Mersey Care NHS Foundation Trust

Community and Mental Health Services

MERSEY CARE NHS TRUST – HOW WE MANAGE MEDICINES

Medicines Management Services aim to ensure that

(i) Service users receive their medicines at times that they need them and in a safe way.

(ii) Information on medicines is available to staff, service users and their carers

How Medicines are Reconciled on Admission to the Trust (Local Services) MM03

KEY ISSUES

- **This procedure applies to all trust prescribers and to the trust Pharmacy Service**
- **Medicines Reconciliation is a key stage in the medicines management process to ensure that medicines are prescribed and administered in a safe and effective manner.**

OBJECTIVES

- **To ensure that all relevant staff follow standard procedures when dealing with Medicines Reconciliation**
- **To provide a standard for Medicines Reconciliation within Mersey Care NHS Trust that provides and auditable process.**
- **To ensure that all members of staff working within Mersey Care NHS Trust are aware of their roles, responsibilities and limitations with respect to Medicines reconciliation.**
- **To ensure that an accurate drug history is obtained at (or as near as possible to), the point of admission.**
- **To identify any drug related causes for admission.**
- **To identify any problems that the service user may have with their medication.**
- **To communicate and record through appropriate documentation, any changes, omission and discrepancies.**

Medicines Management Procedure – MM03

Approved by Drugs and Therapeutics Committee

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Introduction

Medicines reconciliation should ensure that medicines prescribed on admission to hospital correspond to those that the client was taking before their admission, unless there are sound clinical reasons to the contrary. Each service user should have his or her drug history taken and confirmed as soon as practical after admission to the ward. (NICE Safety guidance 1 Dec 2007)

This procedure will provide specific details to be followed when completing a service users' medication reconciliation.

Medicines reconciliation is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer and discharge of patients requiring medicines.

Medicines reconciliation can be considered to occur at different stages or 'levels' which may in practice depend on the training and capability of the available staff, although ideally should be driven by the needs of the individual patient.

The admitting doctor will carry out the first level medicines reconciliation as part of the process of admission. The second stage will involve consolidation of the reconciliation by the pharmacy service. A pharmacist should be involved in the process as early as possible and ideally no longer than 72 hours after the original reconciliation has taken place.

The role of the prescriber

A list of the service users current medication should be collated, sources of information are listed below. Ideally at least two sources of information should be used. Care must be taken to ensure this information is current and accurate.

- GP – A fax of the current medication (including any repeat and acute medication). note any discontinuation dates.
  (Please use the fax request sheet (appendix 1) to request GP summary if confirmation is required)

- Discharge summary from Rio/Clinical Information System
- Drugs team e.g. Methadone dose confirmation
- Service User – Drug History (where possible)
- Relatives/Carers (consider service users' confidentiality)
- PODs
- TTO from recent discharge
- Information from the JAC EPMA system

Confirm details of any allergies (or history of drug interactions) check that this information corresponds with the prescription chart. (If possible also check with service user/Carer for any known allergies)

The role of pharmacy services

At each ward visit the ward pharmacist (or cover ward pharmacist) should collect information from their ward/s of newly admitted service users. The following information should be requested /collected.

- Service Users name
- Service Users DOB & Unit Number
- Service Users current GP – Name, address & telephone number
- Any other information which may assist in reconciliation e.g. nursing home details, recent hospital admission details etc.

1. A list of the service users current medication should be collated, sources of information are listed below. Ideally at least two sources of information should be used. Care must be taken to ensure this information is current and accurate.

- GP – A fax of the current medication (including any repeat and acute medication). note any discontinuation dates.
  (Please use the fax request sheet (appendix 1.) to request GP summary if confirmation is required)

- Discharge summary from Rio/clinical information system
- Drugs team e.g. Methadone dose confirmation
- Service User – Drug History (where possible)
- Relatives/Carers (consider service users' confidentiality)
- PODs
- TTO from recent discharge
- Information from the JAC EPMA system

2. Check the first reconciliation has been completed by the admitting doctor.

3. Check service users name and DOB are correct and correspond with Prescription Chart/EPMA information.

4. Check the faxed GP summary is for the correct service user (name &DOB). Work methodically through the list of prescribed medication on the prescription chart/EPMA system, comparing each item with current prescribed medication (GP summary). Check the following corresponds.

   - Name of medication (check for trade generic/brand name)
   - Formulation of medication e.g. tablet, capsule, liquid etc.
   - Brand specific medication e.g. Diltiazem
   - Strength of medication
   - Frequency of administration
   - Route of administration
   - Stop dates for any medication – corresponds with stop dates on prescription chart/EPMA system.

5 If any discrepancies are found these should be investigated immediately. Query discrepancy with prescribing doctor to confirm if this was an intentional change. If the

discrepancy was due to a prescribing error the doctor should be requested to make an alteration to correct the error immediately. The prescribing discrepancy/error should be reported on DATIX and recorded on Rio.

6 When all of the above information has been collated and checked the reconciliation box on the prescription chart should be signed or the EPMA system should be updated with a record note that the reconciliation has been completed.

7 When a service user is transferred to another ward and a new prescription chart is written a new reconciliation procedure should be carried out, entering information on the service user profile form. The prescription chart reconciliation box should be signed when all checks of currently prescribed medication have been made. In this instance the previous prescription chart can be used to collate the information.

8 If a service user has had an admission to another hospital and returns to the ward, newly prescribed or stopped medication should be reconciled following the above procedure. The TTO discharge prescription or a list of current medication and information regarding stopped medication should be requested, faxed from the hospital doctor.

9 For areas where paper charts are still used, any re-written prescription charts should also be reconciled with previous chart using above procedure and the previous chart to collate the information.

10 A biannual point-prevalence audit of medicines reconciliation will be carried out by pharmacy services and reported to the trust's Drugs and Therapeutics Committee.

Medications with Special Considerations

Oral Methotrexate:

Oral Methotrexate is only prescribed as a once weekly dosage regime. At all times the trust procedure as stated in Appendix 5 of The Handling of Medicines Policy (SD 12) must be followed. Due to the fact that dosing is once weekly there will never be an occasion where the drug needs to be used in an emergency.

Methotrexate must never be initiated by a trust prescriber.

A service user who is admitted on to an inpatient area within the trust who is currently receiving Methotrexate prescribed from a specialist will receive a supply but the following guidance must be followed.

Methadone:

Check whether doses have been confirmed with the GP or Trust Substance Misuse Services. This should be documented in the medical notes/drug chart.
The service user should not receive his/her methadone dose until this has been confirmed.

It is recommended that the community pharmacy that holds a repeat or instalment prescription, if appropriate, is informed of the admission.

Methadone is not usually supplied on discharge unless approved by the GP or Trust Substance Misuse Services – the service user should arrange to pick up their supply from their usual community pharmacy.

At all times the trust's policy for handling of Controlled Drugs must be followed this is found in Chapter 5 of the trust's Handling of Medicines Policy (SD 12).

Steroids (Asthma / COPD):

Ask about any recent courses (i.e. within the past 6 months) and if so, how many and for how long (i.e. whether they were short 5-7 day courses or reducing courses). The Committee on Safety of Medicines suggests that as a guide, the following clients should be weaned off steroids:

Those who have had more than 3 weeks oral steroid treatment

Those who have had recent repeat courses; locally this has been interpreted as 3 or more 1-week (or longer) courses in the past 6 months

Those who have previously been on long-term steroid therapy (months/years)

Those who have other possible causes of adrenal suppression

Those taking more than 40mg prednisolone or equivalent per day

Those who have been taking repeat doses in the evening

Also

Any service user who says that he/she usually has reducing courses from the GP/clinic

In these cases, document on the drug chart ‘reducing course of steroids required’ and add this to the discharge plan for follow up.

Steroids (other):

Service users on long-term steroids – document on the in-patient drug chart as ‘long term steroids’ and their regular maintenance dose where appropriate.

Check whether the client has a steroid card, supply one if not.

For service users taking steroids as part of a treatment regimen (e.g. chemotherapy), double check the steroid plan and if necessary, liaise with pharmacy.

Insulin:

Check type, device, dose and whether supplies are needed on discharge then document device on the In-patient drug chart or in the pharmacy box next to the prescription

For those service users who say that they have an insulin pen, clarify between a pre-filled disposable pen and a cartridge + pen (i.e. reusable). Check whether client needs a supply of needles. Confirm size of needles required.

Please liaise with Pharmacy with regard to stock availability of the insulin product/device.

Alendronate or risedronate once weekly or ibandronic acid once monthly:

Check which day of the week it is taken and ensure that non-bisphosphonate days are clearly crossed through. Check whether service user is also on a calcium and vitamin D preparation and confirm which one.

Nebulisers:

Identify whether the service user uses these at home (document on the In-patient drug chart as 'no home nebs' on home nebs')

Warfarin and Other Anticoagulants :

The National Patient Safety Agency (NPSA) has identified anticoagulants as one of the classes of medicines more frequently causing preventable harm and admission to hospital. All NHS organisations are therefore now required to manage the risks associated with anticoagulants to reduce the chance of patients being harmed in the future.

Prescribers must ensure that:

- they are certain of the details of the service user's anticoagulant treatment. This will include:
    - indication for anticoagulant treatment
    - current dosage of anticoagulant medicine(s)
    - intended duration of anticoagulant treatment, with start and stop dates where appropriate
    - where required, target INR measurement and accepted range of INR measurements
    - frequency of INR monitoring required
    - contact details of the patient's anticoagulant clinic
- they prescribe and monitor the anticoagulant according to the advice of the anticoagulant clinic. This will include:
    - ensuring that the anticoagulant medicine(s) is entered onto the service user's prescription card clearly and completely
    - arranging for the appropriate blood tests to be performed at the time they are required
    - adjusting the anticoagulant prescription as required following the results of blood tests, under the advice of the anticoagulant clinic
    - monitoring the patient for any clinical signs of either over- or under-treatment
    - considering the potential for drug interactions with the anticoagulant and taking appropriate action under the advice of the anticoagulant clinic
- the service user and/or their carer understand their anticoagulant treatment and are fully aware of arrangements for ongoing treatment once they leave the Trust. This will include:
    - discussion of the background to the patient's anticoagulant treatment as above, and signs of potential over-treatment (see toxicity below)
    - ensuring that the patient's yellow anticoagulant therapy booklet contains up-to-date information on their treatment
    - clarifying the arrangements for anticoagulant follow-up once the patient leaves the Trust
- they record all relevant information in the service user's medical records
- they have the required competencies to prescribe and monitor anticoagulant treatment, as advised by the NPSA

For further details please see The Handling of Medicines Policy (SD12)

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Appendix 1

Request for faxed list of current medication

Dear

Could you please fax a list of current medications (repeat prescriptions and acute prescriptions issued in the last 2 months) to the fax number below as soon a possible for the service user below?

Service users name	Service users date of birth
Service users address	
Name of person requesting information	
Position of person requesting information	
Contact phone number of person requesting	
Fax number (to send list to)	
Date and time of request	