

Kent and Medway ICB

Medicines Reconciliation

Best Practice Guidance

Version History

Version	Status	Date	Approved by	Comments
NHS Kent and Medway Integrated Care Board				
1.0	Approved	May 2022	KMMOC, Clinical Cabinet	

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2.0	Approved	December 2024	IMOC	<p>Added version history.</p> <p>Changing of who can carry out medicines reconciliation from care home manager or responsibly listed person to suitably trained and competent member of staff</p> <p>Additional information added under 'what should be included in medicines reconciliation on admission to care home and how to reconcile a patients medications Added sections 'what to do if you find a discrepancy' and 'record keeping'</p> <p>Appendix one changed</p> <p>Appendix 2 added section to document discrepancies</p>
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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 error¹.

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?

Suitably trained and competent care home staff are responsible for carrying out medicines reconciliations as part of a full needs assessment and care plan.

Patients and/or family members or carers, GP, pharmacist and other health and social care practitioners involved in managing the resident's medicines, e.g. end-of-life facilitators, mental health professionals, should be involved in medicines reconciliation where possible.

It is good practice to have the medicines reconciliation checked by a second member of staff with the correct knowledge and skills to carry out this task to reduce the risk of errors.

When should a 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?

- Resident's details including full name, date of birth

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- 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.
- How the resident likes to take their medications.
 - o NOTE: resident's may take their medications differently to how they are prescribed. This must be noted and discussed with the prescriber.
- 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. Efforts should be made to find this information.
- Date and time of any medicine given less often than once a day (weekly or monthly medicines), if known. Efforts should be made to find this information. If unable to confirm the date of the last dose given discuss with the GP or pharmacist regarding when the next dose should be given.
- Recent changes to medications (including stopped medication, dose adjustments, formulation changes)
- 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.
- Vaccine history. (Last covid vaccine, Pneumonia etc)
- Any illicit drugs, alcohol consumption and smoking status as these can affect how some medications work.

How do I reconcile a resident's medication?

See Appendix 1 for a flowchart of the stages involved in medicines reconciliation. Care home staff undertaking the medicines reconciliation must use a **minimum of TWO RELIABLE** sources of information to reconcile medicines. It may be necessary to use numerous sources to confirm an accurate list of medications a resident is taking. The most up to date sources should be used to compare against to. Examples of suitable sources include:

- Resident/carer/relative interview
 - o If the resident received support with their medications, involve this person in the medicines reconciliation.
 - o - Printed discharge summary Ensure it is up to date. Contact ward/hospital with any queries.
 - o Use with caution if it is not clear if the discharge summary has been validated by a pharmacy professional.
- Resident's own labelled medication
 - o Check patient name and date on medication dispensing label
- GP Summary (this should be the resident's GP they were registered with before transferring into the care home)

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- o Note if the resident has transferred from a hospital or other acute setting the GP record may not be the most up to date source of information.
- Other additional specialist services e.g. diabetic nurse, SALT, mental health team, dietician.
- MAR chart
 - o For readmissions to the care home following temporary transition into another care setting the MAR chart should be used to identify what the resident was on prior to admission into another care setting and if there have been any changes during their transitions.
 - o From new admission if they had previously used a MAR chart check it is up to date and all pages are received including PRN medications.
- Discharge prescription or copy of repeat prescription
 - o Check the date on prescription to make sure it is a current list.
- Contacting previous community pharmacy the resident used.
 - o Note if the resident has transferred from a hospital or other acute setting this may not be the most up to date source of information.

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.

What to do if you find a discrepancy?

Any discrepancies identified should be escalated to an appropriate health care professional before any doses of the medication in which a discrepancy has been found is given. The discrepancies should be resolved in a timely manner to prevent any delay in medication being given.

If the resident had not been taking the medication or had been taking the medication differently to how it had been prescribed the reason for this should be discussed with the resident/carer and fed back to the prescriber.

Detail of the discrepancy and outcome of the prescriber's decision should be clearly documented and discussed with the resident and relevant family/carers if appropriate.

If there is any doubt about the medicine reconciliation or the discrepancy cannot be resolved this must be highlighted to a prescriber to investigate further and make a clinical decision regarding the medication(s).

Record Keeping

Each medicines reconciliation should be kept within the medicines section of the resident's care plan (See appendix 2 for a medicines reconciliation record template).

Records must include what sources of information were used, when the medicines reconciliation took place and who carried out the medicine's reconciliation. All details of

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discrepancies found and outcomes following decision made by the prescriber, including the prescribers' details.

New admissions

Once the medication reconciliation has been completed the confirmed list of medications currently being taken should be added to the MAR/eMAR following the care homes policies and procedures.

Readmission of residents following a transition to another health care setting

Once the medication reconciliation has been completed the confirmed list of medications should be checked against the current MAR/eMAR to update any changes following the care homes policies and procedures.

High Risk Medications

For high risk medications (e.g. Insulin (clearly state the number of units per dose), Methotrexate, Lithium (include brand), Clozapine, Sodium Valproate, Phenytoin, Warfarin or other anti-coagulants) it is advisable to check doses and frequencies with the relevant prescriber/support team/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>

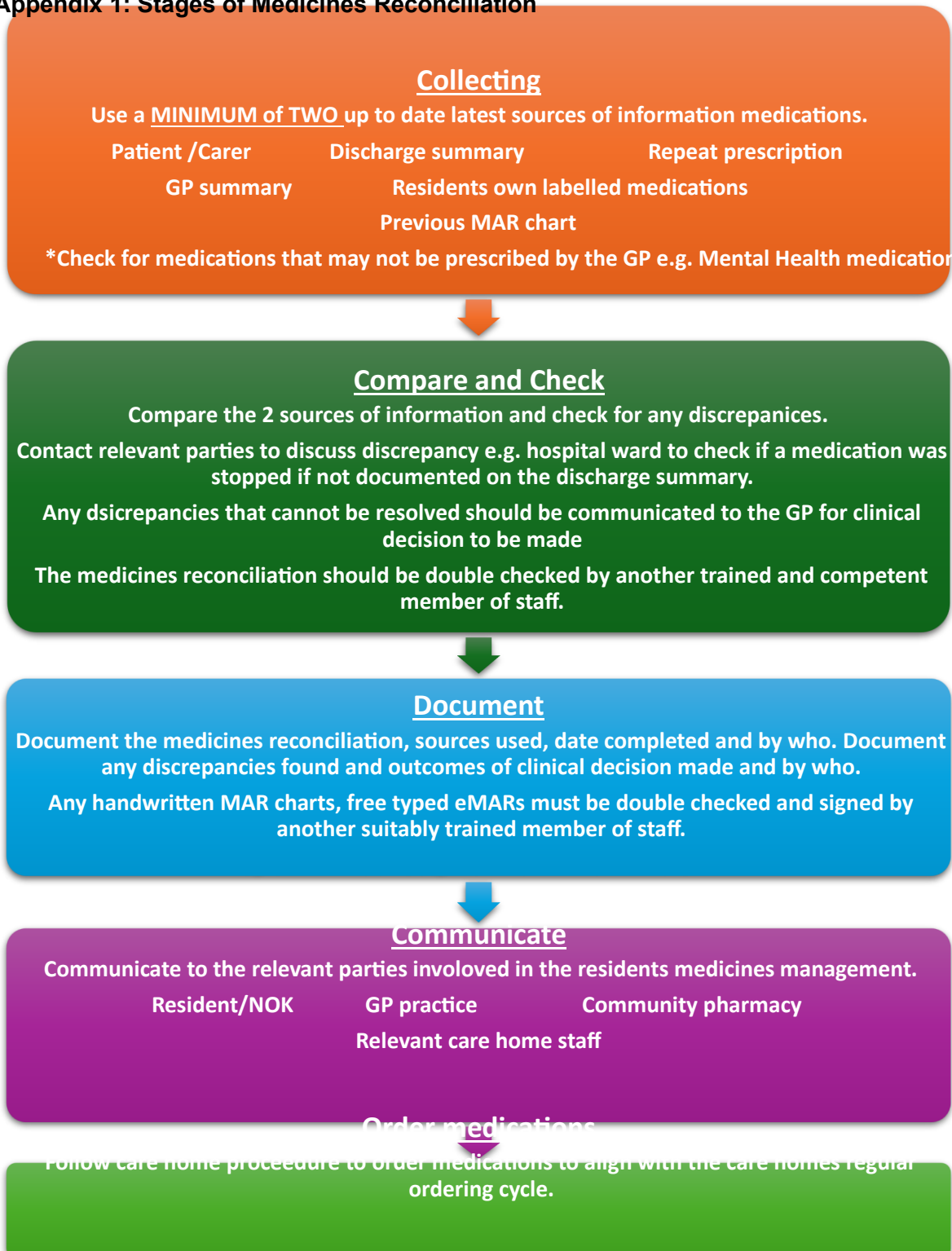
CQC Medicines Reconciliation (how to check you have the right medicines):

<https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-reconciliation-howcheckyou-have-right-medicines>

National Institute for Health and Care Excellence (NICE), 2014. Managing medicines in care homes. NICE: London.

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Appendix 1: Stages of Medicines Reconciliation



Appendix 2: Medicines Reconciliation Sheet

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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 and where they are from 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)			
Any discrepancies found		Discrepancies discussed with	
Outcome decision made by prescriber			
Completed by		Checked by	
Date completed			