Arden and Greater East Midlands Commissioning Support Unit in association with
Lincolnshire Clinical Commissioning Groups, Lincolnshire Community Health Services,
United Lincolnshire Hospitals Trust and Lincolnshire Partnership Foundation Trust

Lincolnshire Prescribing and Clinical Effectiveness Bulletin

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IMPROVING MEDICINES OPTIMISATION IN LINCOLNSHIRE: *THE PATIENT JOURNEY THROUGH UNITED LINCOLNSHIRE HOSPITALS*

- **This *Bulletin* provides clear information on all stages of the patient journey from home to hospital and back again with reference to all aspects of medicines optimisation conducted within United Lincolnshire Hospitals Trust. It is hoped that full collaboration across the interface between primary and secondary care will reduce the risk of errors, enhance the patient experience and optimise the effectiveness and safety of all medicines prescribed.**
- **Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use intended to ensure that people obtain the best possible outcomes from their medicines'.**
- **Access to information on the patient's acute and repeat medicines through the *Summary Care Record*, in conjunction with a review of the medicines brought in by the patient, enables ULH clinical staff to work with the patient to compile a detailed Medication History on admission or during pre-admission with much less need to contact the patient's GP or surgery to confirm or clarify details.**
- **Patients should be encouraged to take all of their medicines into hospital with them as part of pre-admission for elective surgery and, where possible, as part of acute admission. Patients, particularly those at-risk of acute admission, should be encouraged to carry a copy of a repeat prescription slip from their GP surgery in their wallet, purse or handbag at all times. Where the patient cannot bring their medicines into hospital personally, their representative is likely to be asked to bring the medicines into the hospital as soon as possible after admission.**
- **Pharmacy staff are striving to ensure that medicines reconciliation takes place as a matter of priority for all patients as soon as possible after admission with the majority of new patients seen within 24 hours.**
- **Medicines reconciliation is defined as the process whereby an accurate list of a person's current medicines is identified and compared with the current medicines in use. As part of the process, discrepancies are identified and rectified and an accurate and up-to-date list is compiled. This list includes prescribed, over-the-counter and complementary medicines. This usually involves complete review of the prescription by a pharmacist with increasing use of standard review criteria such as START, STOPP, PINCER and PACEF derived interventions.**
- **Wherever possible, ULH pharmacy staff ensure that patient's own medicines are utilised while the patient is in hospital. Where additional medication is required, this is supplied either from ward stock or from the hospital pharmacy. Original packs are always issued where feasible with the usual quantity equating to the length of stay plus 14 days' supply post-discharge.**

Only medicines approved for use through the *Lincolnshire Joint Formulary* are likely to be supplied in this way.

- **Where the patient is prescribed a non-*Formulary* medicine, their own supply will be used while they are in hospital wherever possible. If no supply is available or the patient's supply runs out, consideration will be given to switching the patient to an alternative product available through the *Joint Formulary* and ULH Pharmacy. Unusually, if the patient's supply runs out and a switch is thought to be inappropriate, the patient's partner or carer will be asked to order a replacement supply from the patient's GP.**
- **Within Lincolnshire Hospitals, doctors are encouraged to work towards a Planned Discharge Date. Where a PDD is known, pharmacy staff will deliver medicines reconciliation on discharge, usually about 24 hours in advance of the PDD.**
- **Where a PDD has not been agreed and discharge takes place without ULH pharmacy involvement, it is most likely that the patient will be discharged with the medicines they have been taking while on the ward. This is the most unsatisfactory scenario as it can lead to patient's being discharged with insufficient medication or with a number of key issues remaining unresolved.**
- **Patients will usually be discharged with at least 14 days' supply of medication and/or 5 to 7 days' supply of analgesia.**
- **Non-pharmaceutical items, such as oral nutritional supplements, dressings, stoma care and urology products are not likely to feature in medicines reconciliation on discharge, with ward staff often directly responsible for providing supplies. In this case discharge quantities may be much smaller and more erratic than the standard 14 days' supply of medication.**
- **As part of the discharge process a copy of the Electronic Discharge Document (eDD) is sent via nhs.net email to the patient's GP. The accuracy of information on the eDD is being improved through increasing emphasis on accurate medication history taking pre-admission and as part of the admission process and through pharmacy-led medicines reconciliation and review as detailed above. Through medication review during the patient's hospital stay pharmacy staff strive to ensure that the eDD is up to date at the point of patient discharge.**
- **In order to continue to improve the patient journey and to reduce the risk of error, it would be appreciated if practice staff could continue to report specific issues relating to in-patient or discharge experience to their CCG or relevant prescribing adviser.**

Introduction

In *PACE Bulletin* Volume 9 No 16 (October 2016), we reviewed the recommendations from NICE Clinical Guideline NG5 on *Medicines Optimisation* and undertook to review local processes across both primary and secondary care in order to develop a more coordinated approach to medicines optimisation in Lincolnshire. In conjunction with colleagues from United Lincolnshire Hospitals Pharmacy team and Lincolnshire Community Health Services, we have now mapped the patient journey through ULH from pre-assessment to admission to in-patient stay to discharge. It is the purpose of this *Bulletin* to provide clear information to all Lincolnshire prescribers on all stages of that journey in order to ensure that full collaboration across the interface reduces the risk of errors, enhances the patient experience and optimises the effectiveness and safety of all medicines prescribed.

Medicines Optimisation: a definition

Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use intended to ensure that people obtain the best possible outcomes from their medicines'. At present, the NHS is struggling to cope with an ageing population, lengthening life expectancy, increasing numbers of patients managing one or more long-term conditions and increasing use of medicines to meet the needs of those patients. It is estimated that, in patients aged 60 and over, 58% are managing at least one long-term condition. Adherence with prescribed medicines in people with long-term conditions can be unreliable with 30 to 50% of medicines not taken as prescribed. All of this contributes to poorer than expected patient outcomes, risks to patient safety and health and escalating problems with medicines waste, estimated to cost the NHS approximately £300M per year, approximately half of which is thought to be preventable. This equates to approximately 4% of the total spend on medicines for every CCG wasted each year.

Pre-Admission Assessment Prior to Elective Admission

Elective patients are assessed prior to admission by Pre-Admission or Pre-Booking Clinics within ULH. As part of this process the patient will have a Medication History taken by a nurse. In order to fully inform this process, the patient should bring all of their medicines with them to the Clinic when they attend. The nurse will be seeking to compile a complete list of all the medicines the person is currently taking, including all prescribed, over-the-counter and complementary medicines. Information recorded will include: the name of the medicine, strength, form, dose, timing, frequency and duration, how the medicines is taken and what it is taken for.

PACEF Comment

Practices should ensure that, wherever possible, patients are encouraged to take all of their medicines into hospital with them when they go; this includes pre-assessment prior to elective admission and acute admission.

Clinical staff access information on the majority of patients through the *Summary Care Record*. This means that a much more accurate Medication History can be compiled with much less need to contact the patient's GP or surgery with queries. GP clinical systems in use in Lincolnshire also interface with the *Summary Care Record*.

PACEF Comment

Access to information on the patient's acute and repeat medicines through the Summary Care Record, in conjunction with a review of the medicines brought in by the patient, enables ULH clinical staff to work with the patient to compile a detailed Medication History with much less need to contact the patient's GP or surgery to confirm or clarify details.

Information compiled from the Medication History can help to ensure that the patient gets the correct advice pre-admission. For example, those on anti-coagulants will need to be advised on how to manage their anticoagulation before and after surgical intervention.

Acute Admission

Specific wards and departments within ULH are set-up to receive acute admissions including: Coronary Care Unit (CCU), Stroke Unit, Shuttleworth Ward (trauma), Emergency Eye Clinic, Cardiac Short Stay, Medical Emergency Admissions Unit (MEAU) and Surgical Emergency Admissions Unit (SEAU).

All patients are seen by a doctor on admission and prioritized. Patients should be encouraged to take their medicines into hospital with them on admission, but it is recognized that this is not always possible. It is good practice to advise all patients potentially at-risk of acute admission to carry a copy of the repeat prescription slip from their GP surgery in their wallet, purse or handbag at all times. Where the patient cannot bring their medicines in personally, their partner, family member, friend or carer will be asked to bring their medicines into the hospital as soon as possible after admission.

PACEF Comment
Even as part of an acute admission, patients should be encouraged to take all of their medicines into hospital with them, if possible. Patients, particularly those at-risk of acute admission, should be encouraged to carry a copy of a repeat prescription slip from their GP surgery in their wallet, purse or handbag at all times. **Where the patient cannot bring their medicines in personally, their partner, family member, friend or carer will be asked to bring their medicines into the hospital as soon as possible after admission.**

As stated above, access to the *Summary Care Record* has enabled ULH clinical staff to more readily compile a much more accurate and convenient Medication History on admission with much less need to contact the patient's GP or surgery for clarification of details.

The In-Patient Experience

Medicines Reconciliation

NICE guidance states that: following admission to hospital, medicines reconciliation should be carried out within 24 hours of admission or sooner if clinically necessary. Pharmacy staff are striving to ensure that medicines reconciliation takes place as a matter of priority for all patients as soon as possible after admission with the majority of new patients seen within 24 hours.

Medicines reconciliation is defined as the process whereby an accurate list of a person's current medicines is identified and compared with the current medicines in use. As part of the process, discrepancies are identified and rectified and an accurate and up-to-date list is compiled. This list should include prescribed, over-the-counter and complementary medicines.

Medicines Reconciliation support is prioritised, with new patients and those waiting to be discharged identified as top priority; MEAU and SEAU patients are also seen as high priority for medicines reconciliation. Those patients not seen by a pharmacist or technician on admission are usually seen later on the ward. Doctors are encouraged to work towards a Planned Discharge Date which enables medicines reconciliation to be planned into the patient's in-patient stay rather than hurriedly delivered at the last minute prior to discharge.

One-stop dispensing

Wherever possible, ULH will strive to ensure that patient's own medicines are utilised when the patient is in hospital. Where additional medication is required, the aspiration is that each medicine is only dispensed once for each patient during their in-patient stay with appropriately labelled dosage instructions. Original packs are always issued where feasible with the usual quantity equating to the length of stay plus 14 days' supply post-discharge. Stock medicines are usually supplied to wards as 'over-labelled' packs; these are usually original containers of the required medicine labelled with a pre-printed dispensed label

containing details of the medicine, strength and form with a particular dosage specified. All that the ward staff are required to do is to complete the patient's name and date of issue on the label to create an individual patient supply. Under no circumstances should the pre-printed dose on the label be altered. Only medicines approved for use through the *Lincolnshire Joint Formulary* are likely to be supplied in this way.

Where the patient is prescribed a non-*Formulary* medicine, their own supply will be used while they are in hospital wherever possible. If no supply is available or the patient's supply runs out, consideration will be given to switching the patient to an alternative product available through the *Joint Formulary* and ULH Pharmacy. Unusually, if the patient's supply runs out and a switch is thought to be inappropriate, the patient's partner or carer will be asked to order a replacement supply from the patient's GP.

Self-administration

There are plans to introduce patient self-administration of their own medicines, following successful implementation of the one-stop dispensing scheme. Individual patient lockers are provided within which patients' own medicines can be stored. Wards continue to use medicines trolleys, although these are predominantly reserved for PRN medication and antibiotic therapy of indeterminate length.

Discharge

Doctors are encouraged to work towards a Planned Discharge Date. Where a PDD is known, pharmacy staff will deliver medicines reconciliation on discharge, usually about 24 hours in advance of the PDD. This usually involves complete review of the prescription by a pharmacist utilising standard review criteria such as START, STOPP, PINCER and PACEF derived interventions. Similar criteria are increasingly being used to inform pharmacist review within both ULH and the Arden GEMCSU Prescribing and Medicines Optimisation team.

Definitions
STOPP – Screening Tool of Older People's Potentially inappropriate Prescriptions
START – Screening Tool to Alert doctors to Right Treatment
PINCER – A randomised trial comparing the effectiveness and cost-effectiveness of a pharmacist-led IT based intervention with GPs compared to the IT based intervention alone in reducing rates of clinically important medication related errors in general practice.
PACEF – Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF).

Typically medicines reconciliation on discharge will focus on:

- what the patient has been actually taking while on the ward.
- whether PRN medicines need to continue.
- whether the patient has sufficient medication to meet the minimum 14 day discharge quantity or 5 to 7 days for analgesia..
- whether the patient needs to be discharged on any controlled drugs.
- whether the patient is aware of what they are taking and why and whether any changes in therapy have occurred.

PACEF Comment:
Non-pharmaceutical items, such as oral nutritional supplements, dressings, stoma care and urology products are not likely to feature in medicines reconciliation on discharge, with ward staff often directly responsible for providing supplies. In this

case discharge quantities may be much smaller and more erratic than the standard 14 days' supply of medication.

Where a PDD has not been agreed and discharge takes place without ULH pharmacy involvement, it is most likely that the patient will be discharged with the medicines they have been taking while on the ward. This is the most unsatisfactory scenario as it can lead to patient's being discharged with insufficient medication or with a number of key issues remaining unresolved.

Electronic Discharge Document

As part of the discharge process a copy of the Electronic Discharge Document (eDD) is sent via nhs.net email to the patient's GP. The accuracy of information on the eDD is being improved through increasing emphasis on accurate medication history taking pre-admission and as part of the admission process and through pharmacy-led medicines reconciliation and review as detailed above. At present, the eDD is not subject to a final check by a pharmacist, although focus on drug history taking, medicines reconciliation and medication review during the patient's hospital stay helps to ensure that the eDD is as up to date and accurate as possible at discharge.

PACEF Comment:
It must be stressed that transfer of information is a two way process that requires clear communication from both primary and secondary care. PACEF are aware that there are issues around incomplete discharge information following discharge from Lincolnshire Hospitals that need to be addressed. There are also issues arising from patients not always agreeing to take their own medicines into hospital with them when they are admitted. A multi-disciplinary Medicines Optimisation and Safety Committee has been established, led by United Lincolnshire Hospitals with both primary and secondary care representation specifically designed to address priorities linked to implementation of the NICE Clinical Guideline on medicines optimisation. A work programme has been established to target areas where drug treatment can be optimised to reduce risk and improve patient outcomes; priority areas are diabetes and polypharmacy in elderly patients. To inform this work, it would be extremely useful if practices could continue to report specific issues related to incomplete discharge information or any other issues relating to this patient journey to their CCG or relevant prescribing adviser.

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