Transfer of care Pilot Project

On CCU at Lister Hospital

East and North Hertfordshire NHS Trust
Hertfordshire LPC

Introduction

Background

Discharge communication between secondary and primary care in East and North Hertfordshire is routinely sent to GPs, but communication between hospital and community pharmacists on the discharge of a patient has only been to request supply of a compliance aid.

The introduction in October 2011 of the new community pharmacy advanced services including the New Medicines Service (NMS) and post discharge Medicines Use Reviews (MURs), has provided an opportunity to improve communication between hospital and community pharmacists and importantly the opportunity to improve medicines management when patients care is transferred.

Aims

To provide as many community pharmacists as possible with a copy of the patient discharge summary when discharged from the coronary care unit (CCU).

To establish the percentage of patients that will visit their regular community pharmacy for a post discharge MUR or NMS, after discharge from hospital on receipt of additional discharge counselling

To establish the most effective method for ensuring that patients visit their regular community pharmacy after discharge from hospital.

Objectives

- To establish the percentage of patients that visit their regular community pharmacy for a post discharge MUR or NMS when they are sign posted by hospital pharmacist.
- To establish the percentage of patients that visit their regular community pharmacy for a post discharge MUR or NMS when their discharge information is faxed/e-mailed to their regular community pharmacy.
- To identify if an action/intervention was undertaken by the community pharmacist as a result of the post discharge MUR or NMS.
- To identify the types of action/interventions made by the community pharmacist during a post discharge MUR/NMS.

Method

The Pilot was designed to take place over a four week period in October 2012 on the Cardiac Care Unit (CCU) at Lister hospital and was a joint project between East and North NHS Trust and Hertfordshire Local Pharmaceutical Committee (LPC). It included all patients discharged from CCU between 9am and 5pm on Monday to Friday. Patients were excluded if they did not qualify for an NMS/MUR, identify regular community pharmacy could not be identified or they were deemed by the discharging pharmacist as not appropriate (e.g. patients in residential homes/patients who do not have capacity).

Patients who were eligible were supplied with a leaflet about the NMS/MUR and asked if they would be willing to share their discharge details and contact information with their community

pharmacy, this was then documented in the patient notes.

Patients that were willing to participate in the pilot were then allocated to either group A or B on an alternating basis. The relevant sections on the referral form were completed by the pharmacist for each patient and they indicated if the patient is being referred to the NMS or for an MUR.

Patient in group A were counseled to visit their community pharmacy. The patients were allocated a referral number so that their details were anonymised when sent to the LPC. Patients were given an extra copy of their discharge prescription, the referral form, feedback form (see appendix 3) and envelope addressed to the LPC, which they may take to the community pharmacy.

Patients on list B had a copy of their discharge letter, referral form (including contact number) and feedback forms e-mailed or posted to their regular community pharmacy.

Community pharmacists; who completed an MUR/NMS for patients in the pilot were to complete the feedback form and send or fax it to the LPC. Any details of interventions made were to be posted or sent by secure e-mail to Lister hospital so the types of interventions could be analysed.

LPC; a list of patients included in the pilot were sent from Lister hospital to the LPC, the information included only the referral number and regular community pharmacy so no patient sensitive information is available. The feedback forms received from community pharmacy could then be checked off against this list. If a feedback form was not received then the LPC would contact the community pharmacy and using the patient's referral number see if they had attended for an NMS or MUR.

Outcome Measures

- Number of patients included in pilot versus total number of discharges from CCU.
- Number of patients who attend for NMS/MUR who were sign posted by pharmacist to services (List A).
- Numbers of patients who attend for an NMS/MUR whose discharge letter and contact details were sent to the community pharmacy (list B).
- Hospital pharmacist to identify average time required to complete process for patients in both groups.
- Types of action/intervention undertaken by the community pharmacy as a result of NMS/MUR.

Results

Due to difficulty in initiating the study the recruitment phase did not begin until the 4th of November. The recruitment phase was also extended by another week to ensure an adequate number of patients were recruited to the study.

In total 130 patients were discharged from CCU between the 5th of November and 13th of December. During this time period 24 patients were recruited to the study 12 in each group. In addition to the exclusion criteria reasons for not recruiting patients into the study included an address not in Hertfordshire, patient being transferred to an alternative ward or hospital and patients being discharged when the project pharmacist was unavailable. No patient refused to allow w their discharge summary or contact detail to be shared with their community pharmacy.

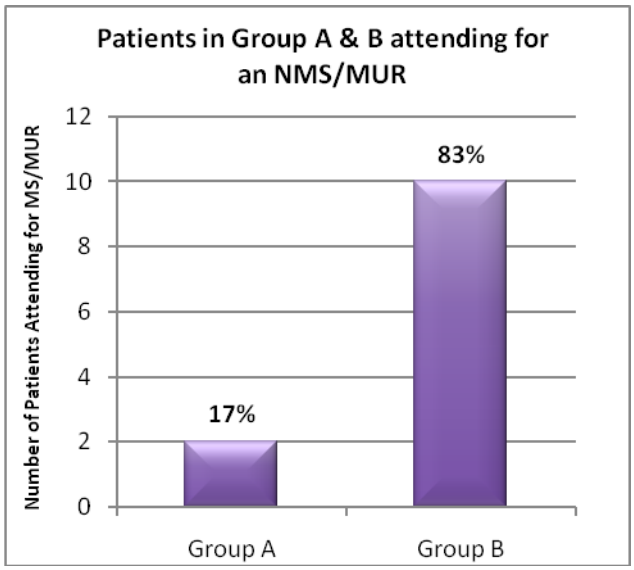
In group B two of the referrals were sent by e-mail the rest were sent by post, the reason for this was that only two of the community pharmacies had nhs net e-mail addresses and the trust will only allow

patients sensitive information to be sent to an nhs.net account.

The time taken to gain consent from a patient, complete the referral form and send the information to the patient's community pharmacy was approximately 15 minutes.

Two feedback forms from community pharmacists in group A and five in group B were received by the LPC. All community pharmacies were then contacted by the Lister project lead to see if patients had attended for an NMS/MUR.

When they were contacted the numbers remained at two for group A but had increased to ten patients attending for an NMS/MUR in group B.



Of the 12 patients who attended from both groups the community pharmacists completed an MUR with six patients, an NMS review with four patients and two patients had both an NMS and MUR.

Of the 12 patient who attended for an NMS/MUR five community pharmacists documented that an intervention did take place. However only one pharmacist sent the information on the intervention made to the Lister hospital.

In this instance it was identified that the dose of Ticagrelor on the patients new repeat prescription from the GP was 90mg once a day which differed from the dose on the discharge letter which should have been 90mg twice daily. The pharmacist contacted the GP and the dose was changed to 90mg twice daily.

Another community pharmacist documented their intervention on the feedback form sent to the LPC. On this occasion the repeat prescription documented the bisoprolol dose as being 1.25mg daily where as the discharge prescription said 1.25mg twice daily. The GP surgery was contacted and the dose corrected to twice daily.

Discussion

While only a small project the results of this pilot demonstrate that actively making referrals and sending contact information to community pharmacists is a much more effective means of recruiting patients to these services than simply signposting them.

The results are also encouraging in the fact that where a referral was sent to their community pharmacist 83% of patients attended for an NMS or MUR. This is most likely due to the fact that the community pharmacists contacted the patients to invite them to a review of their medications and of the two patients that did not receive an NMS/MUR; one pharmacist informed me that they did not contact the patient.

Another positive outcome is that all patients asked were happy to share their discharge summaries and contact details with their community pharmacy.

Five interventions were made by community pharmacists during the pilot and unfortunately we do not have the details of most of these and a more

robust way of obtaining this information would be required for future research.

The two documented interventions could have potentially been serious and led to harm. Ticagrelor is used post ACS often in patient with coronary stenting, the fact that the GP had only prescribed half the licensed dose would put the patient at risk of stent thrombosis potentially resulting in myocardial infarction.

Difficulty in the pilot included how to send the information to community pharmacies. Currently the trust does not like to fax confidential patient information and consequently we had to change the initial project plan to e-mail or posting discharge letters. The trust also allow us to send confidential patient information to an nhs.net secure e-mail addresses, where as many of the national pharmacies for internal security reasons do not allow their stores main e-mail address to be @nhs.net. Consequently most of the referrals had to be posted at a cost to the trust. The LPC is currently looking to whether the pharmacy stores are also available to hold nhs.net e-mail addresses.

The time taken to complete a referral form was also an issue for a busy ward pharmacist. It was actually in some ways less consuming when the discharge letter was e-mailed/posted as this could be done at a convenient time over the next few days following patient discharge. When a patient was handed a copy of their discharge letter this was more difficult as only Drs and nurses could print the initial discharge summary for the patient and this meant the pharmacist was often left waiting for this to happen.

The time taken to document the patients consent to have their information shared with community pharmacy was also time consuming. But this could be shortened by having a signature or tick box on the drug chart or BIMs system.

Reference

- **Royal Pharmaceutical Society.** Keeping patients safe when they transfer between care providers – getting the medicine right. *Good practice guidance for health professionals.* (July 2011)
- **Royal Pharmaceutical Society.** Keeping patients safe when they transfer between care providers – getting the medicine right. *A guide for all providers and commissioner of NHS services.* (July 2011)
- **Pharmaceutical Services Negotiating Committee (PSNC).** Community pharmacy services - *Guidance for hospitals* (January 2012)
- **Pharmaceutical Services Negotiating Committee (PSNC).** Working with hospital colleagues to support patients discharge from hospital - *Guidance for community pharmacists* (January 2012)