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Transfer of Care and Medicines Reconciliation

Kaylie McNaughton
Care Home Pharmacist – Luton

Lisa Woods
Care Home Pharmacy Technician – Luton

Session Plan

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1. Introduction & Housekeeping
2. Transfer of Care
3. Medicines Reconciliation
4. Case Studies – interactive session
5. Quiz
6. Questions

Housekeeping

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- Please write your name and the care home/provider you are from in the chat
- Please remain on mute when not speaking
- Q&A section at the end – please use the “raise hand” function or “chat” function
- This session does not equate to competency in the subject area – individual providers are responsible for assessing competency.
- Session will be recorded

Meet the Team - NHS BLMK ICB Care Home Medicines Optimisation Pharmacists & Pharmacy Technicians

Bedford Borough Place

Team Email:
blmkicb.bedsmocarehometeam@nhs.net

Harprit Bhogal
Care Home Pharmacist
harprit.bhogal1@nhs.net
Tel: 07733 013073

Lindsey Jones
Care Home Pharmacy Technician
lindsey.jones33@nhs.net
Tel: 07771 581922

Central Bedfordshire Place

Team Email:
blmkicb.bedsmocarehometeam@nhs.net

Courtenay Amos
Care Home Pharmacist
courtenay.amos@nhs.net
Tel: 07771 576395

Sharon Tansley
Care Home Pharmacy Technician
sharontansley@nhs.net
Tel: 07469 902006

Luton Place

Team Email:
blmkicb.lutoncarehometeam@nhs.net

Kaylie McNaughton
Care Home Pharmacist
kaylie.mcnaughton@nhs.net
Tel: TBC

Lisa Woods
Care Home Pharmacy Technician
lisa.woods5@nhs.net
Tel: 07557 084888

Milton Keynes Place

Team Email:
blmkicb.mkcarehomespharmacy@nhs.net

Hazel Gervais
Care Home Pharmacist
hazel.gervais2@nhs.net
Tel: 07765 254188

Kasia Wolska
Care Home Pharmacy Technician
k.wolska@nhs.net
Tel: 07901 755443

Please send details of your query/referral to the relevant area's team email address (no proforma required). Individual contacts can be used if needed.

Emails are monitored Monday—Friday, 9am—5pm (excluding Bank Holidays) and will be triaged to the most appropriate member of the team.

Patient identifiable details should ONLY be sent from and to secure email addresses (e.g. NHS.net to NHS.net).

More information, guidance documents & newsletters can be found on the BLMK ICB Care Home Medicines Optimisation (MO) team website.

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Our Role

- Supportive – the ICB is not a care home regulatory body.
- The team provides support to a number of key stakeholders including:
  - Care homes / Learning Disability Homes
  - Primary Care Networks (PCNs) / Practices
  - The ICB Quality Team
  - Local Authorities
  - Other community services
  - Secondary care

BLMK ICB Medication Training Offer – Tiered System

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1. • Medication eLearning – PrescQIPP
2. • Online Medication Training Sessions – BLMK ICB
3. • Medication Champions Scheme

BLMK ICB Care home Medicines Optimisation team – Training offer

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Tier 1 – Medication eLearning:

- Hosted by PrescQIPP (Skills for Care and NICE endorsed)
- Care Home staff- ‘Medicines use in care homes: courses 1, 2 & 3’ (access code needed) *new code needed Nov 23*
- Community-based Care staff –'Managing medicines for adults receiving social care in the community: courses 1 & 2’ (no access code required)
- Fully funded by BLMK ICB / Health Education England - free of charge
- Provides foundation knowledge in medicines management within social care and supports the implementation of recommendations in the NICE SC1 (Managing medicines in care homes) and NICE NG67 (Managing medicines for adults receiving social care in the community)

BLMK ICB Care home Medicines Optimisation team – Training offer…continued

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Tier 2 – Online Medication Training Sessions

- Provided by the BLMK ICB Care Home Medicines Optimisation team, free of charge
- On the selected topics below and will focus on local guidance and procedures:
  - Homely Remedies and Self Care *delivered*
  - When Required (PRN) Medication *delivered*
  - Covert Administration of Medication *delivered*
  - Medicines Reconciliation & Transfers of Care
  - Controlled Drugs & Controlled Drug Regulations in Care Homes
  - Medication Safety, Governance & Safeguarding

Tier 3 – Medication Champions Scheme – COMING APRIL 2024

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Transfer of Care

What is Transfer of Care?

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- When a patient is transferred between care settings. This includes:
  - Home to care home
  - Hospital to care home
  - Care home to care home
  - Care home to hospital

Why is it important?

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- Report in 2012 from Royal Pharmaceutical Society (RPS)
- **'Keeping patients safe when they transfer between care providers - getting the medicines right'**

- Showed that when patients move between different care providers the risk of miscommunication and unintended changes to medicines was a significant problem.
- Between 30% and 70% of patients have an error or unintended change to their medicines when their care is transferred between settings

- Accurate transfer of information about medicines helps:
  - Reduce avoidable harm to patients
  - Improves patient safety
  - Contributes to a reduction in medicine related admissions to hospital

Communication

- The Institute of Health Improvement estimates that as many as 50% of all medication errors are due to poor communication when residents transfer from one care setting to another. Residents recently discharged from hospital are known to be a particularly vulnerable group.

- Good communication is vital

NICE SC1: Managing medicines in care homes

1.3 Sharing information about a resident's medicines

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Includes points below:

- Care home providers should have a process for managing information – include what training is needed
- Should follow the rules on confidentiality set out in the home's process on managing information about medicines and only share enough information with health professionals that a resident visits to ensure safe care of the resident.
- Providers of health or social care services should ensure that either an electronic discharge summary is sent, if possible, or a printed discharge summary is sent with the resident when care is transferred from one care setting to another.
- Health and social care practitioners should ensure that all information about a resident's medicines, including who will be responsible for prescribing in the future, is accurately recorded and transferred with a resident when they move from one care setting to another.
- Care home providers should have a process in the care home medicines policy for recording the transfer of information about residents' medicines during shift handovers and when residents move to and from care settings.

Process to follow when a resident transfers FROM your care home to another setting

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- The care home manager or the person responsible for a resident's transfer should coordinate the accurate listing of all the resident's medicines

- Care home staff should share relevant information about the person and their medicines when a person transfers from one care setting to another. This should include, but is not limited to, all of the following:
  - Resident’s details, including full name, date of birth, NHS number, address and weight (for example, frail older residents)
  - GP’s details.
  - Other relevant contacts for example, the consultant, regular pharmacist or specialist nurse
  - Known allergies and reactions to medicines or ingredients, and the type of reaction experienced.

Continued on next slide

- Medicines the resident is currently taking, including name, strength, form, dose, timing and frequency, how the medicine is taken (route of administration) and what for (indication), if known.
- Changes to medicines, including medicines started, stopped or dosage changed, and reason for change.
- Date and time the last dose of any ‘when required’ medicine was taken or any medicine given less often than once a day (weekly or monthly medicines).
- Other information, including when the medicine should be reviewed or monitored, and any support the resident needs to carry on taking the medicine (adherence support).
- Remember to send any appropriate medicines with the residents

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Types of Transfer of Care & possible issues

Transfers from resident's own home to care home

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- Unreliable information on current regimen.
- Potentially the residents' medicines are in varied quantities and dates of issue.
- Dates of opening may not be recorded, non-prescribed medicines with unclear indications and not checked for suitability
- 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

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- 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 resident.
- The patient's MAR sheet may not be up-to-date if there has been a change in medication.
- MAR sheets are misplaced and are not transferred with the resident.
- Residents may be discharged/transferred without medication.
- Inaccurate or incomplete information transfer could result in discontinued medications being administered which could result in harm.
- Non-clinical staff in the care home may be faced with making decisions about medication which are outside of their competencies and potentially unsafe.

Examples

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- Patient admitted from hospital to care home with insulin
  - No dose on discharge letter
  - Phoned hospital - pharmacy dept unable to help as they had no information on dosage whilst in hospital
  - Family knew dose before admission but unreliable as dose may have changed
  - Time sensitive so important to resolve as soon as possible
  - Ward responded with details of timings and dose
  - Raised as Medicines Safety Incident

- Patient admitted from hospital to care home with eye drops and liquids.
  - Medicines in use but no date of opening!
  - Manager tried to obtain new supplies but will be time delay – resident needs meds!
  - Contacted our care home team for advice
  - Agreed it was acceptable to use ‘date of hospital dispensing’ on pharmacy label as the ‘date of opening’ so can continue to use the meds – added this date to labels and informed all staff
  - Lead to changes in our guidance – advice added to Good-Practice-Guidance-for-care-homes-Expiry-dates-for-medication-V4.pdf (icb.nhs.uk)
  - Prevented potential medication waste

Transfers from one care home to a different care home

- MAR sheets are not transferred with the resident.
- Medications not transferred with the patient e.g. CDs, fridge items, EOL meds
- The medications/MAR sheet is transferred incomplete i.e. some may be missing, particularly “prn” medication, PRN protocols

Medicines when temporarily away from the care home

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Examples – staying with family, attending day centre etc

Care home providers must ensure that the following is given to the resident and/or their family members or carers when the resident is temporarily away from the care home to ensure medicines can continue to be taken safely:

- Any medication that is required whilst away from the home with details of the names of the medicines and what they are for
- Clear directions and advice on how, when and how much of the medicines the resident should take
- The time of the last and next due dose of each medicine
- Any other documentation e.g. PRN protocol, care plan etc
- Contact details for queries about the resident's medicines
- There should be no secondary dispensing
- MAR chart needs to be documented appropriately if resident is away from the home

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Medicines Reconciliation

What is medicines reconciliation?

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Process of identifying an accurate list of a person's current medicines and comparing them with the current list in use
Recognising any discrepancies and documenting any changes
Includes over-the-counter or complementary medicines, prescribed appliances, and nutritional products
Discrepancies should be resolved
Results in a complete and accurate list of medicines
Should be completed for every new resident and when resident has transferred from one care setting to another

What could go wrong if a resident's medication is not accurately listed?

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- The resident might receive the wrong dose, strength, or formulation of their medicine
- The resident may not receive their medicine at all
- There could be delays to a resident's treatment while issues are resolved
- Greater risk of drug interactions and adverse effects
- Additional staff time spent on resolving issues
- The wrong medication could be ordered for the resident

Who can do medicines reconciliation?

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Trained and competent staff should carry out the medicine reconciliation.

They should consult with an appropriate health care professional. Ideally, this should be a pharmacist, pharmacy technician, specialist nurse or GP.

Care homes should have a policy in place to ensure that this process is carried out by a competent person. The policy should ensure timeliness and have a safe and robust process for addressing discrepancies

These staff will need knowledge, skills and expertise including:

Effective communication skills
Technical knowledge of processes for managing medicines
Therapeutic knowledge of medicines use.
E.g., Medication Champion

When to do medicines reconciliation?

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1

When a person is discharged from hospital or transferred from another setting or place of residence (including their home)

2

When treatment has changed, for example dose changes or when starting to take new medicines

3

Before the first dose is administered or as soon as possible afterwards

How to do medicines reconciliation the 3Cs?

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1

Collecting

2

Checking

3

Communicating

1. Collecting information

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- Most up to date reliable source should be used, crossed checked and verified.
- A range of sources can be used including:
  - A computer print-out from a GP clinical records system.
  - The tear-off side of a resident's repeat prescription request.
  - Verbal information from the resident, their family, or a carer.
  - Medical notes from a resident's previous admission to hospital (e.g., discharge summary).
  - Monitoring documents (Yellow book – Warfarin, Purple book – Lithium)
  - Medicine containers or repeat prescription supplies available at the time of the reconciliation.
  - Remember to check for medicines not prescribed by the GP, e.g. hospital outpatient, mental health medicines, over-the-counter medicines, complementary medicines.
  - A patient's previous Medicines Administration Record (MAR) if they are a returning resident

What to include in medicines reconciliation

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- Contact details for relevant healthcare professionals
- Known allergies and reactions to medicines or ingredients and the type of reaction
- Current medicines, including:
  - name
  - strength
  - formulation
  - dose
  - timing and frequency
  - route of administration
  - indication - what the medicine is for (if known)
- How and when the person prefers to take their medicines. This should include an assessment for self-administration

What to include in medicines reconciliation continued

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- Date and time the last dose of any 'when required' medicine was taken, including specific instructions to support their administration.
- Information about any medicine given less often than once a day - weekly or monthly medicines
- When the medicine should be reviewed or any monitoring
- Any other relevant information, for example smoking status, alcohol intake

2. Checking

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- This step involves ensuring the medicines and doses prescribed following the basic reconciliation process are correct.
- These may not be identical to those documented during the collecting process, as the GP or other prescriber may have made some intentional changes.
- Any discrepancies will need to be resolved in the final step of this process.
- Check that nothing has changed, e.g., new adverse effects, the resident's ability to swallow tablets etc.

PAY CLOSE ATTENTION TO:

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- ✓ Medicines that have stopped
- ✓ Medicines that have started
- ✓ Changes in medicine strength
- ✓ Changes in medicine dose
- ✓ Changes in medicine frequency
- ✓ Specific details on length of treatment
- ✓ Specific details on increasing or decreasing regimes
- ✓ Take special precautions with brands and generics (e.g. Losec® and omeprazole are the same drug)
- ✓ New recorded known allergies
- ✓ If a discharge summary appears incomplete, inaccurate or ambiguous, action must be taken immediately to seek clarification to avoid potential harm to the resident.

3. Communicating

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- Any discrepancies need to be resolved as quickly as possible to avoid any harm coming to the resident
- Confirm changes with care provider where the resident has come from
- May need to speak to discharge planning, previous care home, relatives, PCN team, pharmacist

- Communicating is the final step in this process where changes to the resident's prescription are documented and dated and communicated to the next person responsible for the medicines management care of that resident

Record keeping

- Record the information from medicines reconciliation in the person's medicines care plan. Make sure to record:
  - details of the person completing the medicines reconciliation (name, job title)
  - the date of the medicines reconciliation
  - source(s) of information about the reconciled medicines
- Check the medicines administration record (MAR) to make sure it contains accurate information.

Case study – Mrs C

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- Long term resident recently admitted into hospital after a fall in the care home.
- Discharged from hospital with changes made to her medication

Medicines **prior** to admission:

Aspirin 75mg OM
Amlodipine 10mg OM
Ramipril 10mg OM
Atorvastatin 10mg ON
Cetirizine 10mg OM
Levothyroxine 75mcg OM

Paracetamol 1g QDS PRN

Medicines **after** admission:

Amlodipine 5mg OM
Alendronic acid 70mg weekly
Calcichew T OD
Atorvastatin 40mg ON
Levothyroxine 75mcg OM
Paracetamol 1g QDS

Mrs C – Medicines Reconciliation

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What do you do first?	• Identify who will do medicines reconciliation
What resources can you use?	• Hospital discharge letter • Medicines supplied by hospital • Monitoring documents • Resident/Relatives/Carers
What are the changes or discrepancies?	• Aspirin, Ramipril and Cetirizine stopped • Amlodipine dose reduced • Atorvastatin dose increased • Paracetamol made regular • Alendronic acid and Calcium supplement added

Mrs C – Medicines Reconciliation continued

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Are the discrepancies intentional?	• Contact the hospital • Contact HCP at GP surgery • Needs to be done ASAP
Implement changes	• Remove discontinued items • Amend MAR chart and other documents • Remove PRN protocol for paracetamol • Become familiar with new medicines
Who else can you involve?	• PCN pharmacy team • Specialist nurse / CCT pharmacy team • GP (weekly check-in/MDT) • Relative • Resident

QUIZ

Question 1

Between 30% and 70% of patients have an error or unintended change to their medicines when their care is transferred between settings

- TRUE
- FALSE

TRUE

Question 2

When a resident is admitted into hospital you do not need to give details of any allergies they have.

- TRUE
- FALSE

FALSE

Question 3

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What could go wrong if a resident's medication is not accurately listed?

A. The resident might receive the wrong dose, strength, or formulation of their medicine
B. The resident may not receive their medicine at all
C. There could be delays to a resident's treatment while issues are resolved
D. Greater risk of drug interactions and adverse effects

ALL OF THEM

Useful references

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- NICE Guidance: Managing medicines in care homes - Social Care Guideline SC1 https://www.nice.org.uk/guidance/sc1
- CQC: Medicines Reconciliation https://www.cqc.org.uk/guidance-providers/adult-social-care/medicines-reconciliation-how-check-you-have-right-medicines
- PrescQIPP: Bulletin 278 Transfer of care around medicines https://www.prescqipp.info/our-resources/bulletins/bulletin-278-transfer-of-care-around-medicines/
- PrescQIPP: Bulletin 178 Care homes - Transferring patients between care settings https://www.prescqipp.info/our-resources/bulletins/archived-publications/bulletin-178-care-homes-transferring-patients-between-care-settings/

Other resources

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- British National Formulary (BNF)
  - Paper copy - ensure using an up-to-date copy.
  - Online: https://www.medicinescomplete.com
- Electronic Medicines Compendium (EMC)
  - https://www.medicines.org.uk/emc
- National Institute for Health & Care Excellence
  - https://www.nice.org.uk
- CQC Website
  - https://www.cqc.org.uk

Our resources

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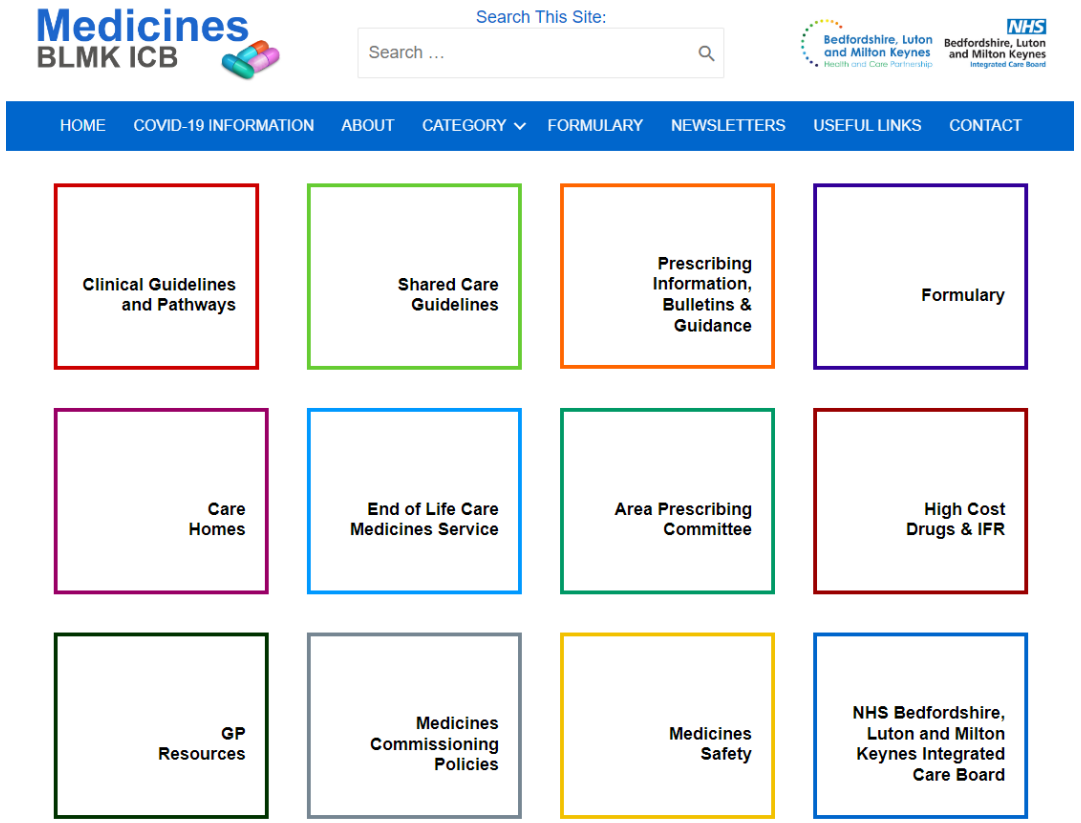
BLMK ICB Medicines website - [BLMKICB Medicines Management]

Care Homes page (purple box):
[Care Homes – BLMKICB Medicines Management]

Key Documents:

- Care Home team Service Referral Pathway
- Homely remedies toolkit and First Dressing scheme
- Self Care Tool Kit for Care homes
- Covert Administration Guidance (Adults)
- 'When required' PRN Guidance for Care homes
- Expiry dates for medication - Guidance for Care homes
- Meds room and refrigerator temperature guide
- Falls Documents – leaflet and poster
- Care home newsletters



BLMK Care Home Medicines Optimisation Team Contact Details

Bedfordshire, Luton and Milton Keynes Integrated Care Board

Bedfordshire team:

Email: blmkicb.bedsmocarehometeam@nhs.net

Luton team:

Email: blmkicb.lutoncarehometeam@nhs.net

Milton Keynes Team:

Email: blmkicb.mkcarehomespharmacy@nhs.net

Questions

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