NHS
Derby and Derbyshire
Integrated Care Board

MEDICINES RECONCILIATION AFTER HOSPITAL DISCHARGE IN PRIMARY CARE

NICE Guidance [NG5] describes Medicines reconciliation as "*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*".

Accurate and timely medicines reconciliation after hospital discharge is essential to reduce the risk of medication errors, and if not carried out could result in patients taking duplicate medicines or taking medicines that are incompatible, increasing the risk of complications. Medication related readmissions may be due to issues such as unintentionally restarting medicines that have been discontinued, patients being unable to cope with their new medication regime on discharge, or the absence of a medication support system for these patients.

Secondary care services are responsible for ensuring that good quality data regarding a patient's medicines is sent to the patients GP on discharge. The supply of information should be secure and prompt.

To be able to reconcile medicines accurately, the following recommended information should be included on the discharge paperwork:

- Complete patient details i.e., full name, address, date of birth, weight if under 16 years, NHS number, consultant, ward, date of admission, date of discharge
- Current and relevant past medical history
- Procedures carried out during admission
- A complete list of all the medicines prescribed for the patient (all medicines should be included, not just those dispensed at the time of discharge)
- Dose, frequency, formulation & route for all of the medicines listed
- Details of medicines stopped and started during the admission, with a clear explanation for doing so
- The intended duration of treatment for medicines where this is appropriate (e.g., antibiotics, short course corticosteroids, hypnotics)
- Details of increasing or decreasing dose regimens (e.g., insulin, warfarin, oral corticosteroids)
- Known allergies and history of any drug interactions
- Any additional patient information provided such as corticosteroid cards, anticoagulant booklets etc.

This information should be clear, accurate and legible and should be available to the practice as soon as possible after a patient is discharged, ideally within 24 hours.

If the discharge documentation is missing any of the information specified above, then the GP practice should attempt to obtain it from the place of discharge as soon as possible, to avoid any risk of adverse effects from medicines or medicines related re-admission to hospital.

University Hospitals of Derby & Burton, Chesterfield Royal Hospital and Derbyshire Healthcare have set up a facility to provide GPs with a means of highlighting problems that have occurred with the prescribing or supply of medicines at discharge from hospital.

This facility can also be used to report on inappropriate prescribing requests made to primary care clinicians.

If your concern relates to the University Hospitals of Derby & Burton follow this link: Prescribing concerns | University Hospitals of Derby and Burton NHS (uhdb.nhs.uk)

If your concern relates to Chesterfield Royal Hospital follow this link: Prescribing Concerns :: Chesterfield Royal Hospital
Or, alternatively, email CRHFT.medicinesinfo@nhs.net directly *(Please include NHS number, GP practice, ward the patient was discharged from and summary of the concern)*

If your concern relates to Derbyshire Healthcare follow this link: Prescribing Concerns (Page 1 of 3) (office.com)

If you have received an inappropriate prescribing request from another Trust follow this link to report: Inappropriate Requests and Prescribing Concerns in Primary Care (derbyshiremedicinesmanagement.nhs.uk). You can also refer to the out of area guidance on the Medicines Management website.

If the query is urgent, please contact the discharging consultant's secretary directly by telephone.

MEDICINES RECONCILIATION IN GP PRACTICES

Duties, Responsibilities and Accountability:
The place of discharge is responsible for providing a sufficient level of information to the patients GP practice to allow accurate and timely reconciliation of medicines after discharge.

GP practices are responsible for ensuring that information regarding a patient's medicines on discharge is clinically reviewed and that the patient's medical record is updated to reflect any changes that were made. These changes should be communicated to all relevant healthcare professionals and the patient in a timely manner so not to impede patient care.

Process:
Each individual practice will have their own way of dealing with information relating to the discharge of patients from hospital.

If you will be dealing with medicines reconciliation from discharges it is important to familiarise yourself with the processes within your practice.

Things to consider may include:

- What are the administrative processes when a discharge is received in practice? E.g., who updates the patient records/read codes, who amends medication, and which order are these actioned in?
- What is the practice's usual timescale to complete actions from discharges/update medication?
- Who would be the best person within the practice to direct queries/tasks to? The prescribing lead or the named GP for an individual patient?
- Are there any items that are never added to the repeat medication list in the practice e.g., contraceptives, injections, high risk drugs? If so what are the processes for these?
- Does the practice follow 28 or 56 day prescribing and do they always add new repeats for a set number of issues/review period?
- What is the practices system for reviewing or recalling relevant patients and do they wish you to feed into that system? (e.g., recalls or scheduled tasks for monitoring and blood tests)
- Does the practice have a way of highlighting patients whose medications are dispensed by pharmacy into a monitored dose system (blister packs)? Do they have a way of communicating medication changes for these patients to the pharmacy efficiently?

A quick reference guide to using discharge information to assess if there have been any changes made to the patient's medicines, and whether any associated patient monitoring/recall is necessary, is shown in appendix 1.

Significant changes in medication may require a review of medicines with the patient, either over the telephone or face to face if necessary. To avoid discontinued medicines being taken in error, patients should be advised to return any discontinued/unwanted medication to their local pharmacy or their GP practice dispensary for destruction.

At this point, consider whether the patient would benefit from support through the New Medicine Service (NMS) via their community pharmacy. If appropriate, contact the pharmacy to arrange. There is also the Discharge Medicines Service (DMS), whereby NHS trusts are able to refer patients to their community pharmacy who they think would benefit from extra guidance around prescribed medicines.

Discharge Medicines Service - Community Pharmacy England (cpe.org.uk)
New Medicine Service (NMS) - Community Pharmacy England (cpe.org.uk)

Ensure any changes made are fully documented on the patient's computer record using one of the following read codes:

- XE1TB Repeat prescription treatment changed.
- XaWST Post hospital discharge medication reconciliation with medical notes.
- XaWSQ Post hospital discharge medication reconciliation with patient.

Useful resources:

NICE guidelines [NG5] March 2015 Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes

NICE guidelines [SC1] March 2014 Managing medicines in care homes

Keeping patients safe when they transfer between care providers – getting the medicines right (Royal Pharmaceutical Society, June 2012)

Records Management Code of Practice for Health and Social Care – August 2023

Acknowledgement: NHS Dorset, Medicines Optimisation

APPENDIX 1

MEDICINES RECONCILIATION ON DISCHARGE QUICK REFERENCE LIST

Medical conditions Have any new health conditions been diagnosed? Have these been updated on practice records?
Changes to medicines Have any medicines been stopped? Why? Have any new medicines been added? Why? Have the doses of any medicines been changed? Have any formulations been changed? Has the frequency/timing of the dosing changed? Is there a clear explanation of the reasons for starting/stopping/dose changes to medication?
Medication recommendations Ongoing monitoring requirements? Advice to patient needed on starting, discontinuing or changing medicines?
Inappropriate medicines Have formulary options been used wherever possible? If not, why not? Are there any traffic lighted drugs that are not suitable for ongoing primary care prescribing? (see MMT website Full Traffic Light Classification for further information) Are there any expensive liquids or 'specials' that need reviewing before adding? (see MMT website http://www.derbyshiremedicinesmanagement.nhs.uk/medicines-management/medicines-management/specials for further information)
Duration of treatment Are the newly prescribed medicines ongoing? Do any of the medicines need to be stopped in a given time frame? Consider adding as acute or with an end date/review date to the directions to support the patient/pharmacy/prescriber reviewing ongoing treatment. *For example, think about analgesics, benzodiazepines, antibiotics.*
Drug interactions Are there any possible interactions between the drugs the patient is taking? Does patient buy any medicines OTC? *Include any self-medication with herbal/supplement preparations. Consider drug – food interactions and any advice that the patient might need.*
High-risk drugs Was the patient started on a drug with a narrow therapeutic margin whilst in hospital? Is the patient on increasing or decreasing dose regimens? Does the patient need any additional monitoring? *Examples: insulin, warfarin and lithium.*

Identifying discrepancies Have there been any (un-explained) discrepancies identified between the discharge information and the information held in the practice? Have these been followed up with the place of discharge?
Repeat prescriptions Has the repeat prescription item list been updated? Do all the medicines need to be on repeat? Are some the medicines more appropriate as acute only?
Allergy status Have there been any changes to the patient's allergy status?
Additional information for the patient Does the patient need any additional information such as a corticosteroid card, anticoagulant booklet?
Other considerations Were any signs of non-adherence identified whilst the patient was in hospital? Are there any clues that the patient might be intentionally or un-intentionally non-adherent with their medicines? Would the patient benefit from the New Medicines Service (NMS), or Discharge Medicines Service (DMS), from the community pharmacy to help ensure that their use of medicines is optimised? Would it be useful if the pharmacy assessed the patient for support in medicines taking e.g., large labels, MAR chart, compliance aids etc.? Where capacity, sensory or language barriers exist, how has all the necessary support information been given to authorised representative/carer? If the patient has had medicines discontinued, do they still have supplies that need to be disposed of? Are there any medicines that have been initiated or stopped that are prescribed by other healthcare prescribers e.g., RED specialist drugs? Refer to guidance on the medicines management website http://www.derbyshiremedicinesmanagement.nhs.uk/medicines-management/non_clinical_guidelines