Cornwall medicines optimisation and pharmacy Protocol

Medicines reconciliation process for new residents in care homes

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Relevance

Pharmacist	X	Pre-registration pharmacist	X
Pharmacy technician	X	Pre-registration technician	X
Assistant		Senior assistant	

1. Purpose of this Procedure

1.1. To set out the general guidance and standard of practice for the medicines reconciliation process for patients newly admitted to a care home.

1.2. The procedure aims to support Primary Care Network (PCN) and care home pharmacists and pharmacy technicians to deliver a standardised and high quality medicines reconciliation.

2. Scope

2.1. All patients admitted to a care home having medicines reconciliation undertaken by a member of the PCN pharmacy team.

2.2. This protocol **does not** set out the process for a full structured medication review (SMR)- see '*Protocol for structured medication reviews (SMR) for people who reside in care homes*' available on the Cornwall Eclipse formulary website

3. Definitions

3.1. Medicines reconciliation (CQC definition) is the process of accurately listing a person's medicines. This could be when they are admitted into a service or when their treatment changes.

3.2. It involves recording a current list of medicines, including over-the-counter and complementary medicines. Then, the list is compared with the medicines the person is actually using. It involves recognising and resolving any discrepancies and documenting any changes.

3.3. The medicines reconciliation process will vary depending on the care setting that the person has moved into (or from).

3.4. A structured medication review (NICE definition) is a critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste. It has the clear purpose of optimising the use of medicines for some people (such as those who have long-term conditions or who take multiple medicines), can identify medicines that could be stopped or need a dosage change, or new medicines that are needed.

4. Ownership and Responsibilities

4.1. This protocol has been developed by the pharmacy and medicines optimisation stakeholders in the Cornwall Integrated Care System and has been approved the NHS Kernow Clinical Commissioning Group (NHS Kernow) Medicines Optimisation Programme Board.

4.2. The NHS Kernow medicines optimisation team are responsible for the ongoing review of this protocol, as a minimum every three years.

4.3. Primary Care Networks and GP practices should ensure the care home medicines reconciliation process undertaken by their pharmacy teams align to this protocol and that the pharmacy teams are trained appropriately.

4.4. It is the responsibility of the pharmacist, pharmacy technician and/or other trained member of staff undertaking the medicines reconciliation in care homes to have read and understood this protocol. Whilst individual care homes, PCNs and GP practices might follow slightly different processes for medicines reconciliation in care homes- the principles set out in this protocol should be met.

5. Standards and Practice

5.1. Medicines Reconciliation

5.1.1. When a resident moves into a care home, a "medication reconciliation" process should be completed. Staff carrying out this process should have the necessary knowledge, training and competence.

5.1.2. Medicines reconciliation should be completed as soon as possible when a person is discharged from hospital or transferred from another setting or place of residence (including home) into a care home.

5.1.3. Medicines reconciliation may also be requested when treatment has changed, for example dose changes

5.1.4. A surgery may request a medicines reconciliation if the patient has been newly registered with them. This may happen if the person has been transferred to a care home outside of the practice boundary of their original GP practice.

5.1.5. The reconciliation process involves two stages. Stage one involves the collection and accurate identification of the medicines the patient was taking prior to admission i.e. medication history taking. Stage two (full reconciliation) builds on stage one by comparing this information to the list of medicines prescribed for the patient in the care home, identifying any discrepancies, resolving them and recording the outcome.

5.2. Information Sources

When undertaking medicines reconciliation, two information sources should be used. Examples of reliable information sources are:

5.2.1. Information available from the Summary Care Record (SCR) or local primary care system.

5.2.2. Recent and dated medication print-out from a GP computer system.

5.2.3. Recent and dated repeat prescription request slip.

5.2.4. Resident's own medication (check dispensing dates).

5.2.5. Verbal information from the resident, their family or carer.

5.2.6. Recent and dated hospital discharge summary.

5.2.7. A referral letter.

Sources that usually need additional verification include:

5.2.8. Medication administration record (MAR) sheet.

5.2.9. Community pharmacy patient medication records (may be able to provide medicines information out of hours).
5.2.10. Care plans.
5.2.11. Previous care setting (may be able to provide medicines information out of hours).
5.2.12. Monitored dose system (MDS) and other compliance aids.

5.3. The reconciliation process

5.3.1. This should be completed by an appropriately trained pharmacist or pharmacy technician as detailed in the care homes medicine policy.
5.3.2. On the day that a resident is newly admitted into a care home the following information should be available for medicines reconciliation:

5.3.2.1. Resident's details, including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents).
5.3.2.2. GP's details.
5.3.2.3. Details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse).
5.3.2.4. Known allergies and reactions to medicines or ingredients and the type of reaction experienced.
5.3.2.5. Medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known.
5.3.2.6. Changes to medicines, including medicines started, stopped or dosage changed, and reason for change.
5.3.2.7. Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines).
5.3.2.8. 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).
5.3.2.9. What information has been given to the resident and/or family members or carers.
5.3.2.10. The quantity of each medication. If the resident arrives "mid-cycle" it may be necessary to contact the surgery and request an interim prescription. This will need to be flagged to the GP practice as "a new patient requesting medication".
5.3.2.11. If the new resident has been discharged from hospital, check the discharge summary to determine if there are any follow up blood tests that need arranging. If any are, or appear to be, outstanding, contact the surgery to arrange. [Nursing homes can complete this when appropriate]

5.3.2.12. Record any queries on the resident's care record. Make note of any healthcare professional that needs to be contacted, by when and by whom. This information will be communicated as soon as possible to the GP practice, either via e-mail or via direct remote access to the GP Clinical System so that patient record is updated.

5.3.2.13. The details of the person completing the medicines reconciliation (name, job title) and the date are to be recorded. (See attached form.)

5.4. Discrepancies

5.4.1. **Intentional discrepancies** involve any difference between the medicines the patient was taking prior to admission and the medicines prescribed on admission to the care home that have been changed intentionally by the doctors responsible for the patient's care.

5.4.2. **Unintentional discrepancies** involve any difference between the medicines the patient was taking prior to admission and the medicines prescribed on admission to the care home that were not intended e.g. errors, omissions, additions.

5.4.3. If a discrepancy is noted, in the first instance contact the healthcare professional identified on the discharge summary if the resident has been discharged, or the resident's GP practice to resolve the discrepancy.

5.5. Communication

5.5.1. The care home will communicate any needs the new resident may have with the medication regime to the practice and/or PCN pharmacy team. The care home manager should be encouraged to discuss these with the supplying pharmacy/dispensing practice.

5.5.2. The GP practice and community pharmacy that the new resident had been registered with may not be the same. Make a note of both the old and the new and communicate with each practice the information collected.

5.5.3. Hospital Discharge. Retain this summary in the patient notes. It may be useful to make copies and make these available with the pharmacy and/or GP practice. Make a note of any contact numbers that are on the hospital discharge summary and the name of the person who completed the form.

6. Governance Information

Author/owner:	Medicines optimisation lead, NHS Kernow
Organisation and contact Details	NHS Kernow Clinical Commissioning Group
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Related documents:	None at present

7. Version Control Table

Date	**Version no**	**Summary of changes**	**Changes made by** (Name and job title)
15/07/2020	V1	Final document approved at CAPC	

This version supersedes any previous versions of this document.

Cornwall and the Isles of Scilly
Health and Care Partnership

Example of care home medicines reconciliation form

Patient name:	**Allergies and type of reaction (if applicable)**
Date of birth:	
NHS no:	

Information sources (at least two must be used), tick applicable box

Recent and dated medication print out from GP computer system	☐
Recent and dated repeat prescription request slip	☐
Resident's own medication (check dispensing dates)	☐
Verbal information from resident, their family or carer (document name)	☐
Recent and dated hospital discharge summary	☐
Other (please state)	☐

Examples of Discrepancies

- Medicine is not currently prescribed
- Resident no longer taking medicine
- Allergy to prescribed medicine
- Duplication of medicine
- Drug interaction
- Formulation incorrect or omitted
- Dose different
- Route different
- Frequency different
- Others (please state)

Blood tests requested (from discharge communication)	Date required	Completed (date and initial)

Additional comments: e.g. explain where there are differences between information source list

Name: Job title: Signature: Date:

To be filed in resident care plan and a copy sent to the GP practice

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Medications (Includes prescription, over the counter and complementary medicines)	Dose	Route	Frequency	Discrepancies Yes or No	Continue Yes or No	Comments and who contacted