TCAM
Transfer of Care Around Medicines

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TCAM

Transfer of Care Around Medicines

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Introduction

- It is estimated that 60% of patients have three or more changes made to their medicines during a hospital stay. The transfer of care process is associated with an increased risk of adverse effects (AEDs) (1)

- 30-70% of patients experience unintentional changes to their treatment or an error is made because of a lack of communication or miscommunication.

- Only 10% of elderly patients will be discharged on the same medication that they were admitted to hospital on. (2)

- and 20% of patients have been reported to experience adverse events within 3 weeks of discharge, 60% of which could have been ameliorated or avoided (3).

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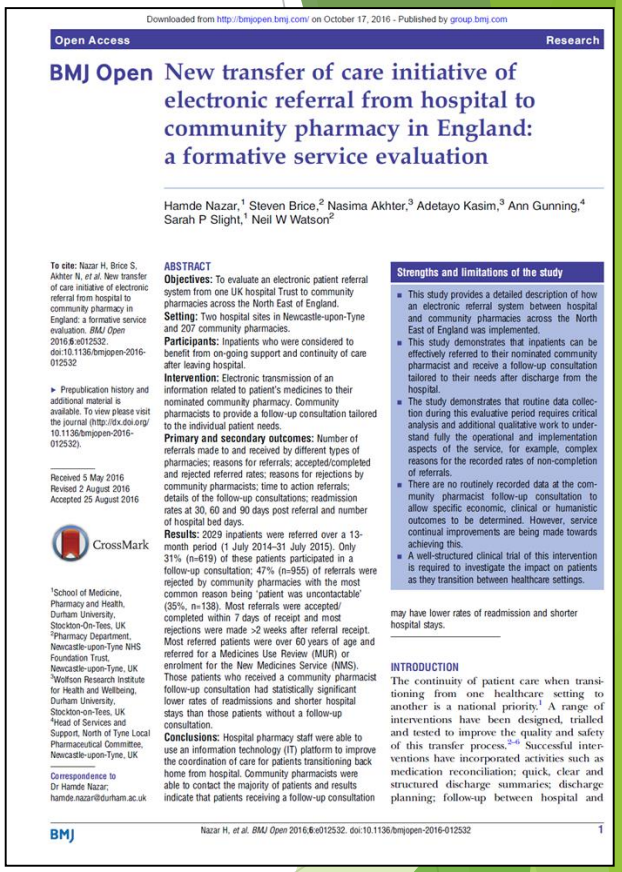
Evidence Base

Community Pharmacy and Hospital Pharmacy - working together to optimise the use of medicines

New transfer of care initiative of electronic referral from hospital to community pharmacy in England: a formative service evaluation
Hamde et al. BMJ Open October 2016

"Those patients who received a community pharmacist follow-up consultation had **statistically significant lower rates of readmissions and shorter hospital stays than those patients without a follow-up consultation"**



Open Access Research

BMJ Open

New transfer of care initiative of electronic referral from hospital to community pharmacy in England: a formative service evaluation

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ABSTRACT

Objectives: To evaluate an electronic patient referral system from one UK hospital Trust to community pharmacies across the North East of England.

Setting: Two hospital sites in Newcastle-upon-Tyne and 207 community pharmacies.

Participants: Inpatients who were considered to benefit from on-going support and continuity of care after leaving hospital.

Intervention: Electronic transmission of an information related to patient's medicines to their nominated community pharmacy. Community pharmacists to provide a follow-up consultation tailored to the individual patient needs.

Primary and secondary outcomes: Number of referrals made to and received by different types of pharmacies; reasons for referrals; accepted/completed and rejected referred rates; reasons for rejections by community pharmacists; time to action referrals; details of the follow-up consultations; readmission rates at 30, 60 and 90 days post referral and number of hospital bed days.

Results: 2029 inpatients were referred over a 13-month period (1 July 2014–31 July 2015). Only 31% (n=619) of these patients participated in a follow-up consultation; 47% (n=955) of referrals were rejected by community pharmacies with the most common reason being 'patient was uncontactable' (35%, n=138). Most referrals were accepted/completed within 7 days of receipt and most rejections were made >2 weeks after referral receipt. Most referred patients were over 60 years of age and referred for a Medicines Use Review (MUR) or enrolment for the New Medicines Service (NMS). Those patients who received a community pharmacist follow-up consultation had statistically significant lower rates of readmissions and shorter hospital stays than those patients without a follow-up consultation.

Conclusions: Hospital pharmacy staff were able to use an information technology (IT) platform to improve the coordination of care for patients transitioning back home from hospital. Community pharmacists were able to contact the majority of patients and results indicate that patients receiving a follow-up consultation may have lower rates of readmission and shorter hospital stays.

Strengths and limitations of the study

- This study provides a detailed description of how an electronic referral system between hospital and community pharmacies across the North East of England was implemented.
- This study demonstrates that inpatients can be effectively referred to their nominated community pharmacist and receive a follow-up consultation tailored to their needs after discharge from the hospital.
- The study demonstrates that routine data collection during this evaluative period requires critical analysis and additional qualitative work to understand fully the operational and implementation aspects of the service, for example, complex reasons for the recorded rates of non-completion of referrals.
- There are no routinely recorded data at the community pharmacist follow-up consultation to allow specific economic, clinical or humanistic outcomes to be determined. However, service continual improvements are being made towards achieving this.
- A well-structured clinical trial of this intervention is required to investigate the impact on patients as they transition between healthcare settings.

INTRODUCTION

The continuity of patient care when transitioning from one healthcare setting to another is a national priority.[1] A range of interventions have been designed, trialled and tested to improve the quality and safety of this transfer process.[2–6] Successful interventions have incorporated activities such as medication reconciliation; quick, clear and structured discharge summaries; discharge planning; follow-up between hospital and

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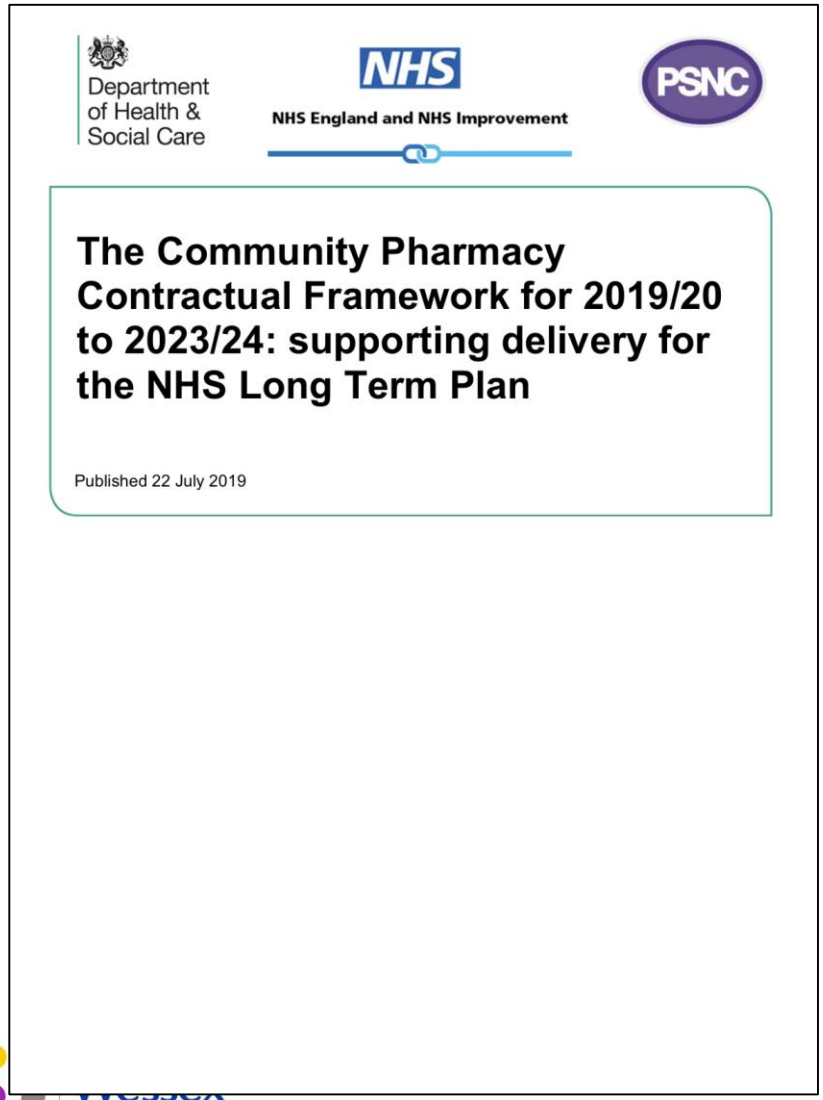
Evidence Base - Summary of studies

Study	Outline	Impact
Newcastle Study BMJ Open October 2016 https://bmjopen.bmj.com/content/6/10/e012532	2 hospital sites in Newcastle and 207 community pharmacies 2029 patients referred over 13 months. 31% received community pharmacy follow up consultation.	Odds of readmission were significantly higher amongst those who did not receive the community pharmacy follow up consultation. Results were seen at 30,60 and 90 days.
Sussex IJPP March 2017 https://onlinelibrary.wiley.com/doi/full/10.1111/ijpp.12364	RCT of 33 participants whose post discharge letter was send to their GP alone or Community pharmacist and GP.	Sending a copy of patients' discharge letters to their community pharmacists could be beneficial in reducing post-discharge prescribing discrepancies and improving patient understanding of the changes made to their medicines
Leeds Teaching Hospital IJPP October 2019 https://link.springer.com/article/10.1007/s11096-019-00887-3	627 patients with a mean age 81 referred from Leeds teaching Hospital NHS Trust to their community pharmacy.	Rate of non elective hospital readmissions reduced by 16.6% and a potential reduction in length of stay.
Cornwall IJPP February 2020 https://onlinelibrary.wiley.com/doi/10.1111/ijpp.12603	Cross sectional cohort study of 1,120 patients receiving transfer of care to their community pharmacy in Cornwall in 2017	The 30 day readmission rates was 8.5% in those received their community pharmacy on discharge compared with 23.3% in those who did not.
Wales discharge serviceBMJ Open February 2020 https://bmjopen.bmj.com/content/10/2/e033551	Retrospective cohort study of all Hospitals and 703 community pharmacies in Wales. 1923 patients referred over 13 months in 2017/18	Discharge MUR after hospital discharge is associated a reduction of readmission within 40 days
https://academic.oup.com/ageing/advance-article/doi/10.1093/ageing/afaa002/5733075	Bradford University reviewed 24 randomised controlled studies in the over 65s (17,664 patients) to study impact on readmission.	Study showed that activities supporting medicines continuation (notably self management, telephone follow up and meds rec) were associates with a statistically associated with reduced hospital admission

Underpinning policy



Year 2

Medicines Optimisation and Safety

- Introduce a medicines reconciliation service as part of a transfer of care around medicine service.
- Conclude phasing out of Medicines Use Reviews.

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Underpinning policy - NHS standard contract

- In Section 41, a series of new Service Development and Improvement Plans (SDIPs) are outlined.
- The Service Development and Improvement Plan (SDIP, Schedule 6D) allows the parties to record action which the provider will take, or which the parties will take jointly, to deliver specific improvements to the services commissioned.
- For 2020/2021, Commissioners are required to agree SDIPS with **providers of acute hospital services**, to set out how, with the support of their local Academic Health Sciences Network (AHSN), they will **jointly take forward implementation of the Transfers of Care Around Medicines (TCAM) initiative**. (TCAM is a national scheme, supported by changes to the national Community Pharmacy Contractual Framework for 2020/21 and facilitated by AHSNs locally, which focuses on specified categories of high-risk patients being discharged from inpatient care; prescribing information for these patients is shared electronically by the hospital with the patient's nominated community pharmacy, so that the patient's community pharmacy can undertake a medicines reconciliation review and ensure the next medicines supply reflects changes made during a hospital admission, thereby reducing the risk of adverse effects from incorrect medication being taken. Further information is available at via AHSNs, including for instance at https://wessexahsn.org.uk/projects/54/transfers-of-care-around-medicines-tcam.

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National Feedback - what helps TCAM to work?

1: Sharing learning
between trusts helps with implementation

2: Consistent support
to community pharmacies to keep up with referrals

3: Community pharmacists like it (anecdotal)
A small survey of community pharmacists was undertaken in London, the results showing:

- 100% were happy to receive the discharge information from the Trust
- 91% thought that receiving discharge information from the Trust improved the information they provide to patients about their medicines
- 80% thought that receiving discharge information from the Trust saved time
- 64% had made interventions as a result of referral, e.g. picked up unintended discrepancies between the hospital summary and the GP prescription.

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How does it work? - referrals from acute trusts

- Referral criteria differs from trust to trust, Dorset County are planning to refer all patients with the exception of the following:
  - Patient with medicines from dispensing Practices
  - Patients being discharged to a community hospital
  - Patients discharged on short-term medicines only (i.e. pain relief / antibiotics)
  - Patients who are not willing to give consent to a referral
- Patients are identified as being in need of additional assistance with medicines shortly after admission. This means that the referring clinician (pharmacist or pharmacy technician) will make a note on the Electronic Pharmacy Medicines Administration (ePMA) system.
- If patient condition changes then this note is altered. Generally, however, when the patient is ready to go home the referral to patients local community pharmacy is made.
- This referral contains all necessary patient details along with summary of discharge medicines.
- The referring clinician will add a couple of notes regarding why the patient is being referred, e.g. change of medicines, start of new medicines….. but the question of how to help their patient is ultimately the decision of the community pharmacist.

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Referrals likely to include…

Experience indicates that the higher the "risk" of the patient the greater the impact of TCAM i.e., the more likely you are to prevent a readmission.

Who should trusts consider as a "high risk" patient?

- People taking more than 5 medications, where the risk of harmful effects and drug interactions is increased
- Those who have had new medicines prescribed whilst in hospital
- Those who have had medication change(s) whilst in hospital
- Those who have experienced Myocardial Infarction ("heart attack") due to likelihood of new medicines being prescribed
- Those who appear confused or muddled about their medicines on admission/when getting ready for discharge and have already needed additional support from a HCP
- Those who have help at home to take their medications
- Those who have scored 1 or 2 in patient activation measures (scores generated by specific questionnaires designed to assess patient engagement in care pathway)

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Referrals likely to include…

Experience indicates that the higher the "risk" of the patient the greater the impact of TCAM i.e., the more likely you are to prevent a readmission.

What are "high risk" medicines?

Multiple resources, including NPSA (now NHS Improvement) cite a list of "high risk medicines"3, 4. They include, but are not limited to; Anticoagulants e.g. Warfarin, Dabigatran, Antiepileptics, Digoxin, Opioids, Methotrexate, Antipsychotics, Cardiovascular drugs e.g. Beta-Blockers, Diuretics, Controlled Drugs, Amiodarone, Lithium, Insulin, Methotrexate, Nonsteroidal anti-inflammatory drugs (NSAIDS) and Acetylic salicylic acid among others.

Newly started respiratory medication including inhalers

Medication requiring follow-up for example blood monitoring, dose increase or dose reduction.

Those with medicines in varying/changing doses, either increasing or decreasing over a period of time

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Referrals likely to include…

- The PREVENT5 prompt is a framework used by to Health Care Professionals to identify patients at risk of preventable medicines-related readmission with unmanaged complex pharmaceutical issues, where the risk is modifiable through pharmaceutical care.

- It can be a helpful guide to determine factors that would prompt a TCAM referral.

Physical impairment	Patient has difficulties with swallowing, impaired dexterity, poor vision, hard of hearing or poor mobility which will impact them taking medication[1,2]
F**R**ailty	Patient is identified as frail using accepted methods [25] eg Clinical Frailty Index[26] 1 = very fit, 2 = well 3 = managing well 4 = vulnerable 5= mildly frail 6 = moderately frail 7 = severely frail 8 = very severely frail 9 = terminally ill
adh**E**rence/ issues/compliance support	Patient has not been taking their medicines e.g. various dispensing dates on medicines, no recent dispensing of medication, newly started on all medicines or cannot give names of medicines they are taking. Patient has decided to stop taking all or some of their medicines which has lead or will lead to worsening of their clinical condition[1,21]. Refer all new requests for compliance support
cogniti**V**e impairment	Patient is unable to take medication regularly without support as they have a condition which affects their memory e.g. delirium, dementia[1]
n**E**w diagnosis/exacerbation of disease/	Admission is related to poor management of medication for a long term clinical condition[13] or deterioration of organ system function eg renal, cardiac[14,21,23] Previous admission or A&E attendance within 30 days[15,16,20,22,23] Depression[17], high level of stress[18], other mental health, alcohol or drug abuse[27]
Medici**N**es related admission/ risk from specific medicines	Patient is taking a high risk medicine (e.g. anticoagulants/antiplatelets, insulin /oral hypoglycaemics, NSAIDs, benzodiazepine, antihypertensives, diuretics, beta blockers, opioids, methotrexate, injectable medicines, drugs requiring therapeutic drug monitoring esp. with no monitoring, steroids) which the patient is unable to manage.[3,4,5,6,24] Patient has a complex of medicine regimen, recent stop, start or change in medicines or Polypharmacy[7] which the patient is unable to manage[8,9,10,11,12,20]
cul**T**ural/social	Patient cannot manage daily activities independently or has carers to help with daily activities but not medicines. Patient has cultural beliefs around illness and treatment impacting medication adherence[27]. Patient has social issues such as no fixed abode, unkempt etc which impacts them taking medication[2] Smoker[19]

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How does it work - Community Pharmacy

TCAM referral

COMMUNITY PHARMACY

Made directly via Electronic prescribing and medicines administration(ePMA) system.
Will include all discharge information including medicines summary. Copy will also be sent to GP.

Choose the services tab for referral info.

Pharmacist r/v pt. information and decide course of action

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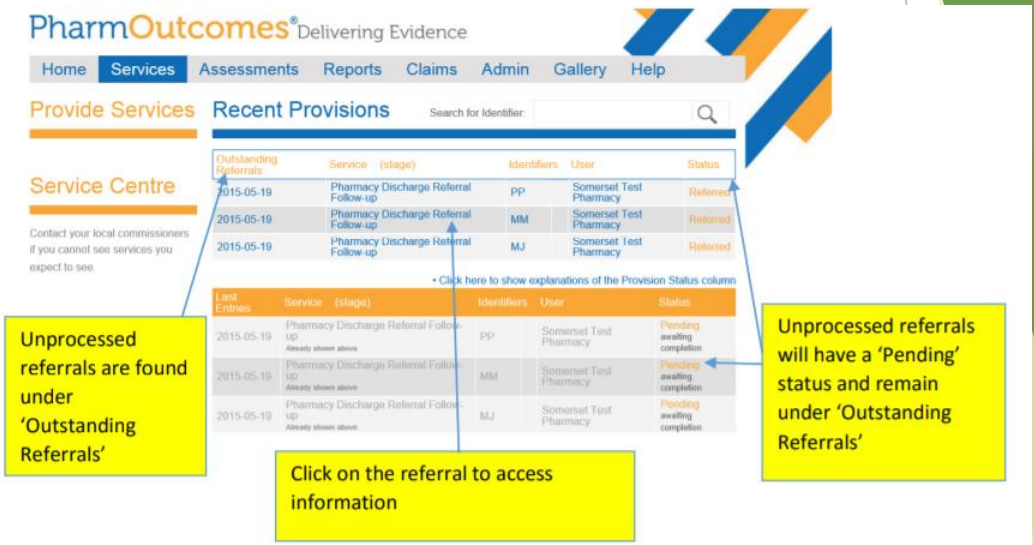
How does it work – Community Pharmacy

COMMUNITY PHARMACY



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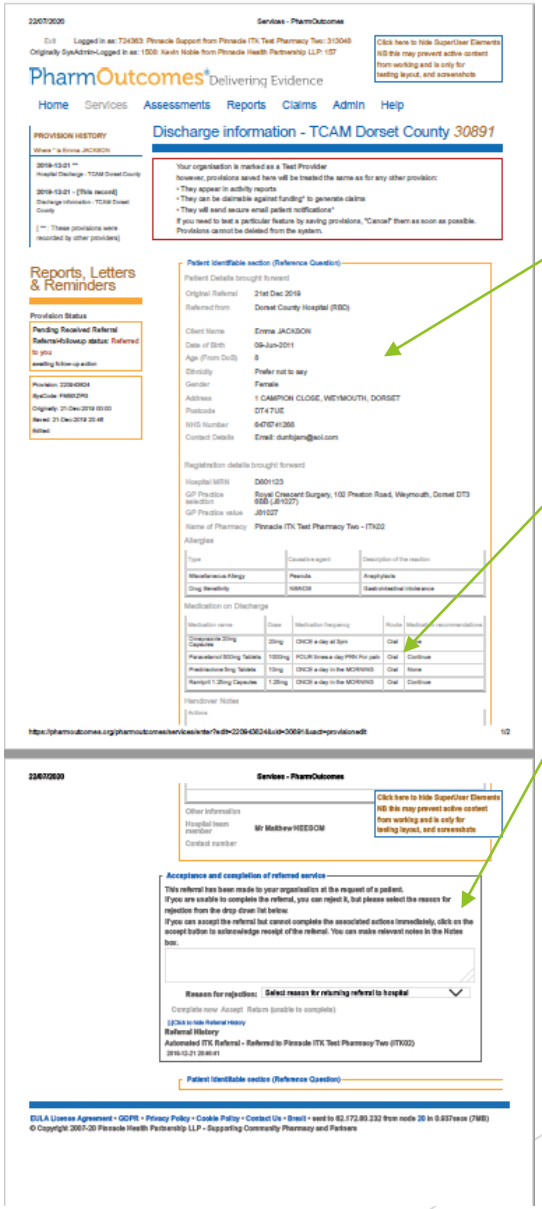
How does it work - Community Pharmacy

CONSULTATION WITH PATIENT

Once course of action agreed contact made with patient. Relevant information discussed over the phone (if patient housebound) or appt made for patient to visit pharmacy for consultation.



Ensure you 'accept' then 'complete' the referral once consultation has been completed.

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FAQs

- How many can I expect?
  - on average 1-2 a week, if a particularly busy pharmacy you may see 4 per week.
- What do I do with the referral once it arrives on PharmOutcomes?
  - Accept it and action it.
- How do I complete the referral?
  - Once action completed, choose ‘complete’ at the base of the referral page on PharmOutcomes.
- Does the GP get notified too?
  - GPs will receive their usual discharge notice from the hospital electronically.
- How often do I need to check for referrals?
  - Generally once a day, but you should be checking PharmOutcomes more frequently for any CPCS anyway.
- What sort of patients will be referred?
  - See slides 9-12 for advice on referrals.
- Do I need to contact the patient straight away?
  - If a follow up consultation is required (eg NMS) ideally you will make contact with the patient within 48 hours to arrange an appointment
- Does it need to be the pharmacist who checks Pharm Outcomes?
  - No, Pharm Outcomes can be checked by any designated member of the team and they can bring it to the pharmacist attention.

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References and Resources

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