# SUMMARY CARE RECORD: Minimising Harm from Missing Data

**The Pan Mersey Area Prescribing Committee recommends that ALL clinicians provide GPs with adequate information about changes to patients' medication regimes to ensure the accuracy of the Summary Care Record**

**SAFETY**

The Summary Care Record (SCR) is an electronic record of important patient information, including current repeat and recently issued acute medication, created from electronic GP medical records. It can be seen and used by authorised staff in other areas of the health and care system involved in the patient's direct care [1].

Not all medications are prescribed by a clinician at a GP practice. Other care settings can also prescribe medication, including those initiated by a specialist (red, purple, amber initiated and retained) and in the therapeutic areas listed in appendix 2. If these medications are not recorded on the electronic GP practice record, it could result in healthcare professionals not having enough information to make an informed clinical decision about a patient's care [5].

Therefore, keeping the SCR up to date is essential for patient safety. Experience shared by Pan Mersey member organisations has demonstrated that quality failings in the availability and accuracy of information on the SCR were a contributory factor in adverse events, resulting in patient harm such as clozapine discontinuation and relapse following acute hospital admission; tacrolimus toxicity, digoxin toxicity and acute kidney injury from clarithromycin; bone marrow suppression and death from trimethoprim co-prescribed with methotrexate.

**Whilst the SCR can only be altered via the GP electronic record, it is the responsibility of ALL clinicians involved in the patient's care to ensure that GPs are equipped with adequate information to allow changes to be updated in a timely manner.**

**Recommendation for all healthcare settings:**

- Clinicians involved in medicines reconciliation are advised that the SCR may not be up to date, accurate, or both. Considerations when interpreting the SCR [2]:
  - When was the SCR last updated?
  - Has there been a more recent hospital or specialist contact?
  - When were the prescription items last issued?
  - Was the issued prescription item collected and dispensed?
- Always ask relevant questions to determine sources of medication outside of the GP practice.
- The SCR will not be updated for patients with a temporary GP registration.
- Ask for any patient-held information about medication.
- To support care integration, the direct electronic production and transmission of letters to GPs should be within 24 hours for discharge summaries and within 7 days of clinic attendance [3].
- Ensure that all changes to the patient's medication regime are communicated to the GP including:
  - New drug initiations (including formulation, dose, intended duration, monitoring required or being undertaken and indication).
  - Dose or form changes of existing drugs.
  - Medication discontinuations or temporary withdrawals.

- Medication prescribed or supplied directly to the patient, i.e., not prescribing responsibility of GP.

**Recommendation for Primary Care**

- Ensure processes are in place to identify medication prescribed outside of the GP practice on receipt of clinical communications and to update the electronic GP medical record accordingly (see appendix 1). Give special consideration to adding the route of administration for people who have a gastrostomy.
- Reconcile medicine as soon as is practically possible and ideally within one week of receiving the clinical communication [4].
- Ensure processes are in place to prevent inadvertent issuing of medication prescribed elsewhere.
- Ensure processes are in place to maintain an accurate list of the patient's current medication on their electronic healthcare record. Medication added using the 'hospital (no print)' function on EMIS remains on the current medication screen until actively removed, even if a GP practice is configured for medication to automatically go into past medication after a defined period.
- Always use a smartcard, otherwise the SCR will not update automatically with changes made to the electronic health record.
- Ensure processes are in place to identify and manage records that have not automatically updated to the SCR. If patient information from the personal demographics service is different to that on the practice's electronic record, the SCR will not update automatically.
- Ensure patients are aware that 'medication prescribed elsewhere' added to the GP system will be shared on the SCR unless they opt-out, e.g., in the GP practice privacy notice.

**References**

1. NHS Digital (2021). *Summary Care Records (SCR)*. [online] Available at https://digital.nhs.uk/services/summary-care-records-scr [Accessed 10.6.21]
2. North West Clinical Pharmacy Forum (2018). *Caution in use associated with Summary Care Record (SCR)*. [Personal communication, available upon request]
3. NHS England (2021). The NHS Standard Contract technical guidance 2021/22. Pg 59. [online] Available at https://www.england.nhs.uk/wp-content/uploads/2021/03/NHS-Standard-Contract-technical-guidance-202122--republished-October-2021.pdf [Accessed 15.10.21]
4. National Institute of Health and Care Excellence (2015). Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. [online] Available at https://www.nice.org.uk/guidance/NG5 [Accessed 10.6.21]
5. NHS Digital (2019). Recording medicines prescribed elsewhere into the GP practice record. [online] Available at https://digital.nhs.uk/services/summary-care-records-scr/recording-medicines-prescribed-elsewhere-into-the-gp-practice-record [Accessed 28.06.2021]

**Appendix 1**

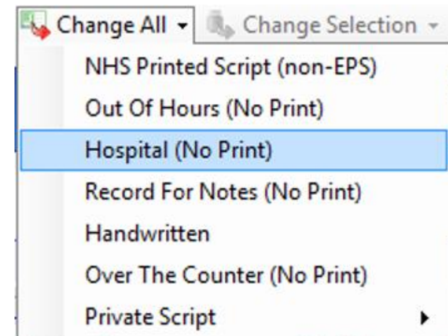
## How to record drugs prescribed elsewhere on to the GP practice electronic record [5].

Drugs Prescribed Elsewhere entered in this way appear on the SCR under the medication "type" headings:

- ***'Prescribed Elsewhere'*** for acute medication issued within 12 months of the last SCR update.
- ***'Repeat Prescribed Elsewhere'*** for current repeat medication issues.

**EMIS Web**

The EMIS Web clinical system has the facility to record drugs prescribed elsewhere on the clinical record using the 'Hospital (No Print)' function. Medication issued using this function is displayed in a different section to medication issued at the GP practice on the EMIS medication screen.




Adding medication prescribed outside of the GP practice using this function enables EMIS to flag up potential drug interactions for subsequently prescribed drugs.

The SNOMED code 394995008 (hospital prescription) can be used to document that the patient has a hospital prescription.

1. Open 'medication' tab.
2. Select 'add drug' icon and enter drug details.
3. Complete the other required details of the Drug Prescribed Elsewhere:
   a. 'Dose': HOSPITAL PRESCRIBED & SUPPLIED – NOT TO BE ISSUED BY GP.
   b. 'Quantity': Enter ZERO or if this is not possible the lowest possible quantity should be entered, e.g., 1 tablet, 1mL
   c. Ensure that either 'acute' or 'repeat' is selected as appropriate.
   d. Where appropriate consider documenting the duration of treatment e.g. individual drug review date
4. Select 'issue'.
5. The 'Issue' screen is then displayed. Here, the user can change where or how the medication has been prescribed.
6. Select "Change All" at the top of the screen and select "Hospital (No Print)" for a medication prescribed at a hospital (for example).
7. In the 'free-text' authoriser" field enter details of who is responsible for prescribing, e.g., hospital and consultant.
8. Change the date of issue to the date the medication was prescribed/initiated from the clinic/hospital appointment.

Authoriser Issue Date 24-Jun-2021

9. Once this has been done, complete by clicking the 'Approve and Complete' button.

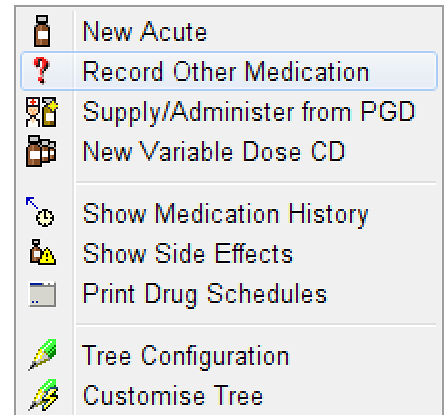
If the GP inadvertently tries to issue the non-practice drug, a warning will appear in the 'Approve and Complete' print box stating it was 'Issued by hospital'.

If this warning is overridden, this could result in the inadvertent issuing of a prescription. Therefore, it is essential that the dosage field contains information regarding where the medication is to be supplied from and that it should not be issued by the GP (as described above). This will warn the patient/dispensing pharmacist in the event a prescription is issued by mistake. It also will warn when a patient changes GP and information is transferred via GP2GP when 'medication prescribed elsewhere' could transfer without being separated from regular repeat medication.

Adding 'medication prescribed elsewhere' using the above process on EMIS will ensure that the item is not automatically put into past drugs.

Using the 'Hospital (No Print)' function the Drugs Prescribed Elsewhere will not be printed on the right-hand side of the repeat prescription, ensuring the patient will not be able to order a repeat prescription from their repeat slip or on any patient-facing portal. The item will not appear on any patient facing online portal.

**System One**




- Right click on Medication in the clinical tree and select Record Other Medication (red question mark). Add the drug and select Hospital Medication as the Medication source.
- Add the drug details such as the strength, dose, quantity, and administration notes with any additional details, e.g., where it is supplied from.
- The medication will then be added to the 'Other Medication' section which is displayed under the 'Template Details' at the foot of the Repeat Templates view. You may have to expand the box by dragging the arrow upwards to view all the details.
  The medication will also appear under the Medication view.

**Appendix 2**

**Therapeutic areas at risk of incomplete or out of date SCR updates [2]**

This list is for illustrative purposes only and is not intended to be exhaustive.

Please ensure that systems are in place to maintain patient confidentiality as needed e.g., medicines used for HIV.

### Cancer

- Chemotherapy, oral and IV
- Denosumab
- Hydroxycarbamide
- Immunotherapy
- Iron infusions
- Oral long-term chemotherapy
- Systemic anticancer therapies
- Warfarin and other anticoagulants supplied by the anticoagulant clinic

### Miscellaneous medicines supplied from hospital or specialist clinic

- Off-label medicines
- Unlicensed medicines
- Red list medicines from secondary or tertiary care
- Clinical trial medicines
- Drugs in pregnancy, e.g., LMWH
- Drugs issued by out-of-hours medical teams
- GnRH analogues, e.g., Prostap
- Handwritten prescriptions

### Mental health

- ADHD medications
- Benzodiazepine reducing regimes
- CAMHS medications
- Clozapine
- Dementia treatments
- Depot and long-acting injection (LAI) antipsychotics
- Illicit drugs
- Lithium
- Medications via community drug or alcohol services, e.g., methadone, buprenorphine
- Melatonin
- Opioid reducing regimes
- Second generation antipsychotics

### Patients' own medicines

- Alternative medicines
- Herbal medicines
- Natural medicines
- OTC medicines

### Anti-infectives

- Anti-TB medications
- Hepatitis medicines
- HIV medicines
- Immunoglobulins
- Outpatient parenteral antimicrobial therapy (OPAT)

### Home care medicines

- Home parenteral nutrition (PN)
- Injectable biologics
- Medication(s) on dialysis
- Oxygen
- Transplant medication(s)

### Disease-modifying agents

- Azathioprine
- Biologic drugs
- Ciclosporin
- Methotrexate
- Mycophenolate (MMF)
- Tacrolimus

### Endocrine

- Insulin: lack of clarity about dose prescribed/intended
- Zoledronic acid

### Family planning clinics/services

- Contraceptives