BRITISH JOURNAL OF HOSPITAL MEDICINE

MMC
Modernising Medical Careers

MODERNISING MEDICAL CAREERS

Medicines reconciliation: a guide for the foundation year doctor M66
Rachel Hooke

The applied anatomy of examination of the knee M68
Harold Ellis

Radiology of acute foot injuries M70
AD Gummow, SHM Khan

An introduction to non-invasive cardiac imaging M74
Henry Boardman, Conn Sugihara

A foundation doctor's guide to clerking the confused older patient M79
Laura Winstanley, Simon Glew, Rowan Harwood

So you want to be ... a neonatologist M80
Imogen Storey, Alex Philpott

IN NEXT MONTH'S MMC SUPPLEMENT

Preventing hospital medication errors

Radiology of acute wrist injuries

So you want to be... a critical care physician

Medicines reconciliation: a guide for the foundation year doctor

Introduction

Most doctors are familiar with the concept of taking a patient's drug history on admission. Medicines reconciliation is about obtaining up-to-date, accurate and reliable information on patients' medication. According to the National Institute for Health and Clinical Excellence and the National Patient Safety Agency (2007), in their joint guidance, 'the aim… is to ensure that medicines prescribed on admission correspond to those that the patient was taking before admission'. This is an important aspect of patient safety, so that patients receive all the correct medication, with none omitted and nothing additional administered by mistake. Medicines reconciliation has the potential to reduce medication errors (National Prescribing Centre, 2008).

Sources of information

You cannot necessarily rely on the patient's account alone, particularly if he/she is confused or anxious or has communication difficulties. Many patients, even when coherent, are not always adept at describing their medicines and believe that 'the little white ones' gives you the information you need. They may not know why they are on certain drugs, or their understanding may be vague ('my heart tablet'). They may assume that you have got access to their medication list anyway and be blasé about giving a complete history.

Patients may become irritated at being asked the same questions over and over again, including those regarding their medicines. However, good communication skills will help to overcome this and explain how important it is to get an accurate picture, given current information constraints and lack of joined-up data. Patients using compliance aids such as dosette boxes or automated pill dispensers may have no idea what the different days' tablets are. The patient may have put tablets in the wrong boxes, or mixed tablets up in the same box. There may be a plastic bag full of random blister packs. Some patients may not see their medications as being that, such as women on the oral contraceptive pill or hormone replacement therapy, or those taking tablets bought over the counter from pharmacies or health food shops. The same may apply with non-tablets, such as topical preparations, inhalers and eye, ear or nose drops.

When admitted to hospital as an emergency, there may have been panic at the patient's home, with relatives and ambulance personnel quickly trying to bundle up all the medicines. This may mean some drugs being omitted, and could also lead to patients bringing in tablets belonging to other people in the household in addition to their own. Anecdotally, some ambulance staff discourage patients from bringing their own tablets as they think the hospital will lose or destroy them, so do not be too hard on a patient who has not brought his/her medicines.

Nor can you count exclusively on a recorded list from primary or secondary care. This will only be as accurate as when it was last updated. Even then, it may not present comprehensively what the patient is actually taking (National Prescribing Centre, 2008).

For completeness, you need 'triangulation' from at least two sources, such as:

- Patient
- Relative or carer
- Medicines brought in
- Repeat prescription tear-off slip
- Nursing or residential home records
- Hospital records
- GP records
- Other primary or community care records
- Community pharmacy patient medication records.

However, some of these methods are not reliable. Any GP computer printout may be imprecise – drugs may still be on the repeat list when the patient has (rightly or

Dr Rachel Hooke *is Working Time Directive (WTD) Implementation Manager, Airedale NHS Trust, Steeton, Keighley, West Yorkshire BD20 6TD*

wrongly) long since stopped taking them. On the other hand, the patient may take medication at a different frequency and you could overload or under-medicate him/her in hospital. The GP list may not include certain hospital-initiated medicines (National Prescribing Centre, 2008). The patient may have brought a handwritten GP letter, with the medications crudely scribbled down, possibly incompletely and inaccurately. A community pharmacy record may show that a patient has cashed in prescriptions recently, but that does not automatically mean that he/she is actually taking the drugs. Patients may use over-the-counter preparations unknown to the GP (National Prescribing Centre, 2008). There may be a discrepancy between what the dispensing label on the medicine box says and what the patient actually takes.

There are timing constraints as well. Out of hours, you cannot easily ring the GP's surgery, although you could contact relatives, carers or nursing or residential homes. You could check previous hospital electronic records, but these may be out of date, so caution is advised. Pharmacy staff, who can be very helpful with medicines reconciliation, are not routinely on duty after certain times.

Trust arrangements

Your trust is likely to have a policy on medicines reconciliation and to carry out audits on it, as it is an important part of clinical governance. You may be given teaching on the subject. There will be varying involvement of the pharmacy team.

The primary care trust commissioners (purchasers of services) may set targets for the acute trust (provider organization) and monitor its performance. Medicines reconciliation may form part of a local CQUIN (Commissioning for Quality and Innovation) payment framework, under which a proportion of a provider's income is conditional on service quality and innovation.

Conclusions

Medicines reconciliation is essential for patient safety. It is about ensuring that a patient's drug history is recorded accurately and that the correct medicines are administered. You cannot necessarily rely on one source alone, and may need triangulation from at least two. It is false economy to skimp on gathering comprehensive information, as it can save time later and reduce the potential for error. **BJHM**

Conflict of interest: Dr Hooke has worked in both management and medicine. Her views are her own and do not necessarily reflect those of her employer or any other organization that she is associated with.

National Institute for Health and Clinical Excellence, National Patient Safety Agency (2007) *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital.* NICE, London (www.nice.org.uk/nicemedia/pdf/PSG001Guidance.pdf accessed 16 March 2010)

National Prescribing Centre (2008) *Medicines Reconciliation: A Guide To Implementation.* National Prescribing Centre, Liverpool (www.npci.org.uk/medicines_management/safety/reconcil/resources/reconciliation_guide-a5ordered.pdf accessed 16 March 2010)

KEY POINTS

- Medicines reconciliation is more than just the traditional drug history.
- For patient safety, it is important to have an accurate, up-to-date and reliable account of medicines being taken.
- Patients should receive the correct drugs and not be over- or under-medicated.
- If unsure of the patient's own account, other information sources should be used.
- The pharmacy team can give useful advice.