

Pharmacist access to the Patient Health Record

The Royal Pharmaceutical Society (RPS) believes that all pharmacists should have full read and write access to the patient health record in the interest of high quality, safe and effective patient care.

Introduction

Access to the patient's health record, their laboratory results and previous treatment with medicines is routine for pharmacists working in hospitals. These pharmacists would consider their practice unsafe to have no such access.

In August 2014, according to new research from YouGov¹, an overwhelming majority of the British public, 85%, said they want any healthcare professional treating them to have secure electronic access to key data from the GP record.

We believe that there should be full read and write access to the patient health record by all pharmacists, but are aware that this could be a stepwise process, with the first step being access to the Summary Care Record (SCR).

Recommendations

A position of "access to health records in the patient's interest" must be adopted for all professionals providing care to patients.

Pharmacists have a legitimate need to access patient health records as the more information available to them when providing care to patients, the better the outcome for patients.

The RPS is calling for NHS England, over time, to enable full read and write access to the patient health record for all pharmacists.

¹ Managing medicines in care homes (2014) <https://www.nice.org.uk/guidance/SC11/chapter/what-is-this-guideline-about-and-who-is-it-for>

Background

The Caldicott 2 Information Governance review² recommended that *'for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professional who have a legitimate relationship with the patient'* (recommendation 2). Pharmacists, as registered and regulated healthcare professionals, should therefore have access to the patients' record when providing direct care to them.

The government response to the Review³ states: *'Sharing information to support care is essential. It is not acceptable that the care a patient or service user receives might be undermined because the different organisations providing health and care to an individual do not share information effectively.'*

The RPS believes that such sharing of information will become even more important when care providers start to provide services under the 'Any Qualified Provider' route, when records of patient care from organisation not previously associated with care provision, will need to be captured on the patient record. For example, private companies may start to deliver health services to patients. Basically, any professional who provides direct care to the patient should have read and write access to the patient record, with patient consent.

The government recognises the need to include pharmacists in information-sharing, set out clearly by Jeremy Hunt on 6 Nov 2013: *'I am aware of the important role that pharmacists play in supporting the rest of the healthcare system, and am keen to explore how this role could be developed through electronic record sharing. I think it is important that the Department, in partnership with NHS England, look strategically at how pharmacy can support the rest of the healthcare system, in the context of working towards more integrated care and a paperless NHS by 2018. In particular, I would like to see if, when a patient gives permission, it would be possible for a pharmacist to access a GP record in order to give the best possible advice. There are many other areas to consider as well, and I look forward to discussion'*.

² <https://www.gov.uk/government/publications/the-information-governance-review>

³ <https://www.gov.uk/government/publications/caldicott-information-governance-review-department-of-health-response>

Access to the Summary Care Record

The SCR contains details of a patient's key health information such as patient demographics, current and most recently prescribed medicines, adverse reactions and known allergies. Access to this information can support pharmacists to ensure there is no interaction between a patient's currently prescribed therapy and any new treatments. It is the first step towards ensuring continuity of medicines when transitioning from primary to secondary care and vice versa.

Currently 57% of hospital pharmacies have access to the patient's SCR. This has shown in audits and service evaluations, conducted by a number of hospital trusts, to have a huge positive impact on the ability to undertake effective medicines reconciliation when a patient comes into the hospital (medicines reconciliation is a process which ensures clinicians know what medicines a patient is currently taking). Hospital pharmacy teams have found that access to the SCR has assisted in improving patient safety and identifying adherence issues.

'This service evaluation has shown that one out of every five patients assessed on a Medical Assessment Unit had an intervention that improved prescribing when the SCR was made available to Pharmacy staff'. (Northumbria Healthcare NHS Foundation Trust)

The results of this audit demonstrate the following benefits of SCR

- *SCR is used for more complex cases*
- *Time taken to complete a medication history is quicker when SCR is used.*
- *There is a reduction in communication time, resources and effort between health care providers*
- *SCR increases the number of discrepancies identified, thereby improving accuracy.*

(Basildon and Thurrock University Hospital NHS Foundation Trust).

In July 2014 NHS England announced that it would undertake a proof of concept exercise to consider how access to the SCR would be undertaken in community pharmacies and what benefits this would have for patients. The areas where this is being piloted are Somerset, Derbyshire, Northampton, Sheffield and West Yorkshire.

A community pharmacy in Sheffield currently has access to a patient's SCR with patient consent. Over the Easter period 2014, they had consultations with 91 people regarding emergency supplies of medicines, which resulted in the dispensing of 165 items that had either run out, not been ordered, forgotten to pick up prescriptions before surgeries closed etc. 39% of these patients said they would have gone to A&E / urgent care centre if the service via the community pharmacy had not been available. The SCR was used in these cases to support safe provision of emergency supplies of the patient's medicines.

Access to the full record

There are already several areas in England where community pharmacists have some access to patient information but this is not standardised and allows access of varying degrees. Whilst we recognise that access to a patient's SCR is the first step we believe that to fully realise the benefit of access to information the full record should be made available to all pharmacists. This will support pharmacists in optimising a patient's medicines, ensuring that patients get the most from their medicines. As many medicines have more than one use, for example, carbamazepine for both epilepsy and pain, and doses can vary according to diagnosis, it is vital that pharmacists know the patient's history to be able to make a fully informed clinical judgement when checking the prescription. To ensure safety and optimum use of medicines it would be useful for the pharmacists to have an accurate picture of the patient's diagnostic history as well as recent investigational data to show the success of, or potential adverse reactions to medicines. In addition a GP is currently limited in their ability to know if a patient is taking a medicine that they have been prescribed, or even if that medicine has been dispensed. With the roll out of a variety of services such as medicines use reviews (MURs) and the new medicine service (NMS) more information on pharmaceutical care issues is being recorded and stored in community pharmacy patient medication record systems. This could be transferred back to the GP as required, but currently there is no link between the pharmacy record and the GP record. Also, medicines that a patient may purchase from the pharmacy are also currently unknown to the prescriber.

Summary

- Information is key to reducing medicine errors, improving medicines adherence and delivering safe and more effective care to patients. Pharmacists should have full read and write access to the patient health record to improve patient care and patient safety
- Access to the patient health record will allow pharmacists to make more informed clinical decisions, in partnership with patients, about the pharmaceutical care that patients receive. This will improve medicines adherence, supporting improvement in the treatment of individual patients and helping the NHS to maximise the value of the significant investment it makes in medicines.
- The ability to access the patient health record will allow pharmacists to play an even greater role in the provision of unscheduled care by improving their ability to respond to emergency requests for medicines safely.