MOVING patients medicines safely

Discharge and Transfer Planning Workbook

Royal Pharmaceutical Society of Great Britain
Guild of Healthcare Pharmacists
amicus
PSNC Pharmaceutical Services Negotiating Committee
PCPA Primary Care Pharmacists Association

WHAT IS THIS WORKBOOK?

This workbook is intended as a practical guide to help PCOs, NHS Trusts and health professionals implement successful processes for discharge and transfer planning.

It is not meant to be a rigid blueprint for implementation, but is intended to help organisations highlight those areas which are already working well, and those areas where improvement could be made.

It is based on the research evidence available, along with examples of good practice taken from organisations across the country, and is intended to be used in conjunction with the main document *Moving Patients, Moving Medicines, Moving Safely*. Examples of documentation from existing schemes and templates for self assessment and action planning are contained within the main document.

HOW TO USE THIS WORKBOOK

The workbook is designed to help PCOs, NHS Trusts and health professionals to assess whether the systems currently in place support effective transfer and discharge in relation to medicines. It identifies the elements of a successful service and provides guidance on what steps to take locally in order to achieve one.

By working through the process as an organisation or health and social care system you can assess where you currently are, and what changes could improve discharge and transfer planning locally. By working through these stages together systems should be able to develop processes which have strong local ownership.

WHO IS IT FOR?

This resource is intended for anyone who is involved in planning or delivering the discharge or transfer of patients between settings. That will include hospital medical, nursing and pharmacy staff, GPs, community pharmacists, staff within care homes and hospices, as well as commissioners and managers within these settings.

INTRODUCTION

Taking any medicine is an inherently risky business.

Even when medicines are used correctly, there is the chance of an adverse event, side effect or drug interaction occurring. When, for whatever reason, medicines are used incorrectly, the risk to patients may be increased. Patients are particularly vulnerable to things going wrong with their medication when they are being transferred from one setting to another, especially when leaving hospital following an episode of in-patient care.

Medicines are involved at almost all stages of the patient journey. Examples of a patient journey include:

- home to hospital
- home to care home or hospice
- home to day centre
- hospital to home
- hospital to care home or hospice
- ward to ward in hospital
- hospital to hospital
- care home to home
- care home to care home

The principles of good medicines practice on transfer or discharge will apply to all these situations. However, on admission to, and discharge from, hospital there are potentially more factors which can lead to difficulties.

In recent years, numerous reports and documents, published both by the NHS and other organisations, have highlighted the need for improvements to the discharge arrangements for patients, which could bring significant benefits for patients and their carers. For England these include *The NHS Plan, Pharmacy in the Future* and *A Vision for Pharmacy*; the National Service Frameworks; and specific documents relating to discharge.

Common policy themes relate to the re-engineering of services to empower patients, giving them more information about medicines with the aim of supporting concordance, and ensuring that they can get maximum benefit from their medicines, and the need to start planning for discharge as early as possible in a patient's hospital stay, if not from the time of admission. Medication errors arising at "handover points" within the healthcare system and the need for greater communication and co-operation between health and social care, and secondary and primary care sectors, are seen as key elements to effective transfer and discharge.

The creation of a patient centred service making the NHS more responsive to patients and users, providing choice at the point of referral, and plurality of providers will lead to patients receiving treatment in settings both geographically further from their homes and outside the NHS. This will have implications for communication about medicines.

Further details of current NHS policy relevant to medicines use can be found in Section One of the full document.

RESEARCH SUMMARY

Research studies investigating communication at transfer from one setting to another span nearly twenty years. Although most of the available research relates to hospital admission and discharge the principles are applicable to any patient transfer situation.

As long ago as the mid 1980s studies showed that after discharge from hospital a significant proportion of patients contacted their GP before discharge information was received; similar results have been found as recently as 2003. As a consequence unintentional changes to medication occur in a high proportion of patients post-transfer. This can include medicines being incorrectly stopped or started, changes to dosage or directions, and inadvertent duplication of medication.

As many as one fifth of patients discharged from hospital may experience an adverse event within one month of discharge, and a proportion of these will require re-admission. Many of these problems relate to medication, are avoidable and could be prevented with better discharge planning.

For the majority of patients, the starting point for prescribing inpatient drug therapy is the medication history taken on admission. Studies have shown that many medication histories taken on admission contain unintentional omissions and errors. Pharmacist-taken medication histories have been found to contain significantly fewer errors than those taken by junior doctors; probably due to the pharmacists' broader understanding of different products, formulations and over-the-counter preparations.

At the opposite end of an admission, effective communication at discharge has been demonstrated to reduce unplanned GP visits and re-admissions, and to prevent adverse effects and pharmaceutical issues. GPs and community pharmacists have expressed a desire for more information about changes which occur to medication while patients are in hospital. In addition many adult patients do not feel that they completely understand the purpose of the medicines they take home. Counselling of patients prior to discharge has been shown to improved drug knowledge and compliance, and reduce unplanned GP visits and re-admissions.

Further details of relevant research studies and examples of good practice can be found in the full document. Information from these has been used to inform and develop the next two sections which provide a guide to setting up a successful service. A self assessment template and action planning template to assist you are available in the main document as part of the "What To Do" section.

WHAT TO DO

The research evidence and examples of what is working well in practice provide a useful starting point from which to develop ideas on how to tackle discharge and transfer planning between different settings within your area.

ELEMENTS OF A SUCCESSFUL SERVICE

To maximise effective admission, transfer or discharge, and minimise the risks relating to medicines use, the evidence suggests that the following elements should be in place:

- mechanisms for effective **communication** need to be in place between all health and social care professionals involved in the care of the patient to allow planning for discharge or transfer to start as early in the admission as possible. Similar mechanisms should be in place in all long-stay situations where transfer occurs e.g. between hospital and care home.

  Depending on the location of transfer, communication may need to include:

  - GP
  - care home staff
  - social worker
  - hospital
  - ward staff
  - discharge or ward based pharmacist
  - primary care discharge pharmacist
  - community pharmacist
  - specialist contractor providing home care
  - pharmacy staff

- pharmacists taking a medication **history** to make sure that patients are taking the correct medication from the time that they are admitted to hospital. Information from GP and community pharmacy records will supplement information provided by patients. Where patients are admitted to a care home from their own home the current medication profile should be available from the GP at the time of admission.

  The need for an accurate medication history will apply in a range of settings. Examples could include:

  ✓ on admission to hospital from home

  ✓ on transfer from one hospital to another

  ✓ on admission to a care home/hospice from home

  ✓ on admission to a care home/hospice from hospital

  ✓ on transfer from one care home/hospice to another

  ✓ on transfer from mental health unit to supported accommodation

  In order to take an accurate medication history the following are needed:

  ✓ GP / hospital summary showing current medication

  ✓ patient's own medication including over-the-counter medicines

- using **patients own drugs and dispensing for discharge** reduce the risk of duplicate or discontinued medication being taken once the patient returns home. All medication is brought with the patient to hospital and only those which are

continued are taken home again. By combining inpatient and discharge supplies, many patients now go home with at least two weeks supply.

- encouraging patients to **self administer** their medication where appropriate reinforces messages about effective use of medicines, provides opportunities for education and allows staff to assess competency. This provides the opportunity to identify patients who may require additional support to manage their medication in a community setting.

  Self administration has a number of benefits:

  ✓ assesses competence at medicines taking

  ✓ identifies need for education

  ✓ identifies need for support with medicines at home

  ✓ reduces nurse/carer time in hospital, care home or day centre

- **reviewing medication**, especially where there have been changes and additions to medication, will reduce the effects of polypharmacy and enable patients to take their medicines more easily without forgetting doses.

- **obtaining prescriptions** in good time and in sufficient quantity, for the destination to which the patient is going, will allow medicines to be obtained in time for discharge or transfer and avoid patients running out in their new setting before they can obtain further supplies (see action plan below).

- **obtaining medication in good time** will allow medicines to be available when needed for discharge/transfer. Ensure that adequate supply is available to suit the destination. For example a patient transferring to a care home for the first time may need to register with a GP which may increase the time needed to obtain further supplies of medication.

- **verbal** counselling of patients (and where appropriate their carers) accompanied by **written discharge information**, increases medication knowledge and compliance. Mechanisms should be in place to assess when support for compliance is required (reminder cards, MAR charts, large print labels, etc) where necessary.

- **pharmacist-written discharge prescriptions** reduces error rates and improves bed-management, allowing patients to be discharged more quickly. Pharmacists can also take the opportunity of writing the prescription to counsel patients/carers on their medication

- for hospitals and care homes ensuring that **discharge medication summaries** are received by the patient's GP and community pharmacist before a repeat prescription is required will reduce the risk of unintentional post-discharge changes to medication. It is probably unrealistic to expect a formal discharge letter to be prepared, typed, received by the patients' GP, and translated into changes to the GP's records before the patient presents for a repeat prescription. Faxing or e-mailing a copy of the discharge summary directly to the GP on the day the patient leaves hospital will improve the chances of information being available in time.

For transfers between other settings (e.g. one care home to another, hospital to care home, ward to ward) the equivalent information about medicines should be supplied, and should arrive before or with the patient.

Information on discharge for medical and elderly patients should include:

- ✓ a complete medication profile
- ✓ whether the drugs are to be continued
- ✓ any changes to medication from medicines on admission and the reason for those changes

For specialist and paediatric patients requiring repeat prescriptions from the GP, information should include:

- ✓ details about drug formulation and supply
- ✓ dosage changes
- ✓ licence status
- ✓ titration
- ✓ monitoring needs
- ✓ discontinuation plans

Discharge summaries should be clear and legible.

- **electronic prescriptions** make the transfer of information between the ward, pharmacy and GP practice easier. This is currently possible via the NHSnet in some areas, and will become standard practice with the introduction of the NCRS. In the future community pharmacy should have access as well.
- clear practice **protocols** within GP surgeries to make sure that information received about revised medication is updated to the patient's medical and computer records.

  These need to include:

  - ✓ who has authority to transcribe discharge information
  - ✓ who has authority to make changes to medication as a result of discharge information
  - ✓ what details need to be transcribed
  - ✓ time-limits within which information should be transcribed
  - ✓ training to be provided to staff undertaking this task
- **medication management** services for high risk patients ensure that they are able to continue with their medication regimen after discharge, and prevent re-admission. Direct contact with the patient's usual community pharmacist can avoid problems with usual medicines and requirements for compliance aids.

Use the self-assessment template in the full document to record your state of readiness in each of these areas.

ACTION PLAN

There is current variability across the NHS about the way in which transfers and discharges are handled. Some element of good practice will exist in most places, but in many, more could be done to improve the efficiency of transfer and the patient's experience of the process.

It is also important to recognise that not all elements of service may be applicable in all settings. For example the use of Patient's Own Drugs (PODs) may be less appropriate in a mental health setting, where self-administration needs to be carefully considered and may only become appropriate for those patients approaching discharge. Similarly for patients with a history of recent self-harm, supply should be limited to 2 weeks or less.

1. Establish the appropriate forum for agreeing a multi-disciplinary approach across primary and secondary care to medication and discharge or other transfer settings.
   - this could be the sub-economy or PCO prescribing committee, NHS Trust drugs and therapeutics committee, a local pharmacy network, or Trust or PCO clinical governance structures.
2. Review what communication processes already exist for the transfer of information to GPs and community pharmacists at discharge.
   - are there standards in place for the time within which discharge information should be received?
   - are fax and e-mail utilised to speed up providing discharge information?
   - is the quality of the information (including legibility) currently supplied acceptable?
   - are there specific arrangements in place for unlicensed products and "specials" which may be difficult to obtain in the community?
   - if the answers are unknown, audit the current practice to identify the problem areas.
3. Review what communication processes already exist for the transfer of information to staff when patients are transferred to a care home, hospice or intermediate care centre.
   - are there standards in place to ensure that information is provided to care / nursing staff in those settings?
   - are fax and e-mail utilised to speed up providing discharge information?
   - is the quality of information (including legibility) currently supplied acceptable?
   - do patients always transfer with adequate supplies of medicines, accompanied by clear instructions?
   - if the answers are unknown, audit the current practice to identify the problem areas.

4. Review the role of junior doctors, pharmacists and pharmacy technicians in taking drug histories at admission and writing up discharge prescriptions.
   - could role redesign contribute to the Trust's work programme for reducing junior doctors' hours?
   - are processes in place to obtain additional information from GPs and community pharmacists to supplement information from patients?
   - are processes in place to ensure that, where necessary, patients receive counselling about their medication, accompanied by written information before discharge?
   - are processes in place to ensure the timeliness of writing discharge prescriptions so that patient's discharge is not held up?
   - could more be undertaken if the pharmacists involved were supplementary prescribers working within clinical management plans? Could independent prescribing by pharmacists be utilised in the future?
   - do protocols exist for these activities?
   - do pharmacy staff require additional training and accreditation for these roles?
5. Review the systems in place for use of patients' own drugs and dispensing for discharge.
   - do discussions need to take place about the balance of resources between primary and secondary care to enable the supply of patients' own medicines for use in hospital and larger quantities of medication from the hospital at discharge?
   - do pharmacy staff require additional training and accreditation for these roles?
   - where inpatient and discharge supplies are being combined is there an agreement on the minimum acceptable quantity which must be remaining at discharge?
   - do some wards need to have arrangements for ward-based discharge dispensing?
   - does the dispensing of discharge medication need to be prioritised or fast-tracked within the dispensary at certain times of day?
   - do protocols exist for these activities?
6. Consider how, if not already in place, the introduction of self-administration could be managed.
   - what physical requirements exist, i.e. lockable bedside cabinets for storage of medication? Should these be fixed or able to move if a patient transfers to another ward? Do wards where patients are encouraged to spend their time in communal areas need a different approach?
   - what training requirements are there for nursing staff?

- do protocols exist to enable nursing or pharmacy staff to assess whether a patient is able to self-medicate? How do these deal with a patient whose condition deteriorates?
- what patient counselling is available to support patients to undertake self-administration?
- what additional resources are available to support patients who are identified as struggling to manage their medication in hospital, i.e. large print or Braille labels, information sheets, medication diaries, eye drop administration aids, large closures, compliance aids?
- how will these be seamlessly continued when the patient is discharged? Do the patient's needs meet the suggested criteria for support provided by community pharmacy for people with disabilities?

7. Consider whether there are adequate systems in place to be able to identify to their GP and community pharmacist that a patient is at high risk of medication non-compliance.
   - does the assessment process for discharge include an assessment of the patient's ability to manage their medicines at home?
   - does the single assessment process (SAP) include triggers for referral for a specialist assessment relating to medication?
   - how is information communicated to the community pharmacist?
   - what ongoing medication management support is available to patients?
   - are processes in place to identify and resolve language considerations?
   - are processes in place to establish whether the patient's needs meet the suggested criteria for support provided by community pharmacy for people with disabilities?
   - are processes in place to identify where patients are receiving, or in need of, support from home care services such as prompting, supervising or administering medication? Is a social worker involved in the patient's discharge? What information do they need?
8. Consider whether information received at discharge is handled optimally at GP surgeries and community pharmacies.
   - are there standards in place for the time within which incoming discharge summaries should be entered onto the practice computer or recorded in the patient's notes?
   - are staff aware of the importance of handling this information quickly, and clear about whose responsibility it is to process such information?
   - is there a system in place to identify patients who have been recently discharged from hospital when they request a repeat prescription?

- is there a system in place to identify patients who have been recently discharged from hospital when they present to collect a supply from a repeatable prescription?
- do protocols exist for these activities?

9. Consider what public relations activity is required to publicise the changes to patients and health care practitioners.
   - do patients understand why they are being asked to bring their medication to hospital with them?
   - do GPs and their staff understand why patients are being asked to bring their medication with them to hospital, or are they providing counter-advice in the belief that it will be destroyed, wasting money?
   - what systems exist to enable frequent users of health services, particularly out-of-hours services, to have an up-to-date list of their medication available in their home?

Use the action planning template in the full document to help you prepare an action plan for your own organisation.

Hopefully you have found this workbook helpful in providing a catalyst for change, allowing the development of effective discharge and transfer processes in relation to medicines in your organisation or health and social care system.

Notes

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