NHS Grampian Medicines Reconciliation Protocol

<table>
<thead>
<tr>
<th>Lead Authors/ Co-ordinators:</th>
<th>Consultation Group/Reviewer:</th>
<th>Approver:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim Cruttenden - Principal Pharmacist</td>
<td>Dr Sarah Ross, Chair of Medication Safety Group</td>
<td>Dr Caroline Hind, Chair of NHS Grampian Medicines, Guidelines and Policies Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature:</th>
<th>Signature:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Signature]</td>
<td>[Signature]</td>
<td>[Signature]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Identifier:</th>
<th>Review Date:</th>
<th>Date Approved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSG/Guid/Med_Rec MGPG711</td>
<td>January 2017</td>
<td>January 2015</td>
</tr>
</tbody>
</table>

Uncontrolled when printed

Version 1

Executive Sign-Off

This document has been endorsed by the Director of Pharmacy and Medicines Management

Signature: [Signature]
Title: NHS Grampian Medicines Reconciliation Protocol

Unique Identifier: NHSG/Guid/Med_RecMGPG711

Replaces: N/A – New document

Across NHS Boards

<table>
<thead>
<tr>
<th>Organisation Wide</th>
<th>Directorate</th>
<th>Clinical Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This controlled document shall not be copied in part or whole without the express permission of the author or the author’s representative.

Lead Author/Co-ordinator: Kim Cruttenden/Lyn McDonald

Subject (as per document registration categories): Clinical Guidelines

Key word(s): Prescribing, medication, medicines, safety, admission, discharge, reconciliation

Process Document: Policy, Protocol, Procedure or Guideline

Protocol

Document application: NHS Grampian

Purpose/description: To ensure accurate medicine reconciliation is performed throughout patients journey

Responsibilities for implementation:

Organisational: Chief Executive and Management Teams

Corporate: Senior Managers

Departmental: Heads of Service/Clinical Leads

Area: Line Managers

Hospital/Interface services: Assistant 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 two years or sooner if current recommendations change
Responsibilities for review of this document: Kim Cruttenden/Lyn McDonald

Responsibilities for ensuring registration of this document on the NHS Grampian Information/Document Silo: Pharmacist, Pharmacy and Medicines Directorate

Physical location of the original of this document: Pharmacy Office, ARI

Job/group title of those who have control over this document: Medication Safety Group, NHS Grampian

Responsibilities for disseminating document as per distribution list: Medication Safety Group, NHS Grampian

Revision History:

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Previous Revision Date</th>
<th>Summary of Changes (Descriptive summary of the changes made)</th>
<th>Changes Marked* (Identify page numbers and section heading)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N/A</td>
<td>New Document</td>
<td></td>
</tr>
</tbody>
</table>

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

This document is also available in large print and other formats and languages, upon request. Please call NHS Grampian Corporate Communications on (01224) 551116 or (01224) 552245.
# NHS Grampian Medicines Reconciliation Protocol

## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>2</td>
</tr>
<tr>
<td>1.1. Definition</td>
<td>4</td>
</tr>
<tr>
<td>1.2. Clinical situations</td>
<td>4</td>
</tr>
<tr>
<td>1.3. Patient groups to which this document applies</td>
<td>4</td>
</tr>
<tr>
<td>2. Medicines Reconciliation Process</td>
<td>4</td>
</tr>
<tr>
<td>2.1. Medicines reconciliation on admission</td>
<td>4</td>
</tr>
<tr>
<td>2.1.1. Sources of information</td>
<td>4</td>
</tr>
<tr>
<td>2.1.2. Medicines reconciliation - information required</td>
<td>6</td>
</tr>
<tr>
<td>2.1.3. Drugs that require special attention</td>
<td>6</td>
</tr>
<tr>
<td>2.1.4. Documented plan</td>
<td>7</td>
</tr>
<tr>
<td>2.1.5. Prescribing continuing medication</td>
<td>7</td>
</tr>
<tr>
<td>2.2. Medicines reconciliation on transfer</td>
<td>7</td>
</tr>
<tr>
<td>2.3. Medicines reconciliation on discharge</td>
<td>8</td>
</tr>
<tr>
<td>2.4. Primary care medicines reconciliation</td>
<td>8</td>
</tr>
<tr>
<td>2.5. Summary</td>
<td>9</td>
</tr>
<tr>
<td>3. Roles And Responsibilities</td>
<td>9</td>
</tr>
<tr>
<td>3.1. Unit Operational Managers/Consultants</td>
<td>9</td>
</tr>
<tr>
<td>3.2. Medical staff/Nurse Practitioners with responsibility for patient admission, transfer and discharge</td>
<td>10</td>
</tr>
<tr>
<td>3.3. Pharmacists</td>
<td>10</td>
</tr>
<tr>
<td>4. References</td>
<td>10</td>
</tr>
<tr>
<td>5. Distribution List</td>
<td>11</td>
</tr>
<tr>
<td>6. Abbreviations Used In This Protocol</td>
<td>11</td>
</tr>
<tr>
<td>7. Groups Consulted</td>
<td>11</td>
</tr>
<tr>
<td>Appendix 1 – NHS Grampian Adult Medicines Reconciliation Forms</td>
<td>12</td>
</tr>
<tr>
<td>Appendix 2 – Paediatric Medicines Reconciliation Sheet</td>
<td>14</td>
</tr>
<tr>
<td>Appendix 3 Summary Of Medication Reconciliation Process</td>
<td>16</td>
</tr>
</tbody>
</table>
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 errors are 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 errors 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 errors 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 record/notes.
- Prescribing medicines for the patient onto the prescription and administration record.

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.

NHS Grampian has developed this medicines reconciliation protocol 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 and that new medicines are prescribed with a complete knowledge of the patient’s current medicines, including non-prescription medicines, and allergy status.

The process of medicines reconciliation involves:

- **Collecting** an accurate list of a patient’s current medicines 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% compliance with accurate medicines reconciliation within 24 hours of admission.
- 95% of patients have an accurate inpatient prescription chart within 24 hours of admission.
- 95% compliance with accurate medicines reconciliation on discharge.
- 95% of patients have an accurate medicines list on the discharge letter (eIDL, IDL).
- Primary care teams should ensure accurate medicines reconciliation occurs for patients discharged back to their care – although no specified target has been set at present it is suggested this should have a 95% accuracy rate.

In hospital, use of a structured 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.

The medicines reconciliation form should be easily accessible in the medical notes during the patients stay to allow for continual medicines reconciliation to occur. The medicines reconciliation form may be a separate sheet in the clerking notes or an integral part of the clerking booklet.
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 health 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 the medicines reconciliation task will initially be undertaken by the admitting doctor, nurse/midwife or pharmacist, depending on individual unit processes.

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 medication management patients.
• GP repeat prescription slip (right hand side of script).
• GP phone call.
• Community pharmacy.
• Nursing home phone call.
• Case notes/previous discharge prescription/elDL 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 acute admissions during normal working hours it is recommended that the GP surgery 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 net. Verbal telephone communication of medication names and doses should be avoided if possible as it may reduce accuracy of information transferred.

If it is known the patient has special medication requirements (for example, is on level 3 medication management, has a compliance aid/dosette or is under care of the Substance Misuse Service), this information should be communicated to the hospital team.

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. 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. If consent is not requested the reason should be annotated in notes or appropriate web based service, e.g. unconscious patient, lacks capacity.

2.1.2. Medicines reconciliation - information required
Use of a medicines reconciliation checklist/form (Appendix 1) is recommended. 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 be annotated on medicine reconciliation form and signed at bottom of form.
- 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 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 that may be apparent.
- If patient has a compliance device/dosette/blister pack or if they are part of level 3 medication management this should be written onto medicines care plan within the prescription and administration record (Kardex).
- Time and date that medication history has been taken.
- Signature of doctor, nurse/midwife or pharmacist documenting the medication history. If a non-prescriber has taken the medication history, the admitting prescriber should check and sign the form prior to prescribing the medication onto the drug Kardex.
- Any follow up required to complete medicines reconciliation accurately should be recorded.

Referral to medical notes or medicines care plan may be necessary if there is not enough space on the medicines reconciliation form.

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. These details can be annotated in the medical notes or on the medicines care plan.
of prescription and administration record (PAR) if not enough space remains on the medicines reconciliation form.

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. (4)

2.1.4. Documented plan

To ensure understanding and clarity amongst healthcare team members, a plan for each medicine should be documented on the medicines reconciliation form using the continue withhold and stop columns. The reason for a medicine being discontinued or withheld should be documented in the notes. 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 and administration record (PAR).

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/e-IDL 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/e-IDL by medical staff and/or nurse practitioners or pharmacists, if appropriate.

If any urgent follow-up is required, e.g. INR monitoring if on warfarin, then this must be organised with Primary Care team ideally 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 prescription 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 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. 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/e-IDL should be workflowed on the day of receipt to specified GP, e.g. duty doctor, registered GP or practice pharmacist.
- Medicines should be reconciled within 2 working days of prescription being workflowed to 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.
- It is good practice to liaise with the patients 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
- #671M - Advice to GP to change patients medication
- #8B3SO - Medication changes discussed with patient/patient’s advocate

2.5. 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/Consultants

- The Consultant or Unit Operational Manager should ensure that medicines reconciliation is an integral part of the education and training given to new staff 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.
- In the inpatient setting it is the responsibility of the receiving Consultant to ensure that medicines reconciliation is completed.
- Incidents/near misses caused by poor medicines reconciliation processes should be reported on Datix, ideally to the receiving Consultant or clinical lead. These incidents 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 it is useful to monitor performance and drive improvement through audit and measurement.
3.2. **Medical staff/Nurse Practitioners 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 medicines reconciliation form. The admission notes 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.
- 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/eIDL by medical staff and/or nurse practitioners/pharmacists.
- Report on Datix, ideally to the receiving ward Consultant, incidents/near misses caused by poor medicine reconciliation processes.

3.3. **Pharmacists**

- Support medical and nursing staff 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 (IDL) 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 Medical staff, and acted upon.
- Sign and date medicines reconciliation Form after verification.
- Sign and date care plan on prescription and administration record/Kardex when medicines reconciliation has been verified.
- Report on Datix, ideally to the receiving ward Consultant, incidents/near misses caused by poor medicines reconciliation processes.

4. **References**

3. SGHD/CMO(2011)16 Extension of ECS to Scheduled Care Settings in Support of Medicine Reconciliation.
5. **Distribution List**

NHS Grampian Globals

6. **Abbreviations Used In This Protocol**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPSP</td>
<td>Scottish Patient Safety Programme</td>
</tr>
<tr>
<td>e-IDL/IDL</td>
<td>(electronic) immediate discharge letter</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>ECS</td>
<td>Emergency Care Summary</td>
</tr>
<tr>
<td>KIS</td>
<td>Key Information Summary</td>
</tr>
<tr>
<td>MAR</td>
<td>Medicine Administration Record Sheet</td>
</tr>
<tr>
<td>CHI</td>
<td>Community Health Index</td>
</tr>
<tr>
<td>INR</td>
<td>International normalised ratio</td>
</tr>
<tr>
<td>PAR</td>
<td>Prescription and Administration Record</td>
</tr>
</tbody>
</table>

7. **Groups Consulted**

- 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 CHP, City And Aberdeenshire
- Consultants Subcommittee (of AMC)
- GP Subcommittee (of AMC)
- Grampian Medicines Management Group
- Medicine Guidelines And Policies group
- Medication Safety Group
- SPSP Primary Care Steering Group
### NHS Grampian ADULT Medicines Reconciliation Form

**Patient Details**  
(attach addressograph)  
Name:  
Address:  
CHI number:  

**Hospital:**  
Ward:  
Date of admission:  

**Drug Allergies/Intolerances (STATE NKDA IF NONE KNOWN):**

Tick if Patient is on NO regular medicines

<table>
<thead>
<tr>
<th>Medication on Admission (include regular “Over-the-Counter”, Herbal etc) – Continue over page if needed</th>
<th>Medication Action Plan – Prescriber to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name, Strength, Formulation</strong></td>
<td><strong>Dose</strong></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Turn over for more lines

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 Reconciliation:  
No ☐  Yes ☐

Follow up actions completed by:  
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:

---

Adult Medicines Reconciliation Sheet Continued over
Continuation Sheet for Medicines Reconciliation

<table>
<thead>
<tr>
<th>Name, Strength, Formulation</th>
<th>Dose</th>
<th>Frequency/Times</th>
<th>Medication Action Plan – Prescriber to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 (e.g. duration of therapy, monitoring), if appropriate:
Name: ___________________________  Signature: ___________________________
Date/time: ___________________________
# Appendix 2 – Paediatric Medicines Reconciliation Sheet

<table>
<thead>
<tr>
<th>Medicine and Form (e.g., Tablets, Liquids)</th>
<th>Strength</th>
<th>Route</th>
<th>Dose</th>
<th>Tick on state time</th>
<th>Assessed</th>
<th>Indication</th>
<th>Prescriber - Medication Action Plan (within 24 hours of admission)</th>
<th>Nurse or Pharmacy Notes</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y N</td>
<td>Y N</td>
<td>Y N</td>
</tr>
</tbody>
</table>

Medication history taken by: Name: ________________________ Signature: ________________________ Date: ________________________

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

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

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

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

---

NHS Grampian Paediatric Medicines Reconciliation Form

Tick Information Sources for medication history (minimum of 2 sources to be used):
- Patient
- Parent/Carer
- Recent Hospital Notes
- Community Pharmacy
- ECS/EIS
- Other...

---

NHS Grampian Medicines Reconciliation Protocol – Version 1
## Paediatric Continuation Sheet for Medicines Reconciliation

<table>
<thead>
<tr>
<th>Medicine and Form (e.g. Tablets, Liquids)</th>
<th>Spec</th>
<th>Name</th>
<th>Date</th>
<th>Tick or state time</th>
<th>Indication</th>
<th>Prescriber - Medication Action Plan (within 24 hours of admission)</th>
<th>Nurse or Pharmacist</th>
<th>Notes</th>
<th>Patient's own drugs suitable for use</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medication history taken by:**
- **Name:**
- **Signature:**

**Admitting Prescriber responsible for medication action plan:**
- **Name:**
- **Signature:**

**Follow up actions completed by:**
- **Name:**
- **Signature:**

**Accuracy check by Pharmacist:**
- **Name:**
- **Signature:**

**DateTime:**
- **Name:**
- **Signature:**
Appendix 3  Summary Of Medication Reconciliation Process

On Admission
1. Access standardised Medication Reconciliation (MedRec) Form
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 Chart (‘Kardex’)
7. Pharmacy Review: Review of accuracy and appropriateness of the medicines list/plan and the prescription 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:
   - prescription chart (kardex)
   - Med Rec form
   - case notes
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 to GP, and ensure patient has own copy of advised medication along with any changes or follow-up required.

Primary Care
1. Discharge prescription workflowed 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.