All Wales Medicines Strategy Group

Grŵp Strategaeth Meddyginiaethau Cymru Gyfan

All Wales Multidisciplinary medicines reconciliation policy

This resource has been retired in June 2025

This resource has been retired and is no longer considered an AWMSG-endorsed resource.

The resource underwent an assessment for review in February 2025. At that time, members of the All Wales Prescribing Advisory Group (AWPAG) considered it appropriate to retire the resource.

The content contained within the resource was considered to be out of date and other suitable alternative guidance available (e.g. QS210 Medicines optimisation (NICE) and Medicines reconciliation (Care Quality Commission)), AWPAG members considered it most appropriate for the resource to be retired at this time.

If you think this resource should be reconsidered for review, please get in touch with AWTTC by emailing AWTTC@wales.nhs.uk.

June 2017

This document has been prepared by the Quality and Patient Safety Delivery Group of the All Wales Chief Pharmacists Group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

This resource has now been retired and is no longer considered an AWMSG endorsed resource.

Please direct any queries to AWTTC:

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1.0 INTRODUCTION

Medicines reconciliation is the process of identifying the most accurate list of a patient's current medication and comparing it with the list currently in use, recognising any discrepancies, and documenting any changes, thus resulting in a complete list of medications accurately communicated[1].

Completion of medicines reconciliation when patients are transferred between care settings reduces the risk of patients experiencing harm from their medication. Ensuring a good medicines reconciliation process will lead to:

- Patients receiving the right medicine, at the right dose, at the right time;
- A reduction in medication errors related to transcription;
- Improved diagnosis and management for medical and surgical patients;
- Reduced confusion for patients and staff about the patient's medication regimen;
- Improved service efficiency;
- Reduced re-admission due to sub-optimal treatment.

As the absence of medicines reconciliation can lead to serious patient harm, Welsh Government released a Patient Safety Notice: PSN028: Medicines Reconciliation – Reducing the risk of serious harm[2].

Ensuring completion of medicines reconciliation, for patients who require it, is the responsibility of all healthcare professionals involved with managing the patient's medication (i.e. pharmacist, pharmacy technician, nurse and doctor).

2.0 PURPOSE

The purpose of this document is to:

- Detail the responsibilities of staff involved in the medicines reconciliation process.
- Provide guidance for completing medicines reconciliation.

3.0 SCOPE

This document applies in all care sectors where medicines reconciliation is required.

4.0 ROLES AND RESPONSIBILITIES

Prescribers:

- In all areas, prescribers are responsible for ensuring accuracy of the patient's medication regimen.
- The prescriber must document any intentional changes to a patient's medication regimen.
- The prescriber is responsible for resolving issues communicated from the medicines reconciliation process.

Healthcare professionals completing medicines reconciliation:

- Healthcare professionals completing medicines reconciliation must be trained and competent to do so, and may be a pharmacist, pharmacy technician, nurse or doctor. All professionals completing medicines reconciliation must do so to an agreed standardised format.
- In the acute setting, healthcare professionals completing medicines reconciliation must do so within 24 hours (or sooner if clinically necessary) of the patient being admitted.
- Healthcare professionals may also need to carry out medicines reconciliation on more than one occasion during an acute hospital stay, for example when a drug chart is rewritten or when a patient is transferred between acute hospitals.
- When patients are discharged from hospital, use of the Discharge Medicines Review (DMR) service should be considered as a method of communicating medicines reconciliation issues for appropriate patients.
- In primary care, healthcare professionals completing medicines reconciliation must do this for all people who have been discharged from hospital or another care setting. Medicines reconciliation should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within one week of the GP practice being informed that the patient is being discharged.

5.0 MEDICINES RECONCILIATION PROCESS

There are three steps to the medicines reconciliation process:

i. Collecting
ii. Checking
iii. Communicating and action

Step i: Collecting

This involves the collection of the medication history (see Appendix 1), usually from a variety of different sources, to gain a comprehensive and accurate list of medications. NICE recommends that the medication history should be collected from at least two reliable sources (see Appendix 2). In practice, one source may be sufficient if the practitioner is confident that this is a complete and accurate record.

The patient/carer should be asked about adherence to their medication regimen.

Step ii: Checking

The checking step involves ensuring that the medicines, doses and formulations that are prescribed for the patient are correct. During the checking step, it should be confirmed whether any discrepancies between the medicines the patient has been taking in their previous care setting and the medicines prescribed in their new setting are:

- Intentional (i.e. documented change by the clinician(s) responsible for the patient), or
- Unintentional (i.e. was not a conscious change).

Step iii: Communicating and action

Communicating and action is the final step in the process. Where changes to the patient's prescription are required, these should be communicated to the prescriber and any changes agreed and actioned appropriately. Medicines reconciliation is complete once communication has occurred.

Pharmacists may action/resolve certain issues in line with pharmacist enabling protocols.

The following information should be documented in the appropriate place (e.g. medicines chart, local pro forma or patient's notes):

- Sources of information used for collecting the medication history.
- Intentional medication changes not already documented.
- Unintentional medication changes that cannot be resolved immediately.
- Adherence issues identified.
- Any follow up requirements identified during the medicines reconciliation process.
- Future transfer requirements between care settings such as medicines compliance aids, medication administration record (MAR) sheets and communication with specialist teams.
- It is also considered good practice to document useful telephone numbers obtained during medicines reconciliation.
- Confirmation that all steps of medicines reconciliation have been completed. On the All Wales Inpatient Drug Chart this can be done by signing and dating the medicines reconciliation box.

The patient/carer must be informed of any changes that are made to the patient's medication.

6.0 REFERENCES

1. National Institute for Health and Care Excellence. NICE Guideline 5: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (NG5). 2015. Available at: https://www.nice.org.uk/guidance/ng5. Accessed March 2017.
2. Welsh Government. Patient Safety Notice PSN028 Medicines Reconciliation – Reducing the risk of serious harm. 2016. Available at: http://www.patientsafety.wales.nhs.uk/sitesplus/documents/1104/PSN028%20Medicines%20Reconciliation%20-%20Reducing%20the%20risk%20of%20serious%20harm1.pdf. Accessed March 2017.

APPENDIX 1: GOOD PRACTICE GUIDE WHEN TAKING A MEDICATION HISTORY FROM A PATIENT

1. Introduce yourself to the patient and explain the purpose of your visit, where appropriate.

2. Confirm with the patient whether they have any medication allergies or experience any adverse drug reactions (ADRs). If so, ask about the nature of the reaction and document this information in the drug allergy/hypersensitivity box on the medication record chart:
   - If the patient has no known drug allergies/hypersensitivities, then document as 'NKDA'
   - If unknown, use other sources to determine allergy status where possible.

3. Ask the patient if they have brought their own medicines and/or a list of their medicines into hospital or out of hospital.

4. Ascertain what medicines the patient was using regularly in their previous care setting prior to admission (see Appendix 2: Sources of medication histories).

5. Ask the patient for details of medicine name, formulation, strength and frequency of administration for each medication.

6. Where the patient has been transferred from another care setting, check the medication history against the medication record chart or administration record from that setting.

7. In addition to asking the patient about regularly prescribed medicines, check if the patient is using any inhalers, eye drops, topical preparations, once weekly medications, injections, over the counter medicines, herbal products, oral contraceptives or hormone replacement therapy, or if the patient uses a nebuliser or oxygen at home – these are often forgotten by patients.

8. Ascertain the patient's adherence to their prescribed medication regimen. Ask the patient/carer if they take/administer the medicines as labelled. Ask if they use a compliance aid. Note: some patients are confused on admission to hospital (especially the elderly) and claim not to be taking any medicines. If you are unsure as to the reliability of the patient's answer, the GP record should be used for confirmation of the medication history, with patient consent where possible.

   Where a patient has additional needs, for example where a patient lacks capacity, consider alternative sources of information, including, where possible and appropriate, relatives and carers.

9. Specific information should be collected about specialist and high risk drugs (see local policies). E.g. some anticancer medications must be stopped at admission and only prescribed after review by the oncology team.

10. Additional questions to help identify any problems:
    - Does anyone help you with your medicines at home? If so, who? What do they do?
    - Do you have any problems obtaining or ordering your repeat prescriptions? (Note: relative/carer may help)
    - Do you have a regular community pharmacy that you use?
    - Do you have problems getting medicines out of their packages?
    - Do you have problems reading the labels?
    - Some people forget to take their medicines from time to time. Do you? What do you do to help you remember?
    - Most medicines have side effects. Do you have any from your medicines?
    - Have any medicines been stopped recently or have any doses been changed recently?

APPENDIX 2: SOURCES OF MEDICATION HISTORIES

The following sources of medication histories are not exhaustive and listed in no order of preference, as reliability can vary according to the situation. It may be necessary to use two or more sources to establish an accurate medication history.

Source	Comments
The patient	– This is an important source as the patient will usually inform you exactly how they take their medicines. – Always try to establish how exactly a patient takes their medicines, as this could be very different from the formal records.
Patient's own drugs (PODs)	– Encourage patients to bring in their medicines from home. – Check that the patient's name is included on the label and that it corresponds to the patient being reviewed. – Discuss each medicine with the patient to establish what it is for, how long they have been taking it, and how frequently they take it. – Do not assume that the dispensing label accurately reflects patient usage. – Check the date of dispensing as some patients may bring all their medicines into hospital, including those stopped. – Check whether the patient regularly takes any over the counter medicines/alternative medicines on a regular basis. – Check whether the patient has any "just in case" medicines.
Relatives/ carers	– Patients may have relatives, friends or carers who help them with their medicines. This is common with elderly patients or with patients where English is not their first language. – Carers can be helpful in establishing an accurate medication history and can also give an insight into how medicines are managed at home. – Be mindful of maintaining confidentiality. – Where possible obtain patient consent.
Repeat prescriptions	– Some patients keep copies of all their repeat prescriptions. Many of these may include medicines that have been stopped. – The dates of issue should always be checked and each item confirmed with the patient. – If there is any doubt, the GP surgery should be contacted, with consent from the patient where possible.
GP referral letters	– These are not always comprehensive. – If hand-written, be mindful that they may not always be complete. – It may be necessary to double-check the medication history with the patient, relative/carer or GP surgery.
GP surgery	– Obtain an up to date list from the GP surgery. The record may be available via the Welsh Clinical Portal or obtained via telephone or fax, with consent from the patient where possible. – Distinguish between acute and regular medication. – Always check when the item was last issued and the quantity issued. – If obtaining information over the telephone, specific questioning may be needed for different formulations, for example type of inhaler (e.g. metered-dose, breath-actuated) or medicines which are brand specific (e.g. insulin or theophylline). – It may be necessary for you to speak to the GP directly to clarify any discrepancies. – Specifically check for any 'hospital only' or specialist medication that may not routinely appear on the usual 'repeat list'.
Medicines compliance aids e.g. Dosette, Venalink, Medimax	– These may be filled by the community pharmacist, relatives or patient. – If dispensed by a community pharmacist, the device should be checked for dispensing labels which will provide the pharmacy contact details. – The date of dispensing should also be checked bearing in mind that the medicines may have changed. – Remember to check for 'when required' medicines and medicines that may not be suitable for compliance aids such as inhalers, eye drops, once weekly tablets etc. – Consider contacting the community pharmacist to inform them of the patient's admission to prevent unnecessary repeat dispensing. They may also inform you of the number of compliance aids that have been filled, since these may still be at the patient's home. This information should be documented to aid the discharge process (e.g. on the patient's drug chart). – For compliance aids filled by a community pharmacy, document which medicines are contained within the tray (e.g. endorse on drug chart). – The community pharmacist's contact details should be documented on the drug chart and a discharge plan agreed.

Medication reminder charts	– The chart should be checked through with the patient and the dates of issue noted.
Recent hospital discharge summary or recent inpatient drug chart	– Check whether any changes have been made since the patient's discharge from hospital. – Discharge summaries or inpatient drug charts that are more than one month old should not be used as a sole source for a medication history. – Discharge summaries or an old inpatient drug chart may not always contain a complete list of medication especially if medicines reconciliation was not completed during that admission.
Residential/ nursing home records e.g. MAR sheets	– Useful and accurate source for medication history. – Usually sent with the patient. – Ensure you have all necessary pages. – Handwritten lists from homes should be used with care as they may have transcription errors.
Other sources	In some cases it may be necessary to investigate additional sources to obtain a complete medication history. Examples of teams that may need to be contacted for further information include: – Anticoagulant clinics – Community pharmacists – Specialist nurses e.g. heart failure/asthma/palliative care nurses – District nurses – Drug and alcohol service – Renal dialysis unit – Hospital only medication – Mental health teams e.g. memory clinics – Homecare teams – Other specialist hospitals e.g. for clinical trials/unlicensed medicines