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NHS Sheffield Clinical Commissioning Group

Collaborative audit across England on the quality of medication related information provided when transferring patients from secondary care to primary care and the subsequent medicines reconciliation in primary care

Sheffield CCG Report

This report has been prepared from the Sheffield CCG Data Report submitted by the facilitators of the national audit, Medicines Use and Safety, NHS Specialist Pharmacy Services based at Northwick Park Hospital (see acknowledgement)

Prepared by:

Hilde Storkes, Medicines Governance Pharmacist, Sheffield CCG

On behalf of the Medicines Safety Group (MSG)

January 2017

Acknowledgement

Medicines Use and Safety Authors:

Chetan Shah

- Project Lead, Medicines Use and Safety - NHS Specialist Pharmacist Services

Jane Hough

- Associate Director, Medicines Use and Safety - NHS Specialist Pharmacist Services

Dr Yogini Jani

- Medication Safety Officer Implementation Project Lead, Medicines Use and Safety - NHS Specialist Pharmacy Service

Overview

In January 2016, Sheffield CCG participated in a national collaborative audit of discharge medication. The aim of this was to assess the quality of information regarding medicines within discharge summaries provided by secondary care and to determine whether GPs have correctly acted upon the information regarding medicines within 7 days of receiving the discharge information (NICE Medicines Optimisation Quality Standard).

Data on a total of 236 patients was submitted to the facilitator for analysis who issued a report of the summary of the national data and an individual report for each participating CCG; the latter compared the CCG's results with the national results. The results from Sheffield have been reviewed by MSG and recommendations made. As the majority (92%) of the discharges were from STHFT, the conclusions regarding secondary care have been directed at STH.

Quality of the discharge summary: overall Sheffield demonstrated good compliance with:

- Discharge summary demographic and format
- TTO prescription standards including allergy status

The results were comparable, if not better, than the national results.
However, the study confirmed the main concern raised by GPs in Sheffield on the lack of documented reasons when medications are stopped, started or have their dose changed during an in-patient stay.
Actions to address this: the current introduction of Lorenzo EPMA at STH is an opportunity to consider how a full electronic prescribing system can be utilised to improve this parameter. The audit results are to be considered at STH Medicines Safety Committee. Use of a CQUIN is under consideration.
An additional recommendation is a review of the format of Lorenzo EPMA discharge summary with primary care clinicians with consideration of the addition of the consultant contact details to enable GPs more easily to clarify any issues.

Medicines reconciliation at GP practices: the results from the process at GP practices are more difficult to interpret. The level of action assessed as incorrect was low (2 to 4% of discharges, less than national); but the reasons for the GP not always incorporating the changes in medicines on the GP system and intentionally disregarding these was not investigated.
Where action was required by the GP, there was evidence that this occurred within 7 days for 47% of patients, approximately the same as the national results. However, in 45% it was documented that no actions regarding medicines were required. The results indicate that there may be a need for improvement with this measure in Sheffield but further data is required.
In approximately half of the patients audited the GP was clearly involved in reconciling the patient's medication following discharge from hospital; however in the remainder various team members from within the GP surgery were involved. The data gathered was not reliable enough to draw any conclusions nationally or locally. In Sheffield, a receptionist was documented as undertaking the medicines reconciliation in 5% of patients, in line with national results.
Actions: the recommendation is for a more detailed review of the processes for managing discharge procedures at GP practices - either by utilising the MMT or through the prescribing quality LCS. Consider the involvement of clinical pharmacists working in GP practices.

Summary care records (SCRs): although not investigated as part of the audit, this is a related topic and a recommendation is included on ensuring that GP practices send updated SCRs to the spine.

Collaborative audit across England on the quality of medication related information provided when transferring patients from secondary care to primary care and the subsequent medicines reconciliation in primary care

Sheffield CCG report

1. Introduction

In January 2016, the MMT participated in a national collaborative audit of discharge medication. The aim of this collaborative audit and service evaluation was to assess the quality of information regarding medicines within discharge summaries provided by secondary care (acute, mental health and community services) and to determine whether GPs have correctly acted upon the information regarding medicines within 7 days of receiving the discharge information (NICE Medicines Optimisation Standard[1]). The audit was led by the Medicines Use and Safety, NHS Specialist Pharmacy Service based at Northwick Park Hospital.

2. Background

Discharge communication (TTOs). In Sheffield, concerns have been raised by GPs on the quality of the discharge communication and the MMT undertook a 'snapshot' review in 2010. Subsequently, STH introduced an interim electronic discharge form via ICE to improve the quality of the TTOs in advance of the full introduction of the proposed electronic prescribing and administration system (Lorenzo EPMS, previously termed IPPMA). The ICE form improved the timeliness and the legibility of the discharge communication but there are continuing concerns about apparent omissions on the TTO of medicines that the patient was taking prior to admission and lack of information when new medicines are started. As these concerns were anecdotal, participation in the national audit allowed quantification of this.

Medicines reconciliation process at GP practices. This was reviewed in Sheffield in 2009/10 and 2010/11 as part of the QoF medicines 6&10 practice prescribing plan. The aim of these process audits was: to ensure that information received into practices with regard to patients medication on discharge is processed in a safe, efficient and timely manner; and that practices have procedures for identify patients who are a priority for early discharge medication review. No further city wide work has been undertaken.

3. Audit methodology

The methodology and audit tools can be accessed at:
https://www.sps.nhs.uk/articles/a-collaborative-audit-on-the-quality-of-medication-related-information-provided-when-transferring-patients-from-secondary-care-to-primary-care-and-the-subsequent-medicines-reconciliation-in-primary-c/

MMSG deemed that participation in the audit was an appropriate use of the team's resource. A minimum of 1 patient discharge audit per 50,000 population within each CCG was the requirement to participate, although each CCG was encouraged to audit as many patient discharges as possible. For Sheffield, the minimum was approximately 11 patients. However, in order to obtain sufficient data to make local analysis valid, it was agreed that the attached MM pharmacists would collect data in 1 session from each of their GP practices during the month of January. The patients were randomly selected from those who had been discharged during the period Oct to Dec 2015, in line with the study methodology.

4. Results and Discussion

Data on a total of 236 patients was submitted to the facilitator for analysis. In addition, the technicians in the team collected data at practices where there was no attached pharmacist. The audit protocol only allowed data to be submitted by pharmacists for consistency across the participating CCGs. However, this additional data was used for local analysis of discharges from STH to support the proposal for a CQUIN for 16/17 on the quality of the discharge communication (see later).

The facilitator issued a report of the summary of the national data and an individual report for each participating CCG; the latter compared the CCG's results with the national results. The national report is available on the SPS website:
https://www.sps.nhs.uk/wp-content/uploads/2015/11/Medicines_Reconciliation_Collaborative_Audit_Report.pdf

The recommendations from the national report and the local Sheffield CCG's data were considered by MSG in July and Sept 2016 meetings.

Demographics

Table 4-1 shows the patient demographics and demonstrates that the Sheffield patients did not differ significantly from those in the national audit. Nationally, 47 CCGs submitted a total of 1454 patients; thus Sheffield, 2% of the participating CCGs, contributed 16% of the patient numbers. The reasons for this include Sheffield CCG having a large MMT with an attached pharmacist in the majority of GP practices and the commitment of the team to prioritise the data collection for the audit.

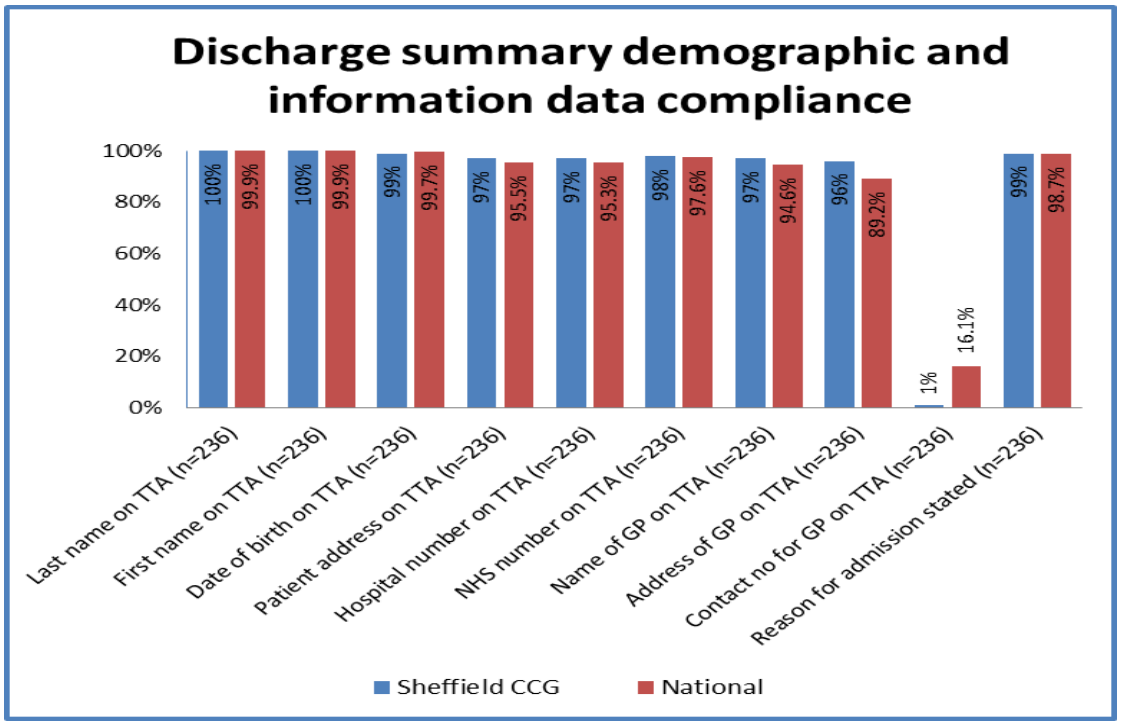
Table 4-1: Study sample data

	Sheffield CCG	National Audit Results
Total number of patient discharge summaries audited	236	1454
Total number of medicines prescribed across all discharge summaries audited	1407	10,038
Total number of participating CCGs	1	47
Total number of hospitals audited	11	159
Median age of patients audited (n=236)	68 years (range 1-99)	72 years (range 0 – 102 years)
Gender of patients audited (n=235)	Female = 53% Male = 47%	Female = 53% Male = 47%
Median length of inpatient stay for patients audited (n=236)	3 days (range 0-140)	4 days (range 0 – 208 days)
Median length of time before GP received the discharge summary/TTO post patient discharge (n=236)	0 days (range 0-38)	1 day (range 0 – 38 days)
Route of admission for patients audited (n=232)	Unplanned – 80% Planned – 20%	Unplanned – 78.6% Planned – 21.4%

Patients were discharged from a total of 11 hospitals in Sheffield. The majority were from the hospitals that are part of STHFT; only 19 of the 236 discharges were from other hospitals, including 9 from SCH. The dominance of the electronic discharges from STH is reflected in the median length of time for GPs to receive the discharge summary (0 days). Nationally, approximately 89% of the discharge summaries audited were electronically generated compared with 95% received for Sheffield.

The discharge summary demographic (Fig 4-1) shows good compliance in all areas except for contact number for the GP. This is not a field on the STH edischarge and MSG did not consider it necessary to recommend that this is added.

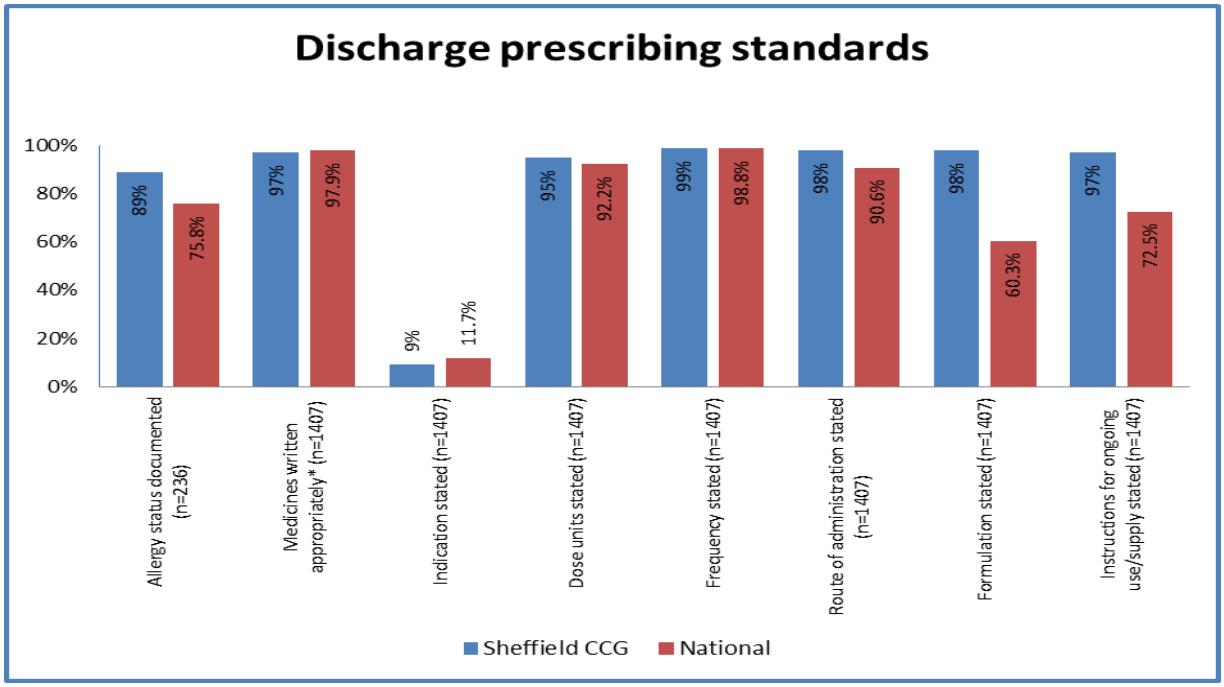
Figure 4-1: Discharge summary demographic and information data compliance



Prescription standards

Fig 4-2 shows the standards for the TTO set. These standards were taken from the RPS - Keeping patients safe when they transfer between care providers –getting the medicines right: Final Report[2]. Sheffield showed good compliance with these standards, in some cases better than the national data. The only indicator with low compliance was for 'indication stated', not a field on the current edischarge form. There may be several reasons for this: the same medicine can be used for several indications; secondary care staff may not always know the indication the medicine is being used for, particularly if it has no bearing on their admission; and adding an indication for each drug may lead to increased confusion for the GP if it is not what they prescribed the medication for. Thus it is not considered necessary to recommend inclusion of the indication when Lorenzo EPMA is introduced.

Figure 4-2: Discharge TTO prescription standards compliance



Allergy status

One of the areas of high priority within the audit was to ascertain the quality of allergy status recording on discharge summaries, in line with the recommendations made in the NICE CG 183 on Drug allergy: diagnosis and management[3]. Omission of allergies on the discharge summary might be indicative of the hospital not receiving from the GP the correct allergy status of the patient when admitted. The results showed that the allergy status was correctly documented on 89% of the discharges from Sheffield compared with 75.8% from the national data.

Medicines newly started (see Table 4-2)

The number of patients who had at least one new medicine started during the admission was 164 for Sheffield patients (69%). This is lower than that from the national data (79%). The results confirmed the anecdotal reports from GPs in that the reason for the new medication started was documented for only 36% of the 449 medicines started. This is lower than the 49% documented nationally.

Medicines reconciliation at GP practice: the results indicated that in 49% of the patients with new medicines started, the GP incorporated onto this onto their prescribing system.

However, in 30% the GP intentionally disregarded the recommendation. This is higher than the national result (16%). The reason for this is not clear but may include the GP awaiting a review of the patient before continuing the medicine. In 2% of the patients, the action by the GP was assessed as incorrect; this is less than the national result of 5.7%.

Table 4-2: Medication changes and communication at discharge for newly started medicines

	Sheffield CCG	National Audit Results
Percentage of patients audited who had at least one new medicine started whilst an inpatient (n=236)	69% (164 patients)	79% (1146 patients)
Total no of medicines started across patients audited (n=236)	449 Mean of 1.9 medicines started per patient audited	3164 Mean of 2.18 medicines started per patient audited
Of the newly started medicines (n=449) what proportion had a reason documented?	36%	49%
For each patient were the newly started medicines incorporated / actioned on the GP prescribing system? (n=164)	Yes = 49% No = 13% No action required* = 37% *for example where antibiotics, laxatives, analgesics may have been prescribed as a short course of therapy	Yes = 53% No = 13% No action required* = 34% *for example where antibiotics, laxatives, analgesics may have been prescribed as a short course of therapy
For each patient were any of the recommendations around newly started medicines intentionally disregarded? (n=164)	Yes = 30% No = 70%	Yes = 16% No = 78.6% Data unavailable = 5.7%
For each patient were any recommendations around starting medicines actioned incorrectly? (n=164)	Yes = 2% No = 98%	Yes = 5.7% No = 93.2% Data unavailable = 1.1%

Medication stopped / omitted from discharge (see Table 4-3)

For medication omitted from the discharge, an element of judgement was required by the pharmacist as to whether the medication was intentionally stopped or was unlikely to have been stopped. From the table it can be seen that 20% of patients were assessed as having at

least one medicine intentionally stopped and 21% as unlikely to be stopped. Of the 99 medicines intentionally stopped, less than half (42%) had a documented reason. This illustrates the concerns raised by the GPs regarding inadequate communication on medicines omitted from the TTO.

Table 4-3: Medication changes and communication at discharge for medicines that have been stopped

	Sheffield CCG	National Audit Results
Percentage of patients audited who had at least one medicine intentionally stopped whilst an inpatient (n=236)	20% (47 patients)	27% (388 patients)
Total no of medicines intentionally stopped across patients audited (n=236)	99 Mean of 0.42 medicines intentionally stopped per patient audited	738 Mean of 0.51 medicines intentionally stopped per patient audited
Percentage of patients who had at least one medicine omitted on their discharge summary/TTO (i.e medicines they normally took prior to admission but which were unlikely to have been stopped) (n=236)	21%	33%
Total no of medicines omitted across patients audited (n=236)	210 Mean of 0.89 medicines omitted per patient audited	1565 Mean of 1.1 medicines omitted per patient audited
Of the medicines intentionally stopped (n=99) what proportion had a reason documented?	42%	57%
For each patient were the medicines that were intentionally stopped incorporated / actioned on the GP prescribing system? (n=47)	Yes = 72% No = 19% Data unavailable = 9%	Yes = 74.5% No = 21.7% Data unavailable = 3.6%
For each patient were any of the recommendations around stopping medicines intentionally disregarded? (n=47)	Yes = 13% No = 79% Data unavailable = 9%	Yes = 12.6% No = 83.8% Data unavailable = 3.6%
For each patient were any recommendations around stopping medicines actioned incorrectly? (n=47)	Yes = 2**%** No = 85% Data unavailable = 13%	Yes = 6.7**%** No = 89.7% Data unavailable = 3.6%

Medicines reconciliation at GP practice: the results indicated that in 72% of the patients with medicines intentionally stopped, the GP incorporated onto this onto their prescribing system. However, in 13% the GP intentionally disregarded the recommendation, which is in line with the national result (12.6%); the reason for this is was not documented. In 2% of the patients, the action by the GP was assessed as incorrect; this is less than the national result of 6.7%.

Medication dose changes on discharge (see Table 4-4)

Table 4-4: Medication dose changes and communication at discharge for medicines with dose changes

	Sheffield CCG	National Audit Results
Percentage of patients audited who had the dose of at least one of their medicines changed whilst an inpatient (n=236)	21% (49 patients)	23% (336 patients)
Total no of medicines that had a dose change across patients audited (n=236)	64 Mean of 0.28 medicines that had a dose change per patient audited	477 Mean of 0.32 medicines that had a dose change per patient audited
Of the medicines with dose changes what proportion had a reason documented	53%	39%
Were the medicines that had dose changes incorporated / actioned on the GP prescribing system? (n=49)	Yes = 76% No = 20% Data unavailable = 4%	Yes = 64.9% No = 34.5% Data unavailable = 0.6%
Were any of the recommendations around dose changes intentionally disregarded? (n=49)	Yes = 18% No = 78% Data unavailable = 4%	Yes = 22.9% No = 76.5% Data unavailable = 0.6%
Were any recommendations around dose changes actioned incorrectly? (n=49)	Yes = 4% No = 92% Data unavailable = 4%	Yes = 8.6% No = 89.9% Data unavailable = 1.5%

From the table it can be seen that 21% of patients were assessed as having the dose of at least one medicine changed during the inpatient stay. Of the 64 medicines with a dose change, 53% had a documented reason, which was higher than the national result (39%).

Medicines reconciliation at GP practice: the results indicated that in 76% of the patients with dose changes, the GP incorporated this onto their prescribing system. However, in 18% the GP intentionally disregarded the recommendation, which is lower than the national result (22.9%); the reason for this was not documented. In 4% of the patients, the action by the GP was assessed as incorrect; this is less than the national result of 8.6%.

Format of discharge summary (Table 4-5)

Table 4-5: Contact details and format of discharge summary/TTO

	Sheffield CCG	National Audit Results
Was there any evidence that the discharge summary/TTO had been clinically reviewed (screened) by the Pharmacist? (n=206)	Yes – 78% No - 22%	Yes – 49% No - 51%
Was there a contact name of the screening Pharmacist? (n=161)	Yes - 93% No - 7%	Yes - 88% No - 12%
Was there a contact number of the screening Pharmacist? (n=161)	Yes - 3% No - 96% Data unavailable 1%	Yes - 4% No - 95% Data unavailable- 1%
Was the name of the consultant/discharging Dr documented on discharge summary/TTO? (n=236)	Yes – 97% No – 3%	Yes – 96% No - 4%
Was the contact details of the consultant/discharging Dr documented on discharge summary/TTO? (n=236)	Yes – 47% No – 53%	Yes – 57% No - 43%
Was the discharge summary/TTO electronically or hand written? (n=235)	Electronic - 95% Handwritten - 5%	Electronic - 89% Handwritten - 11%
How did the GP receive the discharge summary/TTO? (n=235)	Electronically - 79% Posted - 14% Unable to identify - 7%	Electronically - 72% Posted - 12% Unable to identify - 16%

The table shows that 78% of the 236 discharges had a clinical review by a secondary care pharmacist compared with 49% nationally. The name of the pharmacist was mainly documented (93%) but only 3% had their contact number. The name of the consultant/discharging doctor was detailed in 97% but contact details in only 47%. This is an area requiring improvement to enable the GP to follow up any queries on the discharge.

As discussed previously, the majority (95%) were electronic but, surprisingly, 14% were recorded as posted to the GP rather than received electronically.

Medicines reconciliation process in primary care (Table 4-6)

Table 4-6: Medication reconciliation process in primary care

	Sheffield CCG	National Audit Results
For medicines that were started / stopped or doses changed during the hospital inpatient stay, were the changes actioned by the GP within 7 days of the discharge being received? (n=230)	Yes = 47% No = 9% No action required = 45%	Yes = 45.5% No = 12.5% No action required = 42%
Who carried out the medicines reconciliation within the GP surgery for the discharge summaries received? (n=233)	GP = 52% No requirement to undertake Medicines Reconciliation* = 11% Unable to identify = 12% CCG/Practice Pharmacist = 11% Not undertaken* = 4% Practice Receptionist = 5% Practice Nurse = 3% Other = 3% * in these datasets it was difficult to ascertain why these options had been chosen and to draw conclusions	GP = 51.49% No requirement to undertake Medicines Reconciliation* = 15.1% Unable to identify = 7% CCG/Practice Pharmacist = 6.59% Not undertaken* = 5.69% Practice Receptionist = 5.55% Practice Nurse = 0.49% Practice Manager = 0.07% Other = 8.05% * in these datasets it was difficult to ascertain why these options had been chosen and to draw conclusions
Was the medicines reconciliation process READ coded? (n=215)	Yes =26% No = 74%	Yes =17% No = 83%
Was there any evidence that the patient was involved in the medicines reconciliation by the GP surgery? (n=218)	Yes = 11% No = 89%	Yes =16.5% No = 83.5%

Where action was required by the GP, there was evidence that this occurred within 7 days for 47% of patients, which is approximately the same as the national results. However, in a large proportion (45%), no actions regarding medicines were required to be taken by the GP following discharge; although medicines reconciliation presumably occurred to identify that no actions were required, the time scale for this is not known. This appears to be a high percentage considering the number of TTOs with medication changes on discharge. One of the key standards in the NICE Medicines Optimisation Guidance[1,4] is that medicines reconciliation should be carried out for all people who have been discharged from hospital or another care setting and should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within 1 week of the GP practice receiving the information. The results indicate that there may be a need for improvement with this measure in Sheffield but further data is required.

In approximately half of the patients audited the GP was clearly involved in reconciling the patient's medication following discharge from hospital; however in the remainder various team members from within the GP surgery were involved. The data gathered was not reliable enough to draw any conclusions nationally or locally. In Sheffield, a receptionist was documented as undertaking the medicines reconciliation in 5% of patients, in line with national results. This had been noted following the previous medicines discharge reviews and discussions held with the practices to ensure that there was a robust procedure for involvement of the receptionist.

In the majority (74%) of patients audited the medicines reconciliation process was not READ coded but this was better than the national data (83%). Although one of the limitations of the audit methodology was the ability to identify whether the patient was involved in any medicines reconciliation by the GP practice, in 11% of patients audited there was clear documentation that the patient had been involved, compared with 16.5% nationally.

5. Conclusions and Recommendations

The facilitators of the collaborative audit drew the following conclusions and recommendations from the national data. These have been considered at MSG and, based on the results from Sheffield, comments added in bold. As the majority (92%) of the

discharges were from STH, the recommendations regarding secondary care have been directed at STH. An action plan is included in Appendix 2.

- Communication around medication changes when patients transfer from secondary care to primary care requires significant improvement

  The study has confirmed the main concern raised by GPs in Sheffield on the lack of documented reasons when medications are stopped, started or have their dose changed during an in-patient stay. This has been discussed at MSG and MSC on a number of previous occasions. The introduction of a full electronic prescribing and administration system at STH (Lorenzo EPMA) may improve this, particularly when it incorporates the facility to compare the record of medicines on admission with those on discharge. Although this is a later development, the checking pharmacist will be able to refer to the clerking and medicines reconciliation documentation as well as the in-patient record when reviewing the discharge prescription.

- Secondary care providers to consider including the details of the reviewing/screening pharmacist with their contact details so that primary care clinicians can contact them to clarify any issues.

  The need for the contact details of the pharmacist has been considered at MSG and not thought to be as critical as ensuring that the details of the consultant/prescribing doctor are included.

- CCGs and secondary care providers should collaborate to review the local hospital discharge template to ensure that it meets the needs of all involved, is in line with the standards set by the RPS[2] and Academy of Royal Colleges[5] and supports transfer of medication related information.

  STH are introducing Lorenzo EPMA from January 2017. The format of the proposed edischarge has not been reviewed by primary care but will be the same format as the current ICE discharge initially. This can be reviewed and amending following launch and roll out to maximise the benefit.

- Secondary care providers to utilise Summary Care Records (SCRs) to ensure that medicines reconciliation at admission is robust as this will affect the quality of medicines related information contained in the discharge summary/TTO.

A limitation of the study is that it did not collect data on medicines reconciliation on admission. This has a bearing on the quality of the discharge as dose changes/medicines omitted may be as a consequence of lack of medicines reconciliation or inadequate information provided by the GP on admission. STH already utilises SCRs as part of their medicines reconciliation process. It has been noted that GPs do not always send updated information to the spine and this reduces the reliability of the SCR. The importance of the SCR as a means of communication between primary and secondary care has recently been highlighted to GP practices.

- GP practices should have clear processes in place on how the information provided on discharge summaries/TTOs is managed once received. Consideration should be given to whose responsibility is to review medicines on the discharge summaries and who should action on the GP prescribing system. Consideration should be given to the role of clinical pharmacist's in GP practices reconciling medicines post discharge from secondary care

  The results from the process at GP practices are more difficult to interpret. **Action on managing discharge summaries at practice level was undertaken by the MMT following the CQC report – Managing patients' medicines after discharge from hospital (2009)[6]. No further follow up has been carried out since the reviews in 2010 and 2011. It may be timely to repeat this assessment, in particular, whose responsibility it is to review medicines on the discharge summaries, who should action on the GP prescribing system and whether this is within 7 days of receiving the discharge information. However, QoF medicines 6&10 has been retired so another mechanism is required, which may be to utilise the MMT as part of the quality work programme or through the prescribing quality LCS.**

  There are a number of current proposals regarding pharmacists working in GP practices in Sheffield and managing discharge summaries is considered a key role.

- CCGs to consider developing CQUINs to drive improving the quality of discharge communication by secondary care as previously recommended by the CQC.

  A summary of the data from STH TTOs (see Appendix 1) was used to discuss the proposal for a CQUIN in 2016/17 to improve the quality of the discharge communication. However, it has been agreed to postpone the CQUIN until eprescribing has been established in the trust as it is considered that this will be the

main driver of improvement. The roll out of Lorenzo EPMA was expected in 2016 but this has been postponed until 2017. Thus it may not be an option for a CQUIN for 2017/18, depending on the progress with implementation.

6. References

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5. Academy of Medical Royal Colleges. A Clinician's Guide to Record Standards – Part 1: Why standardise the structure and content of medical records? 2008. www.rcoa.ac.uk/docs/Clinicians-Guide-Part-1-Context.pdf
6. CQC report – Managing patients' medicines after discharge from hospital. October 2009. http://webarchive.nationalarchives.gov.uk/20101201001009/http:/www.cqc.org.uk/_db/_documents/Managing_patients_medicines_after_discharge_from_hospital.pdf

Appendix 1 - Discharge audit - data analysis STH

Prepared by Heidi Taylor, Clinical Effectiveness Pharmacist, Feb 2016

Note: data on a total of 236 patients was submitted to the facilitator for analysis. In addition, the technicians in the team collected data at practices where there was no attached pharmacist. The audit protocol only allowed data to be submitted by pharmacists for consistency across the participating CCGs. However, this additional data was used for local analysis of discharges from STH to support the proposal for a CQUIN for 16/17 on the quality of the discharge communication.

Appendix 2 - Action plan (approved by APG 19/01/17)

Appendix 1 Discharge audit - data analysis STH

A total of 253 discharge summaries were reviewed by the team as part of the national collaborative audit throughout the month of January from discharges Oct to Dec 2015. However for local analysis we have not included discharge information if the patient stay in hospital was 0 or 1 day.

A total number of **196** discharge summaries from STH were analysed. A summary of the findings relating to information regarding medication can be seen in the table below.

Indicator	**findings**	**%**
Is the allergy status fully (any newly identified allergies plus known allergies from GP system) documented on the discharge summary/TTO?	181 had allergy status clearly documented.	92%
For every sensitizing agent is a brief description of the allergy reaction documented?	Of the 181 discharge summaries that had an allergy status documented 62 gave a brief description of the allergy documented	34%
In total there were **1613 medicines prescribed** on the discharge summary/TTOs reviewed (Excluding wound care, nutritional supplements, medical devices etc).		
How many medicines were written appropriately with their generic name (consider branded prescribing as appropriate if applicable for example due to bioavailability issues or inhaler preparations where brand specificity is required)?	1575	98%
How many medicines had their indication documented for its use? e.g. Oxybutynin 5mg M/R Tablets PO OD for **Urinary Incontinence**	109	7%
How many medicines had their dose units documented? e.g Oxybutynin **5mg** M/R Tablets PO OD for Urinary Incontinence	1541	96%
How many medicines had their frequency documented? e.g Oxybutynin 5mg M/R Tablets PO **OD** for Urinary Incontinence	1591	99%
How many medicines had their route of administration documented? e.g Oxybutynin 5mg M/R Tablets **PO** OD for Urinary Incontinence	1592	99%
How many medicines had their formulation documented? e.g Oxybutynin 5mg **M/R Tablets** PO OD for Urinary Incontinence	1574	98%

How many medicines had instructions for their ongoing use e.g whether it is to be continued, reviewed (with instructions), titrated or stopped? (use clinical judgement)	1566	97%
When comparing the Pre Admission Medication (PAM) list on the GP clinical system against the discharge summary/TTO **426 medicines had been started** during the inpatient stay		
How many of the medicines that had been started had a reason documented for starting the medicine on the discharge summary/TTO	164	38%
When comparing the Pre Admission Medication (PAM) list against the discharge summary/TTO) review whether any medicines **have been stopped** during the inpatient stay: (Note: Use clinical judgement as to whether medicines have been stopped or just been omitted off the discharge summary/TTO due to possibly a poor or lack of Med Rec at admission to hospital)		
The total no of medicines that had been intentionally stopped i.e where the medicines exists on the PAM list but not on the discharge summary/TTO.	112	
The total no of medicines that had been omitted on the discharge summary/TTO but exists on the PAM list and which are unlikely to have been stopped.	79	Around 5%
How many of the medicines that have been intentionally stopped had a reason documented for stopping the medicine on the discharge summary/TTO	51	45%
When comparing the Pre Admission Medication (PAM) list against the discharge summary/TTO **76 medication dose changes** had occurred during the inpatient stay:		
How many of the dose changes had a reason documented for the change in dose on the discharge summary/TTO.	42	55%
Is there any evidence that the discharge summary/TTO was clinically reviewed (screened) by the secondary care Pharmacist?	166, of which only 9 provided contact details	85%
Is there documentation of the contact details of the discharging Dr or Consultant on the discharge summary/TTO)?	193, of which 109 provided contact details	98%
Was the discharge summary/TTO Electronic (computer generated) or Hand written?	186	95%

Appendix 2 Action Plan

A summary of the Sheffield CCG report was submitted to APG 19/01/17. The summary report was endorsed and the action plan approved.

Recommendation	Action	Time	Evidence
Improvement in the documentation of the reasons for changes in medicines on discharge from STH	1. Introduction of Lorenzo EPMA 2. Consider CQUIN 3. Consider re-audit of TTOs by MMT if CQUIN not agreed	Pilot commence Jan 2017 To be determined; dependent on roll out of EPMA	Feedback from GPs Re-audit by MMT 2018/19 (if CQUIN not agreed.)
Review format of discharge summary; inclusion of consultant / prescribing doctor contact details	Lorenzo EPMA discharge summary will initially have the same fields as ICE discharge; involvement of primary care in reviewing format.	To be determined by STH when EPMA is established across the hospitals.	New format introduced if agreed; MSG minutes
Review management of discharge summaries at GP practices to ensure that the procedures are robust, particularly where non health care professionals are involved, and updates are timely in line with NICE medicines optimisation standard	Repeat the practice process reviews conducted in 2010/11	To be discussed at MSG Jan 17; proposal to MMSG	Utilise the MMT as part of their quality work programme or through the prescribing quality LCS
Summary Care Record to be kept up-to-date (note this was not evaluated in the audit but is a related action)	Review barriers to sending updates to the spine at some GP practices.	Communication sent to GPs via GP ebulletin 29/11/16 Further action to be discussed at MSG Jan 17	To be determined by MSG