NHS
West Hampshire
Clinical Commissioning Group

Medicines Optimisation intervention brief

TITLE
Medicines Reconciliation in Primary Care
WHAT?
• People discharged from a care setting (hospital/ care home/ another general practice) should ideally have a reconciled list of their medicines in their GP record within 1 week of the GP practice receiving the information, and before a prescription or new supply of medicines is issued.[1] • Medicines Reconciliation involves comparing the patient's current medications against any recent correspondence from a healthcare setting, recognising and resolving any discrepancies and documenting any changes, resulting in a complete list of medications which reflects exactly how the patient is taking / using their medications.
WHY?
• Medicines reconciliation is vital to support patient safety. • Prevents medication errors, adverse events and thus patient harm. • Ensures clinical decisions are made based on a complete medication history. • Enables clinicians to optimise medications and improve patient care.
WHO?
• All patients discharged from secondary care or another healthcare setting. • All new admissions to care homes. • All patients transferring to a new GP surgery.
TIPS to discuss with patient/carer/relative
• What medications do you take and when? • Do you take any medications, which you buy over the counter (including herbal or homeopathic remedies)? • Do you use any eye/ear drops, inhalers, creams or ointments? • Do you have any medication allergies? If so, what was the reaction to the medication? • Do you apply any medication patches to your body and if so, when were they last applied? • For patients with diabetes who are insulin dependent, how many units do they administer and what type of device do they use? Do they have a record of their most recent blood glucose levels? • If on warfarin, what dose are you currently taking? What is your INR target range and indication for treatment and do you have a record of your most recent INR results? • If you take a weekly medication, what day of the week do you take it? • Do you take any recreational drugs? • If under 16 years or if on medication that requires monitoring (e.g. to ensure safe DOAC dosage), what is their weight? • (If on a variable dosing regimen), what is your current dose and regimen? • Do you have any injections administered such as Vitamin B12, denosumab or GnRH analogues such as goserelin, leuprorelin etc?

- Do you take nutritional supplements/ feeds?
- If stoma/ incontinence appliances are used, are they correctly prescribed?
- Have you got any problems taking/ using your medicines (ensure appropriate formulation)?
- If follow-up monitoring related to medication is required, communicate this to the patients GP.

HOW?

- Ensure a system is in place at the GP practice to notify the pharmacy team of a recent discharge from a healthcare setting or a new patient registered at the practice.
- Identify the most recent, accurate list of the patient's current medications (including the name, dose, frequency and route) from the hospital discharge summary or other healthcare setting.
    - This may require contacting the discharging ward or previous healthcare setting.
- Compare this list to those medicines actually being used/ taken by the patient (following discussion with the patient, relative or carer as appropriate), recognising any discrepancies.
- Document the changes and reason why on the patients' medical record at the GP surgery.
- Update the patients repeat template and add the code 'medicines reconciliation' to the GP clinical system.
- Add any hospital-only medication to the patient's record.
    - https://westhampshireccg.nhs.uk/wp-content/uploads/2020/01/How-to-record-hospital-prescribed-medicines-on-GP-prescribing-systems-combined050416.pdf
- The complete and accurate list of prescribed medications and non-prescription medications can now be communicated to appropriate healthcare professionals across the primary care setting that are involved in the patients care.
- Refer to community pharmacy New Medicine Service (NMS) if appropriate.
- Advise the patient/ carer to return any medications that have been discontinued or are no longer required to their community pharmacy for safe disposal.

SO WHAT?

- Reduces risk of medication error when transferring between care settings.
- Avoids medicines-related readmission.
- Avoids risk of adverse effects from medication.
- Allows appropriate medicines optimisation to be carried out, improving patient care.

FURTHER INFORMATION

1. NICE Medicines Optimisation, Quality standard [QS120] Published date: 24 March 2016