Medicines Reconciliation in Mental Health

Katherine Roe
Medicines Management Technician
Aims

• Brief overview of medicines reconciliation and relevant guidelines
• Understand local medicines reconciliation policies and procedures
• Assess suitability of different information sources
• Discuss the future of medicines reconciliation in mental health
Technical patient safety solution for medicines reconciliation on admission of adults to hospital

• Issued in December 2007
•Outlined:

1. Current practice
2. The role of the pharmacy team in medicines reconciliation
3. The risk of medication errors on transfer between care settings
NICE - PSG001

• Recommendations
  – All healthcare organisations that admit adult inpatients should put policies in place for medicines reconciliation on admission
  – Pharmacists should be involved in medicines reconciliation as soon as possible after admission
Why is medicines reconciliation important?

- Medication errors pose a threat of harm to hospital inpatients
- Errors occur most commonly on transfer between care settings and particularly at the time of admission
- Medicines reconciliation can identify these errors and prevent them from having an adverse effect on the patient
Medicines reconciliation – Who is responsible?

<table>
<thead>
<tr>
<th>Level ONE reconciliation</th>
<th>Level TWO reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undertaken on admission or transfer of care for all patients</td>
<td>Undertaken on admission or transfer of care for all patients</td>
</tr>
<tr>
<td>By admitting doctor or a trained healthcare professional</td>
<td>By pharmacist or pharmacy technician</td>
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<tr>
<td>Within 24 hours of admission</td>
<td>Within 72 hours of admission* WHO guidance suggests that pharmacist led medicines reconciliation should be completed within 24 hours</td>
</tr>
</tbody>
</table>

(Southern Health Medicines Reconciliation Policy CP 96)
Medicines Management
Technicians & Medicines
Reconciliation

• Establish which information sources are most appropriate
• Check that any necessary drug monitoring has been completed
• Identify any anomalies
• Check PODs
Information Sources

- Patient, relative or carer
- GP repeat list
- GP Summary
- Patients own drugs
- Care home record
- Hospital discharge letter
- Community pharmacy
- Notes/CPNs
Assessing suitability of information

• Patient, relative or carer
  – Refuse to speak to staff
  – Be aggressive
  – Be confused

• GP repeat list
  – Many mental health drugs are only supplied on an acute basis e.g. hypnotics, anxiolytics
Assessing suitability of information

- GP summary print-out
  - In practice the most used source of information
  - Does not always include medication started and managed by mental health services e.g. clozapine, depot injections
  - Non-compliance is a big issue with mental health patients therefore the medication may not be taken as prescribed
Assessing suitability of information

• Care Home Record
  – Useful if up to date
  – Often used when dealing with patients with dementia

• Patients’ own drug
  – Identify issues with storage and hoarding
  – Reuse on the wards following assessment
  – Provide information on any OTC, herbal or homeopathic treatments
Assessing suitability of information

- Community Pharmacy
  - Recently dispensed medication
  - Medidose systems
- Hospital discharge summary
  - Numerous admission to mental health wards from acute hospitals therefore the discharge summary can be useful
  - Medicines reconciliation not always complete at acute hospital therefore discharge summary may be incomplete
Assessing suitability of information

• Notes/CPNs
  – Good record of when depot injections have been administered
  – Not always complete
  – Difficult to ensure accuracy
  – Rarely has full details of physical health conditions and medication prescribed for these
Drug Monitoring

• Lithium Levels in accordance with NPSA guidance
• Clozapine blood tests
• INR if patients are admitted on an anticoagulant
Checking PODs

- Any PODs for reuse on the ward must be checked and have a blue or green sticker attached.

<table>
<thead>
<tr>
<th>PATIENTS OWN DRUGS</th>
<th>PATIENTS OWN DRUGS</th>
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</thead>
<tbody>
<tr>
<td>APPROVED FOR USE</td>
<td>APPROVED FOR USE</td>
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</table>

- For use by trained nursing staff
- For use by Medicines Management Team
Local Procedure

Medicines Management Technician (MMT) prints out ward list and identifies new admissions.

MMT goes through patients’ notes recording demographic details, including GP surgery and any significant medication entries in the notes.

Obtains copy of GP summary and any other required sources of information including recent drug monitoring.

MMT checks current drug chart against all information sources and identifies any anomalies, these are then referred to either the pharmacist or doctor.

MMT makes an entry in the patients’ notes detailing any intervention and records statistics on data collection form.
<table>
<thead>
<tr>
<th>Medication &amp; Form</th>
<th>Current Rx</th>
<th>GP fax</th>
<th>PODs</th>
<th>other info:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance aid information: Required: Yes/No</td>
<td>Supplying Pharmacy: Telephone: Fax: Address:</td>
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</tbody>
</table>
# Medication Admission Reconciliation Check - Intervention / Referral Form

<table>
<thead>
<tr>
<th>Column</th>
<th>Row 1</th>
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<td>Hosp No.</td>
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<td>Admission Date</td>
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<td>Checklist:</td>
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<tr>
<td>Entry Made in MDT Notes:</td>
<td>Y / N</td>
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<tr>
<td>Documented on front of chart:</td>
<td>Y / N</td>
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<td>If Rx’d Lithium-</td>
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<td>Recent Lithium Level : Y / N</td>
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<td>Recent RFT / eGFR : Y / N</td>
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<td>Level 1 Allergy status entered: Y / N</td>
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<td>Level 1 Allergy status correct: Y / N</td>
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<td>Level 1 ARC correct: Y / N</td>
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</table>

**Intervention/Referral**

**Actions Taken**

**Outcome**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>Technician</td>
<td>Date</td>
<td>Pharmacist</td>
<td>Date</td>
<td></td>
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</tr>
</tbody>
</table>
Does medicines reconciliation make a difference?

- Parklands Hospital

<table>
<thead>
<tr>
<th>April 2011</th>
<th>May 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>61% of medicines reconciliation checks identified an issue</td>
<td>69% of medicines reconciliation checks identified an issue</td>
</tr>
<tr>
<td>9% of allergy status’ were incorrectly documented</td>
<td>11% of allergy status’ were incorrectly documented</td>
</tr>
</tbody>
</table>

Between April 2011 and May 2011 over £1100 has been saved through the reuse of PODs
The Future

• The NHS is under pressure to care for as many people as possible in their own homes, as a result of this the number of mental health inpatient beds is reducing.

• This will inevitably lead to changes in the roles of Pharmacists and Technicians.
‘Medicines Management in Mental Health Crisis Resolution and Home Treatment Teams’ was produced by the National Mental Health Development Unit and CMHP and proposed that

– There should be a process for undertaking medicines reconciliation for every patient on admission to the CRHT

– The information should be reviewed by an appropriate clinician and a pharmacist should be involved
The Future

• Medication Safety Project
  – A revised medicines reconciliation form aimed at getting prescribers to carefully consider what they are prescribing and documenting any intentional changes
  – The admitting doctor will complete one side of the form and a member of the Medicines Management Team will complete the second side
  – A full pilot of this system is being carried out from August 2011
Any Questions?
References

- www.nice.org.uk
- www.nmhdu.org.uk
- www.southernhealthft.nhs.uk
- http://www.npsa.nhs.uk/