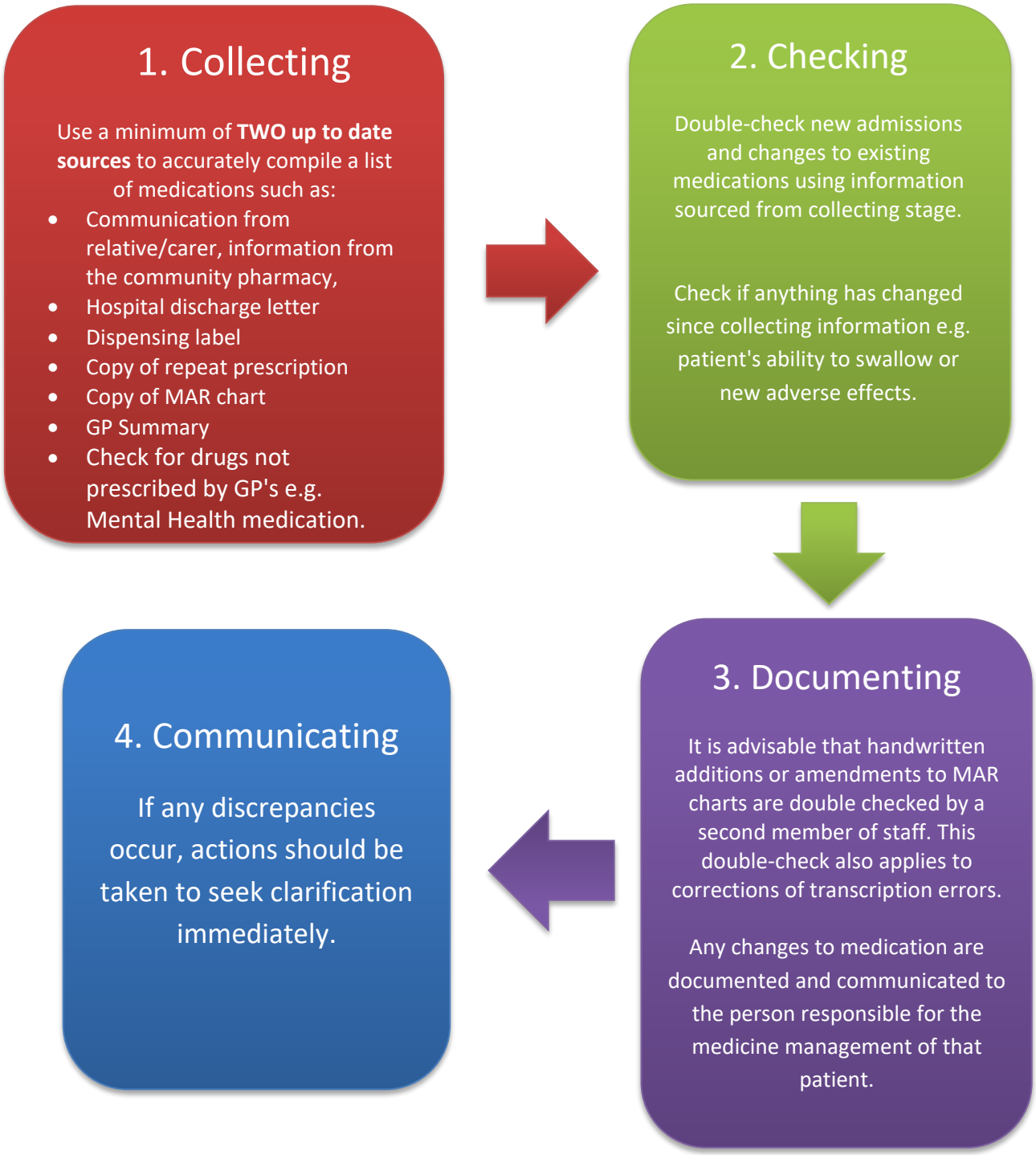
It is always best where possible to ask the resident or their carer the medicines they take and how they take them as patients do not always take their medications as prescribed.

High Risk Medications

For high risk medications (e.g. Methotrexate, Lithium, Clozapine, Sodium Valproate, Phenytoin, Warfarin) it is advisable to check doses and frequencies with the relevant GP/external providers/ monitoring booklets during the medicines reconciliation process.

Sources:
1 NICE Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes [NG5] Published date: 04 March 2015:
https://www.nice.org.uk/guidance/ng5/chapter/Introduction
Care Quality Commission (CQC), 2010. Summary of regulations, outcomes and judgement framework. CQC: London.
CQC Medicines Reconciliation (how to check you have the right medicines):
https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-reconciliation-how-check-you-have-right-medicines
National Institute for Health and Care Excellence (NICE), 2014. Managing medicines in care homes. NICE: London.

Appendix 1: Stages of Medicines Reconciliation



Appendix 2: Medicines Reconciliation Sheet

Medicines Reconciliation Sheet

Name		DOB	
Name and address of usual GP surgery		Name of GP (if known)	
Allergies and type of reaction			
Medical conditions			

Medication: Tablets, capsules, liquids, inhalers, creams, patches, injections (please include medication from other sources e.g. specialist services, community nurses, KMPT, over the counter/patient's own medication etc.)

Name of medication	Strength	Form	Dose and time/frequency	Indication (if known)	Quantity received

Sources of information used:	

Other comments: (recent changes to medication, last time and dose of PRN medications, weekly/monthly administrations)

Completed by		Checked by	
Job Title		Job Title	
Date completed			

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