

Pharmacy Evaluation

Pharmacist use of ECS in acute receiving teams June 2008

Discussion with Pharmacist Representatives from Forth Valley, Lanarkshire and Ayrshire and Arran to gain understanding of how the Emergency Care Summary is being used currently by pharmacists as part of the acute receiving team.

Update on ECS – Current ECS activity, governance and plans for next phase of ECS

ECS has been rolled out across Scotland and is governed through the ECS Programme Board. Plans for the next stage of ECS are being explored and will include proposals to extend access and develop the dataset. The access protocol document has been revised; however explicit consent to access ECS data is a key aspect throughout. Pharmacists continue to obtain consent with the patient in front of them.

A representative of the Scottish Consumer Council spoke about the evaluations and consultations that had been done on public attitudes to information sharing. Members of the public had said that they wanted to know how their data is being used and shared and that patients largely expected the health service to share information if it contributed to their care. It was reinforced that as access to ECS becomes wider, explicit consent becomes more important.

ECS use in hospital setting in medicines management

NHS Ayrshire and Arran reported that pharmacists in Acute Receiving Units are using ECS for acute admissions especially during public holidays and when GP surgeries are closed. Pharmacists were obtaining patient consent verbally and they had not been using ECS in any other situation. NHS A+A have come across a small number of instances of irregular information on ECS and it was agreed that any details of inaccuracies should be emailed to the ECS Programme Manager. Following further discussion it was thought that many of these problems were more likely to be lack of updating or removal of discontinued drugs by the practice and no specific examples have been sent for further investigation.

NHS Lanarkshire's usage is similar to NHS Ayrshire and Arran's. They had been combining information from ECS with other sources in order to gain a fuller picture of patients' medication history. As a result, they had been phoning GP surgeries less than previously and they also had been finding the printed information from ECS more reliable than information given over the telephone. They had been requiring staff to undertake training before being given access to the system. In Monklands hospital it is the clerical staff that ask for patient consent and produce the ECS printout to be attached to the paper records. In Wishaw hospital it is mainly the pharmacists that have been gaining patient consent. No one reported any problems with obtaining consent, the vast majority of patients readily agreed and it had become part of the introduction to the consultation.

In NHS Forth Valley they had been using ECS for unscheduled and some scheduled admissions and that they felt it has been highly successful in providing more accurate and up to date information about patients' medication. Patient consent was always obtained unless patient unable to give informed consent due to confusion etc. They always use a second source to confirm data from ECS and whilst it was sometimes not accurate it was still better than getting information over the telephone. One effect had been that some GPs have become reluctant to speak to them about patient medications because there is a

feeling that they no longer need to because of ECS. Other issues they had encountered included incomplete recorded medication history as some GP practices are not recording anti-depressants on GP IT systems and the problem of not always being able to access all information for cross boundary patients. When patients change practices a new ECS record will be created at the new practice. Another issue was that of patients not able to give consent due to e.g. confusion, unconscious. In this case Forth Valley have been accessing ECS if it was clinically justified and recording this in the patients' record. This was in keeping with the guidance on consent in the access protocol. In general they reported that ECS has improved the quality of the information and medicine reconciliation and offered considerably improved and safer patient care as a result.

There then followed some discussion about Forth Valley's use of ECS for scheduled admissions as an initial pilot. They had been finding it useful for scheduled care since it often brought things to light and reduced calls to local GP surgeries. SCI gateway referrals should contain a list of all the medications prescribed in primary care, but it can sometimes be many weeks following a referral before a patient is eventually admitted and significant changes in medication might occur in that time. This pilot has shown that there might be justifications for using ECS instead of phoning a GP surgery, and these justifications would need to be considered in relation to extending the use of ECS to scheduled care.

In Forth Valley they never print out data from ECS. Lanarkshire have been printing data from ECS and it has been put straight into the case notes. In Lanarkshire ECS had generally been used only for emergency admissions but it had sometimes been used for scheduled admissions. Ayrshire and Arran had only been using ECS for unscheduled care and currently largely restricted to out of hours and bank holiday periods.

All sites were asked if any patients had refused to consent to ECS being viewed. In general this had not been an issue. The feeling was that patients were surprised to be asked at all and that there was often an assumption that data was already being shared. Forth Valley had one example of a very anxious patient who had initially refused consent but had agreed a day later. Lanarkshire had an example of a patient who gave consent but there was then no ECS on the system suggesting that the patient had opted out and previously refused consent.

The issue of what to do on finding that patient's medication history was significantly different from that on ECS was discussed. Any differences on the ECS summary should either be raised as an incident if completely wrong or fed back to the patients practice for clarification.

In Ayrshire and Arran they have been trying to put hospital drugs on GPASS so that they show up on ECS. This is a requirement of the IT DES¹ which practices had signed up to, but expired in March 2008.

This evaluation meeting was discussed with the lead pharmacist in Tayside who reported that NHS Tayside had undertaken small test of usage of ECS accessed via NHS 24 – under 'professional to professional' process with patient consent for 2 patients admitted to the medical assessment unit with mixed results. NHS Tayside are considering technical solutions to enable access to patient medication history including via OOH service IT system and via Long Term Condition website. They noted that a single source of most recent medications as included in ECS was desirable and, even with caveats re potential for incomplete record, added massive patient safety and service benefits.

¹ Post meeting note : Benchmarking IG DES ends at end of March 2008