Medicines Management
Care Homes Support

NHS
Coventry and Warwickshire

Medicines Reconciliation in the Care Home setting

What is a medicines reconciliation?

It's the process of accurately listing a resident's medication. Multiple sources of information are needed to complete a thorough medicines reconciliation e.g., a current repeat slip from the GP surgery, recent discharge summary from hospital, clinic letters, medicines recently dispensed, resident (or representative as appropriate). REMEMBER to check which medicines the person is ACTUALLY taking, not just what they SHOULD be taking. Recognising and resolving discrepancies is a key stage in the process, and any changes MUST be documented.

Why is a medicines reconciliation important?

Medicine errors can happen when a resident moves between care settings e.g., from home to hospital, hospital to home. If the care home ensures that they have an up-to-date list of medicines at the point of transfer, this will reduce the risk of medicines errors which could result in harm to the resident.
It is equally important to ensure a medicines reconciliation is done when changes are made to medication e.g., a medication review done by the GP surgery or pharmacist, discharge from hospital or outpatient appointment.

Who should complete the medicines reconciliation?

Only trained and competent members of staff should perform a medicines reconciliation. It is good practice to include the resident and/or relatives and healthcare professionals also involved in the resident's care e.g., GP, nurse, pharmacy.

When should a medicines reconciliation take place?

- ✓ When a person is discharged from hospital or transferred from another setting or place of residence (including home)
- ✓ When treatment has changed, e.g., dose changes, or medication is stopped or switched to an alternative
- ✓ Before the first dose is administered or as soon as possible afterwards

What should be included in a medicines reconciliation?

When completing a medicines reconciliation, staff must consider *all* medicines the resident is taking. This may include prescribed medicines, medicines bought over the counter and complementary medicines.

The date and time of the last dose should be added for medicines taken less frequently e.g., weekly or monthly medicines, including injections.

The document below can be used to support successful medicines reconciliation

Providers should use this guidance in conjunction with Medicine Patient Information Leaflets, NICE Guidance 'Managing Medicines in Care Homes' SC1 and should check the CQC website for recent updates. Prepared by Care Home Support, Medicines Optimisation Team, NHS Coventry & Warwickshire January 2022. Reviewed July 2022.

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Medicines Reconciliation Form

Name of resident: **Date of Birth:** **Name of GP surgery:** **Name of Care Home:** **Allergies:**	**Name of staff completing medicines reconciliation:** **Date:** **Checked by:** **Names of other healthcare professionals involved:**	**Admitted from:** **Admission date:**

List of current medication:
Please tick source of information and record the date documented on source

- ☐ GP Repeat slip Date:
- ☐ MAR chart Date:
- ☐ Discharge summary Date:
- ☐ Medication brought in from home Date on dispensing label:
- ☐ Other (please state)

Compare to another source:
Please tick source(s) of information **and record the date on the source**

- ☐ GP Repeat slip
- ☐ MAR chart
- ☐ Discharge summary
- ☐ Medication brought in from home
- ☐ Other (please state)

For any medicines that do not match, please state the reason(s) why and any action that is taken

Name of drug	**Strength**	**Form e.g. tabs**	**Dose**	**Frequency and timing***	**Route e.g. oral**	**Indication (if known)**	**Does this match current medication? Y or N**

Has the community pharmacy been informed of any changes? Y / N Date informed:
By email ☐ Phone call ☐ Re-order MAR chart ☐

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List of current medication: Please tick source of information and record the date documented on source ☐ GP Repeat slip Date: ☐ MAR chart Date: ☐ Discharge summary Date: ☐ Medication brought in from home Date on dispensing label: ☐ Other (please state)							Compare to another source: Please tick source of information and date ☐ GP Repeat slip ☐ MAR chart ☐ Discharge summary ☐ Medication brought in from home ☐ Other (please state)	For any medicines that do not match, please state the reason(s) why and any action that is taken
Name of drug	**Strength**	**Form e.g. tabs**	**Dose**	**Frequency and timing**	**Route e.g. oral**	**Indication (if known)**	**Does this match current medication? Y or N**	
				Has the community pharmacy been informed of any changes? Y / N Date informed: By email ☐ Phone call ☐ Re-order MAR chart ☐				

*** The date and time of the last dose should be added for medicines taken less frequently e.g., weekly or monthly medicines, including injections.**

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Example Medicines Reconciliation

Name of resident: Ann Smith **Date of Birth:** 06.11.1936 **Name of GP surgery:** Any Surgery **Name of Care Home:** Any Care Home **Allergies:** Penicillin	**Name of staff completing medicines reconciliation:** J. Brown **Date:** 16.11.21 **Checked by:** B. Jones **Names of other healthcare professionals involved:** Dr Evans	**Admitted from:** UHCW **Admission date:** 15.11.21

List of current medication:
Please tick source of information and record the date documented on source

- ☐ GP Repeat slip Date:
- ☐ MAR chart Date:
- ■ Discharge summary Date: *15.11.21*
- ☐ Medication brought in from home Date on dispensing label:
- ☐ Other (please state)

Compare to another source:
Please tick source(s) of information **and record the date on the source**

- ☐ GP Repeat slip
- ■ MAR chart - *Cycle start 01.11.21*
- ☐ Discharge summary
- ☐ Medication brought in from home
- ☐ Other (please state)

For any medicines that do not match, please state the reason(s) why and any action that is taken

Name of drug	Strength	Form e.g. tabs	Dose	Frequency and timing*	Route e.g. oral	Indication (if known)	Does this match current medication? Y or N	
Nitrofurantoin	50mg	caps	one	Four times a day for 3 days	oral	UTI	N	Course of antibiotics. To finish course then stop
Amlodipine	5mg	tabs	one	Once daily	oral	Blood pressure	Y	
Atorvastatin	40mg	tabs	one	Once daily	oral	Cholesterol	N	Dose increased from 20mg OD. Send discharge summary to surgery
Omeprazole	20mg	caps	one	Once daily	oral	Acid reflux	N	Dose decreased from 40mg OD. Send discharge summary to surgery
Metformin	500mg	M/R tabs	one	Twice a day	oral	Diabetes	Y	
Hydroxocobalamin	1mg/1ml	injection	1mg	Every 12 weeks Last dose: 30.10.21	IM	Vitamin B12 deficiency	Y	
Alendronic acid	70mg	tabs	one	Once a week (Tues)	oral	Osteoporosis	N	New medicine started. Send discharge summary to surgery

Has the community pharmacy been informed of any changes? (Y) / N Date informed: 16.11.21
By email ■ Phone call ☐ Re-order MAR chart ☐