Guidance for health and social care providers

Principles of good practice in medication reconciliation

May 2014
About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high quality and safe care for people using our health and social care services. HIQA’s role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public.

The Authority’s mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

- **Supporting Improvement** – Supporting health and social care services to implement standards by providing education in quality improvement tools and methodologies.

- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.

- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland’s health and social care services.
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Subject

Medication reconciliation

Audience
Service providers

Standards and Regulations relevant to this guidance include

<table>
<thead>
<tr>
<th>Standard</th>
<th>No.</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Standards for Safer Better Healthcare</td>
<td>3.1</td>
<td>Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended)</td>
</tr>
<tr>
<td>National Quality Standards for Residential Care Settings for Older People in Ireland</td>
<td>14 15</td>
<td>Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013</td>
</tr>
<tr>
<td>National Standards for Residential Services for Children and Adults with Disabilities</td>
<td>4.3</td>
<td>21(1)(b) [Sch3(3)(h)]</td>
</tr>
<tr>
<td>National Standard for Patient Discharge Summary Information</td>
<td></td>
<td>21(3) [Sch3] 29</td>
</tr>
</tbody>
</table>

This guidance contains explanations of concepts, illustrative examples and templates that may assist in meeting regulations and implementing standards. There may be other requirements relevant to particular services that are not addressed in this guidance and it is for service providers to identify the regulations, standards and best available evidence relevant to their service. This guidance is current at the time of printing. Please check www.hiqa.ie for the latest version of this guidance.
1. Introduction
Medication management refers to the safe, clinically effective and economic use of medicines to ensure that people using health and social care services get the maximum benefit from the medicines they need, while at the same time minimising potential harm.

Medication safety involves giving the right person the right medication in the right dose at the right time and by the correct route.

In line with the relevant national standards, service providers are expected to have arrangements in place to ensure the safe and effective use of medicines, including assessing, prescribing, dispensing, administering, documenting, reconciling, reviewing and assisting people with their medications. The Authority has produced this guidance to aid service providers in achieving this. In Ireland, the medication incidents most commonly reported to the Clinical Indemnity Scheme (CIS) in 2012 were medication reconciliation incidents.

2. What is medication reconciliation (MR)?
Medication reconciliation is the process of creating and maintaining the most accurate list possible of all medications a person is taking – including drug name, dosage, frequency and route – in order to identify any discrepancies and to ensure any changes are documented and communicated, thus resulting in a complete list of medications.

Medication reconciliation aims to provide patients and service users with the correct medications at all points of transfer within and between health and social care services. It can be considered complete when each medication that a person is taking has been actively continued, discontinued, held or modified at each point of transfer, and these details have been communicated to the next care provider.1

There are three steps in the medication reconciliation process:2

- **Collecting:** This involves the collection of the medication history and other relevant information.
- **Checking:** This is the process of ensuring that the medicines, doses, frequency and routes, etc. that are prescribed for a patient or service user are correct.
- **Communicating:** This is the final step in the process where any changes that have been made to a patient or service user’s prescription are documented,

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1 The National Standards for Safer Better Healthcare; the National Quality Standards for Residential Care Settings for Older People in Ireland; the National Standards for Residential Services for Children and Adults with Disabilities and the National Standard for Patient Discharge Summary Information.
2 The Institute for Healthcare Improvement describes these three steps as ‘verification, clarification and reconciliation.’
dated and communicated to the person to whom the patient’s or service user’s care is being transferred.²

The medication reconciliation process starts when the need arises to transfer or move a person from one service to another. Medication reconciliation is a continuous process and takes place when a patient or service user is admitted to a service, continues whenever the patient or service user is moved or transferred to a different level of care within that service, and occurs again when the patient or service user is discharged from the service.

2.1 Stages for medication reconciliation

Where a person is transferred, for example, from a community residential health or social care setting to an acute hospital and then subsequently discharged back to that setting, four stages for medication reconciliation can be identified. These are laid out below:
The three steps in the medication reconciliation process are required at each one of these four stages. In addition, the definition of a goal or desired outcome for each stage of the medication reconciliation process is essential to facilitate tracking of progress towards those goals.

An example of a goal for Stage 1 would be: ‘the complete, correct and up-to-date medication list is provided for 100% of people transferred from a community residential care setting to an acute setting’.

The three steps in the medication reconciliation process, the four stages at which medication reconciliation is required in this example, and sample goals for each stage are laid out in Table 1 on page 10.

Additional information is available in a recent publication from the Health Service Executive (HSE) that provides practical guidance on the medication reconciliation process as part of the wider discharge and transfer process from hospital.3

3. Background to the medication reconciliation project

In order to provide support to the Irish health and social care system, and help services to implement standards developed by HIQA, the Authority has collaborated with the Institute for Healthcare Improvement (IHI) Open School for Healthcare Professionals to provide education and training, free of charge, to front-line health and social care staff in basic quality improvement science (tools and methodologies).

In 2013, staff from four acute hospitals and six care of the elderly providers undertook the IHI Open School for Healthcare Professionals Programme.

The 2013 programme also involved an action learning component where the staff from the pilot acute hospitals and care of the elderly providers applied the quality improvement knowledge and tools they were learning, via the IHI Open School Programme, to a medication reconciliation quality improvement project.

The purpose of the project was to improve medication reconciliation for residents of nursing homes/community hospitals transferred to acute hospitals for treatment when they became acutely unwell, and who were subsequently discharged back to the nursing home/community hospital.

As part of this project a baseline measurement exercise took place in June 2013 to ascertain the extent to which medication reconciliation was taking place when residents of nursing homes/community hospitals were being transferred to acute
hospitals for treatment and subsequently being discharged back to the nursing homes/community hospitals.

The findings from the baseline measurement exercise highlighted areas that nursing homes/community hospitals and acute hospitals could focus on to improve the overall medication reconciliation process.

The pilot nursing homes/community hospitals and acute hospitals subsequently implemented changes to improve their medication reconciliation processes using plan-do-study-act (PDSA) quality improvement cycles between July and December 2013.

Data from the baseline measurement exercise, and a review of the PDSA cycles undertaken by the pilot sites, highlighted further areas for learning during the 2013 medication reconciliation (MR) project.
Table 1. Medication reconciliation – four stages, goals and three steps:
Example of the transfer of a person from a community residential care setting (CRCS) to an acute hospital (AH) and discharge back to the community care setting (CRCS).

Four stages for Medication Reconciliation:

1. Stage 1: Person transferred from CRCS to AH
   - Goal – The complete, correct and up-to-date medication list is provided for 100% of people transferred.
   - Determine the person’s medication list.
   - Collect the person’s medication list.

2. Stage 2: Person admitted to AH from CRCS
   - Goal – 100% of people admitted from a CRCS have the best possible pre-admission medication checklist collected, checked, communicated and prescribed (or held or discontinued) within 24 hours of admission.
   - Determine the person’s best possible pre-admission medication list (PAML).
   - Check that the medicines, doses, routes, frequencies etc. prescribed for the person are correct.
   - Check that the medicines, doses, routes and frequency etc. that are prescribed for the person are correct.
   - Ensure that the person’s medication list is up-to-date, complete and correct.

3. Stage 3: Person discharged from AH to CRCS
   - Goal – The complete and correct discharge medication prescription / list is received from the AH and transferred to the CRCS medication record / chart for 100% of people within 24 hours of discharge from the AH.
   - Determine the person’s final medication list.
   - Document and date any discrepancies between the person’s prescription and the PAML and communicate these changes to the service where the person’s care is being transferred.

4. Stage 4: Person transferred back to CRCS from AH
   - Determine the person’s best possible pre-admission medication list (PAML).
   - Check that the medicines, doses, routes and frequency etc that are prescribed for the person are correct.
   - Document and date any discrepancies between the person’s prescription and the PAML and communicate these changes to the service where the person’s care is being transferred.

Three steps in Medication Reconciliation:

1. Collect
   - Provide the person’s medication list to the acute hospital.
   - Ensure that the person’s medication list is up-to-date, complete and correct.

2. Check
   - Determine the person’s best possible pre-admission medication list (PAML).
   - Check that the medicines, doses, routes, frequencies etc. that are prescribed for the person are correct.
   - Check that the medicines, doses, routes and frequency etc. prescribed for the person are correct.

3. Communicate
   - Document and date any discrepancies between the person’s prescription and the PAML and communicate these changes to the service where the person’s care is being transferred.
   - Determine the person’s final medication list.
   - Ensure the discharge prescription, including the correct and complete list of continuing medication and communication of in-hospital changes to medication, is provided to the service where the person’s care is being transferred.
4. Learning points

This document outlines the learning from the medication reconciliation quality improvement project undertaken in 2013 and is intended to provide guidance on principles of good practice in medication reconciliation.

The learning points have been grouped around three areas of practice: organisation / structure, communication and documentation. Within each area principles of good practice derived from this project are listed below:

4.1 Organisational-level structure and process to underpin medication reconciliation (MR)

There is a need:

- for each service to review its own requirements for MR – i.e. to ask when and for whom MR is required, identify who completes the MR process, if it happens in/out of hours, what equipment/supplies are required to allow for efficient MR (such as pre-printed checklists, a photocopying facility that is accessible 24 hours a day and produces legible photocopied documents).

- to have an organisational policy and procedure in place on MR.

- for this policy to define a timeframe for completion of the MR process, for example within 24 hours of a person’s entry to a hospital/nursing home/other care setting – regardless of the person’s location within that setting, such as an emergency department or ward.

- to educate staff about the MR process.

- to define and implement the MR process/outcomes/policy and procedure review intervals.

- for continuous quality improvement. It is recommended that progress towards the goals of the MR process be tracked on an active and continuous basis (see Table 1 on page 10).

4.2 Communications around the MR process

- Service user/family involvement is paramount to the MR process. Generally the service user/family should be the first source of information for the MR process and this information can be verified with a second reliable source (such as a medication record from a residential care setting or community pharmacy or general practitioner). Where sufficient clarity is not achieved a third source may be required. Where the service user does
not have the capacity to provide medication information, or is in a
residential care setting, the medication record from that setting may act as
the first source of information.

- Provide service users/family with both verbal and written information
about their medication regime and any changes made.

- An effective MR process involves regular direct communication between
hospital pharmacy services, community pharmacy services, GP services,
nursing homes, and other care settings as indicated by the location of the
person at the time of MR.

- Regular communication helps build relationships between these
stakeholders, which can serve to improve and sustain the MR process.

- ‘Close the Loop’ – when a person is transferred from a care setting, and
the appropriate documentation is transferred with the person, the
transferring service should call and speak to the receiving service to
ensure that all documentation has been received, is complete and has
been understood.

- Where complex or unusual prescription items are required for a person
(for example, drugs requiring advance notice to the Primary Care
Reimbursement Service, dispensed under the High-Tech scheme,
unlicensed or off-label medications), where possible advance notice should
be given to the receiving service to avoid delays in the person receiving
the prescribed treatment.

4.3 Transfer documentation – checklist

- Use of a checklist to facilitate MR at transition points is advisable, such as
at the point of transfer from a nursing home/social care setting to an
acute hospital, or at the time of discharge from an acute hospital to a
nursing home/social care setting.

- The availability of pre-printed service or ward-specific forms may facilitate
the MR process.

- Suggested items for inclusion on a checklist are outlined in the table in
section 5 below. Some of these items may not be relevant for your service
or there may be additional items to include depending on the particular
service setting and whether you are transferring or receiving care of a
person. There are some examples of checklists included in Appendix 2 of
this document, provided by nursing home, acute hospital and palliative
care settings.
5. Items to consider for inclusion on a checklist to facilitate MR

<table>
<thead>
<tr>
<th>Patient demographics and characteristics</th>
<th>Other information required</th>
</tr>
</thead>
<tbody>
<tr>
<td>• name</td>
<td>• list of pages from medication record to include on transfer (see below)</td>
</tr>
<tr>
<td>• date of birth</td>
<td>• ensure all pages being sent as part of the transfer are numbered – i.e. page 1 of 4 etc.</td>
</tr>
<tr>
<td>• address</td>
<td>• contact name and number of the prescriber</td>
</tr>
<tr>
<td>• allergy status</td>
<td>• contact names and numbers for relevant acute hospital (ward), nursing home, community pharmacy, GP.</td>
</tr>
<tr>
<td>• note of swallowing difficulties, if any, and if liquid or crushed medicines are required</td>
<td></td>
</tr>
<tr>
<td>• date and time of transfer</td>
<td></td>
</tr>
<tr>
<td>• person completing checklist (signature).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Record of communication</th>
<th>Pages from medication record to photocopy, number and send with patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>• note of call made to receiving service to confirm they received the MR information sent</td>
<td>• current regular medication list</td>
</tr>
<tr>
<td>• time that MR was completed, and name and signature of person who completed it</td>
<td>• PRN medication (as required) list</td>
</tr>
<tr>
<td>• note of two sources of verification used for the MR process (i.e. patient/carer, medication record from residential setting, community pharmacy, GP, other)</td>
<td>• administration record of regular and PRN medications up to point of transfer</td>
</tr>
<tr>
<td>• record of queries raised during MR process and resolution of same</td>
<td>• three/six-monthly medications and when last administered</td>
</tr>
<tr>
<td>• at discharge – note and rationale for new medications started or of changes to pre-admission medications.</td>
<td>• include oxygen prescription and rate/nebulisers</td>
</tr>
<tr>
<td></td>
<td>• include nutritional supplements</td>
</tr>
<tr>
<td></td>
<td>• include anticoagulant dose and target international normalised ratio (INR)</td>
</tr>
<tr>
<td></td>
<td>• recent antibiotic history</td>
</tr>
<tr>
<td></td>
<td>• other medication history relevant to presenting complaint.</td>
</tr>
</tbody>
</table>
References


Additional resource:

### Appendix 1. Medication Reconciliation Project Advisory Group membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marie Kehoe-O’Sullivan</td>
<td>Chair, Director, Safety and Quality Improvement, HIQA</td>
</tr>
<tr>
<td>Ailis Quinlan</td>
<td>Head of Clinical Indemnity Scheme</td>
</tr>
<tr>
<td>Anne Marie Cushen</td>
<td>Chief II Pharmacist and Medication Safety Officer, Beaumont Hospital</td>
</tr>
<tr>
<td>Brigid Doherty</td>
<td>Patient Focus</td>
</tr>
<tr>
<td>Ciara Kirke</td>
<td>Drug Safety Co-ordinator, Tallaght Hospital</td>
</tr>
<tr>
<td>Clare Mac Gabhann</td>
<td>Interim Director Nursing/Midwifery (Prescribing), HSE</td>
</tr>
<tr>
<td>Colin Bradley</td>
<td>Professor of General Practice, UCC</td>
</tr>
<tr>
<td>Christine Brennan</td>
<td>Department of Health</td>
</tr>
<tr>
<td>Denis O’Mahony</td>
<td>Consultant Geriatrician, CUH, Senior Lecturer in Medicine, UCC</td>
</tr>
<tr>
<td>Elaine O’Connor</td>
<td>Programme Manager, HIQA (resigned April 2014)</td>
</tr>
<tr>
<td>Kevin O’Carroll</td>
<td>Manager, Standards and Technology, HIQA</td>
</tr>
<tr>
<td>Mike Scott</td>
<td>(External Advisor) Head of Pharmacy and Medicines Management, Northern Health and Social Care Trust</td>
</tr>
<tr>
<td>Niamh Arthur</td>
<td>Pharmacovigilence Officer, Irish Medicines Board</td>
</tr>
<tr>
<td>Nuala Prendeville</td>
<td>Community Pharmacist, HSE West</td>
</tr>
<tr>
<td>Tamasine Grimes</td>
<td>Associate Professor, Faculty of Health Sciences, TCD</td>
</tr>
<tr>
<td>Tim Delaney</td>
<td>Head of Pharmacy, Tallaght Hospital/former National Lead, Medication Safety Programme, HSE</td>
</tr>
</tbody>
</table>
Appendix 2. Examples of checklists

See the following pages for four examples of checklists. (Please note that these checklists were produced by the pilot sites and not the Authority).

These checklists were developed by the pilot sites in the medication reconciliation project during 2013. The Authority is very grateful to these sites for their willingness to share their work:

1. **St Vincent’s Hospital, Athy** – this checklist was developed to facilitate the medication reconciliation process when a person is transferred from the residential care setting for older people at St Vincent’s to the acute care setting.

2. **Naas General Hospital to St Vincent’s Hospital, Athy** – this checklist was developed to facilitate the medication reconciliation process when a person is transferred back to their residential care setting from Naas General Hospital.

3. **St Brendan’s Community Nursing Unit, Loughrea, Co. Galway and Portiuncula Hospital, Ballinasloe, Co. Galway** – this two-page checklist was developed to support the medication reconciliation process between these two care settings, i.e. transfer from a residential care setting for older people to the acute setting at Portiuncula and the re-transfer back.

4. **Marymount University Hospital and Hospice** (St Patrick’s Hospital) developed this checklist for when a person is transferred from hospice care to the acute setting.
Examples of checklists

PATIENT TRANSFER FORM

Name: ____________________________ Le Chéile Ward - Ext. No: 059 8643016
Marital Status: ____________ Religion: ____________________________
N.O.K: ____________________ Relationship: ____________ Contact Phone No:________________________
Notified of Transfer: Yes No Comment:_________________________
Reason for transfer: ____________________________

Doctor’s Letter enclosed: Yes No K.Doc / Doctor’s Name: ____________________________

Comments: ____________________________________________

Past Medical/Surgical History: ____________________________

Medication History: A photocopy of all current prescribed medication and administration records (see list below) must accompany the patient/resident.

Front cover page of Medication Record Yes No
PRN Medication Sheet Yes No
Short term Drug Orders Sheet Yes No
Regular Drug Orders Sheet (s) Yes No
Drug Administration Record of drugs given on day of transfer Yes No
Warfarin Prescription/Administration Sheet Yes No
Long Acting Injection Prescription/Administration Sheet Yes No

Known Drug Allergies/Reactions: ____________________________

Bradent Score □□□ □□□ Date last completed: ____________________________

MMSE Score □□□ □□□ Date last completed ____________________________
# Examples of checklists

## Barthel Activity of Daily Living Scale – Current Status

<table>
<thead>
<tr>
<th>Bowels:</th>
<th>Score</th>
<th>Mobility:</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0- Incontinent</td>
<td></td>
<td>0- Immobile</td>
<td></td>
</tr>
<tr>
<td>1- Occasional incontinence</td>
<td></td>
<td>1- Wheelchair independent</td>
<td></td>
</tr>
<tr>
<td>2- Continent</td>
<td></td>
<td>2- Walks with the help of 1 person</td>
<td></td>
</tr>
<tr>
<td>3- Independent</td>
<td></td>
<td>3- Independent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bladder:</th>
<th></th>
<th>Dressing:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0- Incontinent or catheterised &amp; unable to manage</td>
<td></td>
<td>0- Dependent</td>
<td></td>
</tr>
<tr>
<td>1- Occasional accidents (max x 1 per 24hrs)</td>
<td></td>
<td>1- Needs Help</td>
<td></td>
</tr>
<tr>
<td>2- Continent (for over 7 days)</td>
<td></td>
<td>2- Independent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grooming:</th>
<th></th>
<th>Cooking/Feeding:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0- Needs help</td>
<td></td>
<td>0- Unable</td>
<td></td>
</tr>
<tr>
<td>1- Independent</td>
<td></td>
<td>1- Needs Help</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2- Independent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bathing:</th>
<th></th>
<th>Stairs:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0- Dependent</td>
<td></td>
<td>0- Unable</td>
<td></td>
</tr>
<tr>
<td>1- Independent</td>
<td></td>
<td>1- Needs Help</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2- Independent</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transfers:</th>
<th></th>
<th>Toilet Use:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0- Unable</td>
<td></td>
<td>0- Dependent</td>
<td></td>
</tr>
<tr>
<td>1- Major help</td>
<td></td>
<td>1- Needs some help</td>
<td></td>
</tr>
<tr>
<td>2- Minor help</td>
<td></td>
<td>2- Independent</td>
<td></td>
</tr>
<tr>
<td>3- Independent</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Score**  /20

## Diet

- Regular: 
- Soft:   
- Diabetic:   
- Other: 

## Swallowing Difficulties?

- Yes  
- No  

## Infectious Conditions / Current Status

- MRSA Positive: 
- Yes  
- No  
- C.Diff Positive: 
- Yes  
- No  
- Other: 

**Comment:**

---

## Falls Risk

- Med 
- High 
- Falls Risk Programme in Place? 
- Yes  
- No  

## Bed Alarm

- []  
- Chair Alarm 
- []  
- Low Bed 
- []  
- Falling Star 

## Wounds

**Comments:**

---

## Additional Information

---

**Signature:**  
**Date:**  

Examples of checklists

Patient/Resident’s Transfer/Admission from Naas Hospital.

Medication Reconciliation Check List

Name: ____________________________

Date of Transfer: _______________  Ward: _______________

Notified of Transfer: Yes  No

Comment: ____________________________

Doctor’s Transfer Letter enclosed  Yes  No

Medication History:

<table>
<thead>
<tr>
<th>Medication Prescription sent back with Resident.</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to prescription documented</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Rationale for any changes to prescription documented</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Details of Drugs administered on day of transfer back to SVH.</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>Supply of medicines sent with resident</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Prescribing in St Vincent’s Hospital

<table>
<thead>
<tr>
<th>Resident seen and admitted by hospital medical officer on day of admission</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication review completed by SVH medical officer.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Medications accurately prescribed on to resident’s Drug Kardex on day of admission</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Signature: ____________________________  Date: ____________________________
Examples of checklists

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Retail Pharmacy Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Write addressograph here)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D.O.B.:</th>
<th>Ward Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct Tel. No.:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chart No:</th>
<th>Board No:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Weight (kg):</th>
<th>Height (cm):</th>
</tr>
</thead>
</table>

**PHB STAFF ONLY - ADMISSION DATA:** NOTE - All Pre-admission details below must be verified with the source and documented on page 3 of the Drug Chart.

Ensure to identify 2 sources and number as appropriate on the medication reconciliation section of the drug chart. Indicate also if information received by Phone / Fax / Letter.

**NOTE:** Any discrepancies with regard to medications prescribed should be documented in the Comments/Communication section of the Drug Chart - pages 2 & 3.

If there is any discrepancy between the 2 sources used, a third source i.e. GP surgery may be required.

Sources should be made aware of any discrepancies in the medication history their facility provided.

Documentation should clearly explain this on page 3 in the medication reconciliation section of the drug chart.

**Allergies/Sensitivities (please detail):**

**Please tick as appropriate:**
- No swallowing difficulties
- PO with swallowing problems - Tablet/capsules only (crushing required)
- Crushing & thickened liquids required
- NG Tube or PEG Feeding or Other Please specify:

<table>
<thead>
<tr>
<th>CHECKLIST</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
</tr>
</tbody>
</table>

Have all the active page numbers of drug chart been checked

**Copy of Medication chart checked to include (tick to indicate you have checked each item below):**

- Front cover page of medication record
- Drug / Dose /Frequency/Route for all regular medications
- PRN medication
- Warfarin / Anticoagulants if applicable.
  - Specify Indication: Target INR: 
- Also last reading of INR: usual Warfarin dose:
- Injectable - IV/IM/Subcut injections or infusions if applicable
- Inhalers/Nebules if applicable
- Patches if applicable
  - Specify last administration time:
- Depot injections if applicable
  - Specify last administration date:
- Topical if applicable
  - Specify site of application:
- Eye/ear/nose if applicable
  - Specify site of application:
- Feeds/Nutritional Supplements if applicable. Product: Frequency:
- Oxygen Therapy: Specify details -

**Double check of time that drugs were administered up to prior to transfer.**

**NOTE:** Photocopy of kardex should indicate administration times. Specify last admin time Time:

**Previous recent antibiotic history if relevant for an infective admission**
(Note past 12 weeks particularly in the case of C.Diff infection)

**Relevant Comments:**

Name of Pharmacist Med. Rec. on Admission: Date: Time:
Examples of checklists

Portiuncula Hospital, Ballinasloe, Co. Galway
Pharmacy Department Telephone No.: (090) 96 48221 Fax No(090) 96 48221
PATIENT MEDICATION DISCHARGE CHECKLIST REFERRAL

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Chart No:</th>
<th>Chart No:</th>
<th>NB: PLEASE PHOTOCOPY &amp; SEND A COPY BACK TO THE NURSING HOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>affix addressograph here</td>
<td>Board No:</td>
<td>Board No:</td>
<td>Ward Name: Direct Tel. No:</td>
</tr>
<tr>
<td>D.O.B.:</td>
<td>Consultant:</td>
<td>Consultant:</td>
<td>Discharge Date &amp; Time:</td>
</tr>
<tr>
<td>Weight (kg):</td>
<td>Height (cm):</td>
<td>Height (cm):</td>
<td></td>
</tr>
</tbody>
</table>

DISCHARGE DATA:
The following checklist should be used to ensure that all medication related discharge information is communicated to the Care Facility and the Retail Pharmacy as appropriate.

Allergies/Sensitivities (please detail):

Please tick as appropriate:
- No swallowing difficulties ☐
- PO with swallowing problems - Tablet/capsules only (crushing required) ☐
- Crushing & thickened liquids required ☐
- NG Tube ☐ PEG Feeding ☐ or Other ☐ Please specify:

CHECKLIST

Copy of Discharge Prescription faxed to nursing home and retail pharmacy.
Ensure number of active pages are clearly identified i.e. 1 of 2, 2 of 2.

Tick to indicate you have checked each item below has been prescribed below on discharge

Drug / Dose /Frequency/Route for all regular medications

PRN medication

Warfarin / Anticoagulants if applicable. Attach a photocopy of relevant information if applicable

Injectables - IV/IM/Subcut injections or infusions if applicable

Inhalers/Nebules if applicable

Patches if applicable Specify last administration time: ________

Depot injections if applicable Specify last administration date: ________

Topical if applicable Specify site of application: ________

Eye/ear/nose if applicable Specify site of application: ________

Feeds/Nutritional Supplements if applicable

Oxygen Therapy

Indicate times that drugs were administered up to on the day of discharge.
NOTE: Discharge Prescription should clearly indicate all administration times for all drugs and clearly indicate drugs that are stopped or changed and the reason why.

Retail Pharmacy contacted if necessary. Contact No.:

Name:

Contact No.:

Care Facility contacted if necessary.

Name:

Contact No.:

Relevant Comments:

Name of Pharmacist Med. Rec. on Discharge: ______________ Date: ________ Time: ________
Examples of checklists

Resident/Patient Transfer Form

Transferring To: __________________________ Date of Transfer: ____________

Name: __________________________ Date of Birth: ____________

Address: __________________________________________

Medical Card No: __________________________ Religion: ____________

Marital Status: ____________ Last Received Sacrament of the Sick on: ____________

Admitted to St Patrick’s Hospital for: Continuing Care ____________ Palliative Care ____________ Respite Care ____________ on ____________

Next of Kin: __________________________ Phone No: __________________________

Address: __________________________

Family Member Informed of Transfer: Yes ____________ No ____________ Name: __________________________

G.P: __________________________ Phone No: __________________________

Address: __________________________

Previous History:

________________________________________

________________________________________

________________________________________

MRSA Status: Positive □ Negative □ Not Known □ Other Known Infections ____________

Current Symptoms / Reasons for Transfer:

________________________________________

________________________________________

________________________________________

Medications (to include Nutritional Supplements)
All medications due today have been administered up until ____________ am/pm (see copy of drug chart enclosed)

With the exception of the following:

1. __________________________ Last Given ____________ 2. __________________________ Last Given ____________

3. __________________________ Last Given ____________ 4. __________________________ Last Given ____________

5. __________________________ Last Given ____________ 6. __________________________ Last Given ____________
Examples of checklists

Mental State: ___________________________________________

Skin: __________________________________________________

Mobility: _______________________________________________

Risk of Falling: Yes □ No □ History of Wandering: Yes □ No □ Not Known □

Sight: __________________________________________ Hearing: __________________________

Diet: __________________________________________________

Assistance with Meals Required: Yes □ No □ Dentures: Yes □ No □

Assistance with Personal Hygiene: Yes □ No □

Continence: Urine: Yes □ No □ Occasional Incontinence Faecal: Yes □ No □ Occasional Incontinence Catheterised: Yes □ No □

Further Information:

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

Transfer check list:

1. Photocopy and fax front cover and all completed pages of the drug chart to include:
   - PRN medications
   - Anticoagulant medications (e.g. warfarin)
   - Syringe driver prescriptions (on a separate CSCl prescription chart)
   - Patches (e.g fentanyl) and date they are due to be next changed
   - Depot injections (and the date they are next due)
   - Antibiotics (past history where possible)

2. Drs Transfer letter (including printed name and contact number of prescribing Dr)

3. A photocopy of DNAR form

Form Completed By:

Print name: ____________________ Sign name: _______________ Position: RGN/other Date: ____________________

Transferring from: ____________________ Ward/Department, St Patrick’s Hospital (Cork).