Hints and Tips Document

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
Background

This document aims to provide the Pharmacist(s) with some hints and tips when conducting the audit. Much of the information provided within this document is as a result of the feedback provided when the audit was piloted across a number of CCGs.

Hints and Tips

Prior to the audit:
- Read the Audit Protocol and Audit Data Collection Form
- Confirm which GP practices will be utilised for the purposes of the audit. If utilising several GP practices as audit sites, consider: (1) Using a variety of practice sizes (e.g. small, medium and large practices), (2) Varying GP practice sites according to which secondary care NHS trust in the main serves the patients of that GP practice so that a range of secondary care trust discharge summary/TTAs are audited
- Having reviewed the Audit Protocol, Audit Data Collection Form and the Hints and Tips document if you have any queries please contact chetan.shah@nhs.net

When conducting the audit:
- Equipment required for completing the audit:
  (a) Paper copies of audit forms (one per patient to be audited) or laptop if entering directly onto spreadsheet
  (b) Paper copy of the 2015 calendar
  (c) Copy of the audit protocol
  (d) Copy of the hints and tips document
  (e) Some scrap paper to note down the Pre Admission Medication (PAM) list.
- If inputting the data directly onto the Excel Spreadsheet, it is recommended that you work off a laptop rather than the computer in the GP surgery. This will prevent the person conducting the audit having to switch between different programmes/pages/screens.
- **Questions 1-4**: These should be relatively easy to answer from the discharge summary. For identifying the day of discharge it would be worthwhile having a hard copy of the 2015 calendar supplied. The excel spreadsheet is preformatted to calculate the length of stay if the date of admission and date of discharge is inputted in the correct format.
- **Question 5**: Use your judgement to categorise the speciality that the patient was discharged from; it may require you to read the clinical notes in the discharge summary and come to a decision regarding the speciality. Do not add any additional categories.
Question 6: Insert both the discharging hospital and the overarching NHS trust. It is now commonplace for an NHS trust to run several hospitals therefore it is important to identify both sets of data.

Question 7: This question requires you to review the allergy status on the GP system and the discharge summary/TTA and interpret whether the allergy status on the discharge summary/TTA is fully accurate (within the limitations of the information that you have) or whether information is missing.

Question 8: In order to answer YES to this question every sensitizing agent on the discharge summary/TTA must have a brief description of the allergy reaction documented. For example if only 2 of the 3 allergies documented on the discharge summary/TTA have the description of the allergy reaction documented then the answer to the audit question must be NO.

Questions 9 to 16: These are relatively self-explanatory. For question 16 you need to use your clinical judgement as to whether is it obvious to the GP practice what actions need to be taken with each medication e.g whether it is to be continued or stopped after a period of time?

Questions 17 to 19: These questions form the crux of the audit as they measure the quality of medication related information provided when transferring patients from secondary care to primary care. It is vital that the Pre Admission Medication (PAM) List is developed accurately as possible before embarking on answering these questions (In essence conduct a retrospective medicines reconciliation using the information available on the GP system, it is suggested that a list of all medications issued (in addition add any medications that are issued by other providers if that information is available) in the 3 months prior to admission to hospital is made. This part of the audit may take some time and may need clinical judgement). The questions themselves are relatively self-explanatory.

Question 20: This is also a key question as it one of the key recommendations with the NICE Medicines Optimisation Guidance. An effort must be made to try and try and identify when changes (if any) were made to the GP information system based on the information provided in the discharge summary/TTA.

Questions 21 to 23: These are relatively self-explanatory. Question 22 is regarding whether the actual medicines reconciliation in primary care was READ coded. It is NOT asking if other processes such as receiving in the discharge summary were READ coded.

Questions 24 to 27: These are relatively self-explanatory

Question 28: The purpose of this question is to identify whether at any point during the audit did YOU as the person conducting the audit have to intervene in order to ensure that the patient’s medication regime is accurate and safe. If YOU did who did you contact?

Sending the audit results to the Medicines Use and Safety team:

- Check the data inputted onto the Excel spreadsheet for accuracy
- Save excel spreadsheet as your name and CCG name e.g. chetanshahlondonccg
- Send Excel Spreadsheet as an attachment to chetanshah@nhs.net by 31st January 2016. Please state “Data - 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” as the subject title
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