Good Practice Guidance for Care Homes:
Discharge Prescriptions - queries or concerns

Introduction

Medication errors can occur during transfer of care e.g. discharge from hospital or when transferring between care homes.

Medicines reconciliation is time sensitive and should be completed within 48 hours by trained and competent staff for residents:

- on admission to the care home, and
- at any transfer of care setting.

It is good practice for care homes to ensure at least 2 members of staff are trained to carry out medicines reconciliation. Refer to The Medicines Reconciliation Good Practice Guidance for information.

The following types of discrepancies on any Discharge Letter need to be resolved in a timely manner for the resident to receive their medicines safely:

- medicines do not match those the care staff understand the resident to be taking,
- no information provided about medicines that appear to have been:
  - stopped,
  - started,
  - dose and/ or frequency changed.
- one or more medicines altered as above, but medicines reconciliation on admission to hospital appears incorrect or not to have taken place,
- duplicates other medicines the resident is taking, e.g. brand with generic, different brands,
- contradicts other information contained in the Discharge Letter,
- does not contain directions/ instructions for use,
- are contained within the Discharge medicines bag but not listed on the Discharge Letter,
- are contained within the Discharge medicines bag but have someone else's name on them.

If the allergy status on MAR chart does not match the allergy on the discharge letter this should be resolved in a timely manner. Records should be updated to ensure allergy status is correct and current together with sources used to confirm this.

Policies and procedures

The care home medicines policy should include a policy for identifying, reporting, reviewing, and resolving medication discrepancies including allergy status.

Identification of discrepancies

Changes to medications can be intentional or unintentional.

Medicines listed on the Discharge Letter and those in the Discharge medicines bag sent with the resident should be cross-checked and reconciled against the medicines the resident was taking before admission to the hospital for both intentional and unintentional differences.

Discrepancies identified without clear explanation and documentation should be checked with:

- the resident,
- family members,
- carers,
- advocates,
- prescribers,
- discharge teams (changes may have been made at the point of discharge).

Resolution of discrepancies should occur as soon as possible using clinical judgement to minimise any medicine-related risk and potential harm to the resident.

All changes should be clearly documented.

Intentional changes to medication

Intentional changes to medication include:

- stopping medication,
- starting medication,
- changing dose of medication,
- changing formulation of medication.

1. Ensure all changes to medications are clearly documented in the resident's care records including the reasons for stopping a medication wherever possible (to reduce the possibility of it accidentally being restarted in error).
2. Any changes made to the MAR chart by care home staff should be checked for accuracy and signed by a separate trained member of staff (NICE SC1 1.14.9).
3. If a medication has been stopped:
    a. Remove it from the resident's current medication supplies.
    b. Store with the separated medicines waiting for disposal according to the care home medicines policy.
    c. Record in the Record of Medication disposal/ returns register (Appendices 1 or 2 of Good Practice Guidance: Disposal of medicines in care homes and care homes with nursing).
    d. Notify the nominated community pharmacy that it has been stopped.
    e. Update the MAR chart to make it clear that the medication has been stopped.
    f. Document in the resident's care records that the above (3a to 3e) has been done.
    g. Ensure that the GP is aware the medication has been stopped.
4. If a medication has been started:
    a. Store it safely with the resident's current medications. See Good Practice Guidance: Medicines' storage.
    b. If a MAR chart has not been supplied with the new medication, update the current MAR chart to make it clear that the medication has been started.
    c. Notify the nominated community pharmacy that a new medication has been started if supplied by a different pharmacy.
    d. Document in the resident's care records the name and dosage of the new medication, the reason it was started (if this information is provided) and who started it.
    e. Document in the resident's care records that the above (4a to 4d) has been done.
    f. Ensure that the GP is aware this medication has been started.

5. If the dose or formulation of a medication has been changed:
    a. Remove the previous dose/ formulation from the resident's current medications.
    b. Store with the separated medicines waiting for disposal according to the care home medicines policy.
    c. Record in the Record of Medication disposal/ returns register (Appendices 1 or 2 of Good Practice Guidance: Disposal of medicines in care homes and care homes with nursing.
    d. Notify the nominated community pharmacy that the dose and/ or formulation has been changed and the details of the new dose/ formulation.
    e. If a MAR chart has not been supplied with the new medication, update the current MAR chart to make it clear that the medication has been started.
    f. Document in the resident's care records that the above (5a to 5e) has been done.
6. Update the resident's Medicines Administration Record (MAR) chart, ensuring changes to medications are:
    a. Clear.
    b. Signed and dated.
    c. Checked for accuracy and countersigned by a second trained and skilled member of staff before the medication is administered.
    d. Document in the resident's care records that the above (6a to 6c) has been done.

Unintentional/ unexplained changes to medication

1. Check with the resident, their family members, carers, advocates and/ or prescribers as appropriate in case information was provided in an alternative letter/ communication to the Discharge Letter.
2. Check the Discharge Letter for information contained within it which might explain the discrepancy even if this might disagree with the medicines list.
3. Check with those who accompanied the resident to the care home.
4. Check with the information:
    - available on the resident's Connected Care record.
    - sent to the resident's community pharmacy.
    - sent to the GP practice.
5. Check with the Discharge Co-ordinator for the ward from which the resident was discharged.
6. Check with the Discharge Team (see Appendix 1 for contact information).
   Report unintentional medication changes on the care home medication error reporting form. A suggested template for Care Home staff for Reporting and Learning from a medicine-related Patient Safety Incident (PSI) is attached in Appendix 2 of the Good Practice Guidance for Care Homes: Handling of medication errors, incidents, near misses or concerns in Care Homes.
7. Ensure this is shared with the organisation from which the medication error originated.

Resolution of discrepancies should occur as soon as possible using clinical judgement to ensure safe and effective person-centred care, minimise any medicine-related risk and potential harm to the resident. All changes should be clearly documented.

Structured Medication Review (SMR)

A Structured Medication Review (SMR) should be completed for any resident:

- Who has recently moved into the care home,
- Who has moved from one care home to another care home,
- Who has had recent change(s) to their medications (stopped, started, dose and/or frequency changed),
- Who has had a change in their state of well-being,
- Any resident about whom the care staff are concerned.

Residents can be referred for an SMR to the:

- PCN clinicians (Pharmacists, Advanced Nurse Practitioners (ANPs), Paramedics and GPs),
- GP practice,
- ICB MOCH team.
  - ➢ Referral to ICB MOCH team
    Care Home Referral to MOCH Team (frimleyccg.nhs.uk)

An action plan should be agreed and documented for medications reviewed including:

- changes to medications,
- any support required,
- follow up required, including what follow up is needed and when,
- monitoring of medications required and what to do with observations,
- signposting to other services,
- referral,
  - o when to refer,
  - o who to refer resident to, and
- safety netting.

Hospital Pharmacy Teams can refer patients directly to their Community Pharmacy for other types of medicines' support, such as the Discharge Medicines Service (DMS).

Record keeping

All medication changes, including the reasons for the changes, should be recorded in the resident's clinical record.
If a medication is stopped, the reason for stopping the medication should be included to ensure it is not restarted in error.

References

- Good Practice Guidance: Medicines Reconciliation
  file (icb.nhs.uk)
- Good Practice Guidance: Structured Medication Review for Care Home Residents

- Good Practice Guidance: Pathway for Medicines Reconciliation & Structured Medication Review (SMR) of new or recently discharged Care Home residents
- Pathway for Medicines Reconciliation & Structured Medication Review (SMR) of new or recently discharged Care Home residents
- Good Practice Guidance: Medicines' storage
  file (icb.nhs.uk)
- Good Practice Guidance: Disposal of medicines in care homes and care homes and care homes with nursing
  file (icb.nhs.uk)
- Good Practice Guidance for Care Homes: Handling of medication errors, incidents, near misses or concerns in Care Homes

- Managing medicines in care home
  Overview | Managing medicines in care homes | Guidance | NICE
- Structured medication reviews and medicines optimisation
  NHS England » Structured medication reviews and medicines optimisation
- The Framework for Enhanced Health in Care Homes, Version 2 (march 2020)
  the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)
- NICE NG5: Medicines Optimisation: the safe and effective use of medicines to enable the best possible outcomes
  Overview | Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes | Guidance | NICE
- NICE NG56: Multimorbidity: clinical assessment and management
  Overview | Multimorbidity: clinical assessment and management | Guidance | NICE
- Specialist Pharmacy Service: Medicines Reconciliation Best Practice Resource and Toolkit
  Medicines Reconciliation: Best Practice Resource and Toolkit – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice
- NHS Scotland: Polypharmacy: Manage Medicines
  Polypharmacy: Manage Medicines (scot.nhs.uk)

Appendix 1

Discharge Team Contact Information

Hospital	Contact Details and Hours of Operation
Berkshire Healthcare Foundation Trust (BHFT) Our sites | Berkshire Healthcare NHS Foundation Trust	8am to 6pm (Monday – Friday) 8am to 1pm (Saturday and Sunday) 8am to 4pm (Bank Holidays) 0118 322 8729 0118 322 8680 0118 322 5603 0118 322 8920 HospitalDischargeTeam@berkshire.nhs.uk
Frimley Park (FPH, part of FHFT)	8am to 6pm (Monday – Friday) 8am to 4pm (Saturday and Sunday) 0300 6133649 0300 6136771 Senior Duty Nurse Medicine 07818 578212 Surgery 07827 841073 Fph-tr.dischargeteam@nhs.net Fhft.iris@nhs.net Relevant specialities and ward contact details at the bottom of each discharge summary. 'Completed by' field includes name and job role of doctor. If amendments are made to the Discharge prescription: 1) Banner at the top of the edited letter stating, *'This is not a duplicate – this is an addended communication that replaces any previous versions sent.'* 2) A particular section of the letter stating, *'The following section contains corrected or additional information that replaces any previous versions sent.'*
Royal Berkshire Healthcare Trust (RBH)	8am to 4pm (Monday – Friday) 0118 322 8156 07385 406925 rbb-tr.complex.discharge@nhs.net No discharge-specific contact. Contact ward or pharmacy.
Wexham Park (WPH, part of FHFT)	8am to 4pm (7 days a week) 0300 6153538 Senior Duty Nurse 07899 876564 Fhft.clinicaldischargeteamwx@nhs.net