AUDIT OF THE QUALITY OF PATIENT MEDICATION INFORMATION AND DOCUMENTATION PROVIDED BY HOSPITALS DURING THE TRANSFER OF PATIENTS TO THE IN-PATIENT UNIT AT ACCORD HOSPICE

NHS National Services Scotland

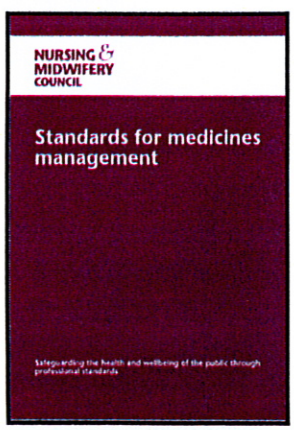
Alison Newlands
Senior Staff Nurse
ACCORD Hospice

Background

A Clinical Audit was undertaken at ACCORD Hospice due to concerns about the quality of patients medication information and documentation provided by local hospitals, during the transfer of patients to the In-Patient Unit at ACCORD.

The Nursing and Midwifery Council (2004) states that there is a particular need within multi-disciplinary teams for correct transcribing policies. This is to ensure that correct and sufficient patient medication information and documentation is transferred between different care settings(1).

Local guidelines have been developed on the Transfer of Medication Documentation and Medication Between Hospitals and Hospices (Clyde Drugs & Therapeutic Committee 2007)(2). Based on these guidelines, an audit tool with 7 standards was devised. A prospective audit was then conducted over 6 months from July '08 until January '09, within the In-Patient Unit at ACCORD Hospice. Data was collected on 15 patients who had been admitted to the Hospice from an Oncology Specialist Centre and two local DGH's.



Aim

The aim of the Audit was to assess the quality of transfer information and documentation with regards to patient medication when they were being admitted to ACCORD Hospice.

Results

Standards		Met	Not Met
1.	Were the hospital case notes readily available on admission?	73%	27%
2.	Was a Doctor's letter provided on admission?	87%	13%
3.	If yes, did the letter contain clear and accurate information regarding the patients current medication?	69%	31%
4.	Was a nursing transfer letter available?	67%	33%
5.	If yes, did the letter contain the relevant information to prompt both Medical and Nursing staff to read the Doctor's letter for details of the patient's medication?	70%	30%
6.	Was there a photocopy of the relevant prescription charts e.g. McKinley syringe driver, warfarin charts etc?	47%	53%
7.	Did the patients drug kardex after admission to ACCORD Hospice contain clear and concise information Regarding the patients medication?	100%	0%

Discussion

A significant minority (13%) of patients did not have a doctor's letter on admission to ACCORD Hospice and, even when a doctor's letter was received, 31% of these letters did not contain sufficiently clear and accurate information regarding the patients current medication. This situation was further compounded by a lack of information including nursing transfer letters and failure to send hospital case notes or relevant prescription charts, etc. These omissions and lack of clear information can lead to a significant potential for prescribing error. In palliative care, up to a quarter of all prescriptions written are for licensed drugs given for unlicensed indications and/or via an unlicensed route.(3) Strong opioids, often in high doses are frequently prescribed for palliative care patients. These facts further heighten the risk of serious or fatal drug errors and reinforce the need for proper procedures. In conclusion, this audit points out the need for improved safer practices in the transfer of information and documentation related to patients medications between care settings.

Recommendations

All medical, nursing and pharmacy staff at ACCORD have been made aware of the audit results. This has helped to raise awareness regarding the issues which can affect safe transcribing practices. It has also highlighted the importance of continued medication incident reporting.

The audit has also helped to change nursing practice within the In-Patient Unit. Nursing staff are now telephoning hospital wards prior to the patients admission, in order to ensure the most adequate and accurate information is provided regarding patient medication.

Awareness has also been raised within the hospitals as the audit results have been taken to the Clyde Joint Drugs and Therapeutic Meeting. There is now a medication discharge protocol in place. Senior staff nurses have also brought this matter to the attention of the multi-disciplinary team at ward level, to ensure that this discharge protocol is being adhered to.

Finally, it was agreed at the ACCORD Hospice Drugs and Therapeutics Meeting that a repeat of this Clinical Audit should be carried out in 6 - 12 months time, in order to see if practice has improved.

References

1. Nursing and Midwifery Council: Standards for medicine management standards. (2004) Standard 3 Transcribing DVD

2. Clyde Drugs & Therapeutic Committee (2007) Guidelines for Transfer of Medication Documentation and Medication Between Hospitals. Pharmacy Prescribing Support Unit Directorate. Clyde Division: NHS Glasgow and Clyde

3. Todd J and Davies A (1999) Use of unlicensed medication in palliative medicine. Palliative Medicine 13:466