

Pharmacist access to the Patient Health Record

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

I. Key Facts and Summary

- Pharmacists should have full read and write access to the patient health record to improve patient care and patient safety. Information is key to delivering more effective pharmaceutical care to patients, improving medicines adherence and reducing the medicine related errors which contribute to unplanned admissions to hospital.
- Access to the patient health record will allow pharmacists to make more informed clinical decisions, in partnership with patients and other health and social care professionals, about the pharmaceutical care that patients receive. It will support improvement in the treatment of individual patients and help the NHS to maximise the value of the significant investment it makes in medicines.
- Pharmacist access to the patient health record will improve patient care by enabling pharmacists to play an even greater role in the provision of safe and effective unscheduled care, treating common clinical conditions and responding to emergency requests for medicines.
- Read and write access by pharmacists will enable other healthcare professionals to be aware of interventions made by pharmacists, to get a fuller picture of medicines dispensed and to know which medicines patients are purchasing over the counter in pharmacies.
- Each healthcare professional records important information about a patient's care. Currently, these separate records cannot be accessed by other healthcare professionals. A single patient record would enable more informed and safer health decisions to be made by practitioners and patients.

2. Recommendations

To enhance patient safety and enable continuity of care RPS is calling for:

- Full read and write access to the patient health record for all pharmacists involved in a patient's care with the patient's consent.
- One single patient health record where all essential information is stored. All registered health and social care professionals involved in the patient journey to have appropriate access to the patient health record with the patient or their designated carer's explicit consent.

3. Background and Introduction

Currently the most complete record available of a patient's healthcare is that kept by their GP. This record is not routinely shared or accessed by other health professionals. If a patient requires healthcare advice when their GP practice is closed or in an emergency, it can be difficult for other healthcare professionals, including pharmacists, to access the critical medical information needed to make clinical decisions.

In a hospital, pharmacists routinely access a patient's hospital health record, laboratory results and information about previous medicines in order to safely advise and input into a patient's care. This information is not currently available to community pharmacists who also need to advise and input into patient care on a regular basis.

Hospital and primary care computer systems are not compatible causing issues of continuity of care when patients migrate through the healthcare system.

As technology develops, consideration must be given to how different systems can interface with each other to ensure continuity of patient care. Having one single patient record accessible with patient consent would alleviate many communication issues and enable improved continuity of care.

Community pharmacists keep their own patient medication records (PMR) which give a history of all items dispensed from that particular pharmacy, patient demographics and GP details as well as any extra information the pharmacist wishes to note, such as patient preferences for a particular brand of medicine, medicines purchased over the counter, or allergies the patient has told them about. Where there is electronic transfer of prescriptions this now allows GPs to see whether or not a prescription has been dispensed and at which pharmacy. However, there is no facility for healthcare professionals to share key information on the pharmaceutical care and medicines optimisation issues which are obtained as part of new pharmacy clinical services such as the Chronic Medication Service (CMS), The New Medicines Service (NMS) and the Discharge Medicines Review (DMR).

According to 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. A recent survey of over 7,000 patients using a pharmacy vaccination service² showed that 80% of patients are happy for the pharmacist to be allowed access to their GP record.

1. <https://www.emishealth.com/news-and-events/news/public-support-wider-access-to-gp-record/>

2. Mahmood H, Tse S, Chung Li W, et al. Community pharmacy vaccination services: customers' perceptions of pharmacist access to GP records. *International Journal of Pharmacy Practice*. 2015;23 (Suppl 2):9

4. The Current Situation

4.1 England – Summary Care Record (SCR)

The SCR contains details of a patient's key health information and consists of 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 current medicines and any new treatments. It is the first step towards ensuring continuity of medicines when patients move from primary to secondary care and vice versa.

Currently 87% of hospital pharmacies have access to the patient's SCR. Audits and service evaluations, conducted by a number of hospital trusts, have shown this to have a huge positive impact on the ability to undertake effective medicines reconciliation when a patient comes into the hospital (the 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 medicines adherence issues.

A patient with drug abuse history was not happy for the hospital pharmacist to directly contact his GP for details on his medicines but consented to SCR access. He was unable to tell the pharmacist the doses of medicines he was taking. Via his SCR, the pharmacist was able to confirm doses of his mirtazapine, gabapentin, diazepam and methadone. Furthermore, via SCR, the pharmacist was able to find out which pharmacy he collects his methadone from and confirm a full collection history with them. This gave important safety information on his dosage requirements to prevent either overdose or withdrawal symptoms.

A patient presented for an operation. He was unwell and unable to confirm his medicines himself. He had been transferred to the hospital from home via another hospital's A&E department and they had taken his medication history from a relative. Only when the pharmacist accessed the SCR was it identified that the patient was on insulin. This meant a sliding scale of insulin could be introduced to enable a safe operation to be undertaken.

In June 2015 it was announced that community pharmacists across England will be given the opportunity to access the SCR. National roll out is expected to commence in October 2015 and could take a period of around 18 months to complete.

A recent pilot carried out in around 140 community pharmacies showed that pharmacists were able to help people who needed access to essential medicines by using the SCR, avoiding an unnecessary visit to their GP. In 92% of encounters where SCR was accessed, the pharmacist avoided the need to signpost the patient to other NHS care settings. 56% of these encounters would have been signposted to the GP practice, 22% to GP out of hours or NHS 111, and 1% to A&E.³

Pharmacists involved in the pilot were also able to provide safer care with a reduction in the number of avoidable medicines errors. 73% of pharmacists who responded to the questionnaire agreed that using the SCR has helped them avoid medication related errors.

3. http://systems.hscic.gov.uk/scr/library/poc_report.pdf

During the SCR pilot at Woodhouse Pharmacy in Sheffield, a patient contacted the pharmacy outside their GP's opening hours to ask the pharmacist about a prescription for an antibiotic. By accessing the SCR, the pharmacist identified the patient had an allergy to penicillin. He was therefore able to advise the patient not to take the prescribed amoxicillin. Commenting on this the pharmacist said: "*Had the patient not contacted the pharmacy, and had I not been able to access their Summary Care Record a significant patient safety incident could have occurred*".

4.2 Scotland – Emergency Care Summary (ECS), Palliative Care Summary (ePCS) and Key Information Summary (KIS)

The ECS contains information about a person's repeat medication, allergies and demographics. It can be invaluable in ensuring safe continuity of care in the out of hours period. Currently access to the ECS is limited to Accident and Emergency units, the Ambulance service, some hospital wards and pharmacists in NHS 24. Community pharmacists wishing to access this information at a patient's request must contact NHS 24 to receive this information verbally from a colleague on a professional to professional line. The Scottish Government committed to providing community pharmacists with access to the ECS by 2014 but to date only a few pilots have been progressed. Patient consent to access the ECS is required each time access is required.

The ECS also gives access to the Palliative Care Summary where available, which informs a health professional of a person's wishes for their end of life care as well as details about their palliative care medicines. Without access to this information community pharmacists have no knowledge of when a patient reaches the palliative stage of care, which can result in confidentiality issues and difficulty in speaking to a patient, their family or their carer about this sensitive area. In addition, not having access to the medication history for the high risk opiate medicines used in palliative care can result in delays in patient access to pain killing medicines and the potential for overdose (or underdose) situations.

The KIS contains more sensitive information than the ECS, particularly around anticipatory care planning and current clinical issues such as medication, facilities and equipment available in the patient's home, care plans, place of care considerations, views on resuscitation, and any arrangements in place for palliative care. Consent for sharing the KIS is requested before recording and uploading information. The usefulness of the KIS depends on having all relevant information uploaded from the GP record into KIS before being made available to share.

In the rural Scottish borders, a tourist on holiday presented to a community pharmacy with a minor ailment request for an infection which needed treatment. On questioning regarding their health conditions and their use of other medicines it transpired the patient had previously had an organ transplant and was immunocompromised. Access to medication history and details were required to safely administer treatment or decide if further medical attention was required.

Discrepancies in GP records resulted in varying prescriptions being issued for compliance aid boxes to a housebound patient suffering from dementia. A chance intervention by a pharmacist revealed the discrepancies after several supplies. The pharmacist corrected the error, alerting the prescriber to the requirement for a blood test to readjust doses to stabilise the patient. Read and write access would have allowed the community pharmacist to amend and correct the discrepancies before dispensing, preventing potential harm and the need for further testing. This incident involved anticoagulant therapy where doses are critical and errors could result in emergency admission to hospital or potentially, a fatal haemorrhage.

Developmental work in progress

There are a few examples around the country of developmental work, examining the different methods by which community pharmacy could access a patient's health record when required.

In NHS Tayside a clinical portal is being piloted in a small number of community pharmacies with explicit patient consent, giving access to the ECS, KIS, all GP data, laboratory results and it connects with the software system currently used by allied health professionals and nurses on home visits facilitating a true multidisciplinary approach to patient care. This supports a multidisciplinary approach to patient care and is being piloted for use in outreach dementia clinics by a community pharmacist independent prescriber. It has been extremely useful in checking test results, dealing with issues on hospital discharge especially with compliance devices, medication change queries and providing a diagnosis to support Chronic Medication Service medication reviews. It is expected that this access will be rolled out to all community pharmacies in Tayside.

The pharmacist checked the clinical portal with the patient's consent to find the dosage of her lithium and venlafaxine medication, post discharge. The patient thought that she had been advised to stop "all her medication" and had done so. However, what was actually intended was that she should stop only her pain medication and was supposed to continue all her other meds. The pharmacist allayed the patient's concerns, spoke to both the hospital and GP surgery, obtaining an appointment for the patient with the latter. They were subsequently able to agree a way forward to restart her lithium and venlafaxine, in accordance with the GP's wishes. The pharmacist then followed up with the patient the next week.

A customer complained of tiredness symptoms and requested to buy iron tablets. The pharmacist checked her blood test results to find her iron levels were fine and that iron tablets were not required; however, on checking, her last blood tests showed her thyroid hormone levels were on the lower side of normal and recommended that she should see her GP to review the dose of her levothyroxine treatment. Her dose was increased and her symptoms resolved.

The pharmacist checked a new prescription for clopidogrel and rivaroxaban post discharge to ensure patient safety. This concurred with the consultant's recommendations to the GP and meant accurate information could be given to the patient on managing this combination of meds without having to contact either the GP or the consultant to query the interaction and confirm intentions.

NHS Highland is now able to authorise individual community pharmacists to have electronic access to hospital discharge letters through Scottish Care Information Store. This is strictly professional-only access, with individual pharmacists – not pharmacies – being given access via a username and password. Currently access is limited to patients receiving managed support from the Care at Home service where the pharmacist supplies a Medication Administration Record which a care worker uses to administer medicines. Having accurate information is essential to ensure this vulnerable group of patients receives their medicines safely after hospital discharge. NHS Highland plans to test this access further as part of the Scottish Patient Safety Programme Pharmacy in Primary Care pilot.

Access to ECS has been granted to some pharmacies where a local need was identified and the community pharmacist was the most accessible health professional at weekends. Other examples include one rural area where a pilot study has now been agreed because the lack of GP cover at weekends has resulted in a steadily increasing requirement for the community pharmacist to phone NHS 24 to access the ECS to obtain essential medicines history and allergy information to safely provide treatment for a minor illness or repeat medication items. Lack of pharmacist access to this information has the potential to compromise patient safety in the use of medicines.

4.3 Wales – Individual Health Record (IHR)

The Individual Health Record (IHR) in Wales is a summary of the information held by the patient's GP and will include the patient's name and address, GP details, up to two years of medication history, allergies and any recent medical problems or appropriate test results.⁴

NHS Wales Information Services have worked closely with health professionals to develop the IHR. The IHR is 'view only', and currently can only be accessed under certain conditions by authorised staff using a computer within a GP Out of Hours (OOH) service or by doctors and pharmacists in hospitals for patients presenting for unscheduled care. Discussions are in progress with the General Practice Committee (GPC) Wales on allowing wider access for health professionals.

All access to the IHR is monitored to ensure patient confidentiality is safeguarded.

Pilot for unscheduled care allows fast access to patient's IHR

A number of unscheduled admission sites throughout Cardiff and Vale University Health Board have been pilot sites for the use of the IHR, allowing pharmacists and doctors immediate access to a summary of a patient's record held by their GP. Anecdotal evidence suggests that without the IHR a pharmacist can wait more than half an hour to get a patient's drug history from a busy GP surgery, the process can be time consuming for both the pharmacist and the GP practice.

4. <http://www.wales.nhs.uk/nwis/page/52698>

The Unscheduled Admissions Ward at Cardiff's University Hospital is always busy and the beds are always full. On calmer days, a dozen new patients are admitted – all very sick, all needing immediate care. On busier days, the number of admissions reaches about twenty. Turnaround is high. Patients come in, are treated then referred or sent home and the bed is filled again.

The Ward Pharmacist is in charge of making sure her patients have immediate access to the right medication. These days, her job has been much easier because she has access to her patients' Individual Health Record (IHR).

“Safe decisions can often only be made with knowledge of what medicines a patient has been taking prior to admission,” said the pharmacist. “Accurate information at this time can be vital to ensure that the best prescribing choices are made, and give sick patients the best chance of recovery. The IHR allows us to see this information as soon as the patient is admitted. Let's say there are 14 or 15 new patients, and each one takes a half hour, sometimes it can take an hour before a GP gets a description faxed to you. That's a lot of time. With the IHR, in seconds I'm on. It's that fast. I can find the information I need in less than a minute.”

5. Policy Background and Government Commitments

The Caldicott 2 Information Governance review⁵ recommended that “for the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the patient” (recommendation 2). The three home country governments have all stated their support for this statement and pharmacists, as registered and regulated healthcare professionals, should therefore have access to the patients' record when providing direct care to them.

The English government response to the Review⁶ 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 Scottish Government response states:⁷ “The Scottish Government agrees that information should be shared among health and social care professionals who have a legitimate relationship with the individual for the purposes of direct care. The fact that different sets of professionals work for different organisations (e.g. local government or NHS) or have different career homes (e.g. qualifications and registration in social care as opposed to medical) should not be used as a barrier to data sharing. Instead, there should always be a presumption in favour of sharing in the case of direct care.”

The Welsh Government has indicated that its long term goal is to ensure individual patient records can be shared appropriately with health and social care professionals. The Minister for Health and Social Services, Professor Mark Drakeford, has stated that the priority must be to move to a secure IT platform that supports the delivery of national services within community pharmacy and enables the sharing of relevant patient information between GPs, hospitals and community pharmacists.⁸

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

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

7. <http://www.ehealth.scot.nhs.uk/wp-content/uploads/sites/7/documents/CMO-Scotland-to-Dame-Fiona-Caldicott-June-2013.pdf>

8. National Assembly for Wales Health and Social Care Committee, HSC(4)-21-14 Paper 1 Evidence from the Minister for Health and Social Services, 24 September <http://www.senedd.assembly.wales/documents/s30898/HSC4-21-14%20Paper%201.pdf>

The Scottish Government stated its commitment to pharmacist access to records when it published "Prescription for Excellence: A Vision and Action Plan" in 2013⁹ which set out the aims and related work programme to deliver safety in pharmaceutical care and medicines with a focus on developing approaches to "Extend access to patient information systems and enable the sharing of information between pharmacists, GPs and other healthcare and social care practitioners."

The Westminster 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."

In Scotland, Prescription for Excellence stated: "In order to deliver safe and effective care, the Vision proposes that pharmacists providing clinical care would be given access to relevant clinical data to ensure medication and care issues can be managed appropriately. Access to electronic Key Information Summary eKIS and Emergency care summaries (ECS), as well as sharing relevant information with social care and other health colleagues will be essential, as more patients with complex and changing support needs are managed at home."

In Wales there has been growing support for sharing patient information among pharmacists and other health professionals. In its inquiry into the contribution of community pharmacy to health services in Wales, the Chief Information Officer for the Welsh Government, noted that there is no technological reason why pharmacists could not access patient information via the individual health record and stated that: "We have to shift this debate away from the risks and problems of sharing to the benefit to the patient. That is, to consider the risks of not sharing information as opposed to the risks of sharing".¹⁰

Patients need to be assured and confident that their records are safe and that confidentiality is assured. They need to know that their records can only be accessed by a registered professional and then only after the patient has given consent.

For future development RPS supports the principles under which current systems operate in that a patient's health record must only be accessed when the user has a valid reason to do so at that time in the interest of patient care; that they must also always have the patient's permission to access their record and that there is a robust audit trail in place to verify when and why access has taken place. Going forward as health and social care integration progresses registered social care professionals will also be given access. The Westminster Government has committed to this by 2020.¹¹

9. <http://www.gov.scot/resource/0043/00434053.pdf> accessed 250815

10. National Assembly for Wales Health and Social Care Committee (2012) Inquiry into the contribution of community pharmacy to health services in Wales, <http://www.senedd.assembly.wales/documents/s7883/The%20contribution%20of%20community%20pharmacy%20to%20health%20services%20in%20Wales%20-%20Report%20-%20May%202012.pdf>

11. <https://www.gov.uk/government/news/health-secretary-outlines-vision-for-use-of-technology-across-nhs>

6. Next steps – Access to the full record

There are already several areas in Great Britain 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/ECS/IHR 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 directly involved in patient care. This will support pharmacists in providing pharmaceutical care, optimising a patient's medicines and ensuring that patients get the most from their medicines.

Many medicines have more than one use, for example, carbamazepine for both epilepsy and pain, and doses can vary according to diagnosis, so 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 crucial 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.

Whilst a pharmacist may not need all the information in a patient's health record at each intervention it is difficult to know what information they will need in each individual case; this is why we are advocating for full read and write access.

“In my view it is important to have access to all the information to provide patient care. To limit the information to certain areas fails to recognise the holistic nature of the pharmacist's role in supporting the individual. For example, it can be helpful to have blood test results to ensure that there are no renal or liver problems that would affect the metabolism of a medicine or other results which may impact on clinical care. Knowing all the medicines that someone may have historically tried can identify classes of drug that may be more likely to cause problems for the patient. Knowing who their principal carer is for their medicines can ensure that information is provided to that person in supporting best use of medicines. From a public health perspective knowing whether someone is a smoker or has problems with their living circumstances can help in understanding why certain interventions may or may not work.”

Ash Soni, President RPS (has full read and write access to patient records in his pharmacy)

With the roll out of a variety of services such as medicines use reviews (MURs), the New Medicine Service (NMS, England), Discharge Medicines Review service (DMR, Wales) and the Chronic Medication Service (CMS, Scotland), more information on pharmaceutical care issues is being recorded and stored in community pharmacy systems. This information could be transferred back to the GP as required, but currently there is no link between the pharmacy record and the G P record. Also, medicines that a patient may purchase from the pharmacy are currently unknown to the prescriber.

In addition, there is a growing number of pharmacist independent prescribers and many pharmacists supply medicines under Patient Group Directions (PGDs). The GP may not be aware of this. Medicines may also be supplied via home care (commissioned by the hospital) or a patient may be part of a clinical trial and again this is not routinely recorded in the GP record.

Non-medical prescribing is the term used for any health professional prescribers other than medical practitioners and this now includes a wide spectrum of professions, all of whom in theory could be prescribing for one patient at any one time. It is important for patient safety that the patient is at the centre of all health and social care interventions and that this information is stored chronologically in one patient record, accessible as appropriate when required by everyone involved in patient care to have an overview of current and historical medication information.

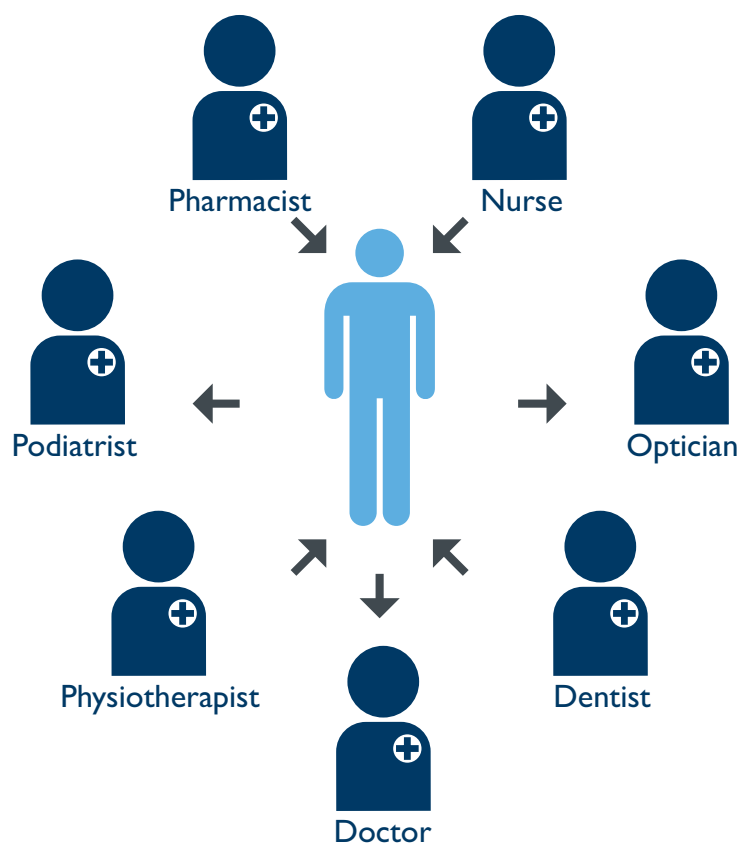


Figure 1: Demonstrating some of the different health records that may be held by different healthcare professionals for just one patient. These separate records cannot be accessed by the other health professionals. If all these healthcare professionals had read and write access, with the patient's consent, to a single patient record, more informed and safer health decisions could be made by practitioners and patients.

Many pharmacists provide public health services such as emergency hormonal contraception, smoking cessation and weight management, and again, the GP will be unaware that the patient is accessing such services. There are numerous community pharmacies throughout Great Britain that offer both private and NHS flu vaccination services to patients. If pharmacists had access to the patient's health record they could record this directly onto the record and GPs would be aware this had taken place, which will avoid duplications of vaccinations.

Implementation via a phased approach:

PHASE 1

Pharmacists, in whichever care setting they are working in, have access to the limited information in the SCR/IHR/ECS with the patient's consent.

For patients, this means improved safety and more timely and accurate health records

PHASE 2

Additional relevant information to be added from the GP record, to the SCR/IHR/ECS either within the body of the record or as an attachment e.g diagnosis and recent laboratory results. E-discharge letters could be attached to the record, improving communications between healthcare professionals and across care settings, particularly around transfers of care.

For patients, assurance that their information is being transferred accurately and ensuring no time delays in updating their information ready for their next prescription, improving safety.

PHASE 3

Pharmacists gaining write access to the patient health record, in whichever care setting they are working in. Examples include adding information around vaccinations and also the supply of urgent repeat medicines via a pharmacy, ensuring a more complete record.

For patients, rather than being asked for the same information by different health professionals, that information is already visible and shared, providing better and safer care.

PHASE 4

Enabling pharmacists to see the full patient health record and be able to write into it. This means that pharmacists could complete an episode of care with the patient rather than having to signpost or refer to other healthcare professionals. It means that the patient record would be more accurate and that the services pharmacists provide become part of the patient care pathway.

For patients, this means all their interactions with both the GP and the pharmacist would be recorded in the same place and they won't have to see as many different health professionals to complete an episode of care.

N.B. THESE PHASES MAY WORK IN PARALLEL RATHER THAN BEING SEQUENTIAL.

7. Support from patients and other organisations

As part of its patient and public involvement work the RPS has held focus groups and seminars with patients representing many health charities. Feedback from these groups has supported pharmacist access to patient records and indeed many patients are surprised to hear that this does not already happen. The focus groups support the principle of a patient record where the patient themselves chooses and explicitly consents who may access their records, thus avoiding any issues of confidentiality.

It is important that patients and the public understand that community pharmacists and their staff are bound by the same principles of confidentiality as GPs and their practice staff.

Comments from the focus groups included:

*They can play
a bigger role
in healthcare*

*If pharmacists
can't see my records,
how can they
possibly advise?*

*I have always had
good experiences
with my local
pharmacist who
knows my history*

*They knew
about me and
my conditions*