Medicines Reconciliation Policy and Procedure

1 SUMMARY

The aim of medicines reconciliation is to accurately collect, compare and communicate the patient's medicines, allergies and ADRs list to the prescriber to prevent medication error and harm.

2 POLICY STATEMENT

2.1 Purpose

A medicine reconciliation policy ensures the right patients receive the right medications in the right dose at the right time. Reconciling medications reduces the risk of medication errors and confusion that may occur during patient transfer of care. The aim of medicines reconciliation is to ensure a process that allows for the 'most accurate' list of medicines that a patient is taking, together with details of any allergies and/or adverse drug reactions (ADRs), with the outcome of providing correct medicines for a given period of time. It is especially important to perform Medicines Reconciliation (MR) at points of transfer of care.

2.2 Background

The Doctors on Riccarton (DOR) medicines reconciliation policy has been created to address concerns brought about by the Health Quality & Safety Commission New Zealand. It is an evidence-based process, which has been demonstrated to significantly reduce medication errors caused by incomplete or insufficient documentation of medicine related information which could potentially cause an error and/or harm to a patient

International studies show:

- between 10-67 percent of medication histories have at least one error
- up to one-third of these errors have the potential to cause patient harm
- more than 50% of medication errors occur at transfer of care
- patients with one or more medicines missing from their discharge information are 2.3 times more likely to be readmitted to hospital than those with correct information on discharge

84% of discrepancies in medication treatment originate from poor medication history takingScope

This policy applies to Medical and Nursing staff working at this practice. Administration and reception staff should also be aware of this policy in order to respond to patient's requests for prescriptions in the appropriate manner.

2.3 Scope / Accountabilities

This policy should be followed by all medical and nursing staff that have responsibility for ensuring the patient's medicines are appropriately prescribed during their enrolment with the practice or transfer of notes from another provider.

Administration staff have a role to play when new notes enter the practice and must follow the "new notes" procedure to ensure the medications are reviewed within an appropriate time frame of arrival in the practice. See Doctors on Riccarton procedure for summarising incoming notes

2.4 Definitions & Abbreviations

In this section define terms that are critical to the interpretation and implementation of the policy.

Medicines Reconciliation (MR)	The process of collecting, comparing and communicating the 'most accurate' list of medicines that a patient is taking, together with details of any allergies and/or adverse drug reactions (ADRs), with the outcome of providing correct medicines for a given time period.
Patient Medical Record (PMR)	Will be referred to as the systematic documentation of a patient's medical history and care on Indici.
Adverse Drug Reactions (ADR)	Injuries caused by taking medication.
Discrepancy	Defined as any difference between the medicines the patient had been taking in their previous care setting and the medicines prescribed in their new care setting. Intentional discrepancies are intentionally changing prescription medications by the clinician responsible for the patient's care. Unintentional discrepancy (errors, omissions or unintentional additions) are subconscious changes made by the clinician responsible for the patient's care.

3 POLICY DETAIL AND PROCEDURES

3.1 Duties (Roles and Responsibilities)

3.1.1 General Practitioner

- Confirms with the patient what medication is being taken including prescribed, OTC, herbal, street/illicit drugs, allergies and ADRs and the nature of their reaction using one but ideally two information sources.
- Ensures that new allergy and ADR sensitivities are documented on the prescription record and PMR.
- Documents this information and the sources under Allergies/Adverse reactions in Indici.
- Prescribes medicines in accordance with record produced by MR process and current patient status.
- Documents further measures required to take medication safely e.g ECG, blood test, lithium level.
- Documents any medication changes made including reason(s) on the PMR.
- Also notes any person other than the patient who is responsible for administering the medication

3.1.2 Nurse Prescriber

- Confirms with the patient about medication including prescribed, OTC, herbals, street/illicit drugs, allergies and ADRs and the nature of their reaction using one but ideally two information sources.
- Documents this information and the sources under Allergies/Adverse reactions in Indici.
- Prescribes medicines in accordance with records produced by MR process and current patient status.
- Also notes any person other than the patient who is responsible for administering the medication.

3.1.3 Registered Nurse

- Collects the patient's history of medications prescribed/used including OTC, herbals or street/illicit drugs within the last 3 months and allergies or ADRs and their respective reactions using one but ideally two information sources.
- Documents allergy/ADRs and their sources under Allergies/Adverse reactions in Indici.
- Also notes any person other than the patient who is responsible for administering the medication.

3.2 Information Sources

At least two information sources (at least one of which must be a primary source) are required to validate an existing medication list.

- Primary - for example verbal information from the competent patient, patient's family/caregiver, patient-held medication list (eg yellow card), patient's own medicines (check supply and expiry date on each container).
- Secondary - for example GP, community pharmacy, community health team (eg diabetic, mental health, child), lead maternity carers, rest homes, private specialists (document full name and contact details).
- Tertiary - for example clinical notes, hospital medication charts, transfer letters, hospital pharmacy records, previous medicines reconciliation documentation.

3.3 Equality and Diversity

Considerations in carrying out medicine reconciliation

- Patients who are deaf or hard of hearing
- Patients who cannot speak English or Chinese sufficiently
- Patients with a learning disability or autism
- Patients who are intoxicated/under the influence of drugs
- Patients with dementia or who are confused or agitated
- Patients who are unconscious

If one or more of the above applies to a patient, the patient's relatives/carers may be used as a source of information or the patient's GP can be contacted. Medical interpreter services may also be used.

3.4 Procedures

3.4.1 Collecting information in New Patient Consultation

1. The initial consultation by the registered nurse will ask the names of any medications that the patient has been prescribed/used within the last three months including over-the-counter medicines and illegal drugs. The nurse will ascertain any allergies or ADRs the patient may have experienced at any time in the past. The nurse may also use other information sources where applicable.
2. The nurse will then document this information in the 'Notes' as well as under Allergies/Adverse reactions in the PMR. If the patient has no known allergies, then 'NKDA' will be documented in the 'Allergies/Adverse reactions tab. Drug use will be documented under Diagnosis and coding/ social history tab of the PMR.
3. The following consultation involving the general practitioner or nurse prescriber will confirm the details documented by the nurse and will further ask about medication strength, formulation, dosage, frequency and route where necessary.

4. They will also ascertain the patient's adherence to their prescribed medication regime and any additional devices required to help support adherence e.g monitored dosage systems.
5. Additional information to be collected for specific drugs include:
   i. Antibiotics - date started and length of course.
   ii. Steroids - if regular or short/reducing course. Long-term steroids should be annotated on prescription chart so that treatment is not abruptly stopped.
   iii. Day of week of administration for once weekly medication (e.g bisphosphonates, methotrexate, patches).
   iv. Warfarin - duration of treatment, indication, target INR, patient's usual or most recent dose and time of day dose taken, whether patient has an anticoagulant diary, date of last INR test and result, details of clinic that they attend for their monitoring and date of next appointment.
   v. Insulin - type, brand, strength, administration device, dose.
   vi. Oral contraceptives - many patients do not consider this as medicine and should therefore be asked about. Additional counselling may also be required if antibiotics are started, which can decrease the efficacy of the oral contraceptive pill.
   vii. Methotrexate - this is prescribed to be taken on specific days, usually once a week.
   viii. Bisphosphonates - the day of administration should be confirmed with patient.
   ix. Methadone - contact the community pharmacist to alert them of the patient's admission and determine the normal dispensing schedule and when the patient last collected their methadone.
   x. Opioids - confirm frequency, dose, strength, brand, any recent dosage changes and if PRN.

3.4.2 New Prescriptions

New prescriptions created by the prescriber are reported in the 'Medications' tab of the patients notes and will include information regarding strength, formulation and directions given. If medication is for long-term use then it will be in the section labelled, Long term medication. Prescribers will read the 'Interactions' that automatically come up on indici when prescribing or look in NZ formulary.

3.4.3 Adjusting Medications

Any adjustments in course directions will be edited in the 'medications' list and the reason for any changes recorded in the patient notes. Only prescribers are able to change anything under medications.

1. The procedure for adding a new medication in Indici without prescribing it is as follows

- Go to patient'' medication list
- Select the first tab called medication
- Search for the medication you wish to enter and select
- The patients medicine interactions come up, read and select OK
- Select – medication update only
- Fill in appropriately
- Change the provider to EXTP (external provider)
- Annotate the reason for the changes
- Save and all the information will be in the notes including the reason for the change
- Many letters don't have the amount and length of time for the prescription. Can look up complete list on Health One or enter 0 in the duration column.

2. The procedure for changing an existing medication is the same as above then also do the following

- Go back to the long- term list
- Select S in the right- hand column

- Reason will come up
- Select dose change (or appropriate message)
- Annotate reason for change
- Select OK

This will now show in history crossed out and the new one as above will be in today's medication activity and in the patient notes.

3. Keywords have been inserted into Indici as follows:

..recon1 = Medications from discharge letter received on..... reviewed. No changes needed. Allergies and ADR updated.
..recon2 = Medications from discharge letter received on ..... reviewed and PMS updated with changes. Allergies and ADR updated. (Consider calling patient to ensure instructions are being followed if necessary.)

4. PRN medications are found under 'other medication activity' list. They are entered into the patient's medication list at time of review at dr/ nurse prescribers discretion and may not be included in medication reconciliation audit.

5. Deleted medication is found under the prescription tab in Indici and they have a line through them. Select the s (for stopped) icon- enter the reason for stopping and save. If a medication is deleted or stopped the reason must be entered into the patient notes.

6. Collecting and Comparing information from Discharge Summaries

   DOR has a 'SUMMARISING INCOMING NOTES,' procedure that nurses use when summarizing /comparing notes. These must be summarized within 10 days of receipt and the medication review within 7 days. The receptionist puts the hard copy of the notes in a box in the nurses room and writes the patients name, NHI, date of receipt and nurse who has been sent a task to do the medications review as this needs to be done first. The aim is to ensure the prescription record is reconciled as soon as possible after admission/transfer. If no discrepancies found, then use the keyword ..RECON1 (Medications from discharge letter received on..... reviewed. No changes needed. Allergies and ADR updated.). The words discharge letter can be changed to notes transfer. If there is a discrepancy then discuss with the patients GP or call the patient to find out what they are taking and communicate with them and the GP. Document adequately. Can check Health One or current pharmacy.

7. Medicines Reconciliation Unintentional Discrepancy

   Any unintentional discrepancies discovered between medication charts, prescriptions, PMR and what the patient is actually taking will be recorded by the nurse/doctor in the 'Daily Record' tab of the PMR, along with actions and outcomes as a result of the discrepancy found. If the nurse discovers an unintentional discrepancy, they will communicate to the prescriber as soon as possible. Examples of discrepancy include: reports penicillin allergy, yet have been prescribed penicillin previously OR states they have no allergies, yet their previous GP notes have an antibiotic allergy reported.

3.5 Training Requirements

Medical Staff - MR procedure will be taught within the standard induction process of new staff.
Nursing Staff - MR procedure will be taught within the standard induction process of new staff.

3.6 Auditing

Monthly auditing of the medicine reconciliation process will involve randomly sampling 10 patients (based on a cohort with either recent discharge form, clinic letters,) who have been on antiplatelets, diuretics, NSAIDs, anti-coagulants or opioids, in order to see if they are reliably receiving the following care:

1. Has medicines reconciliation (a process in which the GP reviews the discharge prescription and then decides which drugs the patient should continue, or be recommenced,) occurred within ten calendar days of the Electronic Discharge Summary (EDS) being received by the practice? (Select N/A in the data collection form if no discharge summary was received)
2. Has the patient's current regular medication list been updated?
3. Is it documented that any significant (new long-term medication started or changed or deemed by clinician) medication changes have been discussed with the patient or their representative within ten calendar days of receipt?
4. How many medication-related adverse events presentations occurred in enrolled patients each month?

The nurse co-odinator will report any significant findings at a clinical meeting and will include any important lessons in the staff induction training process.

3.6.1 Performing a medication reconciliation audit on Indici

Enter details in Doctors on Riccarton Audit sheet for Medication Reconciliation as follows

DOCTORS ON RICCARTON AUDIT SHEET FOR MEDICATION RECONCILIATION												
No.	GP	Patient NHI	Has medicines reconciliation occurred within seven calendar days of the Electronic Discharge Summary (EDS) being received by the practice?		Has the patient's regular medication list been updated within seven calendar days of EDS being received by the practice?			Is it documented that any changes in their regular medications have been communicated to the patient or their representative within seven calendar days of the EDS being received by the practice			Comments	Checked by
1			y	n	y	n	n/a	y	n	n/a		
2			y	n	y	n	n/a	y	n	n/a		
3			y	n	y	n	n/a	y	n	n/a		
4			y	n	y	n	n/a	y	n	n/a		
5			y	n	y	n	n/a	y	n	n/a		
6			y	n	y	n	n/a	y	n	n/a		
7			y	n	y	n	n/a	y	n	n/a		
8			y	n	y	n	n/a	y	n	n/a		
9			y	n	y	n	n/a	y	n	n/a		
10			y	n	y	n	n/a	y	n	n/a		
Audited by:												

Audit sheet can be found in a folder called Templates and set sheets in the server.

Audit procedure

- Go to provider inbox
- Select month that wish to audit
- Enter discharge into subject
- Select all for provider, file status and status
- Search
- Go through list to find 10 patients with discharge letters/documents with medications lists and review these. Do not need to include prn medications that will not be prescribed again.
- Enter on audit sheet which also includes a column

3.6.2 Audit Reporting

The audit results will be discussed at a clinical meeting after each audit

3.7 Importance of Medicine Reconciliation:

https://www.hqsc.govt.nz/our-programmes/medication-safety/projects/medicine-reconciliation/
http://www.conference.co.nz/files/docs/00gp18/1620%20lisa%20eskildsen.pdf

4 REFERENCES

https://www.southernhealth.nhs.uk/_resources/assets/attachment/full/0/71904.pdf
https://www.goodfellowunit.org/sites/default/files/webinars/sip_med_rec_change_package.pdf
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