Medicines-related communication systems and the new NICE guidance

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In March 2015, NICE launched the guideline NG5: *Medicines Optimisation,*[1] which identifies areas for NHS bodies to help patients get the best from their medicines. This article explores the features of the guidance dealing with medicines-related communication systems when patients move from one care setting to another.

Patient name: _____

Hospital /NHS number_____
Or apply an addressograph label

Check each box (or leave blank if not appropriate or not possible to complete)

- ○ **Insert** this checklist into drug history section of notes
- ○ **Check** notes for drug history and likely diagnosis
- ○ **Introduce yourself:** smile, eye contact, state your name and role, and ask "Is it OK to talk about your medicines?"

Can you communicate with patient Yes No

- ○ **Ask** *"Who looks after your medicines at home?"*
- ○ **Record** if and which regular community pharmacy
- ○ **Ask** *"Do you have any difficulties taking your medicines?"*
- ○ **Ask** *"Are they in separate boxes or one big pack?"*
- ○ **Obtain** consent for GP summary/Summary Care Record or GP fax
- ○ **Document** drug intolerance/allergy, **including reaction** in notes, on chart, *etc.*
- ○ **Check/document** PODs: suitable? Plus document quantity
- ○ **Check** MAR (***and*** admin record) or **contact** care home
- ○ **Ask** about PODs at home; **Document 'H'** on chart if PODs at home
- ○ **Ask** *"Any recent meds changes **or** hospital admission?"*
- ○ **Ask** *"Do you get medicines from anywhere other than GP?"*
  eg home delivery, hospital, chemo (refer), clinical trial, MDA
- ○ **Check** if smoker: cigarettes/day? Nicotine replacement therapy? Smoking cessation referral?
- ○ **Ask** (where appropriate) if they use any of the following:
  - ○ If warfarin – where is yellow book? Refer to anticoagulant clinic
  - ○ If diabetes medicine – refer to diabetic nurses
  - ○ Other monitoring booklets, *eg* DMARD, chemo
  - ○ Once weekly medication (state day of week)
  - ○ Home oxygen
  - ○ OTC, herbal, internet, "recreational" drugs
- ○ **Complete** drug history on chart and notes (sign and date)

Take appropriate action to rectify discrepancies

Completed by (initials): Date:

Figure 1. Hospital medicines reconciliation checklist example. PODs = patient's own drugs; MAR = Medicines Administration Record; MDA = Misuse of Drugs Act

Probably the most common movement between care settings is when a person transfers to or from home to hospital. In 2013/14 there were 15.5 million Finished Admission Episodes (FAEs) in NHS England alone.[2] With up to 70 per cent of patients having either errors or unintentional changes to their medicines each time their care setting is changed,[3] the potential for medication misadventure is high.

What is in the NICE guidance?

NICE builds on the Royal Pharmaceutical Society's (RPS) Transfer of Care guidance.[3] The six elements in this section of guidance are summarised below and what this means for prescribers is expanded beneath each point.

1. Organisations should ensure processes are in place so when transfer of care occurs, complete and accurate information about a person's medicines is shared with the new care provider… and the new provider acts on it.

Hospitals, GP practices *etc*. must have policies and procedures in place to ensure the right information is sent to, and/or obtained by, the next care setting. This is essential to aid medicines reconciliation, with NICE recommending a "trained and competent health professional" carry out this activity. There is compelling evidence that, in the hospital setting, pharmacists or pharmacy technicians obtain the most accurate drug histories; with nonpharmacy health professionals creating 1.3 unintended discrepancies for each medicines reconciliation completed,[4] and two-thirds of discharge summary letters inaccurate prior to pharmacy screening.[5]

Checklists are a great way of ensuring the right information is obtained at medicines reconciliation. Figure 1 gives

one example; this elicits more than just GP prescribed information, recognising that patients obtain their medicines from many sources. There is a paucity of evidence on the error rate when GP practice systems are updated following hospital discharge; however, if pharmacy personnel are in a position to assist this process directly, or through training others, then this opportunity should be explored.

Crucially, once information is obtained it *must* be acted upon; not just left in limbo in the patient record or on a note to fix something that is inadvertently wrong.

2. Proactive sharing should occur (ideally electronically) within 24 hours of the person being transferred.
This starts with a desire to send and receive information, creating policies and procedures – and then making them happen. Technology is a key enabler, *eg* hospitals and community pharmacies gaining access to the Summary Care Record or the full GP record. This approach allows on-demand, all-hours access to improve safety and minimises interrupting calls to GP receptionists.

3. The core content of information that should be shared with the next care provider is shown in Table 1.
Providing a high-quality transfer letter, and maintaining accurate information in a health record, is a challenge that requires consistently good behaviour from each clinician involved at either side of the interface. It is common to find health records stating a reaction to a drug without stating the nature of the reaction, and patients may deny or not recall a reaction or allergy.

In hospital, once medicines reconciliation has occurred, maintaining a record of medicines changes requires enormous political will. Paper drug charts can be designed to be transfer of care "friendly" providing they are consistently completed every time medicines are started, stopped and changed (see Figure 2). Electronic prescribing "solutions" offer the tantalising prospect of tracking medicines changes automatically, mandating that indications be captured at the point of prescribing or cessation, and prepopulating the discharge letter with this information; however, in reality most do not! There are over 60 prescribing systems in the UK[6] and most have not been designed to aid transfer of care, with systems suppliers unaware of how enabling this unmet "solution" actually is.

Information to be included in transfer of care documentation should include, but is not limited to, all of the following:
- Contact details of the person and their GP
- Details of other relevant contacts identified by the person and their family members or carers where appropriate, eg their nominated community pharmacy
- Known drug allergies, reactions to medicines or their ingredients, and the type of reaction experienced
- Details of the medicines the person is currently taking (including prescribed, over-the-counter and complementary medicines) – name, strength, form, dose, timing, frequency and duration, how the medicines are taken and what they are being taken for
- Changes to medicines, including medicines started or stopped, or dosage changes as well as the reason for the change
- Date and time of the last (or next) dose for weekly or monthly medicines, including injections, patches, *etc.*
- What information has been given to the person, and their family members or carers
- Where appropriate, any other information needed, *eg* when the medicines should be reviewed
- Ongoing monitoring needs and any support the person needs to carry on taking the medicines. Additional information may be needed for specific groups of people, such as children

Table 1. Information to include in transfer of care documentation

4. Healthcare professionals should discuss relevant information about medicines with the person, and their family or carers where appropriate, at the time of transfer. An accurate list of their medicines (in a suitable format) should be provided.
A discussion with patients or their carers about medicines at the point of transfer is tricky. For elective admissions, patients should be asked to bring their medicines in to hospital. For nonelective admissions via ambulance, many organisations provide transport bags to crews to actively bring patients' own medicines into hospital. This means: less medicines waste, aiding medicines reconciliation; fewer missed/delayed doses; and ceased medicines removed from the patient's access preventing later inadvertent administration. At discharge, the patient's nurse is often the person who counsels the patient as they see them last – ideally the patient will have had a conversation with a pharmacist or pharmacy technician during their stay about their medicines although this opportunity does not always arise due to capacity issues.

5. A consenting person's medicines discharge information should be shared with their nominated community pharmacy.
Informing a community pharmacist that one of their patients has been in hospital, and providing discharge information, is problematic. This is the reason East Lancashire Hospitals NHS Trust drove the development of an e-referral tool called ***Refer-to-Pharmacy*** (details at: www.elht.nhs.uk/refer), which allows quick, easy and secure referral from a patient's bedside to their community pharmacist. A referral can be made at any time in the patient's hospital journey, only being automatically released when the patient is discharged from hospital and their e-discharge letter is completed. The RPS has produced a *Referral Toolkit* to help health economies introduce e-referral solutions.[7]

Sending the patient's preferred community pharmacist a copy of their

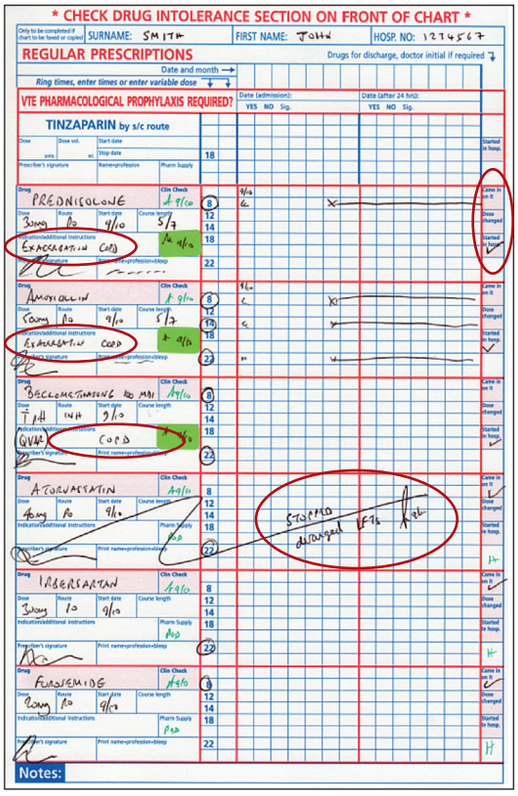

Figure 2. Transfer of care: example of a "friendly" prescription chart

discharge summary may seem novel; however, since October 2012 there have been nationally commissioned services available through community pharmacies that improve medicines adherence, leading to better health outcomes and fewer hospital admissions. These are the New Medicine Service (NMS) and postdischarge Medicines Use Review (MUR; in NHS Wales this is known as a Discharge Medication Review). The NMS improves medicines adherence by 10 per cent in specified long-term conditions,[8] and post-discharge MURs have shown a three-fold return on investment through better utilisation of medicines and reduced episodes of unscheduled care.[9]

6. Organisations should consider arranging additional support for certain people once they have been discharged from hospital, eg pharmacist counselling, telephone follow-up, and GP or nurse follow-up home visits for people taking multiple medicines, those with long-term conditions and older people.

Most health economies will have means of following up patients with complex needs. Some may have advanced services that involve domiciliary pharmacy teams who assess and address such patients' needs, *eg* Lewisham Integrated Medicines Optimisation Service (LIMOS).[10]

Conclusion

There are many challenges faced by organisations in delivering NICE's recommendations, *eg* capacity issues with medicines reconciliation, adjacent Trusts or tertiary centres liaising effectively when there are hospital-to-hospital transfers. A mixture of political will, new ways of working and technological enablers are required.

Opportunities exist to develop and use checklists to improve transfer of care in and out of hospital. Hardwiring community pharmacists into patients' post-discharge care should become *de rigueur*; the RPS toolkit is an essential aid to start a conversation within the local health economy about making this happen.

GPs will be familiar with the sometimes-confounding hospital discharge summaries that do not document what medicines have been started, stopped, changed or why; they may be faced with the dilemma of deciding whether the information is an accurate reflection of their patient's current regimen or an unintentionally introduced error. This is why we need this guidance; and for healthcare organisations to live, breathe and action its recommendations.

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Declaration of interests

None to declare.

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