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Standard Operating Procedure (SOP) Number:

SOP Title: Medication History Taking

Classification :	Standard Operating Procedure
Authors Name:	
Authors Job Title:	**Specialist Pharmacy Technicians**
Authors Division:	**Core Clinical – Cancer and Pharmacy**
Departments/Group this Document applies to:	**Pharmacy**

Approval Group: Pharmacy Management Group, Pharmacy Clinical Improvement Group, Pharmacy Operations Group, Prescribing and Medicines Safety Group.	**Date of Approval:**	
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Scope: Pharmacy Department		**Document for Public Display:** No

To be read in conjunction with the following documents:
· Pharmacy Procedure for Labelling and Dispensing(PHDI01)
· Pharmacy Procedure for Near Miss and Error Incidents (PHDI45)
· Pharmacy Guidance for Assessment and Provision of Compliance Aids (PHDI35)
· Pharmacy Procedure for completing EPMA TTOs with Green Bags(PHDI44)
. Pharmacy Procedure for Medicines Reconciliation
· GPhC Standards for Pharmacy Professionals
· Medicines, Practice and Ethics- A guide for Pharmacists
· Current NHS/MHRA Safety Alerts
· Trust Uniform and Dress Code Policy
· Trust Infection Control Manual
· Trust Policy for Medicines Management
· Trust Policy for Use of Patients Own Drugs
· Self-Administration of Medicines by Adult Inpatients Policy

Index (This is an automatic index for assistance please speak to your Governance Business Partner)

SOP Statement

This procedure describes the processes which must be followed by all Pharmacy staff (following completion of the associated training and, where appropriate, competencies) when undertaking medication history taking. A medication history is defined as "An accurate list of all current and recently prescribed drugs including any over-the counter medications, herbal or alternative medicines, previous adverse drug reactions (including hypersensitivity reactions), and an assessment in adherence to therapy." (1)

An accurate medication history is important as it is the basis for ensuring the patient is taking the correct medication whilst they are in hospital as part of the medicines reconciliation process (defined as "The process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising and resolving any discrepancies, and documenting any changes, thus resulting in a complete list of medicines, accurately prescribed/communicated." (2).

Executive Summary

All healthcare professionals are accountable to the Trust and to their professional bodies in terms of standards of practice and codes of conduct and must adhere to their professional practice guidelines. In addition all healthcare staff should act in accordance with the medicines management policy and related medicines procedures. Where that is not clinically appropriate or

possible e.g. in a major incident all healthcare staff must be prepared to justify their decisions and actions where they differ from the agreed policies and procedures.
All healthcare staff are accountable for their practice and must work within their scope of competence and are accountable for their actions and responsible for the tasks they undertake. They must highlight to their manager when a task is beyond their knowledge, skill or experience. All healthcare staff must ensure that they have received the necessary training, maintain competences expected and required, and that they maintain and update their knowledge and skills in the relevant area of practice.

1.0 Roles and Responsibilities:

Ward based Pharmacy staff must aim to start taking a comprehensive medication history from each patient admitted to a ward area that is covered by MKUH ward pharmacy service, within 24 hours of admission. Exceptions to this will occur at weekends and Bank Holidays depending on service availability and staffing levels.
All staff are responsible for adhering to this and all other relevant Trust procedures.
All staff are responsible for Patient Safety and reporting of errors, near misses, and other incidents.
All staff are responsible for promoting and supporting the safe and secure handling of medicines
Directorate Technicians are responsible for ensuring MMTs are following this procedure and escalating any issues to the lead Pharmacist for the relevant clinical area.
Directorate Pharmacists are responsible for ensuring Pharmacists are following this procedure and are acting on any issues or escalating as required.

2.0 Implementation and dissemination of document

Following ratification this document will be available to all staff via Microsoft Teams/Sharepoint.
All Pharmacy staff will be made aware of where to locate the procedure on induction. Information will be cascaded through department/section meetings.

3.0 Processes and procedures

Abbreviations used
DHx = Drug history
eCARE = Electronic patient record system used by MKUH
ED = Emergency Department
EDM = Electronic Document Management system (where documents are stored from G.Ps, Clinics, Hospitals, etc.)
HIE = Health Information Exchange (G.P. Medication records used for drug histories)
HPC = History of Presenting Complaint (reason for admission to hospital)
ICU = Intensive Care Unit
JAC = Pharmacy computer system
MAR = Medicines Administration Record (Used in Care or Residential Homes, or at home by carers)
MDS = Monitored Dosage System (A common type of compliance aid)
MH = More at Home (of patient's regular medication)
NKDA = No Known Drug Allergy
NoK = Next of Kin
OTC = Over The Counter Medication
PMH = Previous Medical History
PODs = Patient's Own Drugs
SCR = Summary Care Record. (from G.P.)
TTO = Discharge prescription or To Take Out medication (labels produced with complete instructions, patient details, drug, strength, dose, frequency, amount.)

Definitions

Adherence = The extent to which the patient is taking their medicines compared to the prescribing recommendations. Adherence presumes an agreement between prescriber and patient about the prescriber's recommendations. (3).

Transfer = An interface where prescribing is reviewed and potentially amended. Therefore there is a higher risk of errors occurring at this stage. Transfer includes: Change of specialty e.g. transfer from acute medical to a rehabilitation bed; Change in level of care e.g. transfer down from ICU; Post-operatively i.e. transfer from theatres to general wards; Transfer between wards because of availability of beds; Transfer to off-site wards including off-site wards belonging to other Trusts. (4)

3.1 Read the patient's admission notes

1. If the patient was admitted via ED there should usually be an "ED Definitive Assessment MKFT" note which has a basic introduction to the reason for admission and the patient's history
2. All patients should have a note title containing "Clerking" regardless of the route of admission. This note will have more detail than the ED note and is usually written by the ward doctor so will be more specialised. Look for:
    a. Background / PMH / HPC – this will detail any diseases that the patient may have and may tell you about any recent interactions with healthcare providers.
    b. DHx – The medication history may be recorded
    c. Social history – this can help to identify if the patient is responsible for their own medication administration, or if there is a carer / NoK that could be contacted to find out more.
3. Depending on the information you find in the clerking notes you may need to look further into the clinical notes to find entries from other specialities such as Nursing staff, Physiotherapists, or specialist Doctors.

Use the information in the notes to (i) be aware if the patient is likely to be able to communicate with staff, (ii) ensure questions to patients do not cause upset and distress (iii) as a guide to identifying which sources of information will be useful to obtaining a complete drug history. For worked examples of this please see appendix 3.

You may find helpful information to be aware of when questioning the patient, for example if they have hearing difficulties, sight loss, or do not speak English as a first language. This may help you prepare by knowing whether to take extra resources such as paper to write your questions.

Sometimes this information may not be documented in the notes. If you cannot find the "ED Definitive Assessment" or "Clerking Note", you are not expected

to look in any other notes to find this information for the purposes of medication history taking.

3.2 Introduce yourself to the patient

Remember to use 'Hello my name is' and explain your role. Always ask the patient's consent to talk to them about their medicines before proceeding. If needed, explain what you are doing and the reason for performing your role but remember that your patient has the right to refuse to give consent. If consent is refused discuss how to progress the history with a senior in your team. Every effort should be made to get consent however when this is not given document your progress in the notes in a clear, concise, and professional manner, and inform the doctors looking after the patient of their decision so an MDT decision can be made in the best interests of the patient.

Pharmacy staff involved in providing direct patient care are able to access health records without consent under the Data Protection Act 2018 and the best interests of the patient should be considered before proceeding. Respect the patient's right to confidentiality. If there is anyone else present e.g. a friend, relative or carer, ask the patient if they are happy for you to continue with them present, if not advise them where they can wait while you speak to the patient.

3.3 Obtain a medication history

Use the sources from a minimum of 2 groups below. This list is not exhaustive and professional judgement must be used. The number and nature of sources will vary from patient to patient and there is no one solution for all patients. A suggested flow chart is available in Appendix 1 and a further explanation of the sources is in Appendix 2.

Any medications taken in the last 3 months, and all current medications must be recorded. A medication is considered current if the patient takes either on a regular or 'when required' basis for any ongoing conditions regardless of issue date or where this item is obtained from.

3.3.1   Sources of Information

Group 1:

Patient / Carer / Next of Kin. This should be the first option where possible; always involve the patient.

Group 2:

Patients Own Drugs (PODs) including compliance aids. See Trust policy for guidance in assessing PODs for suitability.

Group 3:

Summary Care Record (SCR), Health Information Exchange (HIE), or GP surgery.

Repeat Prescription copy use if dated within the last 6 months.

Specialist services external to MKUH (e.g. Mental Health Liaison Team or District Nurses)

Community Pharmacy. Record the location, contact details, and name of the staff member you spoke to on the "medication history" eCARE task.

Local substance misuse service. Record the contact number, keyworker's name, and patient's collection arrangements on the "medication history" eCARE task.

Group 4:

Medication Administration Record (MAR) chart. Record the details of where the chart is from and the date issued on the "medication history" eCARE task.

Transfer notes from another hospital. Record the medications that the patient was taking prior to being admitted to hospital as well as any updates to those items detailed on the transfer letter.

Care Home / Care Agency. Record contact details and any medication administration arrangements on the "medication history" eCARE task.

Group 5:

Previous Discharge Prescriptions (TTOs) within the last 3 months. Record the name of hospital and date of discharge on the "medication history" eCARE task.

JAC dispensing records

Specialist services within Pharmacy (e.g. Oncology Pharmacist or Anticoagulant Pharmacist)

Group 6:

Electronic Document Management system (EDM)

Healthcare at Home or any other healthcare provider

Notes:

Include any Over the Counter, Alternative, or Herbal products when recording a medication history.

A medication history is complete when the person performing the history is satisfied that there is no further information to add, from the information sources that are available.

3.3.2 Recording the History

Each item in the medication history must be recorded on eCARE.

1. Access the patient's record on eCARE and click on "Requests/Care plans"
2. Click on 'document medication by history'
3. Click on "Add" and search for the drug. Picking an 'order sentence' with pre-populated details is recommended whenever this option is available.
4. Complete the "dose", "route", "frequency", and "form" fields.
5. Additional information must be added to the item where necessary. Use the "special instructions" box for information that needs to be communicated to the patient/GP on discharge, and use "order comments" for information you do not want to be on the discharge letter but is relevant for the patient's care. For specific examples of information, see the notes at the end of this process.
6. Click on "Document history" to save the details you have entered.

Notes:

If another healthcare professional has already documented some medications as history in the current encounter, these must be modified if details need to be amended. Right click on the item and choose the "modify" action. Do not void the item unless the incorrect drug description has been selected.

Remove any incorrectly documented items by right clicking and choosing the "void" action. Do not use the "Cancel/DC" action as this will record the item as stopped on the discharge letter and this action cannot be undone.

Prescribed and documented medications from previous encounters are retained on the "document history" screen for a set period post discharge and are there for your information only. They must be removed from the screen by right clicking and choosing the "complete" action. If this option is not present because the item does not have a frequency, then use the "void" action. Do not "discontinue" items as they will be added as a stopped medication on the current discharge letter and this cannot be undone.

Examples of information to add to each item includes (but not limited to)

     i. The brand/manufacturer of the medication where clinically relevant. Add this to the "special instructions" box.

    ii. Repeat medications do not need an endorsement to state this. Acute medications must specify "acute issue" and the date of issue in the "order comments" box:

    iii. Medications administered on specific days or times must be documented when confirmed with the patient. This information

must be entered into the "special instructions" box. Examples include:

1. Parkinson's Medications must have the time of administration documented

2. Oral Methotrexate must have the strength and quantity of tablets taken as well as the day of administration
3. HRT patches applied "TWICE a WEEK" must have the days that the patient applies them.
4. Hydroxocobalamin must have the date of last and next administration
5. If the time of administration is known, this must be specified using one of the frequencies (e.g. "ONCE a day (morning)") or by using the "special instructions" box if there is not a matching pre-built frequency.

iv. Any stopped medicines (repeat or acute) should have the reason for stopping recorded as well as the previously taken dose and frequency. Use the "order comments" to record this information to ensure the information is visible to both Pharmacy and Doctors.

Other adherence issues must be documented in the "order comments" as well as adding to the "medication history" form (see 3.5 below)

v. Any devices or aids must be documented in the special instructions of the relevant item e.g "via spacer" or "Flexpen"

vi. If the item is added to the patient's dosette box, it must be endorsed with "MDS" in the "special instructions" box. The time of day that it is in the box for administration must be recorded as above.

Details for Metformin

Dose	Route of Administration	Frequency	Duration
500 mg	oral	TWICE a day	

Drug Form: tablet
Special Instructions: MDS - morning and evening
Stop Date/Time: **/**/**** GMT
Dose Change Reason: N/A
Pharmacy validation:

PRN:
Indication:
Start Date / Time: 26/10/2020 1405 GMT
Admission Med: ○ Yes ○ No
Pharmacy supply:
GP to Continue:

vii. If the patient has brought in their own supply, you must record the quantity in the "pharmacy supply" box. Endorse "POD" followed by the quantity you have checked.

When the DHx has been obtained from the patient or NOK, how the patient currently takes the medication should be recorded in the dose/frequency boxes when documenting an item. When this differs from another source, this discrepancy must be recorded in the 'order comments' tab so that it is clearly communicated.

Pending Home Medications
Doxazosin — Document — DOSE: 8 mg - ROUTE: oral - tablet - ONCE a day - START: 18/Dec/20 17:37 GMT
SCR states 4mg OD but patient says dose was increased after renal consultant clinic in November

Details for Doxazosin
Order comments
SCR states 4mg OD but patient says dose was increased after renal consultant clinic in November

For High risk medications and any dose/frequency outside of BNF ranges, the detail must not be documented in the labelled boxes to ensure the prescription is completed by a prescriber before reconciling.

Pending Home Medications
Apixaban — Document — - ROUTE: oral - tablet (film coated) - TWICE a day - START: 31/Mar/21 13:43 BST
Prescribed 5mg BD by GP and documented on SCR but patient says she takes 2.5mg BD after being advised due to side effects.

Details for Apixaban
Order comments
Prescribed 5mg BD by GP and documented on SCR but patient says she takes 2.5mg BD after being advised due to side effects.

> **Commented [MB1]:** After discussion with Michael I understand what is meant and the reasoning. It is not very clear. Looking at the second pictorial examples below, I believe this is how these discrepancies will be documented. Could this be changed with reference to the picture 'e.g.... outside of BNF ranges, these details should be left bank and the information documented in 'order comments' to ensure the prescription is modified by a prescriber before reconciling (see figure x)'

Do not untick the "Leave Med History Incomplete…" option on the "document history" screen. The Pharmacist uses this to indicate the medicines reconciliation, including the resolution of all discrepancies, is complete. An MMT must not untick this box. See procedure for Pharmacy Medicines Reconciliation for further details.

3.4 Record the allergies

Recording the patient's allergies is an important part of the medication history.

1. Click on the allergies hyperlink in the patient's banner bar at the top of the screen or click on "Allergies" on the left side of the screen
2. Review the content and click on "OK" if no further action is needed.
3. To add a new medication allergy
   a. Click on "Add"
   b. Change the "type" of reaction as necessary based on the information you have obtained from the sources
   c. Type the drug name into the "substance" search box and press "enter"
   d. Select the medication from the options presented by double clicking or left click once and press "ok"
   e. Complete the "reaction" box. Freetext entry is allowed for this field.
   f. The "severity" box can be completed if known, and add comments as necessary
   g. Complete the "info source" box
   h. Complete the "category" box
   i. Click on "ok" to finish documenting the allergy

| Type | Allergy | An adverse reaction to a drug or substance which is due to an immunologic response. |

*Substance

Lorazepam   Free text

Reaction(s):	*Severity	Info source	Comments
Add Free Text	Mild	Patient	
Rash	At: <not entered>	Onset: <not entered>	
	Years	xx/xx/xxxx	
	Recorded on behalf of	Category	Status
		Drug	Active

4. To add details to an existing allergy
   a. Right click on the item and choose "modify"
   b. All boxes can be edited apart from the medication.
   c. To remove a reaction, right click on it and select "cancel"
5. To add a non-medication allergy
   a. Click on the "non medication allergies" folder at the bottom of the allergy box
   b. Select the relevant folders and double click on the item to add it into the "substance" box
   c. Complete the other fields as point 3 above.
6. To add an allergy when the substance is not found in the search or folders
   a. Click on the "Other allergy" folder at the bottom of the allergy box
   b. Select the relevant folders and double click on the item to add it into the "substance" box

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    c. Complete the other fields as point 3 above.
    d. In the reaction box, the substance must be written as well as the reaction. This is to ensure it is visible on the allergy screen without needing more clicks to see it.

Notes:

If the patient has an order for an item which there is an allergy recorded, a pop-up will appear once the allergy screen is entered or after documenting the allergy. An override reason must be entered to either continue or cancel the process. Use your professional judgement to record the relevant reason and escalate within your scope of practice if necessary.

If you add an allergy for a patient and they have an item "ordered" which they are allergic to, escalate within your scope of practice and inform the nurse looking after the patient to take appropriate action.

Modify and update the allergy "status" to "resolved" if the patient confirms they can tolerate a medication for which they have a recorded allergy. Document the change and reasons for this in the comments of the allergy.

3.5 Record the Medication History details.

1. Click on "Task List" and select the "Pharmacy Tasks" tab. The "Medication History" task should be visible. If you cannot see the task as expected, follow the steps below.
2. Double click the task to open the Medication History 'form'
3. Document the sources of information that you used to obtain the history. Use the drop down options or type into the boxes if necessary.
4. Indicate if the patient uses an MDS at home. Record the details of the MDS as per "Guideline for the Assessment and Provision of Compliance Aids" document.

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5. Any relevant social history or information that is needed to ensure care is continued on discharge must be documented in the "Discharge Supply Details" box. Record here if the patient has any supply at home.

Discharge Supply Details	Segoe UI ∨	9 ∨	🎨 ✂ 📋 📋 **B** <u>U</u> _i_
	MH for all regular medications. ML 1/10/20		

6. Adherence issues or problems that the patient identifies in taking medications must be documented in the "other details" section of the form. Notes should be left on the "order comment" and "adherence" tab of the relevant item along with any steps you have taken to resolve the issue.

7. Click on the save icon (💾) if the history is not complete. Record the details needed to be able to complete the history and the reason you were unable to do this in the "other details" box to ensure you or your colleagues can complete the history without duplicating work.

Other Details	Segoe UI ∨	9 ∨	🎨 ✂ 📋 📋 **B** <u>U</u> _i_
	Patient is in theatre 10am. Need to confirm DHx with patient when able. No PODs in locker. ML 1/10/20		

8. Click on the tick (✓) to complete the task if there are no outstanding issues with the medication history that need to be resolved.

9. Add a note to the PCO stating "DHx completed" and the date. This ensures communication between pharmacy staff.

Notes:
Always initial and date any comments that you add to the medication history form to aid communication within the department.
Information from previous encounters will automatically populate into the boxes where applicable. You must update or delete these comments as necessary for the current encounter.

If you cannot see the task:
1. Check you have the right time frame by right clicking on the grey bar and select "Change Time Frame Criteria"

Thursday 22 October 2020 00:00:00 BST - Monday 26 October 2020 23:50:00 GMT

Change Time Frame Criteria

It is best to set a "Generic Time Frame" to include the previous day as well as the current day

2. If the task is still not visible you can check from the "requests/care plans" screen to find out if the system generated it correctly:

Take note of the status – if it is "completed" then the task has already been done and you should look for the form in the "form browser." An existing form can be modified by right clicking and choosing the "modify" action. Go to step 6 to continue completing the form
If the order status is "ordered" then the task should be visible and you will need to check your time frame again.

3. If the order for the medication history is not on the screen, then the system did not generate it automatically.
You can create the order yourself by clicking on "add" from the "requests/care plans" screen and searching for "medication history." Complete the information and click on "sign"

The newly created task will now appear in the task list.

4.0   Statement of evidence/references

References:

1. Fitzgerald RJ. Medication Errors: the Importance of an Accurate Drug History. Br J Clin Pharmacol 2009; 67 (6): 671-675.

2. Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NICE guideline [NG5]. March 2015. Accessed July 2020. https://www.nice.org.uk/Guidance/NG5
3. NICE. Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence Clinical guideline Published: 28 January 2009 www.nice.org.uk/guidance/cg76. Accessed August 2020.
4. MEDICATION RECONCILIATION IN ACUTE CARE. Getting Started Kit. September 2011. https://www.ismp-canada.org/download/MedRec/Medrec_AC_English_GSK_V3.pdf Accessed August 2020.
5. MHRA definition 2004

5.0 Governance

5.1 Document review history

Version number	Review date	Reviewed by	Changes made

5.2 Consultation History

Include staff in consultation who will be required to ensure the SOP is embedded. This table should be completed in full even if no comments are received

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Pharmacy MMT group	Medication History	21/10/20		Yes	Yes
Pharmacy Senior Management group	Governance			Yes	Yes
B5 MMTs	Medication History	18/12/20		No	Yes
8a Pharmacists	Medication History			None received	
Junior Pharmacists	Medication History	22/3/21		Yes	Yes

Appendix 1: Suggested Medication History taking flow chart

```
                    ┌──────────────────────────────────┐
                    │ Look at the clinical notes /      │
                    │ documentation.                    │
                    │ Look for the DHx and PMH          │
                    └──────────────────────────────────┘
                                    │
                                    ▼
        ┌──────────────────┐      No      ┌──────────────────────┐
        │ Did the notes    │─────────────▶│ Check with the       │
        │ state patient    │              │ patient/carer/NOK    │
        │ lives in a care  │              └──────────────────────┘
        │ home?            │                        │
        └──────────────────┘                        ▼
                 │ Yes                    ┌──────────────────────┐
                 ▼                        │ Check the PODs       │
        ┌──────────────────┐              └──────────────────────┘
        │ Check the history│                        │
        │ against the MAR  │                        ▼
        │ sheet. Call the  │              ┌──────────────────────┐
        │ home to send it  │              │ Look up medication   │
        │ if it is not on  │              │ from a source in     │
        │ the ward.        │              │ Group 3 to confirm   │
        └──────────────────┘              │ the list is complete │
                 │                        └──────────────────────┘
                 ▼                                  │
        ┌──────────────────┐                        ▼
        │ Confirm the      │              ┌──────────────────┐
        │ medication with  │              │ MDS patient?     │
        │ SCR or HIE       │              └──────────────────┘
        └──────────────────┘               Yes          No
                                            │             │
                                            ▼             ▼
                                  ┌────────────┐   ┌──────────────┐
                                  │ Call the   │   │ Look at any  │
                                  │ nominated  │   │ recent       │
                                  │ pharmacy   │   │ discharge    │
                                  └────────────┘   │ letters / EDM│
                                                   └──────────────┘
```

N.B. Not every patient will fit into this flowchart and it is intended as a guide to the steps needed to take a medication history. Some patients will need more sources than others before a history is completed to a satisfactory level and the final decision on whether the history is complete is up to the professional judgement of the staff member completing the task.
If a history cannot be completed in one session, note the reason and steps taken in the "other details" section of the eCARE form for you or your colleagues to follow up.

Appendix 2: Medication History sources of information

Clerking notes. There two main notes are titled "ED Definitive Assessment" and "Clinical Clerking Note." Use these to find information on the drug history that the doctor recorded or to get some clues where to look next. Any medications listed in the clerking notes should not be considered a source when documenting a medication history.

- o The notes should state a previous medical history ("PMH") which may lead to other investigations that you can make. For example if "asthma" is listed then it is likely that the patient will have inhalers, or if the patient has a cancer diagnosis then they may be under the care of an outpatient clinic and will have notes on EDM.
- o Relevant information can be found regarding the current condition of the patient such as if they are confused. Use this information to help guide you when questioning the patient on their medications.
- o The full DHx may be recorded here but should be treated with caution as we may not know where the Dr got this list from. Often a repeat list is used which has old issues on it, or a relative may not know the doses etc.
- o There should also be a "social history" which may tell you if the patient is in a nursing home or has carers. Often the contact number for this source is recorded in the same note or can be found elsewhere in the notes.

Patient / carer / NOK

- o The patient is usually the best source of information as they will know how and when they take their medications, as long as they normally do this at home. Caution with patients who are confused.
- o It is good practice to read the admission notes before speaking to the patient. There may be sensitive issues around medications which can be identified from the doctors clerking.
- o It is best to check with the Nurse looking after the patient before you call the NOK. Sometimes the NOK will only know of the patient's condition from updates from staff so we need to be careful about giving incorrect or incomplete information. Consider the urgency of your intervention and the clinical impact of you getting the information before you contact the NOK. For example, if you are dealing with a palliative/EOL patient then it is not appropriate to be calling a relative for a drug history in this case.

SCR available through Internet Explorer. Available via the link (https://portal.national.ncrs.nhs.uk/portal/). The site doesn't load properly using Chrome or Edge so if your computer loads either of these browsers just copy the text and paste into Internet Explorer which opens when you double click the eCARE desktop icon.

- o SCR lists the repeat and acute issues and also has information on the nominated community Pharmacy but often has no other information

HIE is also available via eCARE

SOP Unique Identifier Number: Version: **1**   Next Review date: **March 2023**

- o The information is largely the same as SCR but often has more detail
- o Use in conjunction with SCR to confirm validity as sometimes these two sources don't match.
- o The "encounters" section has more detail about appointments and have freetext notes from GPs and nurses including doses of insulin or administrations of hydroxocobalamin
- o Sometimes the headings are duplicated and the links have different information from different healthcare providers (such as GP, District Nurse, Palliative Care)

Previous discharge on eCARE. This can be found either in the "document medication by history" screen if the patient has been readmitted within 28 days or via the notes/documentation titled "GP discharge letter"
- o If the discharge is recent then this can be used with SCR to confirm if anything new has been started since discharge.
- o Look for mentions of outpatient follow ups on the letter or any other clues on sources of information to use

EDM. Login via the desktop icon and search by MRN. You should only need to look at the "correspondence" and "multidisciplinary notes" sections to find what we need
- o Check any letters or notes for mentions of prescriptions. Often Drs in outpatients will write their plan in the notes and issue an FP10

Pharmacy
- o Call the nominated Pharmacy from SCR or click "yes" to the MDS question in the medication history form to see if a pharmacy has been previously recorded.
- o Oncology/haematology pharmacists within the department can advise on chemo regimes and support medications
- o JAC dispensing records may show what has been dispensed as an outpatient in conjunction with EDM information.

Carers / Nursing home
- o The carers may be listed in the notes but could be noted by the clerking doctor or a nurse looking after the patient and it sometimes takes a bit of looking to find this information.
- o Nursing home contact details can be found by searching the internet.
- o Call to confirm the list of medications taken before admission and if the patient has supplies on discharge. Some care agencies need meds in an MDS and some need a MAR sheet before they can administer medications. Nursing home patients are not true MDS patients even though they may look like one on SCR
- o District nurses sometimes administer medications such as insulin in community. Contact them via the GP surgery for your patient.

Appendix 3 – History examples

Mr A has been admitted to the hospital. In the "ED Definitive Assessment" note it documents a PMH of "asthma" but no medication is listed in the note.
On talking to the patient, they initially deny taking any current medication but when asked a direct question about inhalers they admit they have a "blue inhaler" at home that they rarely use. After gaining the patient's consent, you check SCR and find they have a salbutamol inhaler on repeat but was last issued a year ago.
Document the salbutamol inhaler as medication history.

Mrs B has been admitted to hospital. In the clerking note her social history refers to being a resident of a care home. She has a history of dementia and presented with confusion.
The patient is not likely to be a reliable source of information due to her history, and care home residents will usually have a MAR sheet sent in with them.
On the ward, look in the patient's notes folder and document the history as recorded on the MAR – specify timings of all medications where specified.
Mrs B was unable to verbally consent, so access SCR using the "emergency access" function to confirm that the MAR matches the patient's prescription list and no pages of the MAR were missing.

Mr C was admitted directly to the ward and only had a clerking note from the ward doctors. A PMH of Crohns was documented and it also mentioned a recent increase of the patient's Mesalazine by one of the Gastro Consultants in the hospital.
Look at EDM to find the recent outpatient clinic note and GP letter. Write the clinic dates on the documented Mesalazine after speaking to the patient and confirming the dose.