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STATEMENTS ON MEDICINES RECONCILIATION

Reconciliation is at the interface of procurement, clinical pharmacy and patient safety. It is also addressed in the European Statements of Hospital Pharmacy. According to statement 2.7, Hospital pharmacists should be involved in the development of policies regarding the use of medicines brought into the hospital by patients. In addition, according to statement 4.4, all the medicines used by patients should be entered on the patient's medical record and reconciled by the hospital pharmacist on admission. Hospital pharmacists should assess the appropriateness of all patients' medicines, including herbal and dietary supplements. In line with statement 5.6, hospital pharmacists should ensure that high-risk medicines are identified and implement appropriate procedures in procurement, prescribing, preparing, dispensing, administration and monitoring processes to minimise risk. As a result, the hospital pharmacy contribution to medications reconciliation consists of:

- Policy and procedure development
- Implementation and performance improvement
- Training and competency assurance
- Information systems development
- Advocacy

Karapinar, Fatma (Vak..., 13/9/2015 23:46
Comment [1]: This sentence implies medication review and should be removed

Addition to the statements
Definition of medication reconciliation:

- Basic: the process of comparing the medications a patient is taking with newly ordered medications
- Extensive: includes basic evaluation of the medication overview (e.g. obvious errors such as undertreatment, interactions, double medication) and adherence.

Steps	Basic	Extensive
Verification	Collecting an accurate medication history to resolve discrepancies between medication prescribed and/or used at home and the medication record in the hospital	
Clarification	-	Ensure that the medications and doses are appropriate and resolve obvious errors (e.g. double medication, undertreatment)
Reconciliation	Document medication changes and reasons	
Transmission	Educate patient/carer regarding medication changes	+ Transfer information to the next healthcare provider

SPECIFY medication review in the statements to make clear the difference with extensive medication reconciliation (see for example NICE guideline). Medication review is a more in depth review of medication where patient data are used to evaluate every drug a patient uses while med rec focuses on obvious medication errors.

ADD NOTE: In the statements below a Pharmacist can also be the technician supervised by a pharmacist.

0. General Statements

0.1. Med. Rec is essential for safe medical treatment in the hospital setting and the continuum of care.
  0.1.1. Every patient has a right to receive med.rec.
  0.1.2. Patients are counselled regarded intentional medication changes.

Karapinar, Fatma (Vak..., 14/9/2015 00:00
Comment [2]: Statements in the WHO High 5's SOP:
- An up-to-date and accurate patient medication list is essential to ensure safe prescribing in any setting.
- A formal structured process for reconciling medications should be in place cross all interfaces of care.
- Medication reconciliation on admission is the foundation for reconciliation throughout the episode of care.
- Medication reconciliation is integrated into existing processes for medication management and patient flow.
- The process of medication reconciliation is one of shared accountability with staff aware of their roles and responsibilities.
- Patients and families are involved in medication reconciliation.
- Staff responsible for reconciling medicines are trained to take a BPMH and reconcile medicines.

0.2. Med rec is an investment in patient safety in the hospital and the continuum of care and has been shown to be cost-effective.
0.3. A general regulation is needed to implement med.rec. and standardise the med.rec. process.
0.4. Med rec requires trained personnel and the integration of a hospital pharmacist has shown to increase the implementation of a structured med.rec.
  0.4.1. The hospital pharmacist has the overall view of the medication process
  0.4.2. The hospital pharmacist needs to be involved in multidisciplinaire med.rec
  0.4.3. The hospital pharmacist needs to promote the implementation of a structured med.rec.
0.5. Intentional medication changes between the medication prescribed and/or used at home and the medication record in the hospital, including the reason for the change, should be documented.
  0.5.1. The hospital pharmacist resolves unintentional medication changes together with the physician.
0.6. For med.rec. access to relevant patient data has to be granted.
  0.6.1. For med.rec. at least two relevant sources, out of which one is the patient/carer interview needs to be used to assess actual medication use (including adherence).

1. Statements related to Medicines Reconciliation on Admission and transfer

1.1. All the medicines used by patients should be entered on the patient's medical record and reconciled by the hospital pharmacist on admission. Hospital pharmacists should assess the appropriateness of all patients' medicines, including herbal and dietary supplements (statement 4.4 of the European Statements on Hospital Pharmacy).
  1.1.1. Comment from the group: APPROPRIATENESS IS MED REV, There should be a greater emphasis on a multidisciplinary team in the 4.4. European statement
1.2. Within 24 hours, latest at the end of the second day of admission or transfer, med rec should be performed.
  1.2.1. For planned surgical admissions the hospital pharmacist should perform a med.rec. before hospitalisation and evaluate the suitability of the medication, for example discontinuing an anticoagulant

Fatma 12/9/2015 16:57
Comment [3]: Comment of the delegated. Remove this sentence

2. Statements related to Medicines Review for In- and Out-patients

2.1. Hospital pharmacists should identify high-risk medicines and ensure appropriate procedures are implemented in procurement, prescribing, preparing, dispensing, administration and monitoring processes to minimise risk (statement 5.6 of the European Statements on Hospital Pharmacy).
3. Anamnesis, diagnosis, clinical, symptoms, allergies, intolerance, current medication, nutrition, ADE, incompatibilities, interactions, and laboratory data are the substrates hospital pharmacists need to perform medicines reconciliation, review and otimisation.
  3.1.
  3.2.

Fatma 12/9/2015 16:56
Comment [4]: This part has not been discussed. We focused on med.rec.

4. Statements related to Medicines Reconciliation on Discharge

4.1. The hospital pharmacist should be informed in a timely manner of the discharge to perform med.rec.
4.2. Med rec should be performed within 24 hours before a known discharge.
  4.2.1. Additional care should be provided to correct back temporary medication changes made in hospital (e.g. formulary changes, changes due to surgery)
4.3. Patients/carer should receive a written medication summary.
4.4. The next healthcare provider (e.g. general practitioner, nursing home, community pharmacist) needs to receive an updated medication overview