Tees, Esk and Wear Valleys
NHS Foundation Trust

Procedure for medicines reconciliation

Ref: PHARM-0026-v4.0

Status: Approved

Contents

1. Introduction

The purpose of medicines reconciliation is to reduce medication errors occurring when patients transfer between care settings. The aim of medicines reconciliation is to ensure that the correct medicines are provided to the patient at all transition points between admission and discharge from hospital, through a process of checking medicines prescribed against the most recently available information from reliable sources of prescribing and supply.

2. Why we need this procedure

2.1. Purpose

The purpose of this policy is to:

- Specify standardised systems for collecting and documenting information about current medications
- Ensure the responsibilities of pharmacists and other staff in the medicines reconciliation process are clearly defined
- Incorporate strategies to obtain information about medications for people with communication difficulties.
- Comply with NICE Guideline 5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes and NICE Quality Statement 4: Medicines Reconciliation in acute settings

2.2. Objectives

- To define the process for collecting and documenting information about current medications
- To identify relevant sources of information for medicines reconciliation
- To list the data to be collected
- To define when medicines reconciliation should occur
- To clarify responsibilities of pharmacists and other staff in the medicines reconciliation process; these responsibilities may differ between clinical areas

3. Related documents

Medicines Overarching Framework

Admission, Transfer and Discharge of service users within hospital and residential settings

Self-administration guidance for Crisis and Recovery House staff

Medicines Administration Record (MAR) chart – procedure to use

Medicines – management of untoward occurrences

Pharmacy Protocol: Medicines Optimisation Inpatient Toolkit

4. Definitions

4.1. What is medicines reconciliation?

NICE NG5 states the following: [1]

- Medicines reconciliation is the process of identifying an accurate list of a patient's current medicines – including the name, dosage, frequency and route – and comparing them to the current list in use, recognising any discrepancies, and documenting any changes. This results in a complete list of medications, accurately communicated to all professionals involved in the patients care, in which any issues with medicines, such as wrong dosage or omission have been addressed.
- Medicines reconciliation should be undertaken whenever a patient moves between care settings. It is recognised that the process will vary depending on the care setting that the person has just moved into e.g. primary care into acute care setting, transfers between hospitals, prison to secure mental facility, hospital to primary care
- Medicines reconciliation applies to all inpatient admissions to mental health services.
- It is recommended that this occurs within 24 hours of admission, or sooner if clinically necessary, regardless of the time of admission or the day of the week.[2]
- Medicines-related patient safety incidents are more likely when medicines reconciliation happens more than 24 hours after a person is admitted to an acute setting.[2] Undertaking medicines reconciliation within 24 hours of admission enables early action to be taken when discrepancies between lists of medication are identified.[2]
- Medicines reconciliation may need to be carried out on more than one occasion during a hospital stay

4.2. When should medicines reconciliation occur?

- On admission to hospital within 24 hours or sooner if clinically necessary
- Transfer between wards
  - External to Trust e.g. when transferred back to the Trust from an acute hospital
- At discharge from hospital

4.3. What is outside the scope of this procedure?

4.3.1. Community

When a patient is seen in a community setting, it is best practice whenever medication is reviewed or prescribed for a current list of the patient's medication to be established i.e. medicines reconciliation occurs.

For medication that cannot be transferred to the GP where the Trust continues to prescribe e.g. Clozapine and depot antipsychotics, processes are in place to ensure when the 6 month prescriptions are renewed or changed that a medicines reconciliation process takes place to ensure that there are no discrepancies. See separate guidance.

4.3.2. Primary care

When patients are discharged from hospital into primary care, NICE Guideline 5 requires that medicines reconciliation should be completed before a prescription or new supply of medicines is issued and within 1 week of the GP practice receiving the information.[1] To support our colleagues in primary care attaining this target the Trust has its own discharge communication standards and process which includes information about medication on discharge, dose changes since admission, new and stopped medication (see Admission, Transfer and Discharge Framework link)

4.3.3. Transfers between wards in the Trust

For inpatients that are transferred between wards in the Trust, there is no requirement for medicines reconciliation to occur. It is expected, that for all internal transfers, any medication related issues are communicated on Paris.

For inpatient transfers between York and Selby locality and the rest of the Trust, there will requirement for the Inpatient Prescription and Administration Record to be re-written, until such time as there is a unified single record. To ensure there are no discrepancies when re-written, an accuracy check of the chart will be required.

4.3.4. Medication review

Medicines reconciliation should not be confused with medication review. NICE Guideline 5 defines a medication reviews as 'a structured, critical examination of a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste.'[1]

5. What is the process for medicines reconciliation?

5.1. Medicines reconciliation on admission to hospital

For an overview of the whole process see appendix 1.

5.1.1. Collecting information

This involves the collection of the medication history from a variety of sources and should involve patients and their family members or carers where appropriate.

Accurately list all the person's medication, including prescribed, over-the-counter or complementary medicines. A medicines reconciliation form (see appendix 2) is available to support this.

Always record the date that the information was obtained and the source of the information.

Make a record of any discrepancy between what the patient is currently prescribed, and what the patient is actually taking with reasons for this variation if any can be established.

Sources of information:

- A computer print-out from a GP records system or Summary Care Record
- The tear-off side of a patient's repeat prescription request
- Verbal information from the patient, their family, or a carer
- Medical notes or discharge summary from a patients previous admission to hospital
- Take-home (i.e. discharge) prescription summaries
- Medical notes transferred from another ward or unit
- Patient's own drugs
- Medication Administration Records (MAR) from social and care home settings
- Community Pharmacy Patient Medication Records (PMR), repeat dispensing records and medicine use review records. (NB patients may use multiple pharmacies)
- Specialist nurse care and clinical management plans
- Monitored dosage systems and compliance aid

The minimum information available on admission should include:

- Complete patient details i.e. full name, date of birth, weight if under 16 years, NHS number, GP, date of admission
- Presenting condition plus co-morbidities
- A list of medicines currently prescribed, including those bought over the counter
- Dose frequency, formulation and route of the medicines listed
- An indication of medicines that are not intended to be continued
- Monitored dosage systems and compliance aid
- Known allergies and previous drug interactions


Health professionals should recognise that people's ability to understand the issue of medicines reconciliation may differ and this must be taken into account in discussions with the person (be it the patient, their family or carer). Some people may need additional support to understand the issue, for example, if English is not their first language or if they have communication or sensory difficulties.[2]

5.1.2. Checking information

This is the process of ensuring that the medications and doses that are now prescribed for the patient are correct.

This does not mean that they will be identical to those contained in the medication history – the doctor now caring for the patient may make some intentional changes.

5.1.3. Communicating information

This is the final step in the process where any changes that have been made to the patient's prescription are documented and dated, ready to be communicated to the next person that sees them.

It includes documenting such things as:

- When a medicine has been stopped, and for what reason (including topical preparations)
- When a medicine has been initiated, and for what reason
- The intended duration of treatment (e.g. for antibiotics and hypnotics)
- When a dose has been changed
- When the route of the medicine has been changed
- When the frequency of the dose has changed intentionally
- Discrepancies and action take to rectify

 All discrepancies identified MUST be recorded on Paris and include the action taken and outcome.

Where a discrepancy is potentially serious the prescriber must be informed and DATIX report of the error must be made.

See Trust guidance on Medicines – management of untoward occurrences link

5.2. Admission to Crisis and Recovery House

Patients admitted to a crisis bed are required to be able to self-administer their own medication and there is no requirement for prescription or medication administration record to be written during the admission. As part of the admission process an assessment of patients own medication and verbal information from the patient about what medication they currently take is used to reconcile the medication. (See Trust guidance link.)

5.3. Admission to Respite, Residential or Day services

Patients admitted to a respite or community residential bed or accessing day services, where a Medicines Administration Record (MAR chart) is used, require medicines reconciliation to be completed at the first admission using two sources of information. For subsequent admissions medicines reconciliation should be carried out every 3 months or sooner if notified of changes. All service users must have annual medicines reconciliation against the MAR chart. (See Trust guidance link)

5.4. Transfers between wards external to the Trust

When patients are transferred back to the Trust from an acute hospital, medicines reconciliation should occur as soon as possible, using discharge letter / information or a copy of the acute inpatient drug chart, to ensure the Trust Inpatient Prescription and Administration Record is current and correct. (see Admission, Transfer and Discharge Framework link)

5.5. Discharge from hospital

At discharge from hospital, medicines reconciliation must occur to establish the changes to medication since admission. These need to be communicated, along with the reasons, to the GP as part of the inpatient GP discharge letter.

Sources of information:

- Record of admission medicines reconciliation on Paris. If not available go back to primary sources of medication at admission e.g. GP information
- Inpatient Prescription and Drug Administration Record includes information about changes to medication in the **Start Code** (N= new, A= amended, P = previous) and **Stop Code** boxes. The standards for prescription writing on the reverse of the chart give more guidance on the codes used.

6. Roles and responsibilities

Role	Responsibility
Chief Pharmacist and Deputy Chief Pharmacist – Clinical Services	• To implement this policy within the Pharmacy Service • To ensure the implementation of this policy is monitored
Pharmacists and pharmacy technicians	• To undertake the majority of medicines reconciliations within the first 24 hours of admission to an inpatient bed (within agreed pharmacy service levels) • To undertake medicines reconciliation when patients are transferred both within and externally to the Trust. • To support the medical staff undertaking medicines reconciliation at discharge • To provide training and support to non-pharmacy staff undertaking medicines reconciliation. • To work within the single pharmacy competency framework for medicines reconciliation
Medical staff	• To undertake medicines reconciliation at admission when pharmacy staff are not available, especially out of hours or weekends where there is an urgent clinical need. (See appendix 4 for further guidance) • To undertake medicines reconciliation when patients are transferred back to Trust from an acute hospital admission. • To provide information at discharge from hospital to the GP about medication changes and the reason, including newly stopped and started medication.
Nursing staff	• To undertake medicine reconciliations when pharmacy staff are not available especially out of hours or weekends where there is an urgent clinical need. (See appendix 4 for further guidance)

7. How this procedure will be implemented

- This policy will be published on the Trust's intranet and external website.
- Induction training for all clinical pharmacists
- Competency based training for pharmacy technicians undertaking extended roles
- Induction training for all medical staff
- Medicines reconciliation covered in mandatory medicines management training module for registered nurses
- Communicating discharge medicines reconciliation covered in the Paris inpatient GP discharge letter training.

8. How this procedure will be monitored

- Medicines reconciliation rates and time from admission are monitored each month
- Medicines reconciliation is included in the Pharmacy Audit plan to ensure the quality of admission medicines reconciliation undertaken and documented.
- Information about discrepancies identified and actioned during the admission medicines reconciliation process will be collated, analysed and disseminated at regular intervals.

9. References

1. NICE Guideline 5 Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes https://pathways.nice.org.uk/pathways/medicines-optimisation

2. NICE Quality Statement 4 Medicines Reconciliation in acute settings https://www.nice.org.uk/guidance/QS120/chapter/Quality-statement-4-Medicines-reconciliation-in-acute-settings

10. Equality Analysis Screening Form

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Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Pharmacy					
Name of responsible person and job title	Ros Prior, Deputy Chief Pharmacist – Clinical Services					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Pharmacy Leadership Team					
Policy (document/service) name	Medicines Reconciliation Procedure					
Is the area being assessed a;	Policy/Strategy		Service/Business plan		Project	
	Procedure/Guidance			x	Code of practice	
	Other – Please state					
Geographical area	Trustwide					
Aims and objectives	To provide guidance to TEWV staff regarding the procedures relating to medicines reconciliation					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	21/10/16					
End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved)	24/11/16					

You must contact the EDHR team as soon as possible where you identify a negative impact. Please ring Sarah Jay on 0191 3336267/3542

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?
TEWV staff enabling them to comply with NICE Guideline 5 – Medicines Optimisation and NICE Quality Statement 4 Medicines Reconciliation. Patients – ensuring a current and correct list of medication is available when they move between care settings e.g. admission to hospital GP's and other healthcare professionals outside of TEWV – supporting them to comply with NICE guidance
2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Gender** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

No specific negative impacts on the protected characteristic groups. Health professionals should recognise that people's ability to understand the issue of medicines reconciliation may differ and this must be taken into account in discussions with the person (be it the patient, their family or carer). Some people may need additional support to understand the issue, for example, if English is not their first language or if they have communication or sensory difficulties.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.?	**Yes**			

The document pulls information from NICE guidance and quality statement.				

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

   The document has been approved by Drug & Therapeutics Committee which includes a patient representative and carer representative.

5. As part of this equality analysis have any training needs/service needs been identified?

Yes	Please describe the identified training needs/service needs below Training needs include highlighting changes between this document and the previous version for the pharmacy team. Induction training for medical staff and nurse mandatory training need to be updated accordingly.

A training need has been identified for;

Trust staff	Yes	Service users	No	Contractors or other outside agencies	Yes

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so	
The completed EA has been signed off by: You the Policy owner/manager: Ros Prior:	Date: 10/11/16
Your reporting (line) manager: Christopher Williams	Date: 16/11/16

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/6542 or email: traceymarston@nhs.net

11. Document control

Date of approval:	24 November 2016	
Next review date:	01 October 2021	
This document replaces:	Version 3.0	
Lead:	Name	Title
	Ros Prior	Deputy Chief Pharmacist – Clinical
Members of working party:	Name	Title
	Pharmacy Leadership Team Meeting Members	Chief Pharmacist, Lead Pharmacist and Technicians & Lead Nurse for Medicines Management
This document has been agreed and accepted by: (Director)	Name	Title
	Brent Kilmurray	Chief Operating Officer
This document was approved by:	Name of committee/group	Date
	Drugs and Therapeutics Committee	24 November 2016
This document was ratified by:	Name of committee/group	Date
	N/A	
An equality analysis was completed on this document on:	24 November 2016	

Change record

Version	Date	Amendment details	Status
1.0	Apr 2008	New policy	Withdrawn
2.0	Mar 2011	Minor amendments	Withdrawn
3.0	Apr 2013	Reformatted	Withdrawn
4.0	Nov	Change from CLIN0026 to PHARM 00026. Change from policy to procedure. Full revision in line with NICE guidance. Minor amendments throughout. Significant updates to section 4, 5, 6, 8, app 1, 2.	Approved
4.0	18 Oct 2019	Review date extended to 01 June 2020	
4.0	28 May 2020	Review date extended 01 December 2020	
4.0	Oct 2020	Review date extended to 01 April 2021	
4.0	26 Mar 2021	Review date extended to 01 October 2021	

12. Appendices

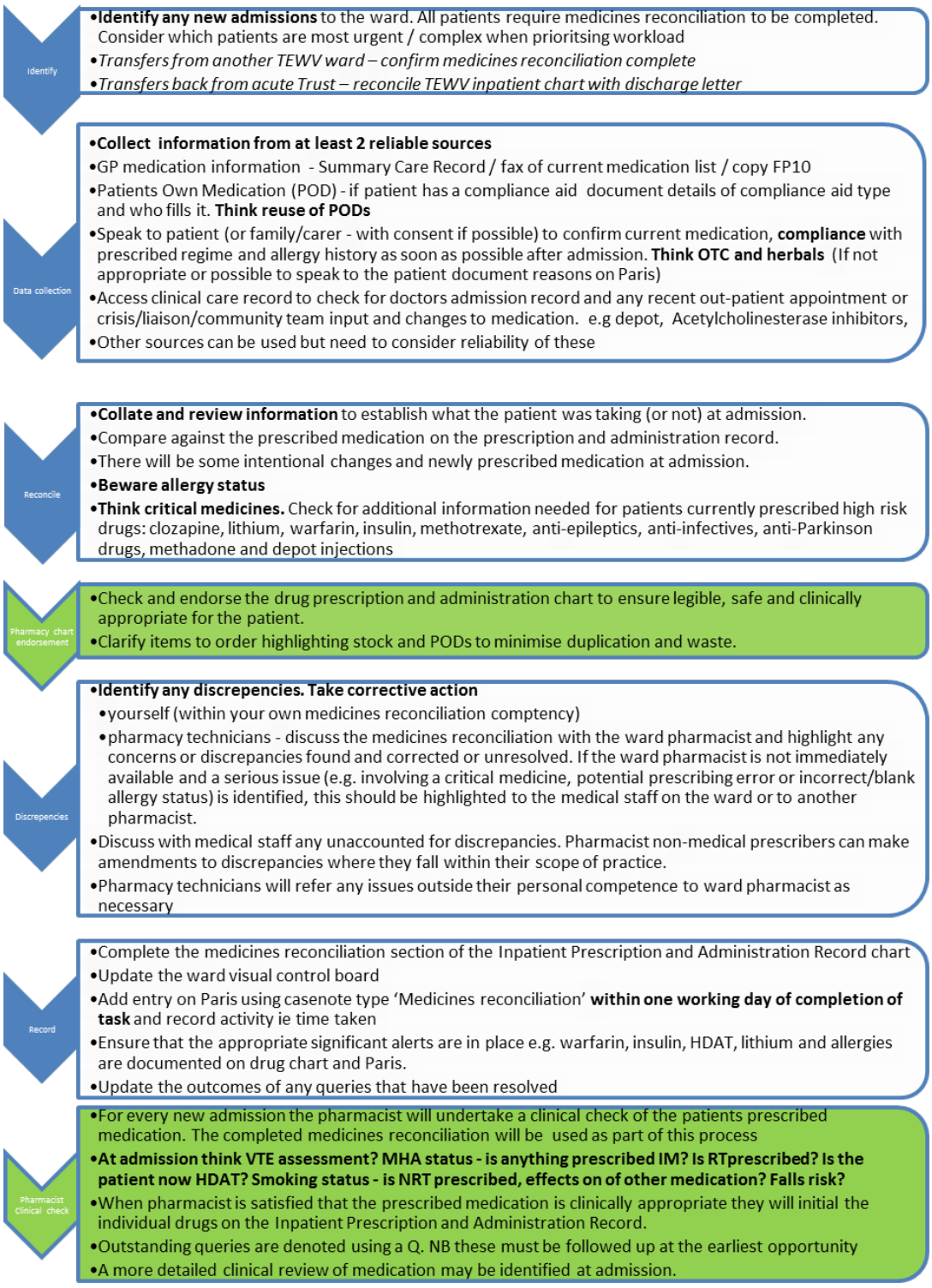
Appendix 1: Medicines reconciliation at admission – pharmacy process overview

Appendix 2: Medicines Reconciliation Form

Appendix 3: Standards for recording medicines reconciliation on Paris

Appendix 4: Guidance for non-pharmacy staff performing medicines reconciliation

12.1. Appendix 1: Medicines Reconciliation at admission –pharmacy process overview



12.2. Appendix 2: Medicines Reconciliation Form

Medicines Reconciliation for				
PARIS No:	Ward:	Date:	Completed by: *Checked by:*	
Allergies				
Medication/Substance	Reaction	Source	Notes	
Medication List				
Drug (and formulation)	Dose & Frequency	Source	Prescribed	Query
Source of Information				
Community Pharmacy (C), Discharge letter (D), FP10 Prescription copy (F), GP fax summary (GP), GP verbal (G), Medical notes - other trust(M) , Nursing home record (N), Paris (P), Previous Meds Rec (MR), Patient (PAT), Relative/carer (R), Patients' own drugs (POD), Summary Care Record (SCR), Other (O) … … … … …				

Continued Medicines Reconciliation for

Queries and outcomes

Information from Patient

Prompts: Other medication *– inhaler / topical / patch / injections / contraceptive pill / OTC / Herbal / Illicit / Internet,* ***Patients Own Drugs, Medication Adherence*** *(compliance aids incl. self-filled),* ***Usual Chemist****,* ***Smoking*** *Status,* ***Allergies*** */ intolerances*

Reason for Admission

Relevant Psychiatric and Physical History

Comments

12.3. Appendix 3: Standards for recording medicines reconciliation on Paris

Standard Process Description:
Recording medicines reconciliation on Paris

Quality Check	Safety Precaution	Standard WIP
◇	✚	●

Notes:

This standard process description describes the steps required to record the medicines reconciliation in a standard format in Paris using the case note type medicines reconciliation.

This also facilitates the easier retrieval of information for medical staff reviewing medication during the inpatient admission and at discharge when completing the GP discharge letter on Paris.

Benefits of new meds rec record: It is safer for the medicines reconciliation list of medication to be included in the central medication history that all paris users can easily access rather than embedded into a pharmacy casenote. The list of medications can also be used by the Dr when creating the GP discharge letter. These changes mean that the pharmacy team will need to record information slightly differently.

Who Must Adopt This Process: Accredited Band 5 Pharmacy Technician Accredited Pre-registration Pharmacist / Pharmacist Non-pharmacy staff recording medicines reconciliation on Paris	**Takt Time:**

GOAL: List key quality and lean targets

STEP	OPERATOR	TASK DESCRIPTION	TOOLS/SUPPLIES REQUIRED
1.	Approved Pharmacy Technician/ Pre-registration Pharmacist/ Pharmacist	**Open casenote** On completion of a medicines reconciliation* open a medicines reconciliation casenote and complete activity section at the top of the casenote Medicines reconciliation must be recorded on PARIS within 24 hours (=1 working day) of completion *An incomplete medicines reconciliation can be recorded on paris but it must be clear when saved that it is incomplete. Complete the medicines reconciliation section of the drug chart.	Medicines reconciliation form Access to Clinical care record (PARIS). Paris Medicines Reconciliation User Guide March 2016 steps 1-16 Clinical Pharmacy Briefing 3 and 4 – activity recording
2.	Pharmacist / Allergy accredited technician Prescriber	**Allergy status** Review and complete the allergy section of the note if it is blank or differs from what is recorded on Paris. If the technician completing the medicines reconciliation cannot record allergies independently this information MUST be passed to the pharmacist who is checking the medicines reconciliation	How to record allergy on paris guide link Paris Medicines Reconciliation User Guide step 17 Medication Safety Standards - Allergy

3.	Approved Pharmacy Technician/ Pre-registration Pharmacist/ Pharmacist	**Recording Medicines** **The list of medications recorded on a meds rec casenote must reflect what the patient was taking (prescribed and OTC/herbal) at the point they were admitted to hospital, as verified from reliable source(s). NB this will not necessarily match what is prescribed on the drug chart** If the patient has stopped taking medication(s) prior to admission or it has been stopped by another service e.g. A+E or crisis team record in stopped medication (See Step 4) Medication taken before came in but stopped at admission before you do meds rec – record in list and note 'NOT TO BE CONTINUED' If the patient isn't prescribed any medication and taking no OTC/herbals record this in the casenote document. (see step 6) Medicines can be added in 2 ways 1. Imported from previous medicines record either as individual medicines or all the medicines in the record (**NB if you import medication and it is wrong you are responsible for the content when you save the casenote**). 2.Added using the medicines entry box You need to record the sources used for each individual drug Include discrepancies identified (and documented in step 5)even if the outcome of these is unknown at the time of recording	Paris Medicines Reconciliation User Guide step 19-24
4	Approved Pharmacy Technician/ Pre-registration Pharmacist/ Pharmacist	**Stopped medication** Record any medication that the patient is prescribed and **NOT** taking at admission or anything that has been stopped prior to admission e.g. by crisis team or A+E.	Paris Medicines Reconciliation User Guide step 25
5	Approved Pharmacy Technician/ Pre-registration Pharmacist/ Pharmacist	**Recording queries** Record ongoing and resolved queries. If there are no queries add a line to indicate 'no queries'	Paris Medicines Reconciliation User Guide step 26-27
6.	Approved Pharmacy Technician/ Pre-registration Pharmacist/	**Additional information** Record any additional information in the document section at the bottom of the casenote.	Paris Medicines Reconciliation User Guide step 28

	Pharmacist	e.g. information from patient Adherence/Compliance aid/POD Reason for admission Relevant physical health diagnosis or findings	
7. ◇	Pharmacist	**Checking step for any medicines reconciliation added by a technician or pre-registration pharmacist requiring a check:** Pharmacist must retrieve the casenote and check the entry within 24hours of completion, by adding a line at the end of the entry and saving. This will date and time stamp with their name and profession. **Medicines reconciliation completed by non-pharmacy staff:** Read any medicines reconciliation added by non-pharmacy staff and complete any outstanding tasks.	
8. ◇	Pharmacist	**Check any significant medication alerts recorded on PARIS** If the information is blank or incorrect or incomplete – update the information with that determined at medicines reconciliation.	Significant alert in PARIS PARIS Briefing: how to complete significant alerts
9.	Accredited technician / Pharmacist	**Complete the outcome of any outstanding queries** identified at medicines reconciliation. When you save the casenote you must add a return under the last name saved so that your name and time will display. Any new queries should be recorded as separate casenotes.	

Version: Pharmacy SPD No. 3b v5 Meds Rec recording Updated March 2016 for Paris upgrade 30 March 2016 Author: Ros Prior, Deputy Chief Pharmacist (Clinical) Next Review Date: March 2019	**Approved by:** Pharmacy Leadership Team April 2016	**Sponsor:** Chris Williams Chief Pharmacist

12.4. Appendix 4: Guidance for non-pharmacy staff performing medicines reconciliation

NICE states that medicines reconciliation should happen within 24 hours of admission or sooner if clinically necessary. The current pharmacy team establishment are able to perform medicines reconciliation within 24 hours of admission for 2/3rd of patients. The purpose of Medicines Reconciliation is to make sure the patient receives all intended medicines and no unintended medicines following admission.
For patients admitted out of hours especially at weekends or if prescribed a critical medicine non-pharmacy staff must undertake the medicines reconciliation process, to ensure patient safety.

Process

1. **Obtain sources of information**
   - ✓ Collect from the most recent and reliable source
   - ✓ A minimum of two sources are required to complete medicines reconciliation

   Most reliable sources
   - A computer print-out from a GP records system or Summary Care Record (SCR)
   - The tear-off side of a patient's repeat prescription request
   - Verbal information from the patient, their family, or a carer
   - PARIS clinical record for medication prescribed by TEWV
   - Medical notes from a patients previous admission to hospital
   - Discharge prescription summaries
   - Patient's own drugs
2. **Cross check all sources** to ensure you have an up to date and accurate list of medicines the patient is taking. Where possible ask a second person to check information.
3. **Confirm compliance with medication prior to admission.**
4. **Check the information from steps 1-3 against the medicines prescribed on admission**
5. **Note any discrepancies and action or discuss with prescriber** (dose changes / discontinuations may be intentional upon admission)
6. **Document all changes** - Once the patient's current medication regimen has been cross checked with the history obtained, document all changes and list the medication regimen on PARIS as a medicines reconciliation casenote – include any changes and reasons why. Also document sources used in medicines reconciliation process.

Points to note

- When using sources it is essential that the staff member ensures the medication is still relevant e.g.
  - if using information from a GP records system (e.g. fax or SCR) – need to look at the last date the medication was supplied – some GP records systems are not kept up to date and old medication can be left on prescribing systems
  - if using patient's own medication – look at date the medication was last dispensed (on dispensing label)
  - if the patient is transferring from an acute hospital make sure you receive a copy of the discharge prescription
  - Check depot administration with community teams
- Obtain a GP summary/Summary Care Record or discharge summary as soon as possible even if the medicines reconciliation process has been completed
- **Always** confirm allergies
- **Critical medicines – check the following medicines carefully, omissions or dosing errors can result in patient harm**
  - Antibiotics
  - Anticoagulants – warfarin, heparin
  - Antiepileptics
  - Clozapine
  - Insulin
  - Lithium
  - Methotrexate
  - Opioid analgesics
  - Parkinson's Disease medicines
  - Methadone (never prescribe without checking dose with Substance Misuse service or community pharmacy)