PART 2

ROYAL PHARMACEUTICAL SOCIETY

Keeping patients safe when they transfer between care providers – getting the medicines right

A guide for all providers and commissioners of NHS services

July 2011

Endorsed by:

ACADEMY OF MEDICAL ROYAL COLLEGES

Royal College of General Practitioners

Royal College of Nursing

Royal College of Physicians

Foreword

Research has shown time and again that there is a significant risk that patients' medicines will be unintentionally altered when they move care providers. A recent study found that when medicines are checked on admission to hospital (through medicines reconciliation) most patients are likely to have at least one omitted medicine or wrong dose.

In addition, it is estimated that five percent or more of hospital admissions are due to preventable problems with medicines.

The NHS outcomes framework has already recognised the significance of this to patient safety. All NHS providers, and commissioners of those services, are now charged with reducing harm to patients caused through medication errors.

Having safe systems in place for managing information and supply of medicines across care providers is also seen as central to safe, high quality care by the Care Quality Commission. Their essential standards on quality and safety have medicines management as one of their outcomes, and cooperation with other providers when care is transferred, as another.

As well as avoiding harm to patients, having safe systems across care settings is likely to lead to an overall reduction in avoidable medicines related admissions, including unnecessary readmissions to hospital. Clearly, this is closely linked to the delivery of Quality, Innovation, Productivity and Prevention (QIPP) programme goals.

The development of this guidance was led by the Royal Pharmaceutical Society, in collaboration with other royal colleges, patients, health and social care professionals, and is closely mapped to a range of related national initiatives and guidance. It gives organisations tools to develop their systems, and to help effect the culture change necessary in their organisations to raise this important patient safety issue higher up everyone's agenda.

All organisations, providers and commissioners, should review this guidance against their current systems and processes and identify where and how improvements can be made to existing services.

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1. Introduction

WHY WE NEED TO TAKE ACTION

- The transfer of information about patients' medicines continues to be a significant risk to patient safety. **Between 30 and 70% of patients** can have either an error or an unintentional change to their medication when their care is transferred (1).
- Reducing medication errors causing harm has already been identified as **an improvement area in the NHS Outcomes Framework** under *Treating and caring for people in a safe environment and protecting them from avoidable harm (2)*.
- The **Health and Social Care Act 2008 (Regulated activities) Regulations 2010 require** that the registered person* must protect service users against the risks associated with the unsafe use and management of medicines, and cooperate with other providers.
- The Care Quality Commission (CQC) therefore considers that managing medicines when a patient transfers from one setting to another is central to safe, high-quality care. Effective management of medicines is a **requirement of CQCs essential standards on quality and safety** (Outcome 9) as is cooperation with other providers when care is transferred cooperation (Outcome 6) (3).
- Improving the transfer of information about medicines across all care settings should reduce incidents of avoidable harm to patients, and contribute to a **reduction in avoidable medicines related admissions and readmissions to hospital**.
- All the above are clearly linked to the Quality, Innovation, Productivity and Prevention (**QIPP**) programme [**www.dh.gov.uk/en/Healthcare/Qualityandproductivity/index.htm**].
- As the NHS restructures, with more providers and new commissioners, the risk to patient safety related to inaccurate transfer of information about medicines is likely to increase.
- It is crucial that organisations commissioning and providing care **actively develop** safe systems that support, **and continuously improve** the safe transfer of information about medicines.

> *A patient was discharged from hospital with an increased dose of their antiepileptic medicine and a request written on the take home prescription for the GP to further increase in 2 weeks. The GP didn't receive a discharge letter and prescribed the patient's pre-admission dose. After taking this dose for about ten days the patient was readmitted with absence seizure.*
>
> ***Incident report from the National Reporting and Learning System***

WHAT THIS GUIDE CAN HELP WITH

- The Royal Pharmaceutical Society (RPS), has published **core principles and responsibilities**, endorsed by other professional royal colleges, that underpin the safe transfer of information about medicines whenever a patient transfers care providers, at any point in the care pathway.
- To support implementation of the core principles and responsibilities, content for transfer records has been developed. This outlines recommended **core information about medicines that should be transferred** when patients move from one care provider to another.
- The good practice guidance can be found in *Keeping patients safe when they transfer care settings – getting the medicines right. Part 1. Good practice guidance for healthcare professions* **www.rpharms.com/toc**.
- This guide (Getting the medicines right – Part 2) is for all providers and commissioners of services to NHS patients. A practical guide, it will help organisations and the people working in them to put the core principles and responsibilities into action locally.

* *"registered person" means, in respect of a regulated activity, a person who is the service provider or registered manager in respect of that activity*

2. Implications for COMMISSIONERS of services for NHS patients

The high level core principles and responsibilities, together with the recommended core information for medicines transfer records, provide a starting point **www.rpharms.com/toc**. They enable commissioners of NHS services to open discussions with providers of NHS services around the quality of information transfer about patients' medicines.

They should be viewed and used in the context of the other national, and where in place, local initiatives already developed to improve the accuracy of information about medicines and transfer arrangements in general.

SUGGESTED NEXT STEPS FOR COMMISSIONERS

- In the context of wider transfer arrangements, review how effectively provider services currently transfer information about patients' medicines.
- Review existing contracts, service level agreements, quality contracts and incentive schemes with provider services. With a view to incorporating the principles and responsibilities, and recommended core information requirements where appropriate.
- Work with provider services to agree robust, patient-focused outcome measures which can then be incorporated into commissioning arrangements.
- Monitor provider services against agreed outcomes and where necessary agree improvement measures.

SUPPORTING NATIONAL GUIDANCE

- The **Care Quality Commission** (CQC) has developed a self assessment tool for commissioners *Managing patients medicines after discharge*. Commissioners should use it to identify how to commission safer services (4).
- National Institute for Health and Clinical Excellence (**NICE**) and National Patient Safety Agency (**NPSA**) patient safety guidance recommends that all adult patients admitted to hospital have their medicines reconciled within 24 hours (1).
- Several **NPSA** alerts have already recommended immediate implementation of safe transfer systems for medicines and medicines information. These include anticoagulants (5), oral anticancer medicines (6), lithium (7), loading doses (8), and insulin (9).
- One of the DH **indicators for quality improvement in community services** is the percentage of discharge letters issued in accordance with national guideline standards (including information about medicines) (10).
- Following **CHUMS** (the care homes' use of medicines study (11)) the integrated approach to medication safety led by the National Care Association and the Health Foundation is working to improve medicines safety in care homes. A set of practical tools to help residents, doctors, pharmacists and care home staff reduce the incidence of medication errors and near misses is being developed. This will include tools to help when residents transfer care settings. See linked work streams at **www.rpharms.com/toc**
- **CQC** recommends that GPs use standard referral forms for the information that GPs will provide to local acute trusts about patients medicines (12). It also recommends that commissioners audit the quality of these forms.

HOW YOU MIGHT PUT THIS INTO PRACTICE

- Work with provider services to incorporate into the Commissioning for Quality and Innovation (CQUIN) payment framework indicators which support the effective transfer of information about medicines. Examples of potential indicators include:
  - The proportion of admitted patients who have their medicines reconciled within 24 hours of admission to hospital.
  - The percentage of discharge summaries with complete information about patients' medicines.

    PRACTICE EXAMPLE *NHS Plymouth has, with Plymouth Hospitals NHS Trust, established arrangements for a high quality electronic discharge document including detailed information about medicines. A summary of the medication-related information is also produced for the community pharmacist. Having agreed what should routinely appear in discharge information, audit was subsequently used to drive continuous improvement.*
    Contact: Oksana.Riley@nhs.net

  The NHS Institute for Innovation and Improvement website contains more examples of indicators developed by local commissioners **(www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html**).

- Explore other options for using contracts and incentive schemes to affect culture change. For example, use of the Quality and Outcomes Framework (QOF) to incentivise GP practices to agree and develop standard templates for referral information about medicines to be supplied to local acute trusts.

  PRACTICE EXAMPLE *NHS Sheffield produced guidance on medicines reconciliation for GP practices. The guidance is for practices to help establish safe systems for receiving information about changes to patient's medicines on discharge from hospital. On initial launch, the guidance was incentivised through QOF and, overall, has been well received and implemented by practices.*
  Contact: Hilde.Storkes@nhs.net

3. Implications for PROVIDERS of services to NHS patients

Provider organisations need to consider how best to incorporate the core principles and responsibilities into organisational practice. Provider organisations should also review the content of the records used to transfer patient information against the recommended core content.

Suggested next steps for provider services

- Review current policies and procedures in line with the core principles and responsibilities.
- Review recommended core content for transfer records against current information provided.
- Audit practice in key areas to establish a baseline.
- Identify where practice requires change or improvement and identify how this might be achieved.
- Consider the implications of information governance requirements.
- Develop an organisational action plan to support a culture of continuous improvement.
- Incorporate into training and development of healthcare professionals and support staff involved in transfer of information about medicines.
- Benchmark against other similar provider services.

How you might put this into practice

- Use the annual patient experience survey to monitor and drive improvement in communication with patients about their medicines when they are discharged.
- Identify and monitor the NICE quality standards that require effective transfer of information. For example the Glaucoma Quality Standard (13).
- Develop systems to monitor the number of readmissions due to avoidable problems with medicines.
- Ensure that patients discharged from hospital who have had changes made to their medicines are aware that they can request a post-discharge medicines use review (MUR) from their community pharmacist (14). Work with community pharmacists to audit the impact of these reviews
- Use implementation tools to help develop processes for medicines reconciliation when patients transfer to (**or back to**) your organisation. For example, the National Prescribing Centre's guide to implementing medicines reconciliation (15).
- Audit the accuracy of information about medicines that is contained in your discharge summaries. Develop processes to improve quality.
- Audit the accuracy of information about medicines contained in letters or communications from hospital out-patient clinics to GPs. Develop processes to improve quality.
- Have risk management and incident reporting systems in place to share learning and near misses.
- Review the RPS website, to see what other (early adopter) organisations are doing to put the guidance into practice.

IN A SNAPSHOT SURVEY NHS DIRECT TOOK OVER 600 CALLS IN ONE MONTH FROM CARERS WHO NEEDED HELP RESOLVING A PATIENT'S MEDICATION PROBLEM.

EXAMPLES OF LOCAL INITIATIVES TO IMPROVE INFORMATION TRANSFER

- Local teams in County Durham and Darlington, and Imperial College Healthcare NHS Trust, have developed personal patient held booklets/ passports that patients take with them when they move between care providers.
  County Durham and Darlington: Labib.Tadros@cddft.nhs.uk
  Imperial College Healthcare NHS Trust: Kandarp.Thakkar@imperial.nhs.uk
- East Lancashire Hospitals Trust systems were reviewed to improve the quality of the medicines information contained in discharge summaries. Improvement measures include, electronic patient tracking to identify patients requiring medicines reconciliation, re-design of Trust stationary, training, and electronic discharge summaries requiring a pharmacy check before they can be released. This means that the medicines information in the summary is an accepted quality, as agreed with commissioners as part of the hospitals quality account. **Contact: Alistair.Gray@elht.nhs.uk**
- The Welsh Ambulance Service NHS Trust has endorsed the use of GREEN bags to collect patients' own medicines. Clinical governance directives have been issued to all employees and posters promoting the GREEN bag initiative have been circulated to all GP surgeries across Wales. The bags are available centrally through Welsh Health Supplies. **Contact: chris.moore@wales.nhs.uk**
- In South Staffordshire, elderly patients recently discharged from community beds in secondary care receive domiciliary medicines use reviews from accredited community pharmacists. This has contributed to fewer re-admissions within 28 days and improvements in measures of functional independence for patients. The service is a locally commissioned enhanced service. **Contact: goldsteinruth@aol.com**
- GP practices in Gateshead have agreed a standard template for information supplied as part of referral documentation. The information is pulled directly from the practice IT system. It includes information about the patients' current medicines. The template has the backing of the LMC, commissioners and the local acute Trust. **Contact: jharness@nhs.net**

4. (Early adopter) Organisations putting the guidance into practice

- The core principles and responsibilities have been developed to provide a high level common framework against which professionals and organisations can judge themselves.
- However, patients have different diseases, can be transferred to and from a whole range of organisations, and have their care managed by different healthcare professionals.
- That means that the method for embedding the principles and responsibilities into professional and organisational practice, and how accurate transfer of the recommended core information is achieved will vary across provider organisations.
- Organisations may already be some or most of the way to implementing many of the recommendations. For the most part, this guidance should be seen as a way of helping to drive change and shift culture within existing resources in order to deliver sustainable improvements in safe medicines practice.
- To test the practical applicability of the good practice guidance and the core standards, early adopter sites will be putting the high level principles and responsibilities into practice. Links to the early adopter sites can be found on the RPS website **www.rpharms.com/toc**.

"I WAS CALLED THIS MORNING BY A PATIENT TO TELL ME THAT HER DISCHARGE MEDICINES WOULD RUN OUT IN THE EVENING.

WHEN PATIENTS ROUTINELY USE THE SAME COMMUNITY PHARMACY, IT WOULD SAVE HOURS OF TIME, AND PATIENT ANXIETY, IF THEIR PHARMACIST KNEW ABOUT CHANGES TO THEIR MEDICINES ON DISCHARGE."

COMMUNITY PHARMACIST

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About the Royal Pharmaceutical Society

The Royal Pharmaceutical Society (RPS) is the professional body for pharmacists and pharmacy in Great Britain. We represent all sectors of pharmacy in Great Britain and we lead and support the development of the pharmacy profession including the advancement of science, practice, education and knowledge in pharmacy.

In addition, we promote the profession's policies and views to a range of external stakeholders in a number of different forums.

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