



Your emergency care summary

Summary Care Records help hospital doctors make swift medical decisions for patients with chronic pain

For Laura Gardner, the launch of Summary Care Records (SCR) has proved an instant boost to patient safety and quality of care.

Laura is the Senior Clinical Pharmacist in the Medical Admissions Unit at the University Hospital of North Durham where SCRs have been in use since July 2011.

"If a patient has an SCR, it's a big help." says Laura. "With a few clicks of the mouse I can get the information I need on their medications, without waiting to receive the information from their GP practice.

"It saves time for the practice as well because they have to spend less time providing information to us.

"Using an SCR means a patient's current medications are sorted out very quickly and they get treatment sooner."



Before SCRs were launched in the ward, Laura and colleagues relied on a phone and fax machine to request and receive the information they needed for all high priority patients with complex medicine regimes.

Now, for those patients who have SCRs, Laura seeks their consent and can see their medications,

adverse reactions and allergies at a glance.

She says: "Having the SCR available is of huge value. Using the SCR means that the number of patients I get to see is increasing because I spend less time on the phone to GP practices asking for information.



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“When a patient is admitted, typically hospital doctors don’t have a lot of information available to them.”

“This means that more people are getting a pharmacist review when they come in to the hospital. The more people we can see the better because it helps us to do the best possible reconciliation of their medicines.”

Using SCRs to reconcile medicines in the admissions unit means that the accuracy of GP notes will also be improved, says Laura.

“When a patient is admitted, typically hospital doctors don’t have a lot of information available to them.

“If there is an error with their medicine at the start, this may stay with them through their time in hospital and be carried through to their GP notes

via the discharge letter when they leave.

“By doing a proper reconciliation and having more time for reviews, the information sent to the GP on the patients’ discharge letter is as accurate as it can be. This is a major win for patient safety.”

The information contained in SCRs has been of particular use in treating patients with epileptic seizures, diabetes or on a course of palliative care.

Laura says: “Prescribing insulin is a good case to show how SCRs support patient safety.

“Patients are often able to say how much insulin they take but cannot be certain which one of seven or eight different types of

insulin they use. Getting the brand wrong can be fatal and so the more information we have the better. SCRs give us that information very quickly.

“I also get a lot of patients visiting the ward with chronic pain.

“Doses of pain relief medication for people receiving palliative care can change quite quickly. A doctor automatically wants to increase relief for patients who come to admissions with chronic pain but you wouldn’t want to do that if their dose had been increased within the previous 24 hours.

“That’s when it’s very useful to have the medication information from the SCR straightaway. We can make swift decisions and increase pain relief fast if it’s safe to do so.”

To find out more about Summary Care Records:

Visit <http://www.connectingforhealth.nhs.uk/systemsandservices/scr>

Contact your local Patient Advice and Liaison Service (PALS) www.pals.nhs.uk

Call the Summary Care Record Information Line on 0300 123 3020

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