Lincolnshire Community Health Services NHS Trust

Policy to support the transcription of medicines in exceptional circumstances incorporating medicines reconciliation within a community hospital or hospice setting

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Lincolnshire Community Health Services
Version Control Sheet

Policy to support the transcription of medicines in exceptional circumstances incorporating medicine reconciliation within a community hospital or hospice setting

Version	Section/Para/ Appendix	Version/Description of Amendments	Date	Author/Amended by
2	Title	Addition of Hospice	August 2014	Petra Clarke
	Background	Various - general	August 2014	Petra Clarke
	Section 1	Transcribing – updated to reflect AHP inclusion and include community care	August 2014	Petra Clarke
	Section 1	Medicines Reconciliation – changed definition to reflect NMP	August 2014	Petra Clarke
	Section 4	Removed Clinical Educator, removed GP replaced by doctor, removed Nurse prescriber, replaced with Non-Medical Prescriber	August 2014	Petra Clarke
	Section 5.1	Added: Prescriber must date, time and sign the transcription within 72 hours; NMP must conduct a holistic assessment of the patient prior to signing off a transcription	August 2014	Petra Clarke
	Section 7	Removed: the use of abbreviated microg and nano is acceptable	August 2014	Petra Clarke
	Section 8	Addition: check that the medicine label/box accurately reflects its contents	August 2014	Petra Clarke
3	Section 5.1	Added Self Administration by the patient to be considered.	August 2016	Lorna Adlington
	Section 6	CDs should not be transcribed.		
	Throughout	Update template, footers and references		
	Throughout	Terminology and process changed to link to e-prescribing	September 2016	Lorna Adlington
	Appendix 8	Process revised to link to e-prescribing.		
4	Throughout	Updated references	September 2018	Lorna Adlington
	Section 3	Added – staff members who transcribe are accountable for their actions and omissions.		
	Section 5	Added - The staff member is accountable for what they have transcribed and must ensure that what is transcribed is signed off by a registered prescriber.		
		Added – all transcribing must be independently checked by a		

		second competent individual.		
	Section 8	Updated definition of medicines reconciliation		

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Policy statement

Policy to support transcription in exceptional circumstances within a community hospital or hospice setting

Background	The main objective of the policy is to: Provide clear guidance in a situation where transcription cannot be avoided i.e. an exceptional circumstance to reduce risk to both patients and staff.
Statement	To comply with "Technical patient safety solutions for medicines reconciliation on admission to hospital" and to standardise ways of achieving this.
Responsibilities	Compliance with the policy will be the responsibility of all Lincolnshire Community Health Services staff working within a community hospital or hospice setting
Trainers	Directors/Heads of Service will be responsible for ensuring that all appropriate staff have appropriate training in line with the policy
Dissemination	Website
Resource implication	This policy has been developed in line with the NHS Litigation Authority Guidelines
Equality Impact Assessment	Equality Impact Assessment Test for Relevance has been undertaken and is attached.

Policy to support the transcription and reconciliation of medicines in exceptional circumstances within a community hospital or hospice setting

1. Background

The Nursing and Midwifery Council (NMC), whilst not encouraging nurse transcription of prescriptions, acknowledge that this practice is permissible. Transcribing should ONLY be done in exceptional circumstances, when the original prescriber or another independent prescriber is not available to prescribe the medication and the patient's condition is such that he/she cannot wait until a prescriber is available. Transcribing should NOT be routine practice. The individual nurse completing the transcription remains professionally accountable for the information they transcribe.

Transcribing is a voluntary activity and, if there are concerns about a prescription or any medicines that cannot be resolved by discussion with a prescriber or responsible doctor, transcribing must not be undertaken.

Medication errors have the potential to cause harm to hospital inpatients, and hence present a serious clinical and financial risk to healthcare organizations'.

Transcribing
Transcribing describes the action of transposing (copying) details of a doctor's/AHP independent prescriber`s prescription onto other order forms. Specifically this can be used to facilitate the transition from Secondary to Community or Primary Care or to enable new medicine record cards to be written when old ones are full, without the prescriber having to be present. Transcribing is a voluntary activity which can only be undertaken by practitioners as outlined in Section 3 and must be undertaken as part of a holistic patient assessment

Medicines Reconciliation
This is a process designed to ensure that accurate and reliable information about the patient's medication is transferred to the community hospital or hospice at the time of admission. This enables healthcare professionals responsible for the care, to be able to match-up the patient's previous medication list with their current medication list; thereby enabling timely, informed decisions about the next stage in the patient's medicines management journey.

2. Aims & Objectives

Aims

The NMC states that as a registrant you may transcribe medication from one "direction to supply or administer" to another form of "direction to supply or administer". However, they go on to say that this is only to be undertaken in exceptional circumstances and should not be routine practice

The aim of this policy is to provide staff with a working framework to support the practice of transcription in those exceptional circumstances.

This policy will also address the recommendations of NICE (2015) Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes

Objective

The objective of this policy is to provide a framework and standards to ensure that risk is minimised to both patients and staff when the need for transcription and/or medicines reconciliation arises. Lincolnshire Community Health Services are committed to providing high quality care to its patients at all times.

3. Training & Competency

Staff members who transcribe are accountable for their actions and omissions.

To be considered for the transcribing / medicines reconciliation role a nurse must:

- Have at least 2 years post registration experience with exposure to drug administration
- Be in a Band 5 position or above

Nurses who fulfil these criteria to transcribe / undertake medicines reconciliation must have completed an in- house accreditation process which consists of the following elements:

- Trainees must have read and understand the following Trusts Policies
  a) Safe and Secure Handling of Medicines Policy (2108)
  b) Controlled Drug policy (2018)
  c) Non-Medical Prescribing Policy (2018)

- Staff members must read and acknowledge their responsibilities regarding transcribing as laid down by the NMC in the "Standards for Medicines Management" (2010),

- Staff members must read and acknowledge their responsibilities as outlined in the recommendations outlined by NICE (2015) "Medicines Optimisation; the safe and effective use of medicines.
- Training will be delivered via an agreed training package.

4. Health Care Professionals Authorised To Transcribe

- Registered Non-Medical Prescribers and/or Registered Nurses who have been deemed competent (Appendix 1) by the Non-Medical Prescriber or doctor for the appropriate locality are authorised to transcribe / undertake medicines reconciliation within Lincolnshire Community Health Services according to these procedures and guidance notes.

- Staff members must be deemed competent to transcribe by their line manager and complete a transcribing signature form (Appendix 2) before undertaking this role. This should be held within the staff member's personal file and be renewed annually.

5. Indications for Transcribing

Definition
"any act by which medicinal products are written from one form of direction to another" (NMC,2003)

Exceptional circumstances
An exceptional circumstance can be described as a "circumstance that cannot be avoided". For community hospitals, medical cover is only provided during the day, with medical staff being present for a short time period, in most circumstances. Therefore for those patients who

are admitted outside of these hours and require medicines to be administered, when all other routes to obtain a written or electronic prescription have been tried and have been unsuccessful, this may be seen to constitute an exception. (See Appendix 8)

The staff member is accountable for what they have transcribed and must ensure that what is transcribed is signed off by a registered prescriber.

5.1 In-patient Setting

Transcribing in this care setting may be undertaken to facilitate the smooth transition of care from the community or Acute Care setting into a nurse co-ordinated bed within a community hospital or hospice where the ongoing administration of medication is required or to facilitate the patient's current medication regime.

- The transcription must be reviewed by the designated doctor/non-medical prescriber at the next available opportunity (or within 72hrs).
- Once reviewed, the prescriber must prescribe appropriately within the electronic prescribing system. The transcription record should be scanned into the patient record to provide a complete record.
- Any Non-Medical Prescriber making a prescribing decision following a transcription must make an holistic assessment of the patient before taking responsibility for the transcription.
- Self-Administration by the patient should be assumed as an option unless assessment proves otherwise.

6. When Transcribing is not appropriate

Transcribing cannot be undertaken within the electronic system. Transcribing can only be undertaken by hand onto designated prescription stationery. An entry onto the electronic system must then be made by the designated prescriber at the next available opportunity (within 72 hours).

Staff must not transcribe details if the requirements are not identical to those that have previously been prescribed. Drugs that have been discontinued or are not clearly legible must not be transcribed. Referral to a non-medical prescriber or doctor must be made.

Controlled Drugs should not be transcribed.

The scope of this protocol does not cover transcribing in Paediatric care therefore transcribing for children aged 16 years and under must not be undertaken.

7. General Guidance

- An entry must be made in the patient's record giving the date and information on where the medication has been transcribed from.
- Patient name, unit number, date of birth and allergies all need to be accurately transcribed.
- Copy all 'current' details from the original prescription to the new order form/prescription. Do not initiate, amend any dose or discontinue any treatment.
- Do not knowingly copy details that are inaccurate or illegible. Contact the prescriber and get clarification before transcribing if necessary.
- Transcribe only on designated prescription stationery. Transcribing electronically is not accepted practice.
- Write legibly using a ballpoint pen (must use black).

- Fill in all prescription details and patient's details. Partial completion can lead to errors and will prevent administration.
- Copy any details that specify the valid period for preparations. For example prescriptions for antibiotics should normally be written for a limited period with a clear stop date made on the prescription.
- Write names and instructions in full. Abbreviations of drug names are dangerous and only acceptable if they can be verified in the British National Formulary e.g. isosorbide mononitrate should be written as such and not as ISMN.
- Drug strengths must be written in full: micrograms and nanograms should not be abbreviated. Similarly units should not be abbreviated. The use of decimal points should be avoided wherever possible e.g. prescribe digoxin 250 micrograms not digoxin 0.25mg. The following units are acceptable:

g	= gram e.g. benzylpenicillin 1.2g
mg	= milligram e.g. frusemide 40mg
ml	= millilitres e.g. 5ml

- If small volumes are prescribed (less than 1ml), write as 0.5ml and not .5ml.
- Indicate the route of administration clearly. Accepted abbreviations are:

IV	= intravenous
IM	= intramuscular
SL	= sublingual
TOP	= topical
PR	= rectally
PO or **O**	= orally
SC	= subcutaneous
INH	= inhaled
PV	= vaginally
PEG	= percutaneous endoscopic gastronomy

- If details of initial prescribing event are incomplete transcribing must not take place. For example if dose interval is not stated or there is no clear maximum dose is annotated.
- Mark 1 of 2, 2 of 2 etc. if a patient requires more than one medicine record card.
- Sign, date and time the medicine record card.
- All transcribed medicines should be independently checked by a second competent staff member.

8. Medicines Reconciliation

The process of medication reconciliation has five steps: list the patient's current medications; list the medications currently needed; compare the lists; make a new list based on the comparison; communicate the new list to the patient and caregivers.

Medication reconciliation was first described in 2003 and introduced following the observation that medication errors often occur when a patient moves from one place to another.

It is therefore one strategy for reducing the risk of adverse reactions is "to reconcile the medication orders between the two transition points."

Medication reconciliation has been defined by the Institute for Healthcare Improvement (IHI) as "the process of identifying the most accurate list of a patient's current medicines—including the name, dosage, frequency, and route—and comparing them to the current list, recognizing discrepancies, and documenting any changes, thus resulting in a complete list of

medications, accurately communicated with the goal of providing correct medications to the patient at all transition points.

Many organizations have demonstrated that implementing medication reconciliation at all transitions in care — at admission, transfer, and discharge — is an effective strategy for preventing adverse drug events.

All medicines must be reconciled on admission to ensure that they correspond to those that the patient was taking before admission (NICE 2007). This refers to admissions to hospital, transfer to other units or acute hospitals.

NICE (2016) The medicines reconciliation process will vary depending on the care setting that the person has just moved into

The nurse will check that medicines are clearly labelled with the following:

- The full name of the patient
- The drug has been dispensed within the previous six months or there is a clear expiry date, e.g. inhalers or blister packed tablets
- The label accurately reflects the medicine dispensed within it
- Ophthalmic preparations should have been in use for less than one month
- Name and address of supplier

If the medicine has no dispensing label, it must not be used unless a current transcript of medication from a pharmacist accompanies the patient on admission and the medication is presented in a blister strip which clearly states it's name, dose, strength and expiry date.

The use of opened bottled medicines is to be avoided wherever possible

The record should detail the following:

- Generic name of the medicine (brand name to be recorded where appropriate)
- Dose
- Route
- Frequency of administration
- Length of therapy if appropriate (e.g. antibiotics)
- Any recently discontinued medicines and the reason for stopping
- Identify any drug allergies or serious adverse drug reactions, ensuring that the nature of the reaction is obtained.

Reconciliation should be undertaken within 24 hours of admission or within a shorter timeframe where patients are on high-risk drugs, there are potentially serious dosage variances and /or upcoming administrations times.

Effectively engage:

the patient or family in medication reconciliation, this is a key strategy for targeting and preventing prescribing and administration errors and thereby reducing patient harm.

Information should be gained from the patient and /or carer using an agreed checklist and process (Appendix 3, 4) and ideally corroborated by at least two reliable sources (Appendix 5). For patients with communication difficulties caused for example by cognitive impairment, mental state features or language barriers, consideration may need to be given to assessing additional sources, depending upon the individual circumstances.

'Communicating' is the final step in the process, where any changes that have been made to

the patient's prescription these must be documented and dated, ready to be communicated to the next person responsible for the medicines management care of the patient e.g.

- When a medication has been stopped, and for what reason
- When a medicine has been started, and for what reason
- The intended duration of treatment
- When a dose has been changed and for what reason

9. Monitoring Compliance with this Guidance

Transcription will be audited six monthly, together with medicines reconciliation using appendix 4 and annually across the organisation using the NPSA reconciliation tool (appendix 7).

10. Related Trust Policies

Safe and Secure Handling of Medicines Policy (2018)

Self Administration of Medicines by Patients in Community Hospitals (2016)

Controlled Drug Policy (2018)

Non-Medical Prescribing Policy (2017)

Policy for the management of Medication errors (2018)

11. References

Clyne, W., Blenknisopp, A., and Seal, R.a. A guide to medication review 2008. National Prescribing Centre / Medicines Partnership Programme

Department of Health 2007 National Institute for Health and Clinical Excellence (2007) NICE Safety Guidance 1 - *Technical patient safety solutions for medicines reconciliation on admission of adults to hospital*

Institute for Healthcare improvement (2018) Medication Reconciliation to Prevent Adverse Drug Events *accessed 26/09/18*

NMC Standards for Medicines Management (2010) *accessed 26/09/18*

NICE (2015) Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes *accessed 26/09/18*

Royal Pharmaceutical Society Guidelines (2005) Safe and Secure Handling of medicines *accessed 26/09/18*

Task Force on Medicines Partnership and the National Collaborative Medicines Management Services Programme (2002). Room for review. A guide to medication review: the agenda for patients practitioners and managers.

World Health Organisation (May 2007) *Assuring Medication Accuracy at Transitions in Care*

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APPENDIX 1: TRANSCRIBING – COMPETENCY ASSESSMENT TOOL

Performance Standard
The nurse will be able to demonstrate the knowledge to support the safe transcribing for patients according to the nurse's care environment.

Action
The nurse to discuss with the assessor (Matron, Non-medical Prescriber, Doctor or Locality Pharmacist attached to the locality) the procedure and implications for transcribing within their care environment

Success Criteria
- The nurse will identify the environment in which he/she will transcribe and explain the indications for transcribing within this environment.
- The nurse will identify and discuss the procedure for transcribing highlighting the requirement and completion of appropriate documentation according to their individual care environment.

The following criteria should be completed according to appropriate care environment

Please tick: Environment in which transcribing will take place In patient setting

Community setting

Criteria	Achieved	Comments
Indication for transcribing		
Identify when transcribing is not appropriate		
Identify correct procedure for transcribing • Requirements prior to transcribing • Documentation i.e. drug card • Record keeping i.e. patient notes • Communication		
Identify when transcribing should discontinue and refer on to a doctor / Nurse Independent Prescriber		
Identify when transcribing should not take place		

Transcribing Record

Transcribers Name ..... Designation .....

Name

Date: Number of Items Transcribed	Name of Verifier:	Date: Number of items Transcribed	Name of Verifier:

Assessors Comments:

Signature .....Date.....

Assessors Signature ..... Designation.....

Signature.....Date.....

Appendix 2: Signature Requirements for Prescriptions – Nurses/Pharmacists

In order to comply with Prescription Only Medicines Legislation (Medicines Act 1968) the prescribing and transcribing of medicines to patients within the Trust may only be undertaken by a duly qualified practitioner. The employing organisation is therefore required to maintain a list of signatures of all Trust employed practitioners before any medicine can be dispensed or administered to a patient. This is also a requirement of the internal audit department.

1 Please complete the form below and send it immediately to your manager.
2 A copy incorporating your manager's signature of approval should be filed in your personal records.

SURNAME (print) _____

FIRST NAME (print) _____

Position _____

Prescribing/Qualifications _____

Ward /Directorate _____

Hospital _____

Signature (full) _____

(initials) Date _____

Line Manager Signature _____

Printed Name _____Date _____

Tick appropriate boxes

I will be functioning as:

Transcriber ☐

Nurse Independent prescriber ☐ Pharmacist independent prescriber

Appendix 3: Checklist to support process of medicines reconciliation

It is **not** intended that this checklist be completed on paper and stored for every patient, rather that it underpins training around medicines reconciliation and practically supports the medicines reconciliation process and guides the documentation that must be added to the patient medical record or the prescription chart.

Patient details (full name, date of birth, weight, NHS/unit/hospital number, GP, date of admission
The condition for which the patient was referred (or admitted) plus details of any co-morbidities
Known allergies and nature of the reaction *Should be signed, dated with documentation of sources used*
A complete list of all of the medicines currently prescribed and by whom
Dose, frequency, formulation and route of all the medicines listed Patient report of treatment adherence Patient report of monitoring (e.g. Lithium levels)
Specific medication to ask about include: • PRN medication • Inhalers • Eye drops • Anticoagulants • Topical preparations • Once weekly medication e.g. methotrexate • Injections including depot antipsychotics and vitamins • Over The Counter medication and any other treatments bought by the patient for personal use • Oral contraceptives • Hormone replacement therapy • Nebules • Home Oxygen • Herbal preparations including Chinese medicines • Insulin • Other non-prescribed medications • Illicit drug use
Additional information for specific drugs e.g. indication for medicines that are for short-term use only (antibiotics), day of week of administration for once weekly medication (bisphosphonates, methotrexate), recent blood levels/assays
Medication management in own home e.g. details of specific support from carers, dosette box, medication reminder charts
Sources used (minimum of 2) Should be documented
Name, signature and date of practitioner carrying out medicines reconciliation to be entered in the notes and annotated on the prescription chart

Appendix 4: Ward Medicines Reconciliation Audit Form

PLEASE USE BLOCK CAPITALS AND ENSURE DRUG NAMES ARE SPELT CLEARLY

WARD MEDICINES RECONCILIATION AUDIT FORM

Name of Patient..... Date of Birth.....

NHS Number: .....

Admitting staff member ..... Date of Admission .....

Allergies (please include details of any reactions).....

	SOURCES CHECKED (please tick)						
MEDICATION (drug, route, dose) PRESCRIBED (include psychotropics, physical and over the counter medicines)	GP	Patient	Inpatient notes	CMHT notes	Chemist	PODs	Family/ carer
Key	□ = checked		X = not checke		n/a = not available		

I AGREE THAT:	**SIGNATURE**
I have discussed with the patient the medication they are currently taking:	
I have compared the patients' medication with records or information as detailed above	
I have requested a Global Summary from the patient's GP	
I have compared the patient's medication with the Global Summary	
I have checked the newly prescribed Inpatient Prescription Card, for unintentional variances	
I have documented any discrepancies found and the action taken below.	
Details of discrepancies or omissions and actions taken: (please continue overleaf if necessary)	

Appendix 5: Sources of Medication Histories

The following sources of medication histories are listed below in no order of preference, as reliability can vary according to the situation. However it may be necessary to use two or more sources to establish an accurate medication history.

The working party would like to acknowledge the policies developed at University College Hospital, London, which underpin this appendix.

- **The Patient**
  - This is an important source as the patient will tell you exactly how they take their medicines.
  - Always try to establish how exactly a patient takes their medicines, as this could be very different from the formal records.
  - Where there is evidence of substance misuse always cross-check with specialist services before prescribing substitution methadone or detox

- **Patients Own Drugs (POD's)**
  - Encourage patients or their relatives to bring in their medicines from home.
  - Discuss each medicine with the patient to establish what it is for, how long they have been taking it, and how frequently they take it.
  - Do not assume that the dispensing label accurately reflects patient usage. - Check the date of dispensing since some patients may bring all their medicines into hospital, including those stopped.

- **Relatives/carers**
  - Patients may have relatives, friends or carers who help them with their medicines.
  - This is common with elderly patients or with patients where English is not their first language.
  - Carers can be very useful in establishing an accurate drug history and can also give an insight into how medicines are managed at home.
  - Be mindful of maintaining confidentiality.

- **Repeat prescriptions**
  - Some patients keep copies of all their repeat prescriptions. Many of these may include medicines that have been stopped.
  - The date of issue should always be checked and each item confirmed with the patient.
  - If there is any doubt, the GP surgery should be contacted.
  - Community Care Coordinator/Case manager
  - Community psychiatrist
  - Case records including correspondence section of R10

- **GP surgery** and referral letters
  - Ideally, a faxed list is preferable, especially if the receptionist appears to be having problems pronouncing the drug names.
  - Be aware of 'acute medicines', 'repeat medicines' and 'past medicines' on the receptionist's screen.
  - Always check when the item was last issued and the quantity issued.
  - Specific questioning may be needed for different formulations, for example different types of inhalers (metered-dose, breath-actuated, turbohaler), different calcium preparations (Calcichew ®, Calfovit D3®, Adcan D3®, or medicines

which are brand specific (aminophylline, theophylline).

- It may be necessary for you to speak to the GP directly to clarify any discrepancies.
- Specifically ask whether there are any 'Screen messages'.
  Some medications are 'hospital only' and do not appear on the usual 'repeat list'.

 Compliance aids e.g. Dosette, Venalinks, Medimax

- These may be filled by the community pharmacist, district nurses, relatives or patient.
- If dispensed by a community pharmacist, the device should be checked for dispensing labels which will provide the pharmacy contact details.
- The date of dispensing should also be checked bearing in mind that the medicines may have changed.
- Remember to check for 'when required' medicines and medicines that may not be suitable for compliance such as inhalers, eye drops, once weekly tablets etc.
- Contact the community pharmacist to inform them of the patients admission to prevent unnecessary repeat dispensing. They may also inform you of the number of compliance aids that have been filled, since these may still be at the patient's home.
- The community pharmacist's contact details should be documented on the drug chart and a discharge plan agreed.

 Medication reminder charts

- The chart should be checked through with the patient and the date of issue noted.

 Recent hospital discharge summary and Community MHT/AHP/Crisis team notes

- Check whether any changes have been made by the teams or GP since the patient's previous discharge from hospital.
- Discharge summaries that are more than one month old should not be used as a sole source for a drug history.

Appendix 6: Collecting information for medicines reconciliation

The 'collecting' step involves taking a medication history and collecting other relevant information about the patient's medicines. The information may come from a range of different sources (some potentially more reliable than others). **See Appendix 4.**

The medication history should be collected from the most recent and reliable sources. Where possible, information should be cross-checked and verified. The person recording the information should always record the date that the information was obtained and the source of the information.

This section covers:

a. Taking a medication history
b. A checklist of questions that can support medicines reconciliation and help to identify any problems

The working party would like to acknowledge the policies developed at University College Hospital, London, which underpin this appendix.

a) Taking a medication history

This process may not be applicable for patients with communication difficulties. If a carer, or translator is not available, consideration should be given to relying solely on a variety of external sources. In such cases, the difficulties in obtaining the drug history, the sources used and possible areas of uncertainty must be clearly documented.

- Introduce yourself to the patient and explain the purpose of your visit
- Confirm with the patient whether they have any medication allergies or Adverse Drug Reactions (ADRs). Ask also about the nature of the reaction and document this information in the patient medical record and the drug allergy/hypersensitivity box on the medication record chart:

  - If the patient has no known drug allergies/hypersensitivities, then document as '**NKDA'**
  - If the patient is unconscious/unavailable use other sources to determine allergy status where possible
  - This information should be signed and dated and include details of the sources used

- Ask the patient if they have brought their own medicines and/or a list of their medicines into hospital.
- Ascertain what medicines the patient was using regularly at their previous care setting prior to admission (see **Appendix 5** on Sources for Drug Histories).

- Ask the patient for details of medicine name, formulation, strength and frequency of administration for each medication.

- Where the patient has been transferred from another care setting you may need to check the medication history against the medication record chart or administration record from that setting. You may need to use your discretion and reconcile medicines from prior to admission to the previous care setting.

- The first source of documentation of a medication history on admission should always be the patient medical record.

- In addition to asking the patient about regularly prescribed medicines, also check if the patient is using any of the medicines listed in **Appendix 3** as these are often forgotten by patients.

- Ascertain the patient's adherence to their prescribed medication regime. Ask the patient/carer if they take/administer the medicines as labelled. Ask if they use a compliance aid.

Note: Some patients are confused on admission to hospital (especially the elderly) and claim not to be taking any medicines. In such instances alternative sources may define what medicines are prescribed and a view will need to be taken on whether the patient complies or not.

- Specific information should be collected about the following drugs:
  - Inhalers and nebulisers
  - Anticoagulants
  - Steroids
  - Insulin
  - Contraceptives/HRT
  - Methotrexate
  - Bisphosphonates
  - Methadone and other abused substances
  - Clozapine

b) A checklist of questions to support medicines reconciliation and help identify any problems

- Does anyone help you with your medicines at home? If so, who? What do they do?
- Do you have any problems obtaining or ordering your repeat prescriptions? (NB: relative/carer might help)
- Do you have a regular community pharmacy that you use?
- Do you have problems getting medicines out of their packages?
- Do you have problems reading the labels?

Appendix 7: Organisational data collection tool for clinical audit

Complete one form for each clinical area within the healthcare organisation. For definitions of the standards, please refer to the NICE guidance.

Organisation	
Service/Unit:	
Date of data collection:	

No.	Data item	Yes	No	NA/ Exceptions	NICE guidance ref.
Patient safety					
1	The following are available in each clinical area: - a trustwide policy for medicines reconciliation on admission of adults - a local policy for medicines reconciliation on admission of adults. (Data source: Clinical area policy file)	☐ ☐	☐ ☐		1.1
2	The policy includes the following:				
2.1	Standardised systems for: • collecting • documenting • verifying information about current medication.	☐ ☐ ☐	☐ ☐ ☐		1.2
2.2	A statement that pharmacists should be involved in medicines reconciliation as soon as possible after admission.	☐	☐		1.2
2.3	Cleary defined responsibilities of: • pharmacists • other pharmacy staff • other clinical staff in the medicines reconciliation process on admission.	☐ ☐ ☐	☐ ☐ ☐		1.2
2.4	Strategies to obtain information about medications for people with communication difficulties. (Data source: Clinical area policy file)	☐	☐		1.2

Patient data collection tool for clinical audit

Complete one form for each clinical area within the healthcare organisation. For definitions of the standards, please refer to NICE guidance.

Service/unit:			
NHS Number[1]:	**Sex:** M / F	**Age:**	**Ethnicity:**
Date patient admitted:	**Time patient admitted:**	Elective/planned: 0 Unscheduled: 0	
Date medicines information collected		**Time medicines information collected**	

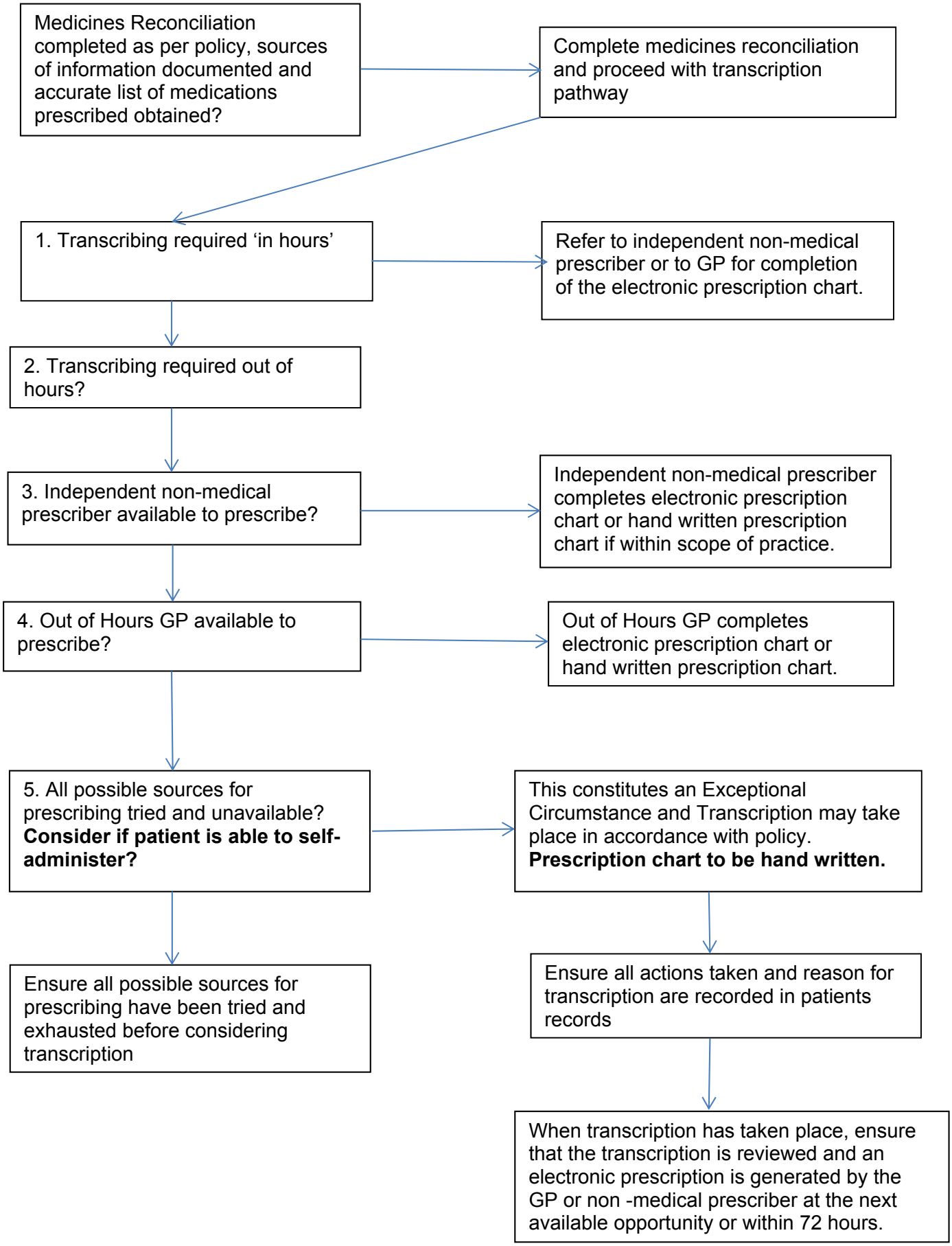
No.	Data item	Number		NA/Exceptions
Medicines reconciliation				
1	How many medicines is the patient taking?			**A** Patient unsure **B** Patient unable to give information[2]
2	Information on how many medicines was collected from the patient including:			
2.1	• medicine name			
2.2	• dosage			
2.3	• frequency			
2.4	• timing			
2.5	• route			
		Yes	**No**	
3.1	Who undertook the medicine reconciliation interview?			
	• pharmacist			
	• pharmacy technician			
	• nurse			
	• doctor			
	Other (specify):			
3.2	Who verified the primary care records with the hospital prescription?			
	• pharmacist			
	• pharmacy technician			
	• nurse			
	• doctor			
	Other (specify):			

[1] Use non patient identifiable code, such as NHS number
[2] If either exception code applies, please either circle A or B or enter the relevant letter into the space instead of a number.

Patient data collection tool for clinical audit

No.	Data item	Tick		NA/ Exceptions
3.3	How long after the patient's admission was a pharmacist involved in medicines reconciliation? <24 hours 24–48 hours 48–74 hours >72 hours Not at all	 D D D D D		
		Yes	**No**	
4	Were primary care records used to obtain information about patient's prescribed medicines?			
	If yes, on what date were they produced?			
5	Did the patient have communication difficulties?			
5.1	If yes, how was information obtained?			

Appendix 8: Transcription Pathway



Equality Analysis

Name of Policy/Procedure/Function*

Equality Analysis Carried out by: Lorna Adlington
Date: September 2018
Equality & Human rights Lead:

Director\General Manager:

***In this template the term policy\service is used as shorthand for what needs to be analysed. Policy\Service needs to be understood broadly to embrace the full range of policies, practices, activities and decisions: essentially everything we do, whether it is formally written down or whether it is informal custom and practice. This includes existing policies and any new policies under development.**

A.	Briefly give an outline of the key objectives of the policy; what it's intended outcome is and who the intended beneficiaries are expected to be	To provide clear guidance in a situation where transcription cannot be avoided i.e. an exceptional circumstance to reduce risk to both patients and staff.		
B.	Does the policy have an impact on patients, carers or staff, or the wider community that we have links with? **Please give details**	The document is relevant to staff employed by LCHS NHS Trust		
C.	Is there is any evidence that the policy\service relates to an area with known inequalities? **Please give details**	None		
D.	Will/Does the implementation of the policy\service result in different impacts for protected characteristics?	No		
		Yes	No	
	Disability		√	
	Sexual Orientation		√	
	Sex		√	
	Gender Reassignment		√	
	Race		√	
	Marriage/Civil Partnership		√	
	Maternity/Pregnancy		√	
	Age		√	
	Religion or Belief		√	
	Carers		√	
	If you have answered 'Yes' to any of the questions then you are required to carry out a full Equality Analysis which should be approved by the Equality and Human Rights Lead – please go to section 2			
The above named policy has been considered and does not require a full equality analysis				
Equality Analysis Carried out by:		Lorna Adlington		
Date:		26th September, 2018		