PrescQIPP Community Interest Company

Care homes - Transferring patients between care settings

This bulletin focuses on medication issues faced by care homes and domiciliary care agencies which occur when patients are transferred between different care settings, for example from hospital to care homes. Improving the transfer of information about medicines across all care settings should help reduce incidents of avoidable harm to patients, improve patient safety and contribute to a reduction in avoidable medicine related admissions and re-admissions to hospital.[1] The bulletin provides some recommendations on how to overcome these issues and improve the transfer of care process with respect to medicines.

Recommendations

- All patients should be made aware of the purpose and the benefits of having a Summary Care Record (SCR).
- Patient consent for their SCR to be shared and uploaded to the NHS spine should be obtained.
- Ensure that SCRs are updated in a timely manner.
- Raise awareness that relevant health care providers can view patients' SCRs where there is a clinical need.
- Ideally, patients with care packages should be identifiable and patient consent obtained to share need to know information with the care agency.
- GP practices should have a Standard Operating Procedure (see attachments 1 and 2, templates for local adaption) describing whose responsibility it is to review medicines on discharge summaries.
- This review of discharge summaries should be conducted by a suitable member of staff, with the relevant clinical knowledge, e.g. a pharmacist working in a GP practice.
- Relevant discharge information should be communicated to the patients community pharmacy if appropriate to ensure Medication Administration Record (MAR) sheets are accurate and up-to-date. Accurate and up-to-date MAR sheets will ensure correct administration of the medications to patients by care homes and domiciliary care providers.
- Ensure the care home has a robust process for checking medication when a service user enters the home and leaves the home (including social leave).

Background

There is evidence that shows when patients move between different care providers the risk of miscommunication and unintended changes to medicines remains a significant problem.[1] The Royal Pharmaceutical Society (RPS) estimated that between 30% and 70% of patients have an error or unintended change to their medicines when their care is transferred from, for example, a GP to a hospital or between different hospitals.[1]

It is likely that an elderly patient will be discharged from hospital on a different medicine regimen from the one they were taking when they were admitted. Between 28% and 40% of medicines are discontinued during hospitalisation and 45% of medicines prescribed at discharge are new medicines.[1] 60% of patients have three or more medicines changed during their hospital stay.[1] Adverse drug events

occur in up to 20% of patients after discharge and it is estimated that 11% to 22% of hospitalisations for exacerbations of chronic disease are a direct result of non-compliance with medication.[1] It is essential that the healthcare professionals involved in the care of a patient ensure the safe transfer of information about their medicines.[1] This is not always easy as patient care can involve multiple organisations, healthcare professionals and pathways.

In August 2014 a Patient Safety Alert was issued highlighting the risks arising from a breakdown in and failure to act on communication at the handover of patients from secondary to primary, community and social care.[2] To inform the alert a National Reporting and Learning System (NRLS) search was performed of incidents reported between 1st October 2012 and 30th September 2013. The aim of the search was to identify the nature and scale of the problems associated with the process of handover from secondary care at the time of discharge.[3] The review reported that out of 10,000 incidents (over one year) involving discharge from acute trusts apparent "breakdown in or failure with communication" was key factor in 33% of all moderate, low and no harm incidents. 13% were medicine related problems which included:

- Delay in providing medication to the patient pre-discharge
- Discharge medication incomplete
- Discharge medication not prescribed
- Discharge medication not supplied
- Discharge medication dose not specified
- Inaccurate medication
- Inappropriate medication.[3]

In December 2015 the National Institute for Health and Care Excellence (NICE) published guidance called "Transition between inpatient hospital settings and community or care home settings for adults with social care needs". It aims to improve people's experience of admission to and discharge from hospital by better coordination of health and social care services.[4] The guideline includes recommendations on:

- Patient-centred care, communication and information sharing.
- Before admission: developing a care plan and explaining what type of care the patient might receive.
- Admission to hospital: Healthcare professional responsible for transferring people into hospital should ensure admitting team have information about current medicines.
- The establishment of a hospital-based multi-disciplinary team.
- During hospital stay: recording medicines (both prescribed and non-prescribed), assessments and regularly reviewing and updating the patient's progress towards discharge.
- Discharge from hospital: the role of the discharge coordinator.[4]

Transfer of care types and possible issues

In order to understand how to improve patient transfers it is important to firstly understand the different care settings between which they might be transferred and the possible issues which could compromise care provision.

- Transfers from patient's own home to care home:
  - » Unreliable information on current regimen.
  - » Potentially the patient's medicines are in varied quantities and dates of issue.
  - » Medicines may be packed in dosette boxes either professionally or by relatives or friends.

- Transfers from hospital to care home following planned or emergency admission (or vice versa):
  - Lack of consistency in transfer information resulting in errors in administration where changes have been made.
  - Electronic discharge information will go to the GP, but the care home may not receive a discharge letter or the discharge information has not been sent with patient.
  - The patient's MAR sheet may not be up-to-date if there has been a change in medication.
  - It is common that MAR sheets are misplaced and are not transferred with the patient.
  - Inaccurate or incomplete information transfer could result in discontinued medications being administered which could result in patient harm.
  - Patients may be discharged/transferred without medication.
  - Non-clinical staff in the care home may be faced with making decisions about medication which are outside of their competencies and potentially unsafe.
- Transfers from hospital to patients own home with care package:
  - Care agencies may be commissioned to support administration of medication. Care staff frequently have no clinical knowledge and cannot interpret discharge information or they receive insufficient discharge information.
  - Patients may be discharged with medication and carers may find that there is medication already in the home of the patient. This can be confusing especially if both generic and branded medication is present.
  - There is a potential for error if the medication is not carefully stored or if doses have changed.
- Transfers from one care home to a different care home:
  - MAR sheets should be provided which indicate compliance. However it is possible that these will not be transferred with the patient.
  - Medications not transferred with the patient.
  - The medications/MAR sheet is transferred incomplete i.e. some may be missing, particularly "prn" medication.

See attachment 3 for an example of the Bedfordshire Clinical Commissioning Groups (CCG) protocol used by care homes and GPs when patients are admitted or transferred to a new care home from hospital, their own home or another care home. This may be adapted for local need and used to reduce potential issues.

Information sharing

The greatest issue in the transfer of care is the timely and effective transfer of accurate information. The main barrier to this is the lack of integration between health and social care. Patient information in primary care is now stored electronically which has made access to information efficient and available through controlled sign-in. When there is a need to transfer information, this can present problems when only one of the care settings stores the information electronically.

A future solution is the Government's vision to establish an NHS IT system, Connecting for Health, which will be able to communicate within itself (e.g. transfer of information between GPs, the hospital sector and community services), with external agencies such as social services, and with health services globally.[5] All patients have the option of having a SCR containing essential information like prescribed medication and allergies. They can also consent to including additional information on the SCR. When a patient consents to including additional information in their SCR, the GP can add it simply by changing the consent status on the clinical system. This means more information will be available to health and care staff viewing the SCR. It will then be automatically updated when the GP record is updated. GP practices can upload the SCRs for all their registered patients to the national NHS 'spine'.[5] Once on the spine the SCRs can be accessed by various healthcare providers:

- Hospital pharmacies – when reconciling medicines for new admissions.
- GP out-of-hours services – when treating patients with whom they are unfamiliar.

- GPs – when temporary residents, such as holiday-makers, visit their practice.
- Accident and emergency clinicians – when treating emergency patients.
- Clinical staff in hospital wards – when admitting new patients.
- Ambulance staff – checking patient details when responding to calls.
- Staff at walk-in centres and minor injuries units – when caring for patients who present for treatment.
- Multidisciplinary teams – when providing community and intermediate care services.[6]

The National Information Board detailed the need to give care professionals and carers access to all the data, information and knowledge they need by 2020.[7] The process has begun with the agreement to allow community pharmacists access to SCRs of patients who have given permission if there is a clinical need. Once a community pharmacist implements SCR, they can view SCR on the spine portal as long as they have a Smartcard with the right codes added on. This is the first step towards potentially granting full read-and-write access to GPs patient health records.[8] Additionally a GP IT system provider has begun a project to connect care homes in Leeds to GP held patient information. This project enabled the home to reduce hospital admissions and care home staff to access their resident's health record online.[9,10]

Meanwhile until the national IT issues are addressed the current situation remains fragmented with common problems, such as:

- There are several IT systems used by GP surgeries which do not communicate between settings. GPs using different IT systems cannot communicate with each other electronically unless an SCR has been made available. GP IT systems do not have the capability of communicating electronically with hospitals although work is in progress to address this in some localities.
- Patient consent to sharing information in and out of their primary care records has not been implemented consistently and patients have concerns regarding who will access their information. Without this consent being clarified, transfer of essential information may be prevented. This may considerably compromise the provision of care by carers both in care homes and the domiciliary environment.
- Although there is pilot work in progress, generally care homes do not have access to primary care IT systems. However, some care homes have limited computer access which would present issues and inconsistencies.
- Non-medical care agencies delivering care in a patient's own home may be put in unsafe situations as insufficient or inaccurate information is not made available to them in a timely way.

It is likely that change will be gradual and engagement in the implementation of change will be locally driven.

The inconsistency in the delivery of safe and appropriate discharge information is well recognised. The Care Quality Commission (CQC) conducted a study in 2009 (now archived) looking at what organisations were doing to ensure the safety of patients who had been discharged from hospital with a change of medication.[11] Following this study the Royal Pharmaceutical Society identified a possible solution. They recognised the potential of community pharmacists to improve patient safety at the point of hospital discharge.[12] Clinical Pharmacists in General Practice is a three year pilot where clinical pharmacist's work as part of the general practice team to resolve day-to-day medicine issues and consult with and treat patients directly. These pharmacists will be well placed to improve care across the interfaces between specialist providers and the wider primary and community care teams.[13]

The NICE guidance NG5 (medicines optimisation) has recommendations regarding communication about medicines when patients move from one care setting to another. It advises that relevant information about medicines should be shared with patients, and their family members or carers, where appropriate.[14] Recommendations include:

- Robust and transparent processes are in place, so that when a patient is transferred from one care setting to another the current care provider shares complete and accurate information about the patient's medicines with the new care provider. The new care provider receives, documents this information, and acts on it.
- Organisational and individual roles and responsibilities should be clearly defined, reviewed and monitored.
- For all care settings, health and social care practitioners should proactively share complete and accurate information about medicines. This should happen in the most effective and secure way, such as secure electronic communication, ideally within 24 hours of the transfer.
- Health and social care practitioners should provide a complete and accurate list of medications and discuss relevant information about medicines, with the patient, and their family members or carers where appropriate. This should include all current medicines and any changes to medicines made during their stay.
- Consider sending a person's medicines discharge information to their nominated community pharmacy, when possible and in agreement with the patient.
- Consider additional support for some patients when they have been discharged from hospital, such as pharmacist counselling, telephone follow-up, and GP or nurse follow-up home visits.[14]

The NICE guidance SC1, Managing medicines in care homes, has recommendations about the sharing of information regarding care home residents medication indicating that information is available for medicines reconciliation on the day that a resident transfers into or from a care home:

- Care home providers should have a process for managing information (information governance).
- Commissioners should review their arrangements with care home providers to ensure that any information about a resident's medicines that is transferred contains the minimum information required as detailed in NICE guidance.
- Providers of health or social care services should have processes in place for sharing, accurate information about a resident's medicines, including what is recorded and transferred when a resident moves from one care setting to another (including hospital).
- Providers of health or social care services should ensure that either an electronic or a printed discharge summary is sent with the resident when care is transferred.
- Health and social care practitioners should ensure that all information about a resident's medicines, including who will be responsible for prescribing, is accurately recorded and transferred with the resident.
- Health and social care practitioners should check that complete and accurate information about a resident's medicines has been received and recorded, and is acted on after transfer.
- The medicines policy should contain a process for recording the transfer of information about residents' medicines during shift handovers and when residents move to and from care settings.
- Care home staff should follow the rules on confidentiality set out in the home's process on managing information about medicines.[15]

In 2016 the NHS Specialist Pharmacy Service conducted a collaborative audit looking at the quality of medication related information provided when transferring patients from secondary care to primary care and the subsequent medicines reconciliation in primary care. The audit found that communication around medication changes when patients transfer from secondary care to primary care requires significant improvement. Recommendations made by the audit include:

- Discharge summaries should including the screening pharmacist contact details for primary care queries.

- Secondary care providers to utilise SCR at admission for robust medicines reconciliation.
- CCGs and secondary care providers should collaborate to review the local hospital discharge template to ensure that it meets the needs of all involved.
- GP practices need clear processes in place on how information provided on discharge summaries are managed once received.
- Consideration should be given to whose responsibility it is to review medicines on the discharge summaries and who should action changes on the GP prescribing system.
- Consideration should be given to the role of clinical pharmacists in GP practices in reconciling medicines post discharge from secondary care
- CCGs may wish to develop or revise CQUINs to help drive quality improvement of discharge communication by secondary care as previously recommended by the CQC.[16]

Inconsistent recording of patient information by care providers

In addition to the issues surrounding the effective transfer and sharing of information there are problems that arise from inconsistency in the recording of patient information.

In care homes it is the staff that are responsible for the safe delivery of care to their residents. When it comes to medication, staff rely on the medication information supplied to them being accurate and up-to-date. This should be provided by healthcare professionals rather than family or friends. Medication is currently recorded on MAR sheets which are normally provided by the supplying community pharmacy and should only detail currently administered medication. Some pharmacies are supporting electronic systems which are paperless and all information is stored through programmed activities in the care home, synchronised through central servers or web based links. Staff in the home who are administering medication are responsible for recording all administration, including non-administration, on MAR sheets either by signing or electronically recording.

For community health service providers such as community nurses or community psychiatric nurses coming into a care home, there is varied practice which can result in information being lost or unavailable. Some providers are utilising IT systems to record their interventions which are not accessible to care homes. If they are responsible for administration of medication, each organisation will have their own recording sheets which may be kept in “single assessment records” separate from the MAR sheets used by the home. Such care providers may be administering depot antipsychotics, insulin, vitamin B12 injections, rectally administered drugs etc. NICE makes it clear that records of administration of medication by other healthcare professionals should be made available.[15] Separate records increases the risks during transfer of care as this record may be missed.

There are now also a number of different “passports” which patients retain for some long term conditions. Whilst they are encouraging patient involvement in their care, if they are forgotten and not updated regularly they may be inaccurate or contain essential information which is again not kept centrally.

Fragmented and inconsistent information recording increases the risk of inaccurate information being transferred and consequently risk of harm.

Summary

Inconsistencies and discrepancies with information regarding a patient's medication can occur on admission to a care home or hospital, transfer from one care home to another or on discharge from hospital back to a care home or the patient's own home. The main barrier to the effective transfer of information is a lack of integration between health and social care. The development of SCRs containing basic information such as current medications and allergies can start to address these issues. Encouraging patients to consent to the sharing of their record on the central NHS spine will enable various health care providers to access them, e.g. hospitals, out of hours services and community pharmacies if there is a clinical need. This will improve patient care across different care settings.

GP practices should have a SOP describing whose responsibility it is to review medicines on discharge summaries. As the number of pharmacists in GP surgeries will be increasing in the future, this could be part of the role for a clinical pharmacist in the practice. The pharmacist would be well placed to liaise with the hospital pharmacy department to ensure the patient medication and SCR are updated correctly post discharge. They can also liaise and share discharge information, if appropriate, with the patients community pharmacy. This will allow the patients MAR sheet to be accurate and up-to-date. Accurate and up-to-date MAR sheets will ensure correct administration of the correct medications to patients by care homes and domiciliary care providers.

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Further reading

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- NHS England. Clinical Pharmacists in General Practice Pilot. www.england.nhs.uk/gp/gpfv/workforce/cp-gp/

Additional PrescQIPP resources

Templates

Available here: https://www.prescqipp.info/resources/category/363-care-homes-transferring-patients-between-care-settings

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