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Discharge Medicines Reconciliation
Sharing experience and good practice

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Agenda

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- Rationale
- What is included and who is involved
- General process
- Considerations during medicines reconciliation
- Other/special circumstances
- Questions

Rationale

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Medicines-related patient safety incidents are more likely when medicines reconciliation happens **more than a week** after discharge from a care setting[1]

"Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated"[2]

- Organisations should ensure that a designated health professional has overall organisational responsibility for the medicines reconciliation process
- Organisations should ensure that medicines reconciliation is carried out by a trained and competent health professional – ideally a pharmacist, pharmacy technician, nurse or doctor – with the necessary knowledge, skills and expertise
- Involve patients and their family members or carers, where appropriate, in the medicines reconciliation process.
- When carrying out medicines reconciliation, record relevant information on an electronic or paper-based form.[3]

What is included

- Any document received mentioning medications
- Clinic letters
- Discharge summaries
- Patient letters
- Medication/appliance/ lymphoedema requests e.g. community nurses, podiatry

Who is involved

- **Pharmacy technicians**
- Clinical pharmacists
- GPs
- (Scanning team)
- (POD care home team)
- (POD dietetics team)
- (POD appliance assistant)

Process

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Scanning team to forward relevant documents to an allocated user group in the documents inbox for processing.

Pharmacy technicians to access documents to process" in both surgeries in allocated time via User group > Prescription Queries. Arrange documents by oldest date created and begin with those flagged red or oldest date.

Select the document and process update to load patient records and view the document to be reconciled. Use the "Medication reconciliation" template to enter an entry into journal.

1. Pass the document with a note to the pharmacists/GP if you have a query or as per SOP
2. Complete the document only once satisfied all appropriate actions have been made.

Process

SystmOne Template

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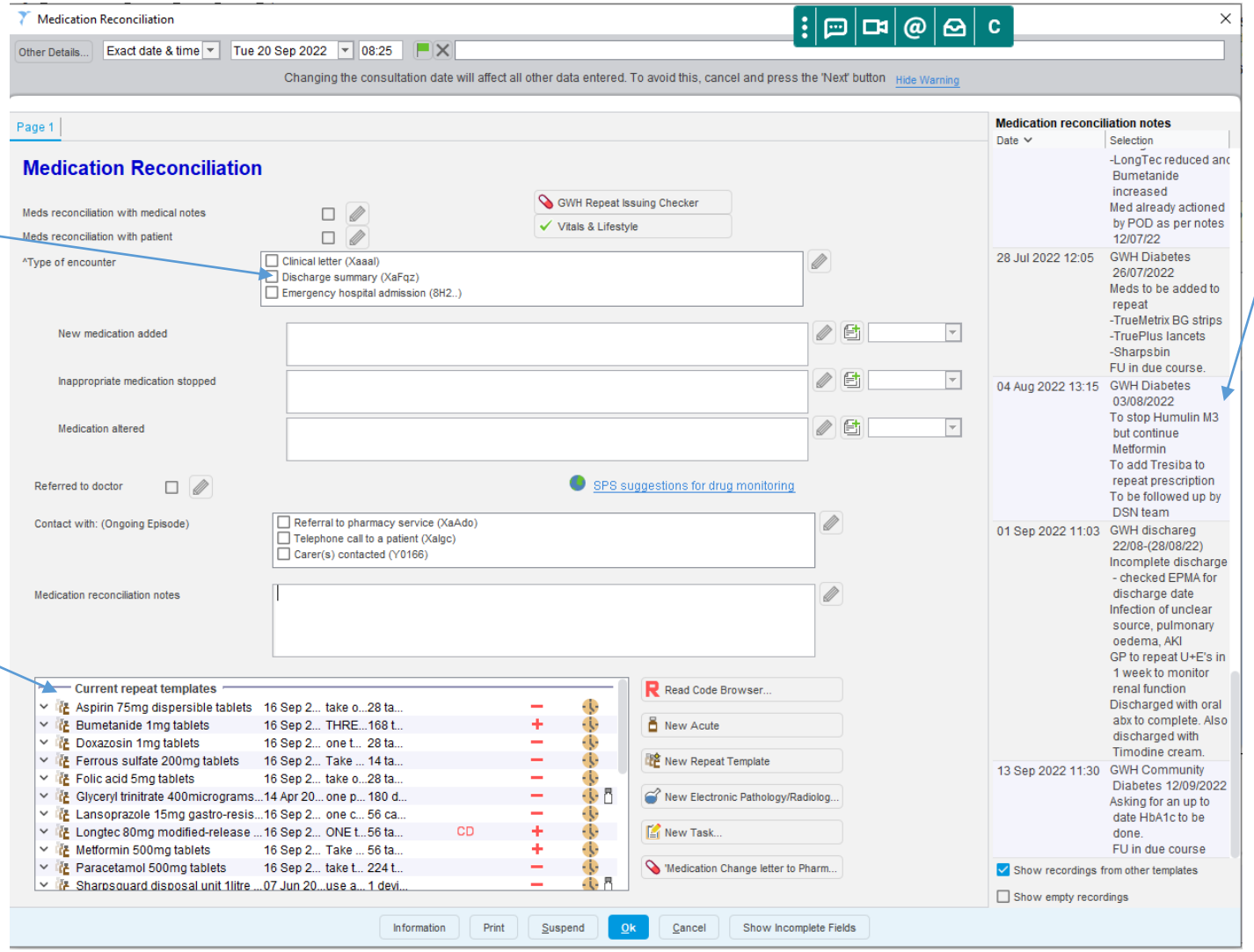
Type of communications

There is a list of all repeat medications and at the bottom is last 3 months of acutes

We can see previous documents that have been reconciled by the pharmacy team.



Medication Reconciliation
Meds reconciliation with medical notes: Yes
New medication added: Aspirin
Clopidogrel
GTN spray
Medication altered: Omeprazole switched to Lansoprazole
^Type of encounter:
Discharge summary (XaFqz)
Emergency hospital admission (8H2..)
Medication reconciliation notes: GWH discharge 11/09-15/09/2022
Unstable angina
Will need to continue DAPT for 12 months and then Aspirin alone ongoing.
FU in ACS clinic
Aspirin 75mg dispersible tablets - 28 tablet - Take ONE in the morning
Clopidogrel 75mg tablets - 28 tablet - Take ONE in the morning
Glyceryl trinitrate 400micrograms/dose pump sublingual spray - 180 dose - Use ONE spray under the tongue when required for the relief of chest pain
Lansoprazole 30mg gastro-resistant capsules - 28 capsule - Take ONE in the morning
ETP Medication Cancellation Sent
Summary Care Record Update
Medication changed (8B316) - Omeprazole switched to Lansoprazole
New medication added (XM1Y8)
Aspirin
Clopidogrel
GTN spray
Post hospital dischrge med reconciliation with medical notes (XaWST)
Medication reconciliation (XaXfG)
GWH discharge 11/09-15/09/2022
Unstable angina
Will need to continue DAPT for 12 months and then Aspirin alone ongoing.
FU in ACS clinic
Emergency hospital admission (8H2..)
Discharge summary (XaFqz)

Medication Reconciliation
Meds reconciliation with medical notes: Yes
^Type of encounter: Clinical letter (Xaaal)
Medication reconciliation notes: GWH Gynae 18/08/2022
Trialled Testogel (1 sachet to last 10 days) - felt well using this.
Wishes to continue on it
Clinic have prescribed a further 3 months supply.
This is amber shared care on formulary - no shared care provided. Queried with pharmacists.
Post hospital dischrge med reconciliation with medical notes (XaWST)
Clinical letter (Xaaal)
Medication reconciliation (XaXfG)
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Considerations during reconciliation

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- Be mindful of **duplicate letters**, or those which are superseded by more recent communication.
- Ensure each entry specified the **date and type of communication** being reviewed.
- **Be concise** and specify any actions you have taken during reconciliation.
- **Clinically check** the changes advised with current medications: consider appropriate dose changes, interactions, duplicate drug groups.
- Check **past compliance** with medication if changes are being made.
- Check **formulary status** if unsure, and challenge recommendations if appropriate.
- Consider if **repeat or acute** prescription is appropriate e.g. salbutamol inhalers, paracetamol, laxatives.
- Set suitable **review dates** for repeat.
- **Contact patient** to clarify if unclear if a medication supply was made
- Inform patients of any **prescriptions being issued** at the time of reconciliation.
- Where appropriate, **read-code medications** added to repeat
- Utilise **script notes** where appropriate.
- Arrange relevant **follow up appointments**, if unsuccessful task PSO to contact patient. Consider the urgency of suggested medication/blood tests/reviews when issuing prescriptions and booking appointments.

Other/Special Circumstances

BSW ICB Medicines Optimisation Team Support

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Care home discharge

Nutrition/dietetics (sip feeds or unclear vitamins)

Lymphoedema requests

Appliance contractor requests (e.g. catheter or stoma items)

Other/Special Circumstances

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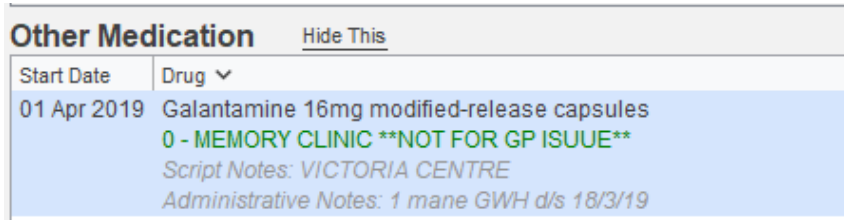
Medicines prescribed in secondary care or elsewhere

- Clinics can prescribe medications that are not for primary care based on the BSW formulary
- To be added to ‘other meds’ to minimise risk of being issued
- This appears on a summary care record in cause of hospital admission
- POD to signpost back to original prescriber e.g. clinic

Galantamine 16mg modified-release capsules - 0 - MEMORY CLINIC **NOT FOR GP ISUUE**

Discharge Medicines Reconciliation (DMR)
New medication added: Galantamine to 'other meds'

*Medicines reconciliation performed: Yes
Inappropriate medication stopped: Amlodipine,Atorvastatin,Solifenacin
Additional note: GWH d/s 18/3/19 already actioned by POD 21/3/19 but repeats not amended.No further action for POD
Summary Care Record Update
Additional note (Xalg3) - GWH d/s 18/3/19 already actioned by POD 21/3/19 but repeats not amended.No further action for POD
Inappropriate medication stopped (XaJYI) - Amlodipine,Atorvastatin,Solifenacin
New medication added (XM1Y8)
Galantamine to 'other meds'
Medicines reconciliation performed (XaRF0)



Other/Special Circumstances

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High risk medications

This includes

- DMARDs
- Lithium
- Amiodarone

- Separate SOP to cover this process but all patients are added to our recall system which is managed by our pharmacy technicians.

Other/Special Circumstances

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Warfarin & DOACs

- **Warfarin**

-Add all strengths of Warfarin to repeat template

-Add patient to Warfarin recall to ensure regular INR checks

Warfarin Monitoring
Monitoring
Monitoring: Anticoagulation monitoring - secondary care (XaL3h)
INR: 2.4
Time in TTR: 58 %
Warfarin dose - new: 4 mg
Recall: Warfarin Monitoring (19 Sep 2022) GWH Anti-Coag LAC
International normalised ratio (42QE.) 2.4
Anticoagulation monitoring - secondary care (XaL3h)
Warfarin Dose (Y0786) 4 mg
INR percentage time in therapeutic range (Xaa68) 58 %

- **DOAC**

Reconciled and then passed to pharmacist for a clinical check

- Check indication
- Check interactions e.g. antiplatelets
- Check BMI/blood test up to date on record
- Calculate CrCl and check dose
- Set review date appropriately
- Referral to anticoagulant service

Other/Special Circumstances

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PCLS or mental health advice

- **PCLS** – tend to be ‘considerations or recommendations’.

-They will advise to titrate medications but it is up to us to follow up this medication change/titration.

-For GP or Mental Health Nurse to discuss to inform patient of what to expect e.g. SE

-If pharmacist is reconciling – they can action this too.

- **Swindon Recovery** - To clarify who is prescribing
- **Swindon Intensive** – To clarify who is prescribing

-Add medication to ‘**other meds**’ so they appear on the SCR

-Can request GP to take over prescribing

-To clarify script frequency with them e.g. weekly, fortnightly or monthly?

-Set an appropriate follow up review date

-Discuss medication with patient – e.g. how to re-order

Other/Special Circumstances

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Communication outside of the PCN

- Including dossette box patients

-To communicate medication changes to the community pharmacy and ask what scripts they require to make the changes ASAP.

-If monitoring is due following a change – ask when they can make this change to arrange appropriate monitoring

- Challenging or clarifying recommendations
- Shared pharmacy inbox
- Record keeping – in patient record

Other/Special Circumstances

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Referring document to GP or Pharmacist

Including Shared care agreement (SCA) requests

Including Smoking cessation

DOACs

P2 requests e.g. for insulin

General queries/discrepancies that unable to identify without justification

Other/Special Circumstances

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NHSE low value medicines[5] and OTC guidance

- Utilise opportunities for cost effective switches or suggesting OTC.
- Implement formulary recommendations at the point of prescribing (Prescribe Well – Spend Less[4])
- Examples

-Eye drops

-Laxatives

-Calcium/Vit D supplements

Other/Special Circumstances

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Discharge summaries to SwICC

- Incomplete discharges

-No discharge date

-No medications on discharge

Transferred to SwICC (Forrest or Orchard Ward)

-Call GWH to check if patient admitted and whether we can expect a full discharge if unsure

Other/Special Circumstances

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Incident reporting

GWH

- We use GWH system to report incidents
- Old discharge summaries affecting medication supply
- Discrepancies (if no obvious clinical indication)

BSW ICB

- Recommendations that are don't fall in line with local formulary

Questions

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References

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5. https://www.england.nhs.uk/wp-content/uploads/2019/08/items-which-should-not-routinely-be-prescribed-in-primary-care-v2.1.pdf