NHS Grampian

# NHS Grampian Medicines Reconciliation Protocol

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|---|---|---|
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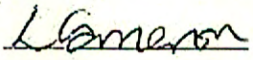
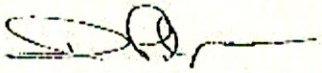
| **Signature:**  | **Signature:**  | **Signature:**  |

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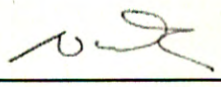
**Signature:** 

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**Organisational:** Chief Executive and Management Teams
**Corporate:** Senior Managers
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**Hospital/Interface services:** Divisional General Managers and Group Clinical Directors
**Operational Management Unit:** Unit Operational Managers

**Policy statement:** It is the responsibility of all staff to ensure that they are working to the most up to date and relevant policies, protocols procedures.

**Review:** This protocol will be reviewed in three years or sooner if current recommendations change.

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| **Responsibilities for review of this document:** | Principal Pharmacist |
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| Revision Date | Previous Revision Date | Summary of Changes (Descriptive summary of the changes made) | Changes Marked* (Identify page numbers and section heading ) |
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| 14/09/23 | 12/03/19 | Word error removed and changed to adverse event. | Section 1 page 2 |
| | | Paragraph added highlighting medicines reconciliation forms in HEPMA and EPR. | Section 1 page 3 |
| | | This form is currently under review and as such the layout may change before the next review of this policy (text removed). | Section 1 page 3 |
| | | Layout changed and sections added for completing medicines reconciliation in HEPMA and EPR. | Throughout document<br>Section 2.4 page 8 |
| | | Medical staff changed to prescriber where appropriate to include non-medical prescribers. | Throughout document |
| | | Case notes changed to patient record to reflect current electronic system in use. | Throughout document |
| | | Section added for nurses in roles and responsibilities. | Section 3.4 page 13 |

* Changes marked should detail the section(s) of the document that have been amended, i.e. page number and section heading.

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# NHS Grampian Medicines Reconciliation Protocol

## 1. Introduction

This protocol aims to ensure that by undertaking accurate medicines reconciliation:

- The right patient receives the right medicine, at the right dose and at the right time.
- The risk of medication adverse events is reduced when a patient moves from one care setting to the next.
- Patients receive personalised medicines management care, thus promoting a patient centred approach.
- Roles and responsibilities of healthcare professionals in medicines reconciliation are defined.

Medication adverse events are one of the leading causes of avoidable harm suffered by hospital inpatients. These can lead to increased morbidity and mortality, a prolonged length of stay in hospital and ultimately an increase in the economic burden. The safe use of medicines requires collective and collaborative effort by the multidisciplinary team and patients.

There are a number of key transition points where medication adverse events can occur including admission, discharge and transfer from one specialty to another.

For instance, errors may occur during the admission process when:

- Determining the medicines that the patient is currently taking.
- Transcribing details of the patient's medication to the hospital patient record.
- Prescribing medicines for the patient onto the prescription chart.

Medicines reconciliation has been a core aspect of the Scottish Patient Safety Programme's (SPSP) work plan as it is an area of high risk for medicines across a range of specialities and settings.

Medicines reconciliation ensures that patients are prescribed the right medicines, in the right doses appropriate to their current clinical presentation and that avoidable harm from medicines is reduced. It is the baseline from which drug treatment is continued on admission, therapeutic interventions are made, and self-caring will be continued on discharge. Medicine reconciliation is an important tool to communicate with the patient/carer and within healthcare teams across the primary/secondary care interface.

This medicines reconciliation protocol has been developed to reduce clinical risk and improve patient safety ultimately improving the quality of the service delivered to patients. This process is vital to patient safety to ensure that important medicines are not unintentionally discontinued during a hospital admission or medicines that should be withheld or stopped unintentionally continued and that new medicines are

prescribed with a complete knowledge of the patient's current medicines, including non-prescription medicines, and allergy status.

NHS Grampian is currently rolling out Hospital Electronic Prescribing and Medicines Administration (HEPMA) in which medicines reconciliation is integrated. Until HEPMA roll out is complete Electronic Patient Record (EPR) and paper medicines reconciliation forms will also be in use. The general principles of medicines reconciliation described in this document are the same for HEPMA, EPR and paper processes. Specific details for each process is described in section 2.4 below. The term "prescription chart" is used throughout this document and refers to the appropriate prescription chart used within a particular clinical area i.e. either the Prescription and Administration Record (PAR) or the HEPMA prescription chart. It is the responsibility of the person completing medicines reconciliation to use the correct form and prescription chart in use within individual clinical areas.

**The process of medicines reconciliation involves:**

- Collecting an accurate list of a patient's current medicines (what they are prescribed and what they are taking) including the name, dosage, formulation, frequency, timings and route.
- Checking that medicines prescribed on admission for the patient are correct. Differences may be identified at this stage and these may be intentional or unintentional.
- Communicating and documenting any changes, thus resulting in a complete list of medicines, accurately communicated to all members of the healthcare team throughout the patient's journey.

**These key steps must take place at each transfer of care**, from start of admission, including any ward transfer, hospital transfer and on to discharge. It is a continuous cycle that involves good communication across the primary/secondary care interface.

NHS Boards are required to be able to demonstrate compliance in discharging their clinical governance responsibility around medicines reconciliation by ensuring implementation and monitoring of the SPSP recommended practice statements.(1)

**SPSP goals of medicines reconciliation:**

- 95% of patients have medicines reconciliation performed within 24 hours of admission.(2)
- 95% of patients have an accurate inpatient prescription chart within 24 hours of admission.(2)
- 95% of patients have medicines reconciliation performed on discharge.(3)
- 95% of patients have an accurate medicines list on the discharge letter/Core Discharge Document (CDD).(3)
- Primary care teams should ensure accurate medicines reconciliation occurs for patients discharged back to their care (4) – although no specified target has been set at present it is suggested this should have a 95% accuracy rate.

### 1.1. Definition

Medicines reconciliation is the process that the healthcare team undertakes to ensure that the list of medicines, both prescribed and over the counter, which the patient is taking is exactly the same as the list that the patient or carers, GP, community pharmacist and hospital team have. This is achieved in partnership with the patient through obtaining an up-to-date and accurate medication list that has been compared with the most recently available information and has documented any discrepancies, changes, deletions, or additions resulting in a complete list of medicines accurately communicated.

### 1.2. Clinical situations

This protocol will apply to key transition points of a patient's admission, transfer from one care setting to the next, and then discharge from the inpatient setting to Primary Care.

### 1.3. Patient groups to which this document applies

This protocol applies to patients in all care settings across NHS Grampian.

## 2. Medicines Reconciliation Process

### 2.1. Medicines reconciliation on admission

The primary care team should be able to provide an accurate medication list for patients admitted during normal working hours. Repeat and recent acute medications should be regularly updated with any changes documented on the prescribing system in the GP Practice.

On admission to hospital the medicines reconciliation task is the responsibility of the admitting prescriber or pharmacist.

Medicines reconciliation should be completed for every patient regardless of their mode of admission.

#### 2.1.1. Sources of information

At least two reliable sources of information should be used to obtain and confirm an accurate medication history.

The following is a list of sources that may be used to obtain an accurate medication history:

- Patient Interview.
- Carer/Relative Interview.
- Patient's Own Drugs.
- GP Letter.
- GP Practice patient admission summary.

- Emergency Care Summary (ECS) or Key Information Summary (KIS) printout from trakcare/web - it is important to check the date of last upload for ECS/KIS at the top of the sheet as there are occasional system disruptions and possible delays in the upload of information to ECS/KIS. Note that not all medications will be on the ECS/KIS information if they are hospital/out-patient prescribed medications, trial or over-the-counter medication.
- Medicine Administration Record Sheet (MAR sheet) – used in care homes and for level 3 medicine management patients.
- GP repeat prescription slips (right hand side of GP10 prescription).
- GP phone call.
- Community pharmacy.
- Nursing home phone call.
- Patient record/previous discharge prescription/CDD if recent.
- Community Nurse.
- Hospital pharmacy records.
- Recent patient-held compliance chart.
- Hospital clinic letters – used as guide only, not as single information source.

The patient/carer remains the primary source of information as long as capacity is considered to be sufficient. If patient has reduced capacity the carer would be the primary source and one or more of the other sources should be used. To assist staff to communicate with non-English speaking patients, relatives and carers, the language line telephone interpretation service or face to face interpreters are available. Material in translation can also be provided. If the patient, relatives or carers have a communication disability, appropriate communication support such as British Sign Language (BSL) interpreters, audio material, accessible/pictorial material, large print and other formats and support can be provided.

The date on the information source(s) used should be checked to ensure the medicine is current.

For admissions during normal working hours it is recommended that the GP surgery provide, or is contacted to provide, the ward/clinic with a summary sheet of a patient's regular medication and recent acute prescriptions. This could be given to either the patient/ambulance staff, or transferred by a secure electronic system, e.g. NHS email. Verbal telephone communication of medication names and doses should be avoided if possible as it may reduce accuracy of information transferred. For admissions outwith normal working hours two other sources from the list above should be used.

Secondary Care, NHS24, Scottish Ambulance Service, Out of Hours organisations, hospices and clinics are permitted access to a patient's ECS/KIS **only** if it is legitimately in support of the direct care of that patient.[(5)] Consent is given by patients for KIS in Primary Care at the point of upload. Patients can opt out of ECS/KIS by informing their GP practice, which will insert a code into the record and switch off consent.

For the specifics of medicine reconciliation, if patient does not have a KIS, then consent to view ECS is implied, but it is good practice to ask the patient for consent before their ECS record is accessed.[(6)] If consent is not requested the reason should

be annotated in the patient record or appropriate web based service, e.g. unconscious patient, lacks capacity.

### 2.1.2. Medicines reconciliation - information required

Medicines reconciliation must be completed for each patient with the following information:

- Patient Name and CHI Number.
- Sources of information used for the medication history.
- Allergy status/adverse drug reactions and the nature of the reaction/allergy.
- If patient is on no medications this should still be recorded in medicines reconciliation
- Generic name of current medicines should be used unless there are clinical reasons to prescribe by brand name, due to differences in bioavailability between some brands, e.g. theophylline, lithium, clozapine or for some modified release preparations.
- Formulation, strength/dose, route, frequency and timing of taking the medication.
- Devices if applicable, e.g. insulin cartridge or vial, inhaler types.
- Non-prescription medicines including over the counter/herbal/homeopathic medicines.
- Any illicit drugs, e.g. cannabis, heroin.
- Recently discontinued medicines if applicable (due to long half-life of some medications).
- Concordance/compliance issues identified.
- If it is known the patient has special medication requirements (for example, is on level 3 medicine management, has a compliance aid/dosette or is under care of the Substance Misuse Service), this information should be communicated to the hospital team and recorded appropriately (see section 2.4 for HEPMA, EPR and paper form processes below). Time and date that medication history has been taken.
- Signature/electronic signature of prescriber or pharmacist documenting the medication history. If a student has taken the medication history, the supervising practitioner should check and sign the form prior to prescribing the medication onto the prescription chart. If the student has taken the medication history in EPR or HEPMA the supervising practitioner should document in the clerking notes that they supervised the medicines reconciliation and confirm that it is correct.
- Any follow up required to complete medicines reconciliation accurately should be recorded in the patient record.

### 2.1.3. Drugs that require special attention

When completing the medicine reconciliation form, be aware that certain medications present a higher safety risk and will require further details to ensure safe prescribing.

**Below are some examples, this list is not exhaustive**.

- Warfarin – record where INR is checked, i.e. GP or anticoagulant clinic, indication, target INR, usual dose and duration of therapy.
- Insulin – there are more than 25 different insulin preparations available and many are available in more than one presentation. Extra care is required to ensure correct name and device type. Use brand names, not generic and include timings in relation to meals.
- Steroids – along with dose, record the length of course, whether it is long term maintenance, a short course or a reducing course.
- Cytotoxics – these are high risk medicines and need careful documentation.
- For weekly/monthly treatments provide the day of the week or date of last dose.
- Depot injections – record dose and frequency and date of next dose.
- Opioid substitute therapies/substance misuse - to minimise risk of dose duplication, overdose or diversion and ensure continuity of prescribing, the patient's prescriber and community pharmacy must be advised of the dates of admission and discharge in good time. The current dose and time/date of last administration should be established by one or more of these sources wherever feasible. Note: Information relating to substance misuse prescribing may not be available or up-to-date on the ECS. Further guidance is detailed in the Policy and Procedures for Secondary Care and Community Hospitals on NHS Grampian in the Safe Management of Controlled Drugs.[7]

### 2.1.4. Documented plan

To ensure understanding and clarity amongst healthcare team members, a plan for each medication should be documented on the medicines reconciliation form. The reason for a medication being discontinued or withheld should be documented in the patient's record. This should be reviewed throughout the patients stay and any further changes to medication documented to aid the next steps of reconciliation.

This will highlight any discrepancies, intentional or not, between the medicines the patient was taking prior to admission and the medicines prescribed in the new care setting.

### 2.1.5. Prescribing continuing medication

All medicines from the patient's medication history that are to be continued should be accurately prescribed onto the prescription chart.

## 2.2. Medicines reconciliation on transfer

Medicines reconciliation should again be undertaken when a patient is transferred between different care settings, e.g. from a critical care area to a general ward, or to another hospital. This will ensure that medicines are appropriately stopped, withheld, restarted or continued in line with the patients changing condition.

## 2.3. Medicines reconciliation on discharge

Accurate and complete medicines reconciliation on discharge will ensure the transfer of accurate medication information between the care settings. The discharge prescription/CDD must contain an accurate list of all the medicines the patient is to take at home including the dose, formulation, route, frequency/timings and duration. Any changes to medicines, along with the reasons for the changes, must be documented on the discharge prescription/CDD by the prescriber or pharmacist, as appropriate.

If any urgent follow-up is required, e.g. INR monitoring if on warfarin, then this must be organised with the primary care team before the patient leaves the ward.
If appropriate the care home or intermediate care setting should be contacted in relation to any clinical follow-up.

Ensure the patient gets a copy of their discharge prescription (CDD) with any changes to medication detailed on it. Changes should be communicated to the patient or their representative/carer both verbally and in writing and a check made of their understanding. An assessment should be made of suitability of patients own drugs before returning them to the patient. Patients should be advised to take any discontinued medication they have at home back to their community pharmacy.

As soon as possible after patient's discharge, the discharge document should be sent to the patient's GP, either electronically or by post.

## 2.4. Instructions for specific forms

### 2.4.1. Hospital Electronic Prescribing Medicines and Administration (HEPMA)

For instructions on how to complete Medicines Reconciliation in HEPMA follow the North of Scotland (NoS) Regional HEPMA Medicines Reconciliation Standard Operating Procedure (SOP) [8]

For instructions on how to add an allergy or sensitivity in HEPMA:
https://scottish.sharepoint.com/sites/NoSHEPMA/SitePages/Allergies-and-Sensitivities.aspx [9]

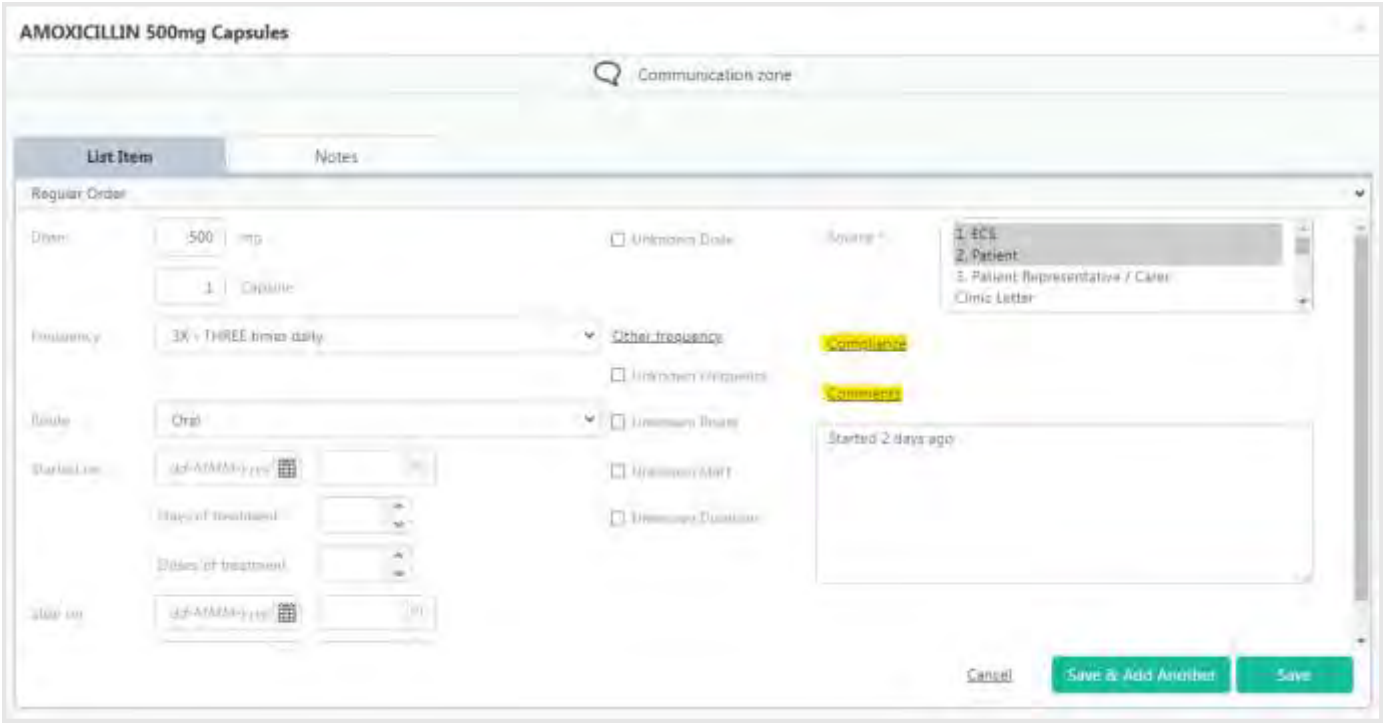
To add a drug that does not appear in the HEPMA system:

- Open the Medicines Reconciliation form in the patient's HEPMA record
- Click 'Add drug'
- Select 'Non-Listed Item'


- Follow the system prompts to enter the drug details
- Note: Non-listed drugs cannot be transcribed to the inpatient chart, instead prescribe directly onto the inpatient chart using the ‘Other Drug’ function
- Do not add the ‘Other Drug’ files to the Medicines Reconciliation form, use ‘non-listed item’ as described above.

Additional points:

- To document that a patient was taking no regular medicines on admission, add a ‘non-listed item’, enter the drug name as ‘Nil regular medicines’, and select the sources you used to confirm this.
- HEPMA will allow you to select drugs from a previous admission to add to the medicines reconciliation list. Use this feature with caution, as it does not tell you which medicines/doses the patient was discharged on. A minimum of two other sources should be used to confirm the accuracy of the medication list.
- Use the ‘Comments’ box to add additional information, such as start/end dates, indications, date of next dose. Note that these comments do not transcribe to the inpatient chart, nor to the discharge prescription.
- Use the ‘Compliance’ box to add information about medicine compliance/concordance, including whether the medicine is included in a compliance aid or MAR chart.



- For patients with special medicine requirements (e.g. compliance aids, MAR charts, weekly/daily dispense medications), the details of their community pharmacy should be documented in a 'Patient Note'. The note type should be set to 'Medicines Reconciliation Note'. The 'Retain note between spells' flag should be ticked, as appropriate, to allow the note to remain attached to the patient's HEPMA record for subsequent admissions. Instructions on how to add a patient note are available here: https://scottish.sharepoint.com/sites/NoSHEPMA/SitePages/Patient-Notes.aspx [(10)]

### 2.4.2. Electronic Patient Record (EPR)

For instructions on how to complete Medicines Reconciliation in EPR follow the Trakcare - Digital Ward Guide [(11)] pages 15-18.

For a video demonstration watch the IP Record video [(12)], medicines reconciliation is demonstrated approximately 8 minutes into the recording.

**Note:** this function will be removed when HEPMA is fully rolled out across NHS Grampian.

### 2.4.3. Paper

In hospital, in areas who have not yet moved to electronic systems, use of a structured paper medicines reconciliation form Appendix 1 is recommended to ensure accuracy and maximise patient safety. This also saves time and avoids confusion with different sources of information in multiple locations, therefore reducing prescribing errors, it can be ordered via PECOS code ZOP300. A medicines reconciliation sheet for use in paediatrics is available (Appendix 2). Refer to pharmacy in Royal Aberdeen Children's Hospital regarding how to order. Appendix 1 and 2 are the only paper medicines reconciliation forms that should be in use within NHS Grampian and only in areas that have not moved to HEPMA, non-approved documents may be discarded by medical records.

The medicines reconciliation form should be easily accessible in the patient record during the patients stay to allow for continual medicines reconciliation to occur.

The plan for each medicine should be documented on the medicines reconciliation form using the 'continue' 'withhold' and 'stop' columns. Document the reason for a medication being discontinued or withheld in the patient's record.

Special medicine requirements (for example, is on level 3 medicine management, has a compliance aid/dosette or is under care of the Substance Misuse Service) should be communicated to the hospital team and recorded in the careplan section on the PAR.

If the patient is on no medicines annotate the medicines reconciliation form that the patient is on no medicines and sign.

If the patient is on medicines that present a higher safety risk record further details on the medicines reconciliation form (see examples in section 2.1.3).

If there is not enough space on the medicines reconciliation form to record all the information required annotate the medicines reconciliation form and record fully in the patient record or medicines care plan section of the PAR.

## 2.5. Primary care medicines reconciliation

GP practices should have a protocol in place to reconcile medicines for patients discharged from hospital. It is suggested the following measures should be included in a practice protocol:

- The discharge prescription/CDD should be work-flowed on the day of receipt to specified person, e.g. duty doctor, registered GP or practice pharmacist.
- Medication should be reconciled within 2 working days of prescription being workflowed to the appropriate clinician.
- Any changes to medication should be documented and acted upon. If there is any ambiguity about medication changes the GP surgery should contact the appropriate prescriber/ward as soon as possible to clarify.
- Any changes to medication should be discussed with the patient/patient's advocate if appropriate within 5 working days of CDD being received by the practice.
- It is good practice to liaise with the patient's community pharmacy regarding medication changes if a compliance aid is in use.
- A read code is available within the practice clinical system to identify when medicine reconciliation has occurred. Practices may wish to start using this Read Code #8B318.
- There follows a list of other read codes which aid recording when any changes to the patient's medications have occurred.
  Practices may wish to use these:
  - #8B316 - Medication Changed
  - #8B3A1 - Medication Increased
  - #8B3A2 - Medication Decreased
  - #8B313 - Medication Commenced
  - #8B3A3 - **New** Medication Commenced
  - #8B3R - Drug Therapy Discontinued
  - #8B396 - Treatment Stopped – alternative therapy undertaken
  - #67IM - Advice to GP to change patients medication
  - #8B3SO - Medication changes discussed with patient/patient's advocate

## 2.6. Summary

A summary/flowchart of medicine reconciliation process can be found in Appendix 3.

## 3. Roles and Responsibilities

Medicines reconciliation is the responsibility of all staff involved in the admission, prescribing of medicines, monitoring, transfer and discharge of patients requiring medicines. Strong collaboration and teamwork with shared accountability across the health care professions, including the patient/carer, are key components of a successful medicines reconciliation process.

Safe and effective prescribing is a core clinical activity and the processes and responsibilities which support it need to be well understood by all clinicians.

### 3.1. Unit Operational Managers/Clinical Leads/Chief Nurses

- The Clinical Leads, Unit Operational Managers and Chief Nurses should ensure that medicines reconciliation is an integral part of the education and training given to new staff who will undertake medicines reconciliation on induction, to locums and temporary staff and when new rotations of junior medical staff take place. Education and training should focus on the importance of medicines reconciliation to clinical decision making and patient care, highlighting the consequences when it is performed poorly.
- Ensure all staff who are involved in the admission, transfer and discharge of patients (medical, nursing and pharmacy staff) have completed the medicines reconciliation (hospital) e-learning module available on Turas.(13)
- In the inpatient setting it is the responsibility of the receiving Consultant to ensure that medicines reconciliation is completed.
- Adverse events/near misses caused by poor medicines reconciliation processes should be reported on DATIX, ideally to the receiving Consultant or Clinical Lead. These adverse events should be collated and reviewed to inform further improvements to the process for each ward/department/service.
- Establishing and maintaining reliable medicines reconciliation processes is a challenge and compliance with the goals listed in Section 1 should be monitored frequently to review performance and drive improvement.

### 3.2. Medical Staff/non-medical prescribers with responsibility for patient admission, transfer and discharge

- Obtain and document on a medicines reconciliation form the best possible medicine history using at least two reliable sources.
- The prescriber should document a plan for each medicine by completing the ‘continue’, ‘withhold’ and ‘stop’ boxes on the paper medicines reconciliation form or the appropriate fields in the electronic form. The patient record should be annotated as to why any drugs are withheld/ stopped.
- Complete medicines reconciliation within 24 hours of admission.
- Accurately prescribe medicines which are to continue onto the PAR/HEPMA chart.
- Ensure appropriate handover as to what follow up is required to complete medicines reconciliation, if unable to complete medicines reconciliation before patient is transferred to another care setting.

- Undertake medicines reconciliation on discharge. Any changes to medicines, along with the reasons for the changes, should be documented on the discharge prescription/CDD by the prescriber or pharmacists.
- Report on DATIX, ideally to the receiving ward Consultant, adverse events/near misses caused by poor medicine reconciliation processes.
- Green bags should be supplied to patients for transporting their medicines between care settings, these should be available in all care areas including the ambulance service (order code for green bags 084098 via National Distribution Centre).[(14)] [(15)]

### 3.3. Pharmacists

- Support prescribers when medicines reconciliation is more complicated, or accuracy is in doubt.
- Verify that medicines reconciliation is undertaken accurately on admission, on transfer between care settings/wards and discharge (CDD) for all patients, dependent on service level agreement and staffing. Exceptions to this may include weekends, out-of-hours, and public holidays.
- Ensure that any errors, omissions and differences are communicated safely and effectively to the prescriber, and acted upon.
- Sign and date Medicines Reconciliation Form after verification (paper or electronic). If on HEPMA – mark each drug as 'verified' and mark form as 'Complete'.
- When paper medicines reconciliation forms are used - Sign and date care plan on the PAR when medicines reconciliation has been verified.
- Report on DATIX, ideally to the receiving ward Consultant, adverse events/near misses caused by poor medicines reconciliation processes.

### 3.4. Nurses

- Highlight to the medical staff if there are medicines that a patient normally takes at home that are not prescribed on the prescription chart.
- Non-medical prescribers may undertake the full medicines reconciliation process.
- Communication with patient regarding any changes to medicines throughout hospital stay.
- Check the correct medicine, dose and frequency are supplied to the patient at discharge using the CDD.

## 4. References


(1) SGHD/CMO (2013) 18 CEL - Safer Use of Medicines: Medicines Reconciliation: Revised Definition, Goals and Measures and Recommended Practice Statements for the Scottish Patient Safety Programme. http://www.sehd.scot.nhs.uk/cmo/CMO(2013)18.pdf
(2) SPSP Medicines Reconciliation Goals on Admission (2017) https://ihub.scot/media/1173/20170109-meds-rec-admission-op-website-v-10.pdf
(3) SPSP Medicines Reconciliation Goals on Discharge (2017) https://ihub.scot/media/1174/20170109-meds-rec-disch-op-website-v-10.pdf
(4) SPSP Medicines Reconciliation Operational Definitions General Practice (2015) https://ihub.scot/media/1105/20150514-medicines-reconciliation-guidance-v2.pdf
(5) SGHD/CMO (2014) 5 Clarification of KIS and ECS Access.
(6) http://www.sehd.scot.nhs.uk/cmo/CMO(2014)05.pdf
(7) SGHD/CMO (2011) 16 Extension of ECS to Scheduled Care Settings in Support of Medicine Reconciliation.
(8) http://www.sehd.scot.nhs.uk/cmo/CMO(2011)16.pdf
(9) NHS Grampian Policy and Procedure For the Safe Management of Controlled Drugs in Hospitals and Clinics (2022 http://foi.nhsgrampian.org/globalassets/foidocument/foi-public-documents1---all-documents/Policy_CDs_Hospitals.pdf.
(10) North of Scotland HEPMA Medicines Reconciliation Standard Operating Procedure North of Scotland (NoS) Regional HEPMA Medicines Reconciliation Standard Operating Procedure (SOP)
(11) North of Scotland HEPMA – Allergies and Sensitivities guidance North of Scotland HEPMA – Allergies and Sensitivities guidance
(12) North of Scotland HEPMA – Patient Notes guidance North of Scotland HEPMA - Patient Notes guidance
(13) NHS Grampian Trakcare - Digital Ward Guide Version 3 February 2023
(14) NHS Grampian IP Record video Published 21/05/2022
(15) Medicines Reconciliation (hospital) e-learning module, Turas
(16) https://turasdashboard.nes.nhs.scot/
(17) Green Bag Scheme Patient Information Leaflet
(18) GreenBag Patient Information Leaflet 2015.pdf (scot.nhs.uk)
(19) Green Bag Scheme Information for Staff
(20) http://nhsgintranet.grampian.scot.nhs.uk/depts/Pharmacy/MedicationSafety/Documents/Information%20for%20NHS%20Grampian%20Staff%20regarding%20Use%20of%20Green%20Bags%202015.pdf


## 5. Distribution List

NHS Grampian Globals

## 6. Abbreviations Used In This Protocol

| | |
|---|---|
| SPSP | Scottish Patient Safety Programme |
| CDD | Core Discharge Document |
| GP | General Practitioner |
| ECS | Emergency Care Summary |
| KIS | Key Information Summary |
| MAR | Medicine Administration Record Sheet |
| CHI | Community Health Index |
| INR | International Normalised Ratio |
| PAR | Prescription and Administration Record |
| HEPMA | Hospital Electronic Prescribing and Medicines Administration |

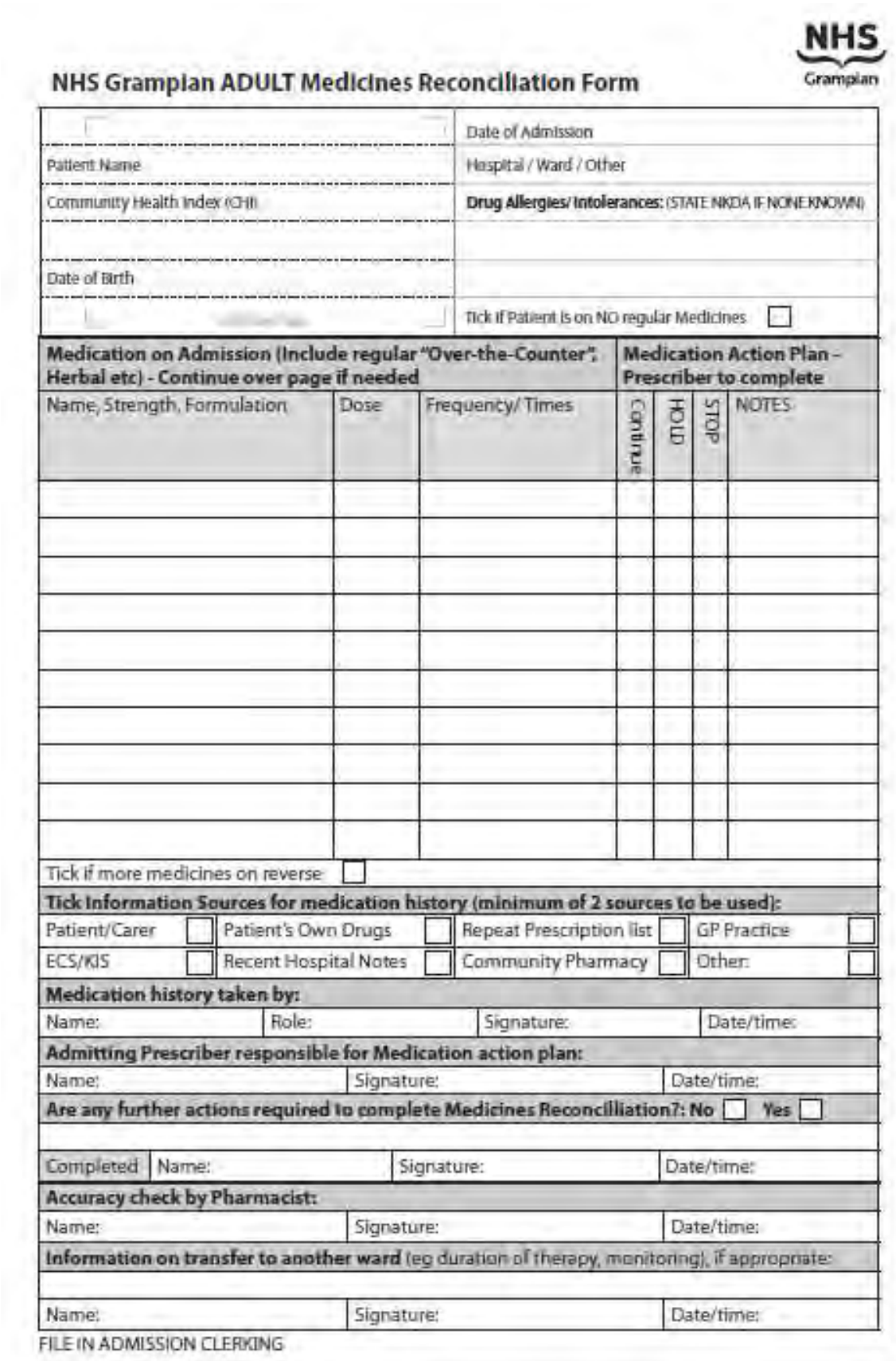
## 7. Groups Consulted for initial protocol

| | |
|---|---|
| Joan Anderson | Staff Side (Policies Subgroup) |
| Debbie Barron | NHSG Clinical Process Documents Review Group |
| Nigel Firth | Equality And Diversity |
| Linda Harper | Lead For NMP |

Area Pharmaceutical Committee
All Clinical Pharmacists - Acute And H&SCP, City And Aberdeenshire
Consultants Subcommittee (of AMC)
GP Subcommittee (of AMC)
Grampian Medicines Management Group
Medicine Guidelines And Policies Group
Medication Safety Group

**Groups consulted for 2023 Update**
HEPMA Pharmacists
Lead Nurse Digital Ward

## Appendix 1: NHS Grampian Adult Medicines Reconciliation Forms



**NHS Grampian ADULT Medicines Reconciliation Form**

NHS Grampian

| | |
|---|---|
| | Date of Admission |
| Patient Name | Hospital / Ward / Other |
| Community Health Index (CHI) | **Drug Allergies/ Intolerances:** (STATE NKDA IF NONE KNOWN) |
| | |
| Date of Birth | |
| | Tick if Patient is on NO regular Medicines ☐ |

| **Medication on Admission (Include regular "Over-the-Counter", Herbal etc) - Continue over page if needed** | | | **Medication Action Plan – Prescriber to complete** | | | |
|---|---|---|---|---|---|---|
| Name, Strength, Formulation | Dose | Frequency/ Times | Continue | HOLD | STOP | NOTES |
| | | | | | | |
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Tick if more medicines on reverse ☐

**Tick Information Sources for medication history (minimum of 2 sources to be used):**

| | | | |
|---|---|---|---|
| Patient/Carer ☐ | Patient's Own Drugs ☐ | Repeat Prescription list ☐ | GP Practice ☐ |
| ECS/KIS ☐ | Recent Hospital Notes ☐ | Community Pharmacy ☐ | Other: ☐ |

**Medication history taken by:**

| Name: | Role: | Signature: | Date/time: |
|---|---|---|---|

**Admitting Prescriber responsible for Medication action plan:**

| Name: | Signature: | Date/time: |
|---|---|---|

**Are any further actions required to complete Medicines Reconcilliation?: No ☐ Yes ☐**

| Completed | Name: | Signature: | Date/time: |
|---|---|---|---|

**Accuracy check by Pharmacist:**

| Name: | Signature: | Date/time: |
|---|---|---|

**Information on transfer to another ward** (eg duration of therapy, monitoring), if appropriate:

| Name: | Signature: | Date/time: |
|---|---|---|

FILE IN ADMISSION CLERKING

## Adult Medicines Reconciliation Sheet Continued over

| **Medication on Admission (Include regular "Over-the-Counter", Herbal etc)** | | | **Medication Action Plan - Prescriber to complete** | | | |
|---|---|---|---|---|---|---|
| Name, Strength, Formulation | Dose | Frequency/ Times | Continue | HOLD | STOP | NOTES |
| | | | | | | |
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| **Medication history taken by:** | | | |
|---|---|---|---|
| Name: | Role: | Signature: | Date/time: |
| | | | |

| **Admitting Prescriber responsible for Medication action plan:** | | |
|---|---|---|
| Name: | Signature: | Date/time: |

| **Accuracy check by Pharmacist:** | | |
|---|---|---|
| Name: | Signature: | Date/time: |

| **Information on transfer to another ward** (eg duration of therapy, monitoring), if appropriate: | | |
|---|---|---|
| | | |
| Name: | Signature: | Date/time: |

FILE IN ADMISSION CLERKING

CGD 140841 ZA04285

## Appendix 2: Paediatric Medicines Reconciliation Sheet

NHS Grampian

Patient Details (attach addressograph)
Name.....
Address.....
.....
.....
CHI number.....

Hospital.....
Ward.....
Date of Admission.....
Allergies (State NKDA if none known)
.....
.....
This child is taking NO regular medicines.
Name/sign: Date:

### NHS Grampian Paediatric Medicines Reconciliation Form

(Turnover for more lines)

**Tick Information Sources for medication history (minimum of 2 sources to be used)**

- ▫ Patient
- ▫ Parent/Carer
- ▫ Recent Hospital Notes
- ▫ Community Pharmacy
- ▫ ECS/KIS
- ▫ GP Practice
- ▫ Repeat prescription list
- ▫ Patients own drugs
- ▫ Other.....

| Medication on Admission (include regular "Over-the-counter", Herbal etc) – Continue over page if needed. | | | | | | | | | | | | Prescriber - Medication Action Plan (within 24 hours of admission) | | | | Nurse or Pharmacy | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Medicine and Form (e.g.Tablets, Liquids) | Strength | Route | Dose | Tick or state time 08 | 12 | 14 | 18 | 20 | 22 | Antibiotic | Indication | Continue | Withhold | Stop | Notes | Pt's own drugs suitable for use Y/N | Pharmacy |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
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| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |

**Medication history taken by:** Name: Signature: Date/time:

**Admitting Prescriber responsible for medication action plan:** Name: Signature: Date/time:

**Are any further actions required to complete Medicines Reconciliation: No/Yes. If yes,detail:**

Follow up actions completed by: Name: Signature: Date/time:

**Accuracy check by Pharmacist:** Name: Signature: Date/time:

**Continuation sheet over**

# Paediatric Continuation Sheet for Medicines Reconciliation

| Continued :Medication on Admission (include regular "Over-the-counter", Herbal etc) | | | | | | | | | | | | Prescriber - Medication Action Plan (within 24 hours of admission) | | | | Nurse or Pharmacy | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Medicine and Form (e.g.Tablets, Liquids)** | **Strength** | **Route** | **Dose** | **Tick or state time** 08 22 | 12 | 14 | 18 | 20 | as required | **Indication** | | Continue | Withdraw | Stop | NOTES | Pt's own drugs suitable for use Y/N | Pharmacy |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |
| | | | | | | | | | | | | | | | | Y N | |

| | | |
|---|---|---|
| **Medication history taken by:** Date/time: | Name: | Signature: |
| **Admitting Prescriber responsible for medication action plan:** Date/time: | Name: | Signature: |
| Follow up actions completed by: Date/time: | Name: | Signature: |
| **Accuracy check by Pharmacist:** Date/time: | Name: | Signature: |

## Appendix 3: Summary of Medication Reconciliation Process

**On Admission**

1. Access standardised Medication Reconciliation (MedRec) Form (paper or electronic)
2. Use minimum of 2 information sources - resolve any discrepancies.
3. Record the name/dose/ frequency/route of admission medicines
4. Record details of Medication Allergies/Sensitivities
5. Record medicine action plan.
6. Write up Prescription and Administration Record (PAR)/HEPMA chart
7. Pharmacy Review: Review of accuracy and appropriateness of the medicines list/plan and the PAR/HEPMA Chart.
8. Ward Round Check: Consultant review/check that Med Rec process has been completed satisfactorily.
9. Daily reviews of patient's medication as appropriate

↓

**Transfer to Downstream Ward (if required)**

1.Before transfer, review Med Rec Form and communicate any changes / durations of therapy / monitoring requirements to receiving ward staff.
2. On admission to receiving ward, check for any outstanding medicines reconciliation issues.
3. Daily reviews of patient's medication as appropriate.

↓

**Discharge**

1. Collate medication information from the following:
   - PAR/HEPMA chart
   - Med Rec form
   - Case notesPatient record
2. Review continued need, including any withheld during admission.
3. Complete all fields in the discharge prescription – any changes to medication, durations of therapy, advised titrations, monitoring.
4. Accuracy check of prescription by Pharmacy team if appropriate according to ward/unit procedures.
4. Send completed discharge prescription/CDD to GP, and ensure patient has own copy of advised medication along with any changes or follow-up required.

↓

**Primary Care**

1. Discharge prescription work-flowed according to practice protocol
2. Document and act on any changes to medications.
3. Discuss medication with patient if appropriate.
4. Ensure accurate medication list on prescribing system
5. Liaise with Community Pharmacist about any medication changes.