Hertfordshire and West Essex Integrated Care System

NHS Hertfordshire and West Essex Integrated Care Board

Care Homes Good Practice Guidance

MEDICINES RECONCILIATION AND TRANSFER OF CARE

Introduction

Transfer of care

Improving the transfer of information about medicines across all care settings would help to support a reduction in incidents of avoidable harm to patients, improve patient safety and contribute to a reduction in avoidable medicine related admissions/re-admissions to hospital. **Good communication between all care settings is necessary for good transfer of care.**

What is Medicines reconciliation?

Medicines reconciliation is the process of accurately listing a resident's medicines and allergies. This could be when they are admitted into a service or when their treatment changes[1].

Who should carry out medicines reconciliation?

The care home manager or the person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines (medicines reconciliation) as part of a full needs assessment and care plan.

The person carrying out the medicines reconciliation must ensure they are trained and competent in this process, otherwise they should seek help from a trained colleague.

These staff carrying out medicines reconciliation will need knowledge, skills and expertise including:

- effective communication skills
- technical knowledge of processes for managing medicines
- therapeutic knowledge of medicines use.

Where appropriate the resident, their family members and carers should be involved.

How to carry out medicines reconciliation?

This process should include a discussion with the resident and/or carer. Where possible evidence should be gained regarding the resident's medication.

There should be an accurate account of all the resident's medication for example:

- Prescribed medications including:
  - Creams
  - Lotions
  - Drops
  - Ointments
  - Inhalers
  - Injections
- Over the counter medications
- Herbal medications
- Any illicit drugs
- Any medications that are given in any other specialist location (e.g. hospital only medicines)

If any discrepancies between the current medication list and the two sources of information (listed below) are found, they should consult with a qualified health professional. Ideally, this should be the person's GP, nurse or pharmacist. Any discrepancies and actions taken should be documented in the care plan.

Best practice is to use two sources of information to ensure the information you have is correct.

Possible sources of information:

- Medication boxes/bottles (ensure current date and right patient)
- Medications Administration Record (MAR) charts

- Hospital discharge letters
- Resident's own list
- Resident/relative/carer
- Handover notes (from other health care professionals)
- GP medication list
- Contact with resident's regular community pharmacy
- Any other medication information e.g. Lithium booklet, warfarin booklet, Steroid card

What information to include in medicines reconciliation?

It is important that accurate up to date medication information for the residents is captured.The types of information to collect during a medicines reconciliation are:

- Contact details for relevant healthcare professionals (e.g. GP, community pharmacy etc)
- 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)
- Any known allergies and reactions to medicines or ingredients and the type of reaction (if none, ensure you have noted this too)
    - If known when the reaction occurred document this too
    - If resident has no known drug allergy (NKDA) this should be documented
- All of the resident's current medicines, including:
    - medication name
    - strength
    - form
    - dose
    - timing and frequency
    - route (if topical, where or how it is applied)
    - indication - what the medicine is for
- How and when the resident prefers to or usually takes their medicine. This should include an assessment for self-administration
- Changes to medicines and reason for change, including:
    - medicines started
    - medicines stopped
    - dose changes
- Date and time the last dose of any 'when required' medicine was taken - include specific instructions to support the administration of these
- Information about any medicine given less often than once a day - weekly or monthly medicines
- Information about any medicines which are given by anyone else e.g. hospital only, community nursing team
- Information given to the resident, family members or carers
- When the medicine should be reviewed and any monitoring involved
- Any short courses of medication: information on when to give the last dose should be obtained. e.g., nitrofurantoin for a urinary tract infection may have only finished the day before the resident arrives
- Any medications recently started or stopped (if known the reason)

Where should this information be recorded?

This information should be recorded in the medicines care plan.

Ensure the following is recorded:

- details of the person completing the medicines reconciliation (name, job title)
- the date of the medicines reconciliation
- source(s) of information about the reconciled medicines

- any discrepancies and how they were resolved

If resident needs to be registered with new GP

If new GP registration required at new placement, care home to:

- Contact current GP practice to request information required for transfer including past medical history and a list of current medication (if not hospital transfer).
- Arrange for at least two weeks supply of medication to be available (if not hospital transfer).
- Contact new GP practice for new registration form.
- Complete registration form and send with details from previous GP.
- Ensure pharmacy who supplies medication is aware of changes.
- Ensure patients medication are reviewed ideally within 2 weeks of being transferred

If resident is returning to same GP to the home from another setting

- Ensure sufficient supply of current medication, from discharging place
- If new to the care home ensure GP surgery is aware of change in address
- Ensure the pharmacy who supply medication is aware resident is returning home/to new care home setting
- Arrange for a review once the individual arrives at the new home within two weeks

Patients should not be transferred until medication is available or arrangements have been made for medication to be supplied to the care home in a timely manner to ensure doses are not missed.

Some high risk medications and considerations for medicines reconciliation

Please note this list is not exhaustive

Medication type	Considerations
Parkinson's Disease medications	It is important to note the exact prescribed administration times so that these timings can be continued. Some residents may have a Parkinson's Disease passport or the home may like to use 'Get it on time stickers'
Analgesic patches	Often have set administration instructions, e.g. fentanyl patches should be applied every 72 hours. Establish when the last patch was administered and the location of the patch so the site can be altered as directed and old patch removed.
Warfarin	Establish if there is a recent INR or if there is an updated anticoagulant record book. The current dose and time of administration should be recorded; it is useful to record the contact details of any anticoagulant clinic the resident attends. Ensure patient does not have any signs of bleeding or bruising.
Direct-acting oral anticoagulants (DOACs)	These are the newer blood thinning medication e.g. rivaroxaban Ensure patient does not have any signs of bleeding or bruising. See Good practice guidance for anticoagulants.
Insulin	It is important to identify the type of insulin, device used, the most recent insulin dose and information about managing hypo- or hyper-glycaemic episodes.
Methotrexate	Double check methotrexate strength and doses - these are administered weekly. Check and record which day of the week it should be administered. Check the day of the week for folic acid - ensure both are not administered on the same day.
Depot/long-acting injectable (LAI) antipsychotic	Identify the LAI antipsychotic and the frequency of administration. Some have similar sounding names and can be given at different dosing intervals. Staff must have the necessary knowledge, skills and competency to safely administer depot antipsychotic injections by deep intramuscular injection. (Usually done by specialist service/GP nurses). Ensure you have the information for last dose given and who is your contact for next dose. Ensure that a clinical management plan is available to support the home to ensure safe administration of the LAI.
Lithium	Brands are NOT interchangeable. Prescriptions should always state the brand. It is important to continue to administer the same brand of lithium. If a change in formulation is required seek specialist advice. If a liquid preparation is prescribed it is important BOTH strength and volume are specified. Hot weather, infections, diarrhoea and vomiting can all result in higher lithium levels. Many medicines interact with lithium and can affect lithium levels.

Reference

[1] CQC: Medicines reconciliation (how to check you have the right medicines) (Nov 2022). Accessed March 2023

Additional references

National institution of clinical excellence (2014) : Managing medicnes in care homes. Accessed online May 2023 Managing medicines in care homes (nice.org.uk)

Good practice Guidance: Anticoagulants (2023) Hertfordshire and West Essex ICB. Accessed June 2023 gpg-anticoagulants (icb.nhs.uk)

Acknowledgements

Some information within this guidance has been adapted from:

CQC: Medicines reconciliation (how to check you have the right medicines) (Nov 2022). Accessed March 2023

Firmly CCG Good practice Guidance medicines reconciliation (Jan 2022) Accessed May 2023

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