

Dear Colleague

Safer Use of Medicines

Medicines Reconciliation: Revised Definition, Goals and Measures and Recommended Practice Statements for the Scottish Patient Safety Programme

Purpose

This letter and its appendices set out a number of changes and developments to build on current good practice, strengthen and consolidate compliance with Medicines Reconciliation in the Scottish Patient Safety Programme and support for NHS Boards to meet this strategic direction.

Background

Medicines are the most common intervention in western healthcare; their safe use requires collective and collaborative effort by the multidisciplinary team and patients. The Scottish Patient Safety Programme has identified areas of highest risk for medicines across a range of specialities and settings, including primary and acute care. Medicines reconciliation has been a core aspect of this work since its launch in 2008; the work to date has invested energy in narrowing the focus to identifying, testing and refining the improvements which, if reliably implemented, have highest impact. Medicines reconciliation is a key step to ensuring that patients are prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation and that avoidable harm from medicines is reduced. (See definition of medicines reconciliation Appendix I).

Accurate timely Medicines reconciliation on admission to, and discharge from, hospital is an integral part of clinical care and takes time to complete.

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This work is focussed on the quality ambitions set out in The Healthcare Quality Strategy for NHS Scotland, that care will be safe, effective and person-centred and it is strategically related to the Scottish Government HEAT Standard on 4 hour wait, patient flow, Older People in Acute Care (OPAC) and Hospital Standardised Mortality Ratios (HSMR). NHS Boards may wish to gain efficiencies by aligning these strategic and clinical priorities.

Through extensive consultation with clinicians from many disciplines, patients and representatives from the Royal College of Physicians of Edinburgh a national definition, goals and measures and a series of recommended practice statements have been developed. (Appendices I and II).

These aim to consolidate current improvement initiatives and support their reliable and sustained implementation. This will not only reduce avoidable harm from medicines, but will empower patients to become more active in their own care in relation to medicines.

There is an ongoing national improvement plan for medicines reconciliation which is continuing to co-ordinate, through the Safer Use of Medicines Network, hosted by Healthcare Improvement Scotland, the testing and spread of improvements. The Definition, Goals, Measures and Recommended Practice Statements will be reviewed on an on-going basis.

Action

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 this guidance.

NHS Boards are required to:

Have involvement of patients in safer medicines work. There should be a system in place where patients and the public can be involved in, and contribute to, both NHS Board steering groups for medicines reconciliation and medicines reconciliation quality improvement work in clinical areas.

Establish multi-professional leads for medicines reconciliation (doctor, pharmacist and nurse) to drive forward improvement.

As clinical leadership is imperative in creating a culture in which patient safety improvements can be implemented and sustained, these leads should be supported by medical clinical champions in individual specialties.

Establish local mechanisms to co-ordinate quality improvement work around medicines reconciliation which report to the local Area Drugs and Therapeutics Committee.

Undertake a gap analysis and develop local action plans which set out how compliance with the guidance in this letter in relation to medicines reconciliation will be achieved. These action plans should include:

- Ensuring that medicines reconciliation is integrated with other key strategic policies e.g. the Scottish Government HEAT Standard on 4 hour wait, patient flow, OPAC and HSMR reviews.
- Development and implementation of a ratified policy clearly outlining the medicines reconciliation process; including roles and responsibilities of key professions in medicines reconciliation. This should be widely available to frontline staff.

- Ensuring medicines reconciliation is a core part of training for all doctors, pharmacists, nurses and pharmacy technicians; including induction training.
- Adopting the medicines reconciliation e-learning module as mandatory training for all doctors, pharmacists, nurses and pharmacy technicians. This is hosted by NHS Education for Scotland and is planned to be available early 2014.
- Implementing medicines reconciliation in acute receiving units as a priority area, where it should be tested, embedded and spread to other clinical areas.

Include medicines reconciliation prompts and charting in standardised paper and electronic in-patient prescribing systems.

Develop and implement electronic enablers to safer medicines reconciliation in collaboration with e-health.

Monitoring

Implementation of the guidance is the responsibility of the NHS Board Medical Director who will report compliance with the CEL to the NHS Board Chief Executive as part of their clinical governance procedures.

NHS Boards are required to demonstrate compliance with the standards contained within this practice statement, measured using case note review of 20 case notes per calendar month, by uploading monthly data on MMP1, percentage of patients with medicines reconciliation completed, to the Extranet. (<https://app.ihl.org/extranetng/index.aspx>)

A timeline will be developed in relation to changes to data collection and the Extranet. Expected progress in relation to testing/embedding and spread planning will be communicated through the Safer Use of Medicines Network.

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Healthcare Improvement Scotland hosts a Safer Use of Medicines Network with multi-professional and patient membership from across NHS Scotland and Royal Colleges. (<http://www.knowledge.scot.nhs.uk/safermedicinesnetwork.aspx>)

Yours sincerely

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Appendices

Appendix I – Definition, Goals and Measures

1. National Definition, Goals and Measures

Medicines Reconciliation Definition

The process that the healthcare team undertakes to ensure that the list of medication, both prescribed and over the counter, that I am taking is exactly the same as the list that I or my carers, GP, Community Pharmacist and hospital team have. This is achieved in partnership with me 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.

Goals and Measures

Goals and measures are defined for admission and discharge only. A small number of NHS Boards are testing the process of medicines reconciliation on transfer/step-down from intensive care. This learning will be included in the on-going review of medicines reconciliation.

Compliance with medicines reconciliation should be measured using case note review of 20 case notes per calendar month; NHS Boards should aim to align this with other case note reviews e.g. global trigger tool (GTT), however it is recognised that this will not be possible during the early stages of testing as GTT case notes will not give a representative sample of patients in the areas testing medicines reconciliation.

The verification of the medicines reconciliation by a pharmacist provides the definition of accurate medicines reconciliation, if pharmacist verification has not been completed then an assessment would require to be made on the accuracy during the case note review process.

1.1 Admission

Goals

- 95% compliance with medicines reconciliation within 24 hours of admission
- 95% of patients have an accurate in-patient prescription chart within 24 hours of admission

Measures

- Patient demographics documented
- Allergy status on admission documented
- 2 or more sources, one of which should be the patient/carer, used on admission to give the best possible medicines history
- Medicines Plan documented for each medicine i.e. continue, withhold, stop
- Safe and accurate transcription of clinically appropriate medicines on in-patient prescription chart

1.2

1.3 Discharge

Goals

- 95% compliance with medicines reconciliation on discharge
- 95% of patients have an accurate medicines list on the Interim Discharge Letter (IDL)

Measures

- Patient demographics documented
- Allergy status on discharge documented

- Changes from admission medicines documented to include changes, discontinuations and new medicines started
- Safe and accurate prescribing of clinically appropriate medication on Interim Discharge Letter

2. Recommended Practice Statements

Medicines Reconciliation Definition

The process that the healthcare team undertakes to ensure that the list of medication, both prescribed and over the counter, that I am taking is exactly the same as the list that I or my carers, GP, Community Pharmacist and hospital team have. This is achieved in partnership with me 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.

Medicines Reconciliation (MR) is completed within 24 hours of a patient's admission to hospital and applies to patients admitted for longer than 24 hours.

2.1 Transition from primary care to secondary care

- Communication of accurate up-to-date medicine information is essential in facilitating the MR process. The information is communicated for all patients admitted via the GP or out-of-hours services.

2.2 Secondary care admission

- MR on admission encompasses a standardised process to record all medicines that a patient is taking at home, including prescription and non-prescription medicines.
- MR is as integral as possible to the prescribing process, reducing the need for transcription and repetition of work.
- MR uses at least 2 sources. Using one source may result in only 75% information accuracy.
- The MR process starts with the Emergency Care Summary (ECS) then the information is verified with the patient or carer.
- NHS Boards ensure staff carrying out MR have access to ECS and at least 2 other sources of information.
- NHS Boards are encouraged to use patients' own medicines which are an excellent source for MR.
- Other possible sources include:
 - GP letter
 - GP practice print-out
 - Medicine Administration Record Sheet (MAR)
 - GP repeat slip
 - GP phone call
 - Community pharmacist
 - Nursing home phone call
 - Case notes/previous discharge prescription
 - District Nurse
 - Anticoagulant clinic
 - Hospital pharmacist records including chemotherapy

- Compliance chart
 - Clinic letters
- The MR document includes an indication if each medicine is to be continued, withheld or stopped with a documented reason for any variance.
- The MR process is completed by timely and accurate transcribing of clinically appropriate medicines onto the in-patient prescription chart.
- The use of electronic information e.g. ECS is used wherever possible to streamline the process and minimise potential for transcription errors.
 - The ECS MR template is utilised.
 - ECS is accessed using a portal rather than web browser.
- The integration of electronic solutions with hospital electronic prescribing and medicine administration (HEPMA) is proposed as a solution to facilitate MR on admission and discharge. Clinical break points must be included in the system to allow clinical checks.
- The MR process is initially undertaken by the admitting clinical team and the complete process finalised within 24 hours of a patient's hospital admission.
- Pharmacy team input takes place as soon as possible during patient admission.
- Twenty minutes is allowed per patient to include completing the list, action plan and transcribing of clinically appropriate medicines.
- Interruptions are minimised during this process.
- Checks and balances are put in place to identify patients where MR has not been completed within 24 hours of admission, to enable the process to be completed.

2.3 Secondary care discharge

- MR on discharge encompasses a standardised process to record all changes made to medicines during the patient's hospital stay. MR on discharge includes comparison of the admission MR document with current inpatient prescription chart. Any medicines intentionally discontinued or amended have a reason recorded on discharge documentation. Newly started medicines include an indication on discharge documentation. This should comply with the principles outlined in the SIGN discharge document.
- Approximately 30 minutes is required to permit accurate completion of MR within the discharge document.
- As soon as possible after patient discharge, the discharge document is 'sent' to the patient's GP and named community pharmacist who is responsible for providing pharmaceutical care to that individual patient. All information shared in this way must be managed in accordance with Protecting Patient Confidentiality, NHSScotland Code of Practice, the General Pharmaceutical Council's Guidance on Patient Confidentiality and your employer's policies and procedures. Patients should be informed regarding the purpose of sharing the discharge document with their community pharmacist and their consent sought.

- The MR process ensures changes are communicated to the patient or their representative/carer and a check made of their understanding.
- The care home, hospice or intermediate care setting is contacted for other patients as identified by the multidisciplinary team in relation to their clinical requirements.