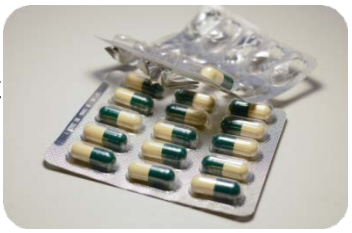
Caring for Care Homes

Accurately listing a residents medicines



It is essential that the resident's previous medication list is compared with their current medication list every time a resident is transferred from one healthcare setting to another, to check for discrepancies and to ensure that these are communicated to the resident and relevant clinicians.

It is important to identify the most accurate list of a resident's medicines, including the name of the medicine, the dose, frequency and route. This should be compared to the current list you are working from.

Why should medicines be accurately listed?

The Institute of Health Improvement estimates that as many as 50% of all medication errors are due to poor communication when residents transfer from one care setting to another. Residents recently discharged from hospital are known to be a particularly vulnerable group. 30-70% of residents experience an error with medications during transfer between settings.

What could go wrong if a resident's medication is not accurately listed?

- The resident might receive the wrong dose, strength, or formulation of their medicine
- The resident may not receive their medicine at all
- There could be delays to a resident's treatment while issues are resolved
- Greater risk of drug interactions and adverse effects
- Additional staff time spent on resolving issues
- The pharmacy could order in the wrong medication for the resident

Who is the best person to accurately list a resident's medication?

Medicine reconciliation can be carried out by any member of staff, as long as they are competent and have the information they need to carry out the task. It is important to establish who has responsibility for the process.

Who else should be involved in accurately listing a resident's medication?

- The resident and/or their family members or carers
- The pharmacist
- Other health and social care practitioners involved in managing medicines for the resident

What can be done by care homes to ensure the process of listing a resident's medication is being carried out in an accurate and timely manner?

- Care homes should have a policy in place to ensure that this process is carried out by a competent person. The policy should ensure timeliness and have a safe and robust process for addressing discrepancies.
- An 'up to date' copy of the resident's repeat list must be kept in a safe place in case of emergency admission.

Care homes should follow the three steps below to make sure their process is robust.

1. Collecting: This step involves taking a medication history and collecting other relevant information about the resident's medicines. The most up to date reliable source should be used, crossed checked and verified. Any discrepancies must be recorded, and a reason established for variation. A range of sources can be used including:

- A computer print-out from a GP clinical records system.
- The tear-off side of a resident's repeat prescription request.
- Verbal information from the resident, their family or a carer.
- Medical notes from a resident's previous admission to hospital (e.g. discharge summary).
- Medicine containers or repeat prescription supplies available at the time of the

reconciliation.
- Remember to check for drugs not prescribed by the GP, e.g. hospital outpatient, mental health drugs.

2. Checking: This step involves ensuring the medicines and doses prescribed following the basic reconciliation process are correct. These may not be identical to those documented during the collecting process, as the GP may have made some intentional changes. Any discrepancies will need to be resolved in the final step of this process. **Check that nothing has changed,** e.g. new adverse effects, the resident's ability to swallow tablets.

3. Communicating: This is the final step in this process where changes to the resident's prescription are documented and dated and communicated to the next person responsible for the medicines management care of that resident. **Be extra observant for any of the following:**

- Medications that have stopped
- Medications that have started
- Changes in medication strength
- Changes in medication dose
- Changes in medication frequency
- Specific details on length of treatment
- Specific details on increasing or decreasing regimes
- Known allergies, including those newly recorded
- Take special precautions with brands and generics (e.g. Losec® and omeprazole are the same drug)
- If a discharge summary appears incomplete, inaccurate or ambiguous, action must be taken immediately to seek clarification to avoid potential harm to the resident.

The following information should be available on the day a resident transfers into or from a care home:

- Resident's details, including full name, date of birth, NHS number, address, weight (for those aged under 16 or where appropriate, e.g. frail older residents) and their GP's details.
- Details of other relevant contacts defined by the resident and/or their family members or carers (e.g. the consultant, regular pharmacist, specialist nurse).
- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced.
- Medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what the medication is for (indication), if known. Indication for 'when required' medication must be recorded.
- Changes to medicines, including medicines started, stopped or dosage changed, and reason for change.
- Date and time the last dose of any 'when required' medicine was taken or any medicine given less often than once a day (weekly or monthly medicines).
- Other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support).
- What information has been given to the resident and/or family members or carers.

Ensure that the details of the person completing the list of resident's medicines (name, job title) and the date are recorded. It is everyone's responsibility to make sure that where involved, they have 'collected, checked and communicated' any changes made.

Remember: NICE Managing Medicines in Care Homes - 6 R's of administration.

Right Resident	Right Medicines	Right Route	Right Dose	Right Time	Right to Refuse