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Making the most of a moving experience

Detailed guidance for those involved in moving patients between different health care settings has been launched by a group of pharmacy organisations with the aim of reducing medicine-related risks on admission, transfer or discharge. **Andrew Haynes** investigates

Patients who move from one care setting to another have always faced the risk of something going wrong in relation to their medicines. Poor communication between the different care settings, inadequate record-keeping, poor medicines management practice and a lack of effective transfer protocols have been major factors in allowing patients to be put at risk with their medicines.

The problem has long been a concern for the pharmacy profession and now a group of national pharmacy organisations has produced detailed guidance to help local primary care organisations, NHS trusts and health professionals, including pharmacists, to put in place a high quality service that will improve patients' experience of their transfer and remove many of the risks they face with their medicines.

The guidance is contained in a 124-page A4-size book, 'Moving patients, moving medicines, moving safely: guidance on discharge and transfer planning', with an accompanying 12-page discharge and transfer planning workbook.

The policies set out in the guidance document relate mainly to England and Wales, although the principles are also appropriate to practice in Scotland.

So what exactly does the guidance do? Its stated objectives are:

- To raise awareness of patients' experiences with medicines and discharge
- To identify the principles of good practice and to illustrate these principles with examples
- To develop strategies and identify standards based on best practice and the available evidence
- To make recommendations to reduce the risks of incidents with medicines for patients moving between different care settings, and in particular patients being discharged from acute hospitals

Risky business

In an introduction, the guidance points out that taking any medicine is an inherently risky business and that patients are particularly vulnerable to things going wrong with their medication when they are being transferred from one setting to another, and especially when leaving hospital following inpatient care.

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The introduction summarises the risks faced by patients if things go wrong with their medication during transfer or discharge and emphasises the need for high quality practice around discharge and medicines use.

Although discharge from acute hospitals is seen as a particular problem, the introduction makes clear that the principles of good medicine practice on transfer or discharge apply to all patient journeys, including transfer in any direction between home, care home, hospitals and hospices, and transfers between care homes, between hospitals or between wards of the same hospital.

The next section of the document looks at the policy context and summarises the relevant content of a wide range of reports and documents published by the NHS and other organisations. These illustrate the need to improve discharge arrangements, using medicines management as a key factor in supporting good discharge arrangements.

Preparing the guidance

The guidance has been prepared by the Royal Pharmaceutical Society, the Guild of Healthcare Pharmacists, the Pharmaceutical Services Negotiating Committee and the Primary Care Pharmacists Association. It was drawn up by a small steering group with at least one member from each organisation, working with the National Patient Safety Agency, helped by advice from a range of other health care organisations and informed by the experiences of many practitioners.

Among those who have had an input into the guidance are representatives of patient groups, nursing, pharmacy and medical organisations and the Department of Health. The guidance has also been informed by local evidence of good practice in transfer planning obtained from bodies such as NHS acute trusts, local pharmaceutical committees, primary care trusts and pharmacy development groups.

This section is followed by a summary of the evidence provided by research undertaken into the patient journey and the associated medicines risks. It sets out 24 key messages arising from the findings of research into various aspects of patient discharge.

Elements of a successful service

These preliminary sections are followed by a section headed "What to do", which builds on the research findings and the examples of what works well in practice to provide the essential guidance under two headings, "Elements of a successful service" and "Action plan".

The first of these sets out a list of 13 elements that need to be in place to maximise effective admission, transfer or discharge and minimise the risks relating to

Copies of 'Moving patients, moving medicines, moving safely" can be purchased from the practice division of the Royal Pharmaceutical Society. The cost is £20 for both the guidance document and the workbook. To obtain a copy, send an e-mail request to practice@rpsgb.org.

medicines use. The elements are summarised in Panel 1.

On the first element, mechanisms for effective communication, the document says that such mechanisms 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. It says that, depending on the location of transfer, communication may need to include any or all of 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 and pharmacy staff.

On the need for pharmacists to take an accurate medication history, the guidance says that medication information from the patient (including details of over-the-counter medicines) needs to be supplemented by information from GP and community pharmacy records.

The guidance says that using patients' own drugs and dispensing for discharge reduce the risk of duplicate or discontinued medicines being taken once the patient returns home.

On encouraging self-administration of medicines, the guidance says that this reinforces messages about effective use of medicines, provides opportunities for education, allows staff to assess competency and reduces nurse or carer time in hospitals, care homes and day centres.

The document says that medication review, 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.

It goes on to says that the writing of discharge prescriptions by pharmacists reduces error rates and improves bed management, allowing patients to be discharged more quickly.

On discharge medication summaries, the document says that ensuring that they reach 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 adds that information on discharge for medical and elderly patients should include a complete medication profile, information on whether the drugs are to be continued and details of any changes to the medication from the medicines being taken on admission and the reason for those changes.

On the need for clear practice protocols for updating GPs' records, the guidance says that protocols should 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; and training to be provided to staff undertaking this task.

Panel 1: Elements of a successful admission, transfer or discharge service

- Mechanisms for effective communication
- Pharmacists taking a medication history
- Using patients' own drugs and dispensing for discharge
- Encouraging patients to self-administer their medicien swhere appropriate
- Reviewing medication
- Obtaining prescriptions in good time and in sufficient quantity
- Obtaining medicines in good time so that they are available when needed for discharge or transfer
- Verbal counselling and written discharge information
- Pharmacist-written discharge prescriptions
- Ensuring that discharge medication summaries reach the patient's GP and community pharmacist before a repeat prescription is required (or, for transfers between care settings, ensuring that the equivalent information arrivs before or with the patient)
- Using electronic transfer of prescriptions (where posisble) to ease the transfer of information between the ward, the pharmacy and the GP practice
- Implementing clear practice protocols in GP surgeries to ensure that patient records are updated with information about revised medication
- Using medication management services to ensure that high-risk patients are able to continue with their medication regimen after discharge

Panel 2: Action plan for better admission, transfer or discharge

1. Establish the appropriate forum for agreeing a multidisciplinary approach across primary and secondary care to medication and discharge or transfer to other settings
2. Review existing communication processes for the transfer of discharge information to GPs and community pharmacists
3. Review existing communication processes for the transfer of information to staff when patients are transferred to a care home, hospice or intermediate care centre
4. Review the role of junior doctors, pharmacists and pharmacy technicians in taking drug histories at admission and writing up discharge prescriptions
5. Review the systems in place for use of patients' own drugs and dispensing for discharge
6. Consider how the introduction of self-administration could be managed, if it is not already in place
7. Consider whether adequate system are in place to be able to identify to their GP and community pharmacist that a patient is at high risk of medication non-compliance
8. Consider whether GP surgeries and community pharmacies handle optimally the information they receive when a patient is discharged
9. Consider what public relations activity is required to publicise the changes to patients and to health care practitioners

The description of the 13 necessary elements is followed by a six-page self-assessment template for recording the state of readiness of the guide user's organisation in each of the 13 areas.

Action plan

The "What to do" section then moves on to set out a nine-point action plan, which is summarised in Panel 2. For each of the nine points the action plan sets out a number of specific elements that need to be considered. The section concludes with a six-page action planning template to help in the preparation of a specific action plan for an organisation.

The document concludes with a number of appendices, two of which set out guidance produced by the Society's Hospital Pharmacists Group — its guidance on good practice medicines management during patient discharges and its guidance on implementing one-stop dispensing, schemes for using patients' own drugs and self-administration schemes.

Other appendices contain an overview of relevant research studies and synopses of a number of examples of good practice in managing medicines during the discharge process.

The four organisations behind the guidance are all confident about its value. Speaking for the Pharmaceutical Services Negotiating Committee, Barbara Parsons, head of pharmacy practice, said: "'Moving patients, moving medicines, moving safely' focuses on the practical aspects of discharge and provides a multidisciplinary tool which can be adapted and used for any transfer across different care settings. We all know the problems and the need to improve communication.

"All four organisations have worked together to analyse the problems and the PSNC has been particularly concerned about timely and accurate information reaching community pharmacists. Current policy, past research and learning from examples of good practice from across the country, along with input from many organisations, have been used to produce a practical approach which has been successfully piloted.

"I hope that this resource will assist many in addressing transfer problems and providing solutions to enable patients and their medicines to move more safely."