PrescQIPP
Community Interest Company

Transfer of care around medicines

This bulletin focuses on medication issues that can occur when adult patients over the age of 12 years are transferred between different care settings. This includes transfer between home, care home (providing both residential and nursing care), hospital, private healthcare, prison and other secure settings.

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]

Good communication is key to good transfer of care.[2] This bulletin provides some recommendations on how to improve the transfer of care process with respect to medicines across various different settings.

Recommendations

- Robust and transparent processes should be in place covering the sharing of complete and accurate information about the person's medicines with the new care provider and receiving, documenting and acting upon this information.
- Health and social care practitioners transferring people into hospital should ensure the admitting team is given all appropriate information about current medicines.
- For all care settings, health and social care practitioners should share the required information about medicines ideally within 24 hours of the person being transferred.
- During discharge planning, the discharge coordinator should share medicines information with both the hospital and community-based multidisciplinary teams. The discharge plan should include information about the person's medicines, including any assessed support needs.
- The discharge coordinator should provide people who need end-of-life care, their families and carers, with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge. This should also be considered for people with complex needs.
- People (and their family/carers if appropriate) should be given a complete list of their medicines when they transfer between hospital and home (including their care home).
- Consideration should be given to sending a person's medicines discharge information to their nominated community pharmacy, when possible and in agreement with the person.
- In England, patients suitable for community pharmacy review post hospital discharge should be referred to a relevant community pharmacy under the Discharge Medicines Service (in Wales this would be to the Welsh Discharge Medicines Review Service).
- Organisations should consider arranging additional support for some groups of people when they have been discharged from hospital, such as pharmacist counselling, telephone follow-up, and GP or nurse follow-up home visits. These groups may include those with polypharmacy, chronic or long-term conditions and older people.
- Setting up a secure electronic interface between the hospital IT systems and tools such as Pharmaoutcomes and Refer-to-Pharmacy (web-based platforms) have the opportunity to enhance transfers of care around medicines by providing patient data quickly and seamlessly with a discharge summary to their community pharmacist for review.

Recommendations

- In primary care, medicines reconciliation should be carried out for all people who have been discharged from hospital or another care setting. This should happen as soon as is practically possible before a prescription or new supply of medicines is issued and within one week of the GP practice receiving the information.
- Medicines reconciliation should be carried out by a trained and competent health professional – ideally a pharmacist, pharmacy technician, nurse or doctor with the necessary knowledge, skills and expertise.
- Patients and their family members or carers, where appropriate, should be involved in the medicines reconciliation process.
- The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients in the absence of a specific need requiring a monitored dosage system ('blister pack').
- All required information should be available for medicines reconciliation on the day that a resident transfers into, or from a care home.
- When a patient is discharged from inpatient or day case care in hospital, sufficient medication must be supplied by the hospital pharmacy for at least seven days after discharge, to allow patients or their carers time to contact staff at their general practice. Exceptions are if a shorter period is more clinically appropriate, or the patient has an adequate supply, or will receive a supply through an existing repeat prescription.
- Where a patient has an immediate clinical need for medication as a result of attending an outpatient clinic, the secondary care provider must supply sufficient to last at least until the point at which the outpatient clinic's letter can reasonably be expected to have reached the patient's GP, and when the GP can therefore accept responsibility for subsequent prescribing. This is usually a minimum of seven days' supply unless the medicines are not required for that length of time.
- Patients attending an urgent and emergency care setting should also receive from the emergency department a supply of prescription medicines for seven days, or shorter if medicines are not required for that length of time.
- When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP (and the patient) to share their care, including details of the medicine, monitoring, review and action to take in the event of difficulties.
- When a GP accepts responsibility for prescribing medicines which are not usually dispensed in the community there should be liaison with the transferring hospital and if appropriate the relevant community pharmacist to ensure continuity of treatment.
- In all cases, it is essential that there is prompt and clear communication on the transfer of care between secondary/tertiary and primary care, and at key stages during the outpatient pathway. Legal responsibility for prescribing lies with the health professional signing the prescription and it is their responsibility to prescribe within their competence.
- People released or transferred from prison and other secure settings should have sufficient medicines and dressings (including Controlled Drugs) when they are released or transferred to another health and justice setting until the person or new setting can reasonably be expected to visit a community GP or obtain further supplies. Supply will be for a minimum of seven days and usually a maximum of a month's supply. People can also receive substance misuse medication and other not-in possession doses of "once daily" medicines before they leave to maximise the time available before their next dose.
- Where the release is unplanned, people should be given or be able to access FP10/FP10MDA prescriptions so they can obtain their medicines via a community pharmacy.

Recommendations

- People should be given a discharge summary on release or transfer from prison/secure settings that provides information about their ongoing needs for medicines. The discharge summary should be available to the person and clinicians taking on the care of the person ideally at the time of, and certainly within 24 hours of them leaving.

National guidance

In 2012, the Royal Pharmaceutical Society (RPS) produced a report entitled 'Keeping patients safe when they transfer between care providers - getting the medicines right'.[1] This report outlined the results of a six-month project involving over 30 healthcare organisations who volunteered to implement RPS guidance on transfer of medicines information.[1]

This included evidence showing that when patients move between different care providers the risk of miscommunication and unintended changes to medicines present a significant problem.[1] It was 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]

The National Institute for Health and Care Excellence (NICE) published a guideline (NG27) covering the transition between inpatient hospital settings and community or care homes for adults with social care needs with the aim of improving people's experience of admission to, and discharge from, hospital by better coordination of health and social care services.[3]

Additionally, the NICE Social Care Guideline: Managing Medicines in Care Homes (SC1), includes recommendations around sharing information about a resident's medicines and medicines reconciliation.[4]

More generally, the NICE Guideline: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes (NG5), specifically includes information on medicines-related communication systems that should be implemented when patients move from one care setting to another.[5]

In 2018, NHS England published guidance on the Responsibility for prescribing between Primary & Secondary/Tertiary Care.[6] This aimed to address additional issues concerning the following:

- Patients being caught in the middle where there is lack of agreement over prescribing responsibilities and the risk that they might be left without the medication they need.
- Perverse cost incentives to shift responsibility for medicines between secondary care and primary care.
- GPs' concerns over taking responsibility for unfamiliar treatment.
- Lack of consultation between professionals over the transferring of prescribing responsibilities.
- Hospitals providing insufficient quantities of medication on discharge or following out-patient or emergency treatment.
- Patients having to make a special trip to their GP to obtain a prescription immediately after a hospital visit.

Communication

Good communication is key to good transfer of care.[2] Relevant information about medicines should be shared with patients, and their family members or carers, where appropriate, and between health and social care practitioners when a person moves from one care setting to another, to support high-quality care.[5] This includes transfers within an organisation – for example, when a person moves from intensive care to a hospital ward – or from one organisation to another – for example, when a person is admitted to hospital, or discharged from hospital to their home or other location.[5]

Organisations should ensure that robust and transparent processes are in place, so that when a person is transferred from one care setting to another the current care provider shares complete and accurate information about the person's medicines with the new care provider and the new care provider receives and documents this information, and acts on it.[5]

Organisational and individual roles and responsibilities should be clearly defined and the effectiveness of these processes regularly reviewed and monitored.[5]

For all care settings, health and social care practitioners should proactively share complete and accurate information about medicines, ideally within 24 hours of the person being transferred, to ensure that patient safety is not compromised and in the most effective and secure way, such as by secure electronic communication, recognising that more than one approach may be needed.[5]

Health and social care practitioners 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:[5]

- Contact details of the person and their GP.
- Details of other relevant contacts identified by the person and their family members or carers where appropriate – for example, their nominated community pharmacy.
- Known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced.
- Details of the medicines the person is currently taking (including prescribed, over-the-counter and complementary medicines) – name, strength, form, dose, timing, frequency and duration, how the medicines are taken and what they are being taken for.
- Changes to medicines, including medicines started or stopped, or dosage changes, and reason for the change.
- Date and time of the last dose, such as for weekly or monthly medicines, including injections.
- What information has been given to the person, and their family members or carers where appropriate.
- Any other information needed – for example, when the medicines should be reviewed, ongoing monitoring needs and any support the person needs to carry on taking the medicines. Additional information may be needed for specific groups of people, such as children.

Health and social care practitioners should discuss relevant information about medicines with the person, and their family members or carers where appropriate, at the time of transfer. They should give the person, and their family members or carers where appropriate, a complete and accurate list of their medicines in a format that is suitable for them. This should include all current medicines and details of any changes to medicines made during their stay and why.[5]

Strong consideration should be given to sending a person's medicines discharge information to their nominated community pharmacy, when possible and in agreement with the person.[5]

Organisations should consider arranging additional support for some groups of people when they have been discharged from hospital, such as pharmacist counselling, telephone follow-up, and GP or nurse follow-up home visits. These groups may include adults, children and young people taking multiple medicines (polypharmacy), adults, children and young people with chronic or long-term conditions and older people.[5]

The following NICE (NG27) recommendations specifically concern patients with social care needs[3] but equally apply to all:

- People should be given information about their diagnoses and treatment and a complete list of their medicines when they transfer between hospital and home (including their care home). If appropriate, this should also be given to their family and carers.
- Health and social care practitioners, including care home managers and out-of-hours GPs, responsible for transferring people into hospital should ensure that the admitting team is given all available relevant information, including current medicines.
- During the hospital stay, prescribed and non-prescribed medicines should be included in an electronic data system, made accessible to both the hospital- and community-based multidisciplinary teams, subject to information governance protocols.
- During discharge planning, the discharge coordinator should share medicines information with both the hospital- and community-based multidisciplinary teams. They should provide people who need end-of-life care, their families and carers with details of who to contact about medicine and equipment problems that occur in the 24 hours after discharge. This should also be considered for people with complex needs.
- The discharge coordinator should ensure that the discharge plan includes information about the person's medicines.
- All relevant staff should be trained in the hospital discharge process, including medication review in partnership with the person, including medicines optimisation and adherence.

Furthermore, the RPS has highlighted some key communication links relevant to pharmacists to assist with the transfer of care of medicines. These include:[7]

- Better communication and engagement between hospital and community pharmacy providers. This could be facilitated by those pharmacists working in for example Clinical Commissioning Groups, Health Boards, Integrated Care Systems, Primary Care Networks. This will help to build relationships to support patient care as new services are developed.
- Community pharmacists could provide information to their secondary care colleagues if their patients are admitted into hospital.
- If pharmacists find inaccuracies with a patient's medicines following a transfer of care, the patient's GP should be contacted so that the inaccuracies are not continued. This could also be reported as a near miss or an intervention.
- Pharmacists working in all sectors should check unusual doses of prescribed medicines. In secondary care, doses are often prescribed as a total dose rather than as unit doses so instead of two 10mg tablets a dose of 20mg would be prescribed. If left unchecked it could lead to the supply of an unlicensed special.

PharmOutcomes (a web-based platform used by community pharmacies to record data on pharmacy service provision) has also been successfully utilised to facilitate a secure method of electronic transfer of discharge information related to medicines between hospital and community pharmacies.[8,9]

Medicines reconciliation

Medicines reconciliation is defined as the 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, thereby resulting in a complete list of medicines, accurately communicated. The term 'medicines' also includes over-the-counter or complementary medicines, and may also include prescribed appliances, borderline substances and nutritional products, and any discrepancies should be resolved. This is particularly important for high risk medicines, such as insulin and others, that may prove harmful or even fatal. The medicines reconciliation process will vary depending on the care setting that the person has just moved into – for example, from primary care into hospital, or from hospital to a care home.[5]

In an acute setting, medicines reconciliation should occur within 24 hours or sooner if clinically necessary, when the person moves from one care setting to another – for example, if they are admitted to hospital. An accurate list of all of the person's medicines (including prescribed, over-the-counter and complementary medicines) should be produced.[5]

Medicines reconciliation may need to be carried out on more than one occasion during a hospital stay – for example, when the person is admitted, transferred between wards or discharged.[5]

In primary care, medicines reconciliation should be carried out for all people who have been discharged from hospital or another care setting. This should happen as soon as is practically possible, before a prescription or new supply of medicines is issued and within one week of the GP practice receiving the information.[5]

In all care settings, organisations should ensure that a designated health professional has overall organisational responsibility for the medicines reconciliation process. The process should be determined locally and include organisational responsibilities, responsibilities of health and social care practitioners involved in the process (including who they are accountable to) and individual training and competency needs.[5]

Organisations should ensure that medicines reconciliation is carried out by a trained and competent health professional – ideally a pharmacist, pharmacy technician, nurse or doctor – with the necessary knowledge, skills and expertise including effective communication skills, technical knowledge of processes for managing medicines and therapeutic knowledge of medicines use.[5]

Patients and their family members or carers, where appropriate, should be involved in the medicines reconciliation process.[5]

When carrying out medicines reconciliation, relevant information should be recorded on an electronic or paper-based form.[5]

Monitored dosage systems (MDS)

When care is transferred from one setting to another or there is a handover of care, e.g. hospital admission, care home, there can be some concerns around not being able to reconcile accurately what is in the MDS or multicompartment compliance aid (commonly referred to as a 'blister pack') with the person's current prescription list or what the person is taking. This can result in wastage of prepared MDS if a medicine needs to be stopped or started, for example during a hospital admission.

The use of original packs of medicines, with appropriate support, is the preferred option of supplying medicines to patients in the absence of a specific need requiring an MDS as an adherence intervention.[10]

Furthermore, a MDS is no longer considered the best method of managing medicines in care homes. Instead, the use of original packs is being endorsed as the preferred option for carer administration. Please refer to PrescQIPP bulletin 174 – ' Care homes - Reviewing the use of monitored dosage systems (MDS)' for further information.[11]

Transfer of medicines between care homes and other settings

The care home manager or the person responsible for a resident's transfer into a care home should coordinate the accurate listing of all the resident's medicines as part of a full needs assessment and care plan. The care home manager should consider the resources needed to ensure that medicines reconciliation occurs in a timely manner.[4]

Care home providers should ensure that the following people are involved in medicines reconciliation: the resident and/or their family members or carers, a pharmacist and other health and social care practitioners involved in managing medicines for the resident, as agreed locally.[4]

Commissioners and providers of health or social care services should ensure that the following information is available for medicines reconciliation on the day that a resident transfers into or from a care home:[4]

- Resident's details, including full name, date of birth, NHS number, address and weight (for those aged under 16 or where appropriate, for example, frail older residents).
- GP's details.
- Details of other relevant contacts defined by the resident and/or their family members or carers (for example, the consultant, regular pharmacist, specialist nurse).
- Known allergies and reactions to medicines or ingredients, and the type of reaction experienced.
- 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).
- What information has been given to the resident and/or family members or carers.

Providers should ensure that the details of the person completing the medicines reconciliation (name, job title) and the date are recorded.[4]

Sharing information about a resident's medicines

Care home providers should have a process for information governance covering the five rules set out in the Health and Social Care Information Centre's, 'A guide to confidentiality in health and social care (2013)'. The process should also include the training needed by care home staff and how their skills (competency) should be assessed.[4]

Commissioners and providers of health or social care services should ensure that the minimum required information is available for medicines reconciliation on the day that a resident transfers into or from a care home (see under medicines reconciliation for care homes above). Commissioners should monitor this through their contracting arrangements.[4]

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).[4]

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.[4]

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.[4]

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 a resident's care is transferred from one care setting to another.[4]

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.[4]

Care home staff 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.[4]

Responsibility for prescribing between primary & secondary/tertiary care

Clinical responsibility for prescribing should sit with those professionals who are in the best position and appropriately skilled to deliver care which meets the needs of the patient. In many cases it will be the GP who is the most appropriate clinician to provide continuing care. However, when decisions are made to transfer clinical and prescribing responsibility for a patient between care settings, it is of the utmost importance that the GP feels clinically competent to prescribe the necessary medicines. If a GP considers themselves unable to take on this responsibility, then this should be discussed between the relevant parties so that additional information or support can be made available, or alternative arrangements made.[6]

Legal responsibility for prescribing lies with the doctor or health professional who signs the prescription and it is the responsibility of the individual prescriber to prescribe within their own level of competence.[12]

In all cases, it is essential for good patient care that there is prompt and clear communication on the transfer of care between hospital and primary care, and also at key stages during the outpatient pathway.[6] This is also important in the context of virtual consultations and hospital-issued prescriptions to ensure that the patient's primary care prescriber has a complete and up-to-date list of prescribed medicines, even if they are not responsible for prescribing all of them.

Given the increasing use of, and benefits derived from, the Summary Care Record and other digital innovations, it is important that a comprehensive primary care record is available in general practice, particularly in situations where not all medicines for a patient are prescribed by their GP and supplied by their community pharmacy.

The NHS Standard Contract sets out specific requirements for providers of secondary and tertiary care in relation to the supply of medicines to patients.[13] The Contract requires the provider to supply medicines, where clinically appropriate, on discharge from inpatient or day case care, following clinic attendance (where a patient has an immediate need for medication, for example, where treatment is expected within seven days) and in accordance with local policy agreed with its commissioners, but subject to covering a minimum period.[6]

Inpatients and day cases

When a patient is discharged from inpatient or day case care in hospital, sufficient medication must be supplied by the hospital pharmacy for a minimum period of seven days after discharge, taking into account bank holidays and weekends, to allow patients sufficient time to contact staff at their general practice. Exceptions to this are if a shorter period is more clinically appropriate, or the patient has an adequate supply, or will receive such a supply through an existing repeat prescription.[6]

The GP to whose care the patient is being transferred should receive notification, via a Discharge Summary within 24 hours of discharge, of the patient's diagnosis and medication; so that any necessary ongoing treatment can be maintained.[6]

Outpatients

Where a patient has an immediate clinical need for medication as a result of attending an outpatient clinic, the secondary care provider must supply medication sufficient to last at least until the point at which the outpatient clinic's letter can reasonably be expected to have reached the patient's GP, and when the GP can therefore accept responsibility for subsequent prescribing. Consideration should be given to providing a minimum of seven days' supply to allow patients sufficient time to contact staff at their general practice (or shorter if medicines are not required for that length of time).[6] The primary care prescriber is responsible for reviewing whether the treatments are suitable for continuation and for ongoing prescribing in primary care.

Patients attending emergency departments

Patients attending an urgent and emergency care setting should also receive from the emergency department a supply of prescription medicines for seven days, or shorter if medicines are not required for that length of time. Again, any appropriate prescribing after that period will then rest with the GP responsible for the patient's continuing care.[6]

Shared care

When a specialist considers a patient's condition to be stable or predictable, they may seek the agreement of the GP concerned (and the patient) to share their care. In proposing shared care agreements, a specialist should advise which medicines to prescribe, what monitoring will need to take place in primary care, how often medicines should be reviewed, and what actions should be taken in the event of difficulties.[6]

When a GP accepts responsibility for prescribing medicines which are not usually dispensed in the community, and where the patient is stabilised on a particular medication, there should be liaison with the transferring hospital and if appropriate the relevant community pharmacist to ensure continuity of treatment.[6]

Specialists retaining responsibility for prescribing

There are circumstances where shared care may not be the most appropriate mechanism, and where specialists would therefore normally retain responsibility for prescribing. This determination is usually made under an Area Prescribing Committee (APC) traffic light system, and may include the following:[6]

- Medicines undergoing or included in a hospital-based clinical trial.
- Medicines requiring specialist monitoring and ongoing specialist intervention.
- Medicines that are unlicensed or are used off-label without an associated evidence base or being recognised as standard treatment.
- Medicines that are only available through hospitals.

Transfer between private and NHS care

For guidance on issuing NHS prescriptions after a private consultation or issuing private prescriptions to NHS patients, please refer to PrescQIPP bulletin 238 – Guidance for prescribers when patients access both NHS and private services.[14]

Transfer to, within and from the prison service or other secure settings

Continuation of medication for people in prison/secure settings is important to maximise benefits and reduce the risk of harm. This is particularly important for people who receive regular medication for long-term conditions. Medicines reconciliation helps ensure that people continue to receive the medicines they need and reduces the risk of harm caused by delayed or inappropriate medication.[15] This should be done within seven days of arrival in a prison to ensure parity with primary care in the community.[5,15]

Transferring people between prisons/secure settings with a minimum of seven days' prescribed medicines (excluding opioid substitution therapy, which is available from stock at all prisons) ensures that they have an adequate supply of medicines until they can get more at the prison they are transferred to.[15]

Discharging people from prison/secure settings with a minimum of seven days' prescribed medicines or an FP10 prescription to obtain medicines from a community pharmacy ensures that they have an adequate supply of medicines until they can get the next prescription after their release.[15] When prisoners have an unplanned/unexpected release into the community they are given or can access FP10/FP10MDA prescriptions. This enables them to get their medicines for free from a community pharmacy until they arrange to see their GP or register with a new GP.[16,17]

Where the transfer or release date is known in advance, people should receive information about their medicines before they leave to support them in being able to continue to take their medicines and have ongoing care provision in place for when they leave if released into the community for specialist care or substance misuse services or individual needs to support safe medicines adherence.[17]

People released from prison or transferred between secure settings (including Approved Premises) should have sufficient medicines and dressings, in dispensed packs (including Controlled Drugs). This ensures continuity of care and safety, until the person can reasonably be expected to visit a community GP. Supply will be for a minimum of seven days and usually a maximum of a month's supply. People can also receive substance misuse medication and other not-in possession doses of "once daily" medicines before they leave to maximise the time available before their next dose.[17]

People should be given a discharge summary on release or transfer that provides information about their ongoing needs for medicines. The discharge summary should be available to the person and clinicians taking on the care of the person ideally at the time of, and certainly within 24 hours of, them leaving. The summary should be shared in the most effective and secure way, such as by secure electronic communication, a paper copy for the person. More than one approach may be needed.[17]

The following information should be included on the prison/secure settings discharge summary:[17]

- Contact details of the person and contact details of the current healthcare leads in the event of any queries after they have left.
- Details of other relevant contacts identified by the person and their family members or carers where appropriate – for example, their nominated community pharmacy for people released into the community.
- Known drug allergies and reactions to medicines or their ingredients, and the type of reaction experienced.
- Details of the medicines the person is currently taking (including prescribed, over-the-counter medicines). Details could include name, strength, form, dose, timing, frequency and duration, how the medicines are taken and what they are being taken for.
- Changes to medicines, including medicines started or stopped, or dosage changes, and reason(s) for the change.

- Date and time of the last dose, such as for weekly or monthly medicines, including injections.
- What information has been given to the person, and their family members or carers.
- Details of any specialist medicines and appliances including medicines supplied via homecare.
- Where appropriate any other information needed – for example, when the medicines should be stopped or reviewed, ongoing monitoring needs and any support the person needs to carry on taking the medicine safely.

People who are transferred for hospital treatment should have a summary of the current prescribed and other relevant medicines needs included in the shared clinical information.[17]

People who need doses of critical medicines during transit or in court should be able to access these doses.[17]

Medicines that are not needed during transit should be stored safely within the person's property with a clear audit trail where responsibility for safe and secure storage is passed between healthcare and transport organisations and to the healthcare organisation concerned.[17]

Community pharmacist support for patients leaving hospital

It has been demonstrated that patients who see their community pharmacist after they've been in hospital are less likely to be readmitted and, if they are, will experience a shorter stay.[18]

Setting up a secure electronic interface between the hospital IT systems and PharmOutcomes, a community pharmacy system, has the opportunity to enhance the transfer of care around medicines by providing patient data quickly and seamlessly to their community pharmacist.[18]

In England, a new community pharmacy essential service called the Discharge Medicines Service (DMS) will be provided from 15th February 2021 by all community pharmacy contractors.[19] Suitable patients should be identified using the DMS toolkit (due to be published in January 2021) and referral to the relevant community pharmacy should take place within 24 to 48 hours of discharge, ensuring key clinical information is shared.[20]

The community pharmacist will then undertake a clinical review and medicines reconciliation, to ensure any medicines prescribed post discharge reflect any changes and any discrepancies are resolved and a consultation with the patient will be undertaken.[19]

By referring patients to community pharmacy on discharge with information about medication changes made in hospital, community pharmacy can support patients to improve outcomes, prevent harm and reduce readmissions.[20]

Summary

Improving the transfer of information about medicines across different care settings has the potential to 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 transfer of care process has been associated with an increased risk of adverse effects. 30-70% of patients experience unintentional changes to their treatment or an error is made because of a miscommunication.[18]

Consequently, there are significant opportunities for improving communication about medicines at points of transfer of care. These include patient transfer to and from care homes, hospital and prison services; in addition to transferring prescribing responsibility between different care settings.

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Additional PrescQIPP resources

Briefing	https://www.prescqipp.info/our-resources/bulletins/bulletin-278-transfer-of-care-around-medicines/
Implementation tools	

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