Transfer of care around medicines

This bulletin focuses on medication issues that can occur when adult patients are transferred between different care settings. This includes transfer between home, care home, hospital, private healthcare, prison and other secure settings, as well as transfer of prescribing responsibility between primary, secondary and tertiary care. 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]

Key recommendations

- Health and social care practitioners transferring people into hospital should ensure the admitting team is given all appropriate information about current medicines, ideally within 24 hours of the transfer.
- During discharge planning, the discharge coordinator should share medicines information with both the hospital and community-based multidisciplinary teams.
- The discharge coordinator should provide people who need end-of-life care, their families and carers, details of who to contact about medicine and equipment problems which may occur within 24 hours of 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).
- In England, patients suitable for community pharmacy review post hospital discharge should be referred to a 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 PharmOutcomes (a web-based platform) has the opportunity to enhance transfers of care around medicines by providing patient data quickly and seamlessly with a discharge summary to their community pharmacist or primary care pharmacist for review.
- In primary care, medicines reconciliation should be carried out by a trained and competent health professional for all people who have been discharged from any care setting. This should happen before a new supply/prescription and within 1 week of the GP practice receiving the information where appropriate patients (and their family/carers) should be involved in the 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 time to contact 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 following an outpatient clinic or after attending an urgent or emergency care setting, the clinician must supply sufficient to last until the GP can 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.
- 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.
- There are circumstances where shared care may not be the most appropriate mechanism, and where specialists would normally retain responsibility for prescribing. This is usually determined by an Area Prescribing Committee traffic light system.
- On release or transfer from prison/secure settings, people and their relevant clinicians should be given a discharge summary that provides information about their ongoing needs for medicines within 24 hours of them leaving prison.

References and further reading

1. Royal Pharmaceutical Society (RPS). Keeping patients safe when they transfer between care providers – getting the medicines right. Final Report. Published June 2012. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Publications/Keeping%20patients%20safe%20transfer%20of%20care%20report.pdf
2. NICE. Improving transfer of care. How NICE resources can support local priorities. https://stpsupport.nice.org.uk/transfer-of-care/index.html Accessed 04/01/20.
3. NICE. Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE guideline 27 [NG27]. Published December 2015. https://www.nice.org.uk/guidance/ng27
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5. NHS England. Responsibility for prescribing between Primary & Secondary/Tertiary Care. January 2018. https://www.england.nhs.uk/wp-content/uploads/2018/03/responsibility-prescribing-between-primary-secondary-care-v2.pdf

Additional resources available	Bulletin Tools	https://www.prescqipp.info/our-resources/bulletins/bulletin-278-transfer-of-care-around-medicines/

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