THE CONTINUING

PROFESSIONAL DEVELOPMENT PROGRAMME

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MODULE 188

Welcome to the one hundred and eighty eighth module in the *Pharmacy Magazine* Continuing Professional Development Programme, which looks at MURs at discharge. It is valid until May 2014.

Continuing professional development (CPD) is a mandatory requirement for pharmacists. Journal-based educational programmes are an important means of keeping up-to-date with clinical and professional developments and form a significant element of your CPD. Completion of this module will contribute to the nine pieces of CPD that must be recorded a year.

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Self-assess your learning needs:

- Patients recently discharged from hospital should ideally have a MUR within how many weeks of discharge?
- What medicines-related factors affecting clinical outcomes should be addressed as part of a post-discharge MUR?

This module supports the following CPD competences: C4g, C5c, PC1b and PC2h. More details on pvii

CURRENT THINKING ON...

POST-DISCHARGE MURs

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Introduction

During a stay in hospital a patient's medicines may be changed. Studies suggest that almost half of all patients may experience an error with their medicines after they have been discharged[1,2,3].

This problem was highlighted in a major report by the Care Quality Commission (CQC) in 2009. As a result, Jonathan Mason, national clinical director for primary care and community pharmacy in England, urged community pharmacists to use medicines use reviews (MURs) to improve the transfer of information between primary and secondary care[4].

The transfer of patients and their medicines from secondary to primary care and *vice versa* can lead to:

- Incorrect transmission of information
- Unintended changes in medication
- Intended changes in medication not being followed through (e.g. changes in medicine, dose or formulation)
- Continuation of medication that should have been stopped.

Figure 1 shows the steps that need to be in place to ensure that medicines are obtained and used by patients as intended after discharge from hospital. It should be noted that patients recently discharged from hospital who have had changes made to their medicines form one of the new national MUR target groups agreed as part of England's revised contractual framework.

The standard contract for NHS hospitals has, since April 2010, required them to share discharge summaries with a patient's GP within 24 hours of discharge, including a summary of diagnosis and details of any medication prescribed at the time of the patient's discharge. The contract (and the NHS constitution) also requires hospitals to give patients a copy of their discharge letter. However the CQC found that this happened in only seven of the 12 areas it studied.

FOR THIS MODULE

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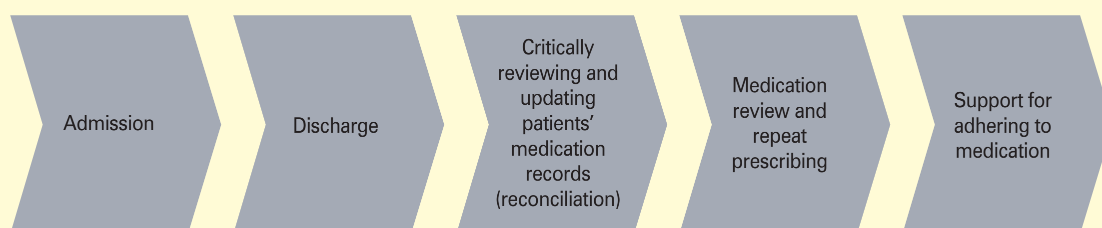
GOAL: To describe how community pharmacists can support the hospital discharge process using the medicines use review (MUR) service.

OBJECTIVES: After completing this module you should be able to:

- Identify common medicines-related problems that result after discharge from hospital
- Produce an action plan for conducting post-discharge MURs
- Explain the benefits of post-discharge MURs to GPs and service commissioners.

Figure 1: The medicine pathway across admission and discharge



Source: Care Quality Commission (2009): Managing patients' medicines after discharge from hospital

All hospitals are expected to have a policy on discharge medicines and, increasingly, the aim is to reduce preventable problems (including unplanned readmissions) due to medicines issues after discharge.

The hospital's pre-discharge assessment is supposed to take into account the patient's previous care needs, changing medication needs (including compliance aids), likely changes as a result of admission, transport needs and social needs (e.g. patient living alone), possible vulnerabilities (e.g. frail elderly, terminally ill, learning disability, mental health problems), and eligibility for NHS continuing care, sometimes referred to as continuing health care (CHC).

Patients may be discharged to their own home or transferred to a community hospital or care home. Hospitals sometimes categorise discharges as 'simple' or 'complex'. A 'simple' discharge can be defined as one that will:

i) Involve minimal disturbance to the patient's activities of daily living

ii) Does not prevent or hamper a return to their usual place of residence

iii) Will not require a significant change in support offered to the patient and their carer in the community.

A 'complex' discharge is where one or more of these criteria do not apply. Patients may sometimes have a 'rapid discharge' to free up a hospital bed and be transferred to intermediate or transitional care.

Reflection exercise 1

- What is the policy of your local trust/s on medicines management at discharge?
- What is the policy on use of patients' own medicines, often referred to as Patients' Own Drugs (PODs), and the number of days' supply of medicines at discharge?

The Care Quality Commission concluded that changes were needed to improve the quality and safety of patient care in relation to medicines management after discharge from hospital. The CQC describes the "ideal" patient pathway in relation to medicines in Figure 2. Community pharmacists can contribute to "Support for adhering to medication" through MURs.

How post-discharge MURs can help

The overall aim of the MUR service is to improve patients' knowledge of their medication via a concordant consultation, resulting in more effective use of medicines. In the context of discharge MURs, the aims of the MUR service may be tailored (see Table 1). There are also a number of issues that contribute to poor outcomes from treatment (see Table 2).

A MUR is not a clinical medication review and the types of interventions which are intended during a MUR are described in the national service specification and summarised in Table 3.

When considering a MUR after a discharge from hospital, the emphasis is on trying to improve treatment outcomes by reducing medication errors and hopefully reducing adverse drug incidents.

Community pharmacists tend not to have access to medical notes, and have limited information on diagnosis and condition management (including rationale for choice of medicines, any tests done and their results), and may have difficulty influencing, instigating and following up changes in medication. These are issues that would normally be covered in a clinical medication review rather than a MUR.

Let's now consider a South Staffordshire service offering post-discharge domiciliary MURs.

Domiciliary MURs in South Staffordshire

Community pharmacists in South Staffordshire have been commissioned to provide a local enhanced service to support vulnerable patients at high risk of problems with medicines. The pharmacists conduct MURs in the patients' homes within seven days of their discharge from local "community beds" in the local hospital. The service, which runs alongside the standard MUR advanced service, received a Pharmaceutical Care Award in 2010.

The project was initiated in April 2009 as part of the locality consortia identifying a need to tackle hospital admissions and re-admissions of the elderly, and is based on discharge from 27 community beds in the Littleton Ward at Cannock Chase Hospital. The overall aim of the community beds is threefold:

Figure 2: The ideal patient pathway

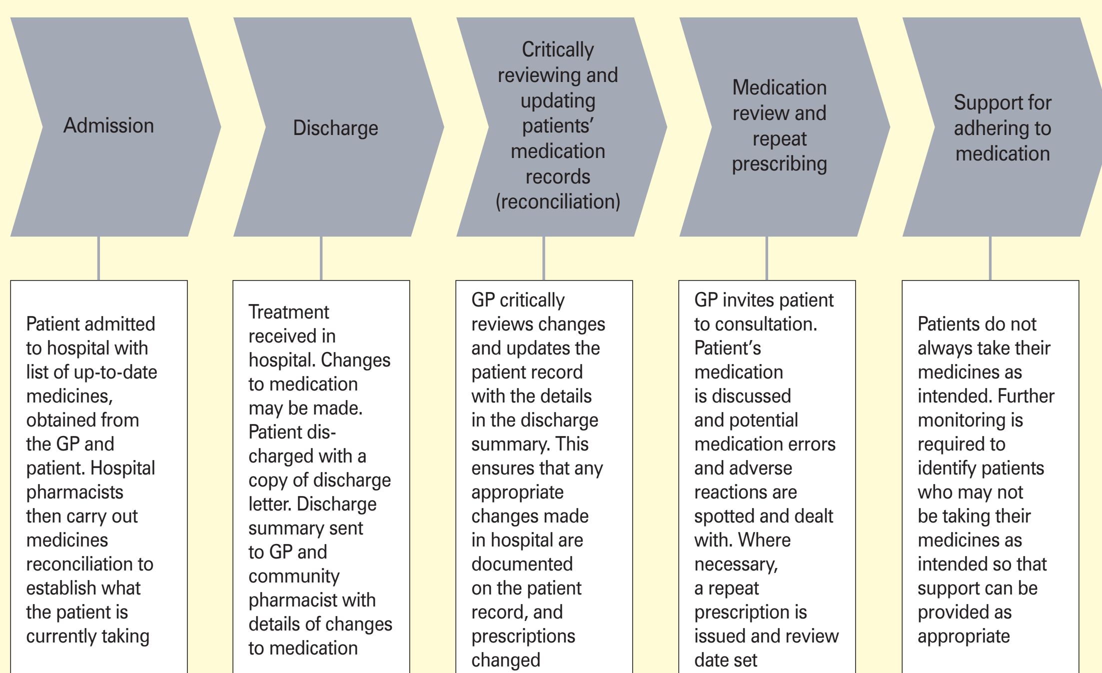


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Table 1: Aims of MUR service in relation to hospital discharge

Aim of MUR service (from Advanced Service specification)[5]	Relevance to post-discharge MURs
Establishing the patient's actual use of medicines, including his/her understanding and experience of the medicine	Patients may have changes in medication, dose, strength, frequency and formulation, as well as being on 'high risk' drugs, such as antiplatelets, diuretics, NSAIDs and anti-coagulants[6]. The MUR will establish the patient's perception, knowledge and experience of medication, including changes.
Identifying, discussing in a concordant manner and working towards medicines solutions in situations where there is deemed to be poor or ineffective use of medicines	Ascertaining actual rather than prescribed use from the patient's perspective, looking at intentional and unintentional changes in medication, dosing route, timing, and whether medication is to be taken with, before or after food.
Identifying medication side-effects and potential interactions	Side-effects may affect patient compliance. The MUR also allows OTC medication and herbal remedies to be discussed.
Improving the cost-effective use of medicines with a view to reducing waste	Improving adherence, education about re-ordering and avoiding stockpiling, and the repeat prescription system, and encouraging waste medication accrued to be returned to pharmacy for safe disposal. This is especially important in situations where medication has been discontinued and the patient may still have stock at home.

Table 2: Medicine-related factors leading to poor outcomes from treatment that can be addressed in a post-discharge MUR[7]

Problem	Causes	General points	Medicines-specific points
"High risk" medicines associated with hospital admissions & readmissions	NSAIDs	These four medicines account for half to two-thirds of medicines-related hospital admissions	Including OTC
	Aspirin		Including OTC
	Diuretics		
	Warfarin		NPSA community pharmacy guidance on INR test results and 'currency' of anticoagulation book
Compliance	Not able to obtain medicines/ ordering medicines	These issues relate to how the patient is obtaining and using his/her medicines and fall directly within the remit of a MUR	
	Not taking medicines because unable, unwilling or misunderstanding		
	Taking wrong medicines (e.g. continuing to take after discontinued, inadvertent duplication of treatment)		
	Taking too little		
	Taking too much		
	Taking over-the-counter or herbal medicines that interact or are contraindicated		
	Taking other people's medicines		
Concordance	Not been given sufficient information about the condition being treated	Petty advises that "exploring the patient's health beliefs and wishes is essential if the patient is to accept what has been prescribed". The CQC report stated: "It is important that patients are given clear information about their medicine and possible side-effects, and then have an opportunity to discuss how the regimen is working out. At a national level, however, between 11 per cent and 34 per cent of people say they were not given enough information on leaving hospital."	
	Not been given sufficient information about the risk or benefit of treatment		
	Not been asked or involved in discussions about treatment and treatment options		

Adapted from Petty D. 2008

- Reduction of admissions, delayed discharge and unnecessary excess bed days
- Facilitation of discharge in a manner that will prevent acute inpatient re-admission
- Maintain a maximum length of stay of six weeks.

The domiciliary MUR service is part of a much wider service which follows the patient from admission to being back in his/her own home or in residential/nursing care as appropriate. Included for community bed admission are patients:

- Admitted directly to the community beds from an acute admission according to accident and emergency (A & E) triage
- Already admitted into hospital and then 'stepped down' to community beds
- Who are suitable and medically fit for discharge but are still inpatients and awaiting discharge.

Training and accreditation

Community pharmacists providing the domiciliary service must be accredited to provide the service in accordance with the specification of delivery of the national advanced service. Competences are demonstrated via completion of competency programmes or courses (dependent on the higher education provider) and accreditation is via certification. Pharmacists participating in the service provide their certificate to the PCT medicines management department for the purpose of audit.

Premises

Normally MURs are conducted in a confidential environment within a pharmacy that can self-certify using a PREM 1 form. The premises can later be verified by the PCT as required as part of any contract monitoring arrangements.

Domiciliary visits

PCTs can give consent for MURs to be completed away from pharmacy premises under the following circumstances:

- A specific named premises (e.g. a defined room in a local surgery/GP practice)

Table 3: Interventions possible during a MUR[5]

Interventions possible	Aim
Advice on medicines usage	To develop compliance via concordance
Advice on 'when required' medication	Clarify and document 'when required' use to avoid accidental under- and over-dose
Appropriate use of different dosage forms	Counsel on best use (e.g. inhaler technique, soluble, sublingual use, patches)
Advice on tolerability of medicines	Recognising side-effects and counselling on predicted side-effects; management and reporting of ADRs via yellow card scheme
Dealing with practical problems preventing adherence	Specifically to address issues on obtaining medication, especially ordering and avoiding running out, including synchronisation of quantities
Advice on medication 'as directed by prescriber'	To provide detailed instructions on how to take medication and when
Identify medicines no longer taken	To avoid unintentional consumption of discontinued medication
Identify a dose or strength change	To advise on pharmaceutical optimisation (e.g. one 40mg tablet instead of two 20mg tablets)
Identify generic vs. branded prescribing	To facilitate cost-effectiveness where prescribing is not restricted to a brand
Identify branded vs. generic prescribing	To facilitate prescribing of branded products where formulation or medicine requires continuity of brand (e.g. diltiazem)

- A specific premises/category of premises for a category of patients (e.g. a care home for care residents)
- A specific premises for a specific defined patient (e.g. patient in his/her own home)
- Exceptionally, by telephone (it must not be possible to overhear the conversation).

To conduct MURs at a patient's own home, consent is given by the PCT by signing up to the enhanced service level specification agreement, and can be done using PSNC's PREM 2 form. PCTs may also produce their own form.

In South Staffordshire, self-certification is part of the service level agreement and the pharmacist must consider the following criteria, which are applicable to conducting MURs in pharmacy premises and then tailored for a domiciliary visit:

- The patient and pharmacist are able to sit down together in a comfortable environment, preferably with a table where paperwork can be filled in
- The patient and pharmacist can talk at normal speaking volumes without being overheard, more applicable in situations where there are members of family residing in the same premises or home care staff present
- The MUR can be conducted without being disturbed and paperwork may be completed without distraction.

See Table 4 (below) for the domiciliary MUR process. If the patient is eligible for a MUR with their normal dispensing pharmacist and that patient satisfies the MUR criteria, then the MUR fee is claimed from the NHSBSA. If the patient is not a regular with the pharmacy that has 'provided' the pharmacist to complete the domiciliary MUR, then in this situation payment is claimed as part of the local enhanced service agreement.

Outcomes of a domiciliary post-discharge MUR

The South Staffordshire project has run for one fiscal year in support of the second year of the community beds project. The whole clinical service in 2009-2010 for the Littleton Unit Ward detailed good Functional Independence Measure (FIM) scores, and small numbers of both admissions to A&E and re-admissions within 28 days of discharge. There was also a reduction in delayed discharges.

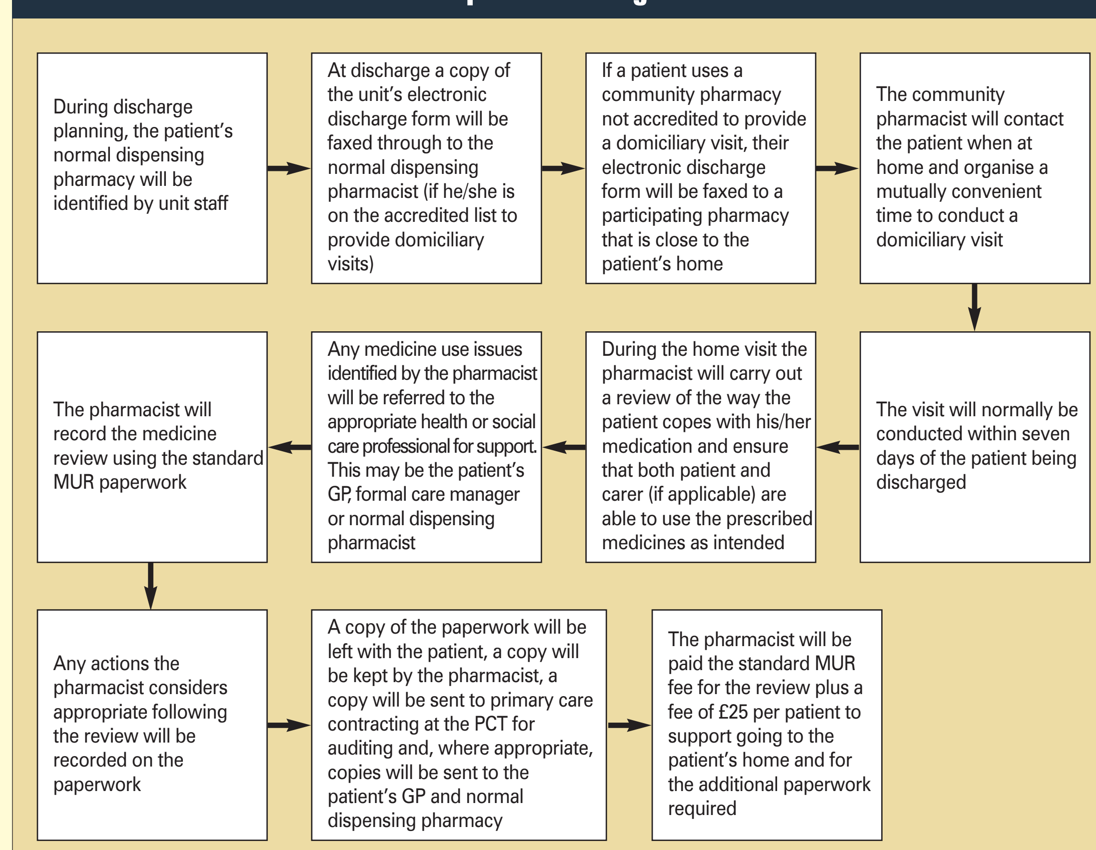
FIM utilises an 18-item seven-level ordinal scale measuring disability and rehabilitation outcomes across the following areas:

- Eating
- Grooming
- Bathing
- Dressing upper and lower body
- Toileting
- Bladder and bowel management
- Bed
- Chair and wheelchair
- Toilet
- Tub and shower transfer
- Walking
- Wheelchair locomotion
- Stairs
- Comprehension
- Expression / social interaction
- Problem solving
- Memory.

Reflection exercise 2

What procedures would need to be put in place in your pharmacy to implement MURs post-discharge? Consider the information you will need, information governance, the areas you would cover in the MUR, record keeping and communication with the patient's GP.

Table 4: Enhanced and advanced post-discharge MUR service



Quality of outcomes

From April 2009 to March 2010, 69 domiciliary visits were claimed for by community pharmacists taking part in the South Staffordshire project, of which 63 were paid for as part of the agreed enhanced service.

The Littleton Unit annual report for 2009/2010 details a net health saving of £413,819 by using the community beds as step-up and step-down admissions.

Further analysis of re-admissions within 28 days after discharge from the Littleton Ward, via case notes, show that of the 39 re-admissions in 2009-2010, five were unrelated (e.g. clinical deterioration of condition), 32 were unavoidable (e.g. acute or unstable condition), and two were related or a regular occurrence. There was an 81 per cent improvement in FIM score on discharge. The domiciliary MUR, which is completed within seven days, is viewed as part of the discharge process.

Records and paperwork

A standard two-page template is required to complete the MUR. This can be paper-based or may be undertaken in electronic form on a laptop – but the patient must have a copy of the MUR form following the consultation so if there are not printing facilities available, a copy must be supplied to the patient at a later date.

Under the MUR discharge scheme a copy of the MUR form is required for the:

- Patient
- Community pharmacist conducting the MUR
- PCT primary care contracting unit (for audit and analysis).

The GP template notification form is sent to the patient's GP and the full MUR form may be requested. If the community pharmacist conducting the MUR is not from the patient's usual dispensing pharmacy, a copy of the MUR form is also sent to that pharmacy.

MUR forms are kept for a period as is reasonably required by the PCT; this has not currently been defined but is envisaged as being two years from the date on which the MUR was conducted. Table 5 summarises key differences between the advanced service MUR and the enhanced domiciliary service equivalent.

Other points to consider

As the pharmacist undertaking the domiciliary MUR is leaving the pharmacy premises, a standard operating procedure should clearly highlight details of the responsible pharmacist arrangements. The professional indemnity aspects of visiting and undertaking enhanced and advanced services in the patient's home should also be considered and insurers informed. Consideration should be given to utilising the skill mix within the pharmacy to structure the delivery of the service, and staff should be encouraged to fulfil any necessary information governance requirements, record keeping and documentation.

Domiciliary MURs are not needed for all patients after discharge and should be targeted at those most vulnerable. A key advantage of a domiciliary MUR is that the pharmacist can see how the patient stores medication and if there is any stockpiling taking place.

Optimal storage conditions can be recommended and tips given on how to utilise a daily routine to aid compliance when taking medication. Physical barriers to taking medication can be observed (e.g. therapy placed in a cupboard too high to reach; dexterity issues when opening containers).

Additionally, at a domiciliary visit the pharmacist can remove medication that has been discontinued since the stay in hospital and is no longer required, as well as previously stockpiled medication that may be out of date. This can be removed as part of the community pharmacy contractual framework 'disposal of unwanted medicines' essential service.

Improving post-discharge support

There is plenty of scope to improve the support that patients get after discharge from hospital. Views differ as to the 'ideal' time to conduct a post-discharge MUR. Factors to consider are:

- How many days' supply of medicines is the patient likely to have when discharged from hospital?

Table 5: Differences between normal and post-discharge MURs

	Advanced service MUR	Enhanced service MUR
Setting	Pharmacy Telephone (with authorisation from PCT)	Patient's home
Patients	Prescription intervention and MUR	'High risk'/vulnerable patients
Timing	Takes into account: Number of days' medicines at discharge and when the patient's medicines will run out	Defined by service specification (e.g. in South Staffs within seven days of discharge)
Availability of information		
Discharge summary	Pharmacists do not generally receive this. In some areas the hospital faxes the summary to the patient's usual community pharmacist. The pharmacist can also ask the patient to bring his/her copy of the discharge summary to the MUR consultation	Medication discharge information is faxed by the hospital to the community pharmacy
Previous medicines	i) PMR ii) Pharmacist can ask patients to bring in the medicines they have at home	i) PMR ii) Pharmacist can ask to see medicines in the home (quantities and storage)
Medicines post-discharge	Pharmacist can ask the patient to bring in the medicines he/she has brought home from hospital	Pharmacist can ask to see medicines in the home

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Table 6: Sharing discharge summaries with community pharmacists – an example

The CQC asked 17 PCTs: "Are acute providers required to send community pharmacists a copy of the discharge summaries and, if so, in what circumstances would the community pharmacist receive a copy? If not, has consideration been given by the PCT to including community pharmacists in this way?"

Lewisham PCT replied: "Discharge summaries are faxed to community pharmacists for patients who are using compliance aids and those who are on high risk medications such as NSAIDs and anticoagulation."

- Will the patient have been using his/her own medicines while in hospital?

Having the right information

Community pharmacies currently do not generally receive any information about patients admitted to or discharged from hospital. This can be a barrier to a more active role in supporting patients after discharge. It has been argued that the requirements of confidentiality mean that the patient's discharge summary cannot be shared with community pharmacists.

However the CQC report made specific mention of the provision of medicines discharge information to community pharmacists and indicates that patient confidentiality need not be a barrier to information-sharing under the NHS Confidentiality Code of Practice. Some areas are already doing this (see Table 6).

Planning post-discharge MURs

Talk to your local GPs about supporting patients after discharge from hospital and suggest that you trial the provision of post-discharge MURs with a small number of patients.

- Explain the potential benefits of a MUR, the sort of issues you would discuss with the patient and agree the scope of a post-discharge MUR
- Find out which patients GPs think could benefit from a MUR and about the best timing for conducting the consultation
- Explain how your pharmacy meets NHS information governance requirements
- Discuss how you might be sent a copy of the medication discharge summary
- Consider asking the patient to bring in all of his/her medicines so that you can look at them, together with the intended medicines list
- Agree the information you will then share with the GP.

Discussions with the patient may include:

- Comparing the intended list of medicines with what the patient is taking and thinks they should be taking
- What the patient thinks each medicine is for, and when and how it is taken
- How adherent they are with the intended instructions
- How and when they take medicines labelled 'as required' or 'as directed'
- Advice on tolerability and side-effects
- Dealing with practical problems in ordering, obtaining, taking and using medicines
- Identification of medicines the patient is no longer taking
- Identification of a potential change of dosage form to facilitate effective usage (with due regard to formularies and cost implications, and observing that the final decision lies with the GP)
- Proposals for dose or strength optimisation.

Reporting criteria

Under the service specification for MURs, there are two criteria for reporting the findings of a MUR to the relevant GP:

- Items within the action plan that need to be considered by the GP and practice.

Within seven days of conducting a MUR, the pharmacist is required to forward the overview action plan page to the GP, and a professional judgement is required as to whether the consultation page is also required. The GP is able to request all paperwork of the completed MUR as required.

- No items within the action plan that need to be considered by the GP and practice.

Reflection exercise 3

How do you envisage running the New Medicine Service (NMS) for patients with long-term conditions who have had new medicines initiated in secondary care?

A completed form need not be sent to the GP/practice, but the fact that a MUR has been completed should be notified to the GP/practice within a month of the MUR being conducted.

Information governance arrangements

Post-discharge MURs need to be considered in light of IG requirements:

Electronic discharge form

Where a discharge summary is faxed to a community pharmacy, the fax machine must be secure as this is patient identifiable information and the IG lead should identify the risks associated with this. Consideration needs to be given to the storage of faxes, visibility of the fax machine to members of staff and other patients, and storage and disposal of faxes in a secure manner

Computer MUR forms

Computer MUR forms may be used to conduct the consultation, and will require password protection, back-up facilities, secure printing facilities, and consideration given for secure transport

Paper-based MUR forms

Storage of completed MUR forms and their safe disposal should be in line with IG arrangements, and will include the transfer of MUR forms in a secure manner to the GP practice.

The future – next steps

National discussions about better targeting of the MUR service have been going on for some time, and targeted MURs will become a reality from October 1. There is general agreement that post-discharge MURs are a key priority but

Case study: What the South Staffordshire enhanced MUR service looks like

Mrs Smith is admitted as a 'step down' patient from another hospital into a community bed. She is admitted with sepsis, morbid obesity, acute renal failure (which had resolved), immobility and a pelvic ulcer. She lives with her husband and was able to independently walk short distances and cook, but mainly relied on her husband for daily living and activities.

On admission to the Littleton Unit, Mrs Smith is bedbound with limited mobility, as well as complaining of lower limb pain. She is keen to regain her mobility but was worried about falling. Her care would typically involve risk assessment initially and physiotherapy, as well as consultations with a dietician. Mobility would be assessed over a period of time, culminating in discharge within six weeks.

At discharge, the Littleton ward faxes a unit discharge form to a community pharmacist providing domiciliary MURs, and the pharmacist contacts Mrs Smith who confirms that she would like a MUR completed. A mutual time is agreed and the pharmacist visits Mrs Smith at home. The summary sheet from the hospital details the medication that Mrs Smith was discharged with. The pharmacist is not Mrs Smith's usual dispensing pharmacist so does not have PMR information for her, but has been able to contact the usual pharmacy and has obtained this information.

During the MUR, the pharmacist identifies that there have been a number of changes to her medication since admission to hospital and takes time going through the changes. Mrs Smith still has residual stock of medicines that have been discontinued, and agrees that the pharmacist may dispose of these for her. Additionally, Mrs Smith asks about a number of medications that have been labelled as 'daily' as she is unsure about what time of day would be best to take them. She also reveals that she has stock of ibuprofen that she purchases over the counter, and the pharmacist notes that a reason for admission initially was a peptic ulcer. Checking stock-holding at home also shows a bottle of antacid.

Mrs Smith is counselled on possible OTC medications affecting her condition, the importance of disposing medicines when not required and given lifestyle advice to help reduce her weight. Also, arrangements are made with her local pharmacy to have medication delivered as she has limited mobility. The pharmacist will communicate any changes to her GP, and Mrs Smith will have a copy of the information.

national implementation will remain difficult until there is a solution to appropriate information sharing with community pharmacists. But there is no reason why pharmacists cannot develop local post-discharge MURs in collaboration with GPs and hospital colleagues.

With the announcement of the New Medicine Service (NMS)[8], which will see the injection of up to £55m a year for the next two years, the role that pharmacists can play in supporting patients with long-term conditions who have been prescribed new medication has been highlighted again. The NMS will be an advanced service of the contractual framework and the aim is to encourage medicines adherence in patient groups that have long-term conditions.

In light of the current climate of austerity and the QIPP agenda for healthcare, services such as post-discharge MURs must be evaluated in terms of reduction of waste through improving adherence, as well as reduction in medicines errors after discharge[9,10].

The NHS Operating Framework 2010-2011 detailed that significant QIPP agenda gains under quality and productivity are possible by encouraging co-operation at the interface. This includes health and social as well as primary and secondary care. It even goes as far as suggesting that integration of these services is the key to seamless care. There is recognition that emergency admissions could be reduced or even prevented by implementing integrated services across the interface.

Conclusion

Whatever the results of the Government's listening exercise, the Health and Social Care Bill has clearly indicated that patients and the public will be at the centre of the NHS and follow shared decision-making processes (i.e. "no decision about me, without me"). The 'Equity and Excellence' white paper also states that there will be payment for performance via the pharmacy contract, incentivising the better use of medicines.

Pharmacists are encouraged to work with healthcare professionals including doctors to aid the optimisation of medicines use in the NHS. The scope for services such as post-discharge MURs can be justified as part of a wider NHS drive to aid adherence, reduce waste and encourage patient participation in their own care.

CPD competences

This module supports the following community pharmacy competences:

Competence	Where this module supports competence development
C4g Working across professional boundaries	The role of the community pharmacist in facilitating medicines usage in conjunction with prescribers and secondary care is highlighted. Reflection exercise 1 encourages pharmacists to identify local hospital policies on medicines at discharge
C5c Developing and implementing new services under local and national contracts	This module illustrates how MURs can be provided post-discharge as an advanced service and describes how an enhanced domiciliary MUR service can be run in conjunction with the advanced service. Reflection exercise 2 encourages the planning and implementation of post-discharge MURs including information governance, record keeping, documentation and audit
PC1b Understanding the primary care environment, how it is developing, and the NHS documentation and guidance which supports it	The recent national policy change introducing a new advanced service, the New Medicine Service (NMS), and the forthcoming introduction of targeted MURs, is outlined. Reflection exercise 3 asks pharmacists to consider how best to optimise the use of medicines and to consider how services such as MURs and the NMS can be used to best effect for patients discharged from hospital
PC2h Seeing the future consequences of policy change	This module considers the progress of the Government's Health and Social Care Bill, and contemplates some of the roles that pharmacists may have in supporting patients, medicines use and NHS commissioning boards. Reflection exercise 4 encourages reflection on the future of pharmacy services within the wider sphere of commissioning groups and justifying services against the QIPP agenda

Reflection exercise 4

How can services such as discharge MURs be used to support the commissioning and QIPP agenda? How can pharmacists in particular support better use of medicines?

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ASSESSMENT QUESTIONS

POST-DISCHARGE MURS

1. Find the TRUE statement regarding a patient's hospital discharge summary:
a. A copy must be sent to the patient's GP within three working days
b. Hospitals can decide whether or not a patient should be given a copy
c. Hospitals are prevented from sending a copy to pharmacists because of confidentiality requirements
d. A copy must be sent to the patient's GP within 24 hours

2. For the completion of a post-discharge MUR, which of the following is required?
a. Access to patient notes
b. The patient's consent
c. A PMR history of at least six months
d. A patient representative

3. When should a full MUR form be sent to the relevant GP?
a. When there are no changes to make
b. Every time
c. At the end of the month
d. If the GP requests to see the form

4. To undertake a post-discharge MUR a pharmacist must be accredited by:
a. The Royal Pharmaceutical Society
b. The PCT under PREM 1
c. The PCT under PREM 2
d. A higher education institute

5. Information governance post-discharge deals with all except storage of:
a. MUR paperwork before it is completed
b. Completed MUR information on a laptop
c. Unit discharge fax forms from the hospital
d. MUR paperwork after it has been completed

6. A MUR is NOT used to identify which of the following?
a. An adverse drug reaction
b. Issues in compliance
c. Adherence to NICE technology appraisals
d. Formulations that are unsuitable

7. The New Medicine Service:
a. Is only intended for patients whose new medicine was started in primary care
b. Is intended to increase treatment adherence
c. Is essentially a MUR but focused on newly prescribed medicines
d. Involves a single consultation with the patient

8. What percentage improvement was there in the FIM score in South Staffordshire on discharge?
a. 51 per cent
b. 61 per cent
c. 71 per cent
d. 81 per cent

PHARMACY MAGAZINE CPD RECORD – JUNE 2011

USE THIS FORM TO RECORD YOUR LEARNING AND ACTION POINTS FROM THIS MODULE ON POST-DISCHARGE MURS OR DOWNLOAD FROM WWW.PHARMACYMAG.CO.UK AFTER COMPLETING THE ONLINE LEARNING SCENARIOS

Activity completed. (Describe what you did to increase your learning. Be specific)
(Act)

Name/date: **Time taken to complete activity:**

What did I learn that was new in terms of developing my skills, knowledge and behaviours? Have my learning objectives been met?*
(Evaluate)

How have I put this into practice? (Give an example of how you applied your learning. Why did it benefit your practice? How did your learning affect outcomes?)
(Evaluate)

Do I need to learn anything else in this area? (List your learning action points. How do you intend to meet these action points?)
(Reflect)

* If as a result of completing your evaluation you have identified another new learning objective, start a new cycle – this will enable you to start at **Reflect** and then go on to **Plan**, **Act** and **Evaluate**. This form can be photocopied to avoid having to cut this page out of the module. Complete the learning scenarios at **www.pharmacymag.co.uk**

MODULE 188 ANSWER SHEET

ENTER YOUR ANSWERS HERE Please mark your answers on the sheet below by placing a cross in the box next to the correct answer. Only mark one box for each question. Once you have completed the answer sheet in ink, return it to the address below together with your payment of £3.75. Clear photocopies are acceptable. **You may need to consult other information sources to answer the questions.**

1.	2.	3.	4.	5.	6.	7.	8.
a. ☐	a. ☐	a. ☐	a. ☐	a. ☐	a. ☐	a. ☐	a. ☐
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Processing of answers
Completed answer sheets should be sent to Precision Marketing Group, Precision House, Bury Road, Beyton, Bury St Edmunds IP30 9PP (tel: 01284 718918; fax: 01284 718920; email: cpd@precisionmarketinggroup.co.uk), together with credit/debit card/cheque details to cover administration costs. This assessment will be marked and you will be notified of your result and sent a copy of the correct answers. The examiners' decision is final and **no correspondence** will be entered into.

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