NHS
Birmingham and Solihull
Mental Health
NHS Foundation Trust

Medicines Reconciliation for Inpatient Wards Policy

Policy number and category	**C06A** *to be read in conjunction with the Medicines Code - C 06*	**Clinical**
Version number and date	**4**	**February 2025**
Ratifying committee or executive director	**Trust Clinical Governance Committee**	
Date ratified	**May 2025**	
Next anticipated review	**May 2028**	
Executive director	**Medical Director**	
Policy lead	**Chief Pharmacist**	
Policy author *(if different from above)*	**Chief Pharmacist with Lead Pharmacist**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

Medicines reconciliation is an important process to ensure that unintentional discrepancies between medicines taken immediately prior to admission and those prescribed on admission do not occur, either when a service user has been admitted or at any other transitions of care

Wherever possible, all service users admitted to BSMHFT inpatient ward should undergo medicines reconciliation **within 72 hours of admission or sooner if practicable**. This process should be initiated by the admitting doctor/medical team and followed up/completed by the medical team responsible for the service users' episode of inpatient care or pharmacy staff looking after the ward. The medical team will have overall responsibility for medicines reconciliation on admission including documentation in the service users' Rio record. The medical team will be supported by pharmacy professionals in obtaining sources of information or resolving discrepancies to complete the medicines reconciliation process.

Policy requirement (see Section 2)

This policy defines:

- The process of medicines reconciliation on admission of a service user to an inpatient unit. Where possible, medicines reconciliation should be completed within 72 hours of admission or sooner if practicable.
- The information sources and requirements to be used when collecting information about a service users' medication.
- The roles and responsibilities of medical, pharmacy and other staff in the medicines reconciliation process.

This policy ensures that medicines reconciliation process is in line with NICE Guidance NG5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes. *March 2015*

Date	Version	Author (Name & Role)	Reasons for review / Changes incorporated	Ratifying Committee
Feb 2025	**4**	**Matthew Haggerty, Chief Pharmacist.**	**3 Yearly Review**	**CGC**

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1: Introduction

1.1 Rationale

Medication errors are one of the leading causes of harm to hospital service users. It is estimated that between 30 -50% of medicines prescribed for long–term conditions are not used as intended (WHO 2003), with 5 – 8% of unplanned hospital admissions due to medication issues. Adverse events of medicines represent a considerable burden on patients. When people are transferred between different care providers such as the time of hospital admission/discharge, there is a greater risk of poor communication and unintentional changes to medicines. Around 30-70% service users have an error/unintentional change to their medicines when they move between different care-settings.

Medicines reconciliation aims to ensure that when a service user is admitted to hospital, important medicines aren't stopped inappropriately and new medicines are prescribed, with a complete knowledge of what a service user is taking. It therefore aims to significantly reduce medication errors caused by incomplete or incorrect documentation.

The objectives of medicines reconciliation are to:

- Reduce the risk of prescribing errors occurring when the care of the service user is transferred from one care setting to another.
- Reduce hospital admissions and re-admission due to harm from medicines.
- Reduce the number of missed doses and improve the quality and timeliness of information available to clinicians, thereby leading to improved therapeutic outcomes.
- Increasing service user involvement in their own care promoting better concordance and reducing waste.

1.2 Scope

This policy applies to all clinical staff involved in the admission and management of a service user to an inpatient unit. Wherever possible, for each service user admitted to an inpatient unit, the medicines reconciliation process should be within 72 hours of admission (or sooner if practicable) of the admission and reviewed again at any transition of care to other wards, units or teams. The medical team looking after the service user's inpatient episode is the designated team who will have overall responsibility for the medicine's reconciliation process and documentation. This will be closely supported by the Pharmacy service who will liaise with the medical team in completing the medicines reconciliation process.

1.3 Principle

Medicines reconciliation ensures that each service user admitted to the inpatient unit within BSMHFT:

- Receive all intended medications following a move from one care setting to another.
- Unintentional discrepancies between medicines prescribed prior to admission and those prescribed on admission do not occur.
- Prescribers are fully informed of all medicines taken by service user prior to admission to facilitate safe prescribing practice.

The Trust positively supports individuals with learning disabilities and ensures that nobody is prevented from accessing the full range of mental health services available. Staff will work collaboratively with colleagues from learning disabilities services and other organisations to ensure that service users and carers have a positive episode of care whilst in our services. Information is shared appropriately in order to support this.

2: Policy

The medicines reconciliation process is to collect, compare and communicate the most up-to-date and accurate list of medicines that a service user is taking, together with details of any allergies and/or adverse drug reaction (ADRs) with the goal of providing a contemporaneous and correct list of medicines for a given time period at any transition point between care episodes.

Wherever possible, for each inpatient admission this process should be recorded on the service users Rio records within 72 hours of admission.

The medicines reconciliation process should be completed by a trained and competent healthcare professional that has the necessary knowledge, skills and expertise including effective communication skills; technical knowledge of processes for managing medicines; and therapeutic knowledge of medicine use (NICE 2015).

The medical team have overall responsibility for the medicines reconciliation process. Pharmacy and other staff will assist or complete this process; however, prescription discrepancies and amendments need to be made by a prescriber within the team responsible for the service user's inpatient care.

The first Multi-disciplinary Team meeting should ensure that the medicines reconciliation process has been completed competently. The patient's consultant psychiatrist is responsible for checking this is completed and documented within Rio.

Key Components of Medicines Reconciliation:

- Accurate drug history recorded together with sources used (minimum 2 sources).
- Identification of discrepancies between pre-admission and admission medication.
- Discrepancies resolved in an appropriate time scale.
- Written communication of outcomes, to include justification of discrepancies.
- An accurate list of medicines prescribed within the current inpatient episode for the service user.

3: Procedure

This procedure outlines the stages required to ensure medicines reconciliation process is completed and accurately documented on the service users Rio record. See **appendix 2** - for quick summary and **appendix 3 –** for a flow chart of medicines reconciliation process.

3.1 Collecting information for medicines reconciliation

The healthcare professional should collect the most accurate list of medicines, allergies and significant adverse drug reactions using a variety of source types (minimum of two, which includes at least one information source regarding physical health i.e. GP and at least one other regarding mental health, e.g. the most recent prescription on the Electronic Prescribing and Medicines Administration (EPMA) record). If the service user has been in another healthcare setting for at least 3 months prior to admission to BSMHFT (e.g. prison or another hospital), ideally at least two sources should be used for medicines reconciliation, but it may be appropriate to use the information from the previous healthcare provider as a single source providing there is full confidence in that record. If this occurs, this must be clearly documented on Rio.

This step also involves assessing concordance with treatment as prescribed prior to admission and identifying potential for partial or non-compliance.

When a service user is admitted to an inpatient unit they are often at their most vulnerable and are not always able to contribute accurately to a medication history –taking discussion. Medicines reconciliation should therefore consist of two or more documented sources used to ensure drug history is accurate (single sources are rarely complete and accurate). For example, a previous home treatment prescription and GP summary, both verified with service user when possible. If there are discrepancies, other additional information sources should be used to resolve the discrepancies. See **Section 3.5,** for key information sources.

The number of sources required must be sufficient to resolve any issues or discrepancies that arise in the medicines reconciliation process, to give confidence in the final list of prescribed medicines following admission.

Details should be collected and recorded on the service users Rio Progress Notes under a heading of ‘medicines reconciliation’ and should include:

- Name of the medicine(s), dosage, frequency and route of administration for each medicine.
- A comprehensive list of all the medicines currently prescribed or brought over the counter/alternative therapies/herbal medicines/supplements.
- Specific medication to ask about include: PRN medication, inhalers, eye drops, topical preparations, insulin, once weekly medicines (i.e. methotrexate, alendronic acid, including the day of the week it is taken on) injections (depots, vitamins), over the counter medicine or other treatment brought by service user for personal use, oral contraceptives, hormone replacement therapy, nebules, home oxygen, herbal preparations including Chinese medicines, other non-prescribed medications.

- Pay specific attention to doses, particularly insulins or other critical medicines with narrow therapeutic windows such as lithium.
- Medicines stopped/started with reasons or with special arrangement (i.e. titrations/ short courses).
- Known allergies, hypersensitivities and adverse reactions with nature of the reactions if known.
- An assessment of concordance/adherence with the treatment as prescribed prior to admission and identification of any compliance/adherence issues (i.e. compliance aid details, any medicines intentionally/unintentionally omitted by the patient).

The person recording the information must record the date that the information was obtained and the source of the information used as well as their name and designations.

Where a medicines reconciliation process is incomplete, the Rio record should include all of the details compiled at that point and the outstanding tasks to be completed should be listed in the Rio record. When the medicines reconciliation process is complete, the final record should include the remaining details and a final list of medicines that should be prescribed on the patients EPMA record following admission.

3.2 Comparing information sources and reviewing current prescription

Using the second or subsequent source of information for medicines history, the healthcare professional should confirm or highlight any discrepancies in the medicines list recorded from the first source of information. They should always record the date that the information was obtained, and the source of the information used as well as their name and designation.

For each medicine listed in the medicines history, a decision should be made and recorded as to whether it is to be continued, amended, stopped or withheld. Details of amendment and reasons for amending/stopping should also be recorded.
The healthcare professional should then compare the collected medicines history, allergies and ADR list against the current prescribed information such as the medication chart/electronic prescription.

If any discrepancies are identified throughout this process they should be resolved using the appropriate additional source of information and clinical judgement. These discrepancies and action taken to resolve as well as any changes, deletions and additions should be documented on the Rio Progress Note. This also includes documenting any intentional changes made to the medicines post medicines reconciliation process.

The service user's current electronic prescription should accurately reflect the list of medicines compiled by the medicines reconciliation process as continued or intentionally added medicines. Any medicines that need reviewing (i.e. those withheld) should be reviewed in a timely manner. The prescriber should document on Rio Progress Notes that they have reviewed the service user's prescription after the medicines reconciliation process.

3.3 Documenting the medicines reconciliation process

Wherever possible, the medicines reconciliation process should be documented in Rio Progress Notes within 72 hours of the service user's admission under the title 'Medicines Reconciliation'. The following is a recommended format

Medicines Reconciliation:

Medicines reconciliation done using the following sources:

1.

2.

Allergies - either Nil Known or list of what patient is allergic to and reaction.

Regular medication prior to admission - (list all the medicines including dose, frequency, route and any over the counter/internet purchased medication).

PRN medication prior to admission:

Interventions – including any prescribing discrepancies, and any actions required to resolve discrepancies.

Comments – If additional source of information are used to resolve discrepancies, these should be documented here.

Any intentional changes made post admission should also be recorded in the Rio Progress Note for completeness.

Name, date and designation of the practitioner completing the medicines reconciliation documentation should also be recorded.

3.4 Communicating the medicines reconciliation process

At each transition point, all changes that have occurred to the service user's medicines, allergies, and ADR list should be documented, dated and communicated to the appropriate prescriber to ensure the care of the service user is continued. Communication must include reasons for the change(s) and any follow up requirement.

3.5 Key sources of information

Establishing key medicines information for a service user may come from a variety of sources some of which are more reliable than others. A minimum of two sources should be used to establish an accurate medicines history. The source used should be most recent available and the person recording the information should always record the date that the information was obtained and the source of the information used.

Examples of reliable information sources

- A computer print-out from a GP clinical records system/recent referral letter. GP Practice will usually require for the information to be requested via an e-mail. You should ensure that you send any e-mail to the correct e-mail address for that GP practice.

- Summary Care Records.
- Shared Care Record.
- A recent Trust electronic prescription record – in doing so, you should seek the most recent inpatient or outpatient EPMA episode for mental health medicines. The GP record will also need to be accessed for any medicines currently prescribed by the GP.
- Verbal information taken from GP practice and documentation of information provided on Rio Progress Notes:
  - Ideally, an e-mailed list is preferable, especially if there are difficulties in pronouncing drug names. Be aware of 'acute medicines', 'repeat medicines' and 'past medicines' on the receptionist's list/screen.
  - Always check the date 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®, Adcal D3®), or medicines which are brand specific (e.g. aminophylline and theophylline).
  - It may be necessary to speak to the GP directly to clarify any discrepancies.
  - Specifically ask whether there are any 'Screen messages'. Some medications are 'hospital only' (e.g. clozapine) and do not appear on the usual 'repeat list'.
- The tear-off side of a service user's repeat prescription (FP10) request if available. The date of issue should always be checked and each item confirmed with the service user. If there is any doubt, the GP surgery should be contacted.
- Verbal information from the service user, their family, or a carer. An important source as the service user will tell you exactly how they take their medicines and their level of adherence.
- Where there is evidence of substance misuse always cross-check with specialist substance misuse services before prescribing substitution methadone or buprenorphine.
- Carers can be very helpful in establishing an accurate drug history and can also give an insight into how medicines are managed at home, including levels of adherence. Be mindful of maintaining confidentiality.
- Recent Rio Discharge/Clinic Letters.
- Medical/Rio notes from previous admission(s) to hospital.
- Acute hospital or another mental health trust hospital recent discharge letter or prescription chart.
- Rio will be an accurate source of information for service users mental health history, however, should be used in conjunction with an alternative source on the service users physical health i.e. GP summary.
- Prison inmate/medical records.
- Residential/Nursing Home Records e.g. Medicines administration record (MAR) Sheets.

- Handwritten lists from homes should be used with care as they may have transcription errors.

- Service Users Own Drugs (PODs) – medicines, containers or repeat prescription supplies available at the time of the reconciliation:

  Encourage service users or their relatives to bring in their medicines from home. Discuss each medicine with the service user 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 usage. Check the date of dispensing since some service users may bring all their medicines into hospital, including those stopped. If considering use within an inpatient unit, assess for suitability of use as outlined in the Medicines Code.

- Details of any medicines supplied by a specialist clinic or homecare service. This may be notified by the patient, family and carers or the patient's GP. They may be found in any PODs that the patient brings with them.

Examples of less reliable information sources (complementary sources)

- Community pharmacy record.

- Compliance aids e.g. Nomad, Dosette, Venalinks, Medimax, Medidose:

  These may be filled by the community pharmacist, district nurses, relatives or service user. 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 aids such as inhalers, eye drops, once weekly tablets etc. Contact the community pharmacist to inform them of the service user's admission to prevent unnecessary repeat dispensing. The community pharmacist's contact details should be documented on Rio.

- Care plans.

- Previous admission notes.

- Hospital discharge summary and CMHT/AOT/Crisis team notes, especially if more than one month should not be used as a sole source for a drug history. Check whether any changes have been made by the teams or GP since the service user's previous discharge from hospital.

In some cases it may be necessary to investigate additional sources to obtain a complete medication history. Examples of teams that may need to be contacted for further information include:

- Anticoagulant Clinics.
- Community pharmacists.
- Specialist Clinics such as HIV clinics.
- Renal Dialysis Unit.

3.6 Education and Training

Medicines reconciliation should be an integral part of the education and training given to pharmacists at undergraduate level. The pharmacy team will therefore have responsibility towards supporting and training medical staff and other staff on the medicines reconciliation process.

3.7 Medicines Incidents

Any medicines incident relating to the process of medicines reconciliation should be reported using the Trust's Incident Reporting System (Eclipse) with a clear description of the event and individual(s) involved. See Medicines Code (Appendix 5) for further details/guidance.

Medicines incidents are reviewed for information and learning at the Medicines Safety Group (subgroup of the Medicines Optimisation Committee).

4: Responsibilities

This list summarises defined responsibilities relevant to the policy.

Post(s)	Responsibilities	Ref
Medical Director	The executive Medical Director has overall responsibility safe medication practices including ensuring reviews and compliance with this policy.	
Chief Pharmacist	The Chief Pharmacist has overall responsibility for implementation, monitoring and compliance with this policy.	
Medical Staff	The consultant responsible for service user's new episode of acute inpatient care will be responsible for ensuring medicines reconciliation is completed. This process will usually be delegated to pharmacy staff or junior doctor(s) within the medical team.	
Nursing or other Staff	Nursing staff and other staff on the acute inpatient wards may assist with the collection of information sources for medicines reconciliation and ensuring this is available for the medicines reconciliation process to be completed within 72 hours of a service user's admission.	
Pharmacy Staff	Pharmacy staff are responsible for:	

	• Ensuring they are suitably trained to undertake medicines reconciliation. • Undertaking medicines reconciliation as soon as possible after admission. • Where the medical team are unable to complete the medicines reconciliation process, supporting and assisting the completion of the process. • Following up incomplete medicines reconciliation documentation. • Assisting in assessing any patient's own medicines as suitable for use on the ward and using these to clarify medication history. • Resolving complex medication issues that require a detailed medication history following admission when prompted by the medical team. • Ensure the medicines reconciliation process is completed for each service user on admission or soon as practical and the prescription reflects an accurate list of medicines that the service user is prescribed on admission. • Professional screen of electronic prescriptions for each ward on a regular basis, which includes checking if medicine reconciliation process has been completed. • Train clinical staff on medicines reconciliation process and standards of documentation on Rio Progress Notes. • Participate in audit on medicines reconciliation.	
Ward/Team Managers	The ward/ team manager should have an oversight of how the ward is performing on completing medicines reconciliation process. The ward/ team manager will be responsible for: • Ensure all ward/team staff are aware of the medicines reconciliation policy and process. • Ensuring all ward/team staff have received the medicines reconciliation training in order to competently complete their role in the medicines reconciliation process.	
Non-Medical Prescribers	Non-medical prescribers should ensure that medicines reconciliation has been completed before prescribing for service users.	

5: Development and Consultation process

Consultation summary		
Date policy issued for consultation	February 2025	
Number of versions produced for consultation	1	
Committees / meetings where policy formally discussed	**Date(s)**	
Medicines Optimisation Committee	February 2025	
Senior Pharmacy Meeting		
Where received	**Summary of feedback**	**Actions / Response**

6: Reference documents

6.1 NICE Guidance NG5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes. *March 2015*

6.2 Technical service user safety solutions for medicines reconciliation on admission of adults to hospital. National institute of health and clinical excellence and the national patient safety agency **www.npsa.nhs.uk/corporate/news/guidance-to-improve-medicines-reconciliation**.

6.3 National patient safety agency. Patient safety incident reports in the NHS: Reporting and Learning system Quarterly Data Summary. Issue 11: Feb 2009 – England. 6.5 NHS Specialist Pharmacy Service. Improving the quality of medicines reconciliation. A best practice resource and toolkit. Version 1 June 2015.

7: Bibliography:

None

8: Glossary

None

9: Audit and assurance

Element to be monitored	Lead	Tool	Frequency	Reporting Committee
Medicines Reconciliation KPIs (including pharmacy staff completion rates and time from admission to medicines reconciliation)	Chief Pharmacist	Pharmacist monitoring	Quarterly	Medicines Optimisation Committee
Eclipse Medicines Incidents originating from the medicines reconciliation process)	Chief Pharmacist	Pharmacist monitoring	Quarterly	Medicines Optimisation Committee
Medicines Reconciliation audit	Chief Pharmacist	Audit	Annual	Medicines Optimisation Committee

Appendix 1 Equality Analysis Screening Form

Title of Policy	Medicines Code		
Person Completing this policy	Matthew Haggerty	**Role or title**	Chief Pharmacist
Division	Corporate	**Service Area**	Medical
Date Started	January 2025	**Date completed**	January 2025
Main purpose and aims of the policy and how it fits in with the wider strategic aims and objectives of the organisation.			
This policy outlines the policy and procedures to be followed within Birmingham & Solihull Mental Health Foundation Trust for completing medicines reconciliation processes for patients admitted to inpatient units			
Who will benefit from the proposal?			
Service users and all clinical staff involved in medicines reconciliation.			
Does the policy affect service users, employees or the wider community? ***Add any data you have on the groups affected split by Protected characteristic in the boxes below. Highlight how you have used the data to reduce any noted inequalities going forward***			
Service users and staff			
Does the policy significantly affect service delivery, business processes or policy? ***How will these reduce inequality?***			
The policy is central to the accurate prescribing, dispensing and administration of medicines to service users following admission to inpatient units			
Does it involve a significant commitment of resources? ***How will these reduce inequality?***			
All patients are eligible to receive medicines on admission to an inpatient unit. This policy sets how clinical staff ensure service users are prescribed, dispensed and administered all appropriate medicines on admission to an inpatient unit			

Does the policy relate to an area where there are known inequalities? (e.g. seclusion, accessibility, recruitment & progression)				
No				
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
Does this policy promote equality of opportunity? ***Yes*** *Eliminate discrimination?* ***No impact*** *Eliminate harassment?* ***No impact*** *Eliminate victimisation?* ***No impact***				*Promote good community relations?* ***No impact*** *Promote positive attitudes towards disabled people?* ***No impact*** *Consider more favourable treatment of disabled people?* ***No impact*** *Promote involvement and consultation?* ***No impact*** *Protect and promote human rights?* ***No impact***
Please click in the relevant impact box and include relevant data				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit regardless of age.
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your policy? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit regardless of any disability.
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit regardless of gender.

This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your policy?				
Marriage or Civil Partnerships	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit. Marital status or being in a civil partnership should not affect this.
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit especially any female patients during pregnancy or if they are breastfeeding.
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation in to pregnancy and maternity?				
Race or Ethnicity	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit regardless of race or ethnicity.
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit regardless of religious belief. Medicines reconciliation may pick up discrepancies in a service users list of medicines that need to take account of their religious beliefs.
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area?				

When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit regardless of sexual orientation.
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment	X			Medicines reconciliation should be carried out to all patients on admission to an inpatient unit including those who are transgender or who have undergone gender reassignment.
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your policy or service?				
Human Rights	X			Medicines reconciliation should be carried out for all patients on admission to an inpatient unit.
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e. Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				
	Yes	**No X**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the policy does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the policy to the Senior Equality and Diversity Lead at bsmhft.edi.queries@nhs.net. The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis

Appendix 2: Medicines Reconciliation- Quick Summary.

Key Components of Medicines Reconciliation:

- Accurate drug history recorded together with sources used (minimum 2 sources).
- Identification of discrepancies between pre-admission and admission medication.
- Discrepancies resolved in an appropriate time scale.
- Written communication of outcomes, to include justification of discrepancies.

Step 1: Identify suitable source of information for medication history:
A minimum of 2 information sources must be used e.g. EPMA and GP summary, ideally both verified with service user. Resolve any discrepancies. Other information sources should be used if information is incomplete to resolve discrepancies.

Step 2: Record information from source 1
Record the name, dose, frequency and route of all medicines currently being taken (immediately before admission). Include medicines bought over the counter or alternative/herbal medicines. The person recording the information should always record the date that the information was obtained and the source of the information used.

Step 3: Record information from source 2
Use the second source to confirm or highlight any discrepancies in the medicines recorded using this first source. Record the date the information is obtained and the source used.

Step 4: Resolve any discrepancies
Document action taken to resolve any discrepancies, which may include consulting additional sources of information. Document the sources of information used.

Step 5: Plan for medicines
Record whether each medicine is to continue, or be amended, withheld or stopped. Record the reason for any changes. Also include any intentional medication additions/changes on admission for service user.

Step 5: Allergies/ Sensitivities
Record details of any allergies/sensitivities.

Step 6: Service user's prescription
Ensure the service user's electronic prescription accurately reflects the list of complied by the medicines reconciliation process as continued or intentionally added medicines. Any medicines that need reviewing (i.e. those withheld) should be action plan to do in a timely manner.

Appendix 3: Medicines Reconciliation Process Flow Chart.

Service User admitted to acute inpatient ward

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Admitting Nurse to identify and collect medicine information from service user (before admitting doctor available):

- Is the service user or their relative able to provide information on medicine taken prior to admission?
- Has service user brought in medicine from home (PODs) or any other information sources for medicine reconciliation i.e GP repeat prescription, clinic letter, nursing or residential home charts, other hospital transfer summaries etc?
- If the service user is known to Trust mental health services, are there appropriate records of current medication, e.g. a RiO entry, EPMA record, home treatment or community prescription?
- Contact the GP to request medication and allergy information for service user as soon as possible after admission

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Admitting Nurse to handover information collected to the Admitting Doctor

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Admitting Doctor to review information and collect any outstanding information from service user/sources available:

- Review information collected by the admitting nurse, if any information from above list is outstanding, attempt to collect.
- If service user/carer or relative available to contribute towards medicine history taking discussion - document on RiO Progress Notes the name, dose, frequency and route of all medicine taken including compliance.
- Use information to compile a list of medicine taken by service user immediately prior to admission – document on RiO Progress Notes (information- name, dose, frequency, route, compliance if known, and sources used to obtain information).

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Admitting Doctor to compare information from sources, prescribe treatment and document activity on RiO:

- Use more than one source (if available) to confirm or highlight any discrepancies. This must include information on physical health medicine (medicine prescribed by GP) where possible. If discrepancies identified, attempt to resolve via consulting additional sources.
- Use information to prescribe medicines on the electronic prescription record.
- Documentation on RiO Progress Notes must include the source(s) used to prescribe treatment, rational for stopping, amending, or withholding treatment as well as documentation of any intentional medication additions/changes to treatment on admission.
- Handover medicine reconciliation process to regular medical team/nursing staff - any gaps in the process, outstanding information sources (i.e. GP information) and any unresolved discrepancies should be documented to be followed up in RiO.

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Named Nurse to check GP information is received, if not follow up until available. (Inform regular medication team)

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Regular Medical Team (Resident doctor) review and action handover from admitting doctor

- Review handover from admitting doctor, take action to complete the medicine reconciliation process and resolve any outstanding discrepancies. • If service user/carer or relative was unavailable to contribute towards medicine history taking discussion on admission, re-attempt to obtain information from service user once they are settled.
- Check at least two information sources have been used to confirm medicine taken immediately prior to admission including information physical health medicine. If not, taken action to consult additional information sources and document this on RiO progress notes.
- Liaise with nursing staff to check if GP information has been requested and received. If not requested or requested but not received, re-request information and liaise with GP surgery until received. When received ensure resident doctor is aware to review for omissions / discrepancies. Resident doctor to document review and changes to medicine on RiO Progress Notes.
- Follow up on any outstanding discrepancies, which may include consulting another information source. Document discrepancies and action taken to resolve on RiO Progress Notes. Any unresolved discrepancies should be discussed with consultant.

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Regular Medical Team (Resident doctor) – review electronic prescription and document medicine reconciliation:

- When sufficient information is available (minimum two sources including GP information), no outstanding discrepancies, and information is confirmed with service user (where possible), documentation of the process should be made on RiO Progress Notes with the title 'Medicine Reconciliation'. This must include Medicines reconciled with: (list ALL the sources used – minimum of two); Prior to admission patient prescribed: (list all the medicines including doses and frequency); Allergies: either Nil Known or list of what patient is allergic to and reaction; Prescribing discrepancies identified: (as a list); Action taken to resolve (as a list); and a plan for these to continue, stop, amend, withheld as well as intentional changes to treatment.
- Resident doctor must confirm on RiO they have reviewed the electronic prescription to reflect this plan.

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Consultant to check medicine reconciliation status at service users first ward review. If incomplete, plan to complete the process in MDT action plan.

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Pharmacy Staff to audit medicine reconciliation process has been completed:

- Inform nursing staff/ medical team of incomplete medicine reconciliation process.
- Assist and complete medicine reconciliation process especially with complex queries.