Chapter 6: Facilitating Continuity of Medication Management on Transition Between Care Settings

INTRODUCTION

Transfer of patients between health professionals, health service organisations and within health service organisations provides opportunity for medications errors if communication of the patient's medicines information is incomplete or inaccurate.[1] More than 50% of medication errors occur at transitions of care and up to one-third of these errors has the potential to cause harm.[1-3]

The *Guiding Principles to Achieve Continuity in Medication Management* have three guiding principles that relate to the continuity of medication management on transition between care settings: supply of medicines information to consumers, ongoing access to medicines and communicating medicines information.[4]

Pharmacists' participation in the transition of patients between care settings supports these guiding principles. Pharmacist participation in facilitating discharge and transfer of care has been shown to reduce adverse outcomes and importantly to reduce hospital readmissions.[5]

When patients move between different settings there is a risk that their care will be fragmented. Poor communication of medical information at points of transition has been shown to be responsible for up to 50% of medication errors and up to 20% of adverse drug events.[6] Omitting one or more medicines from the discharge summary exposes patients to 2.31 times the risk of re-admission to hospital.[7]

Communication and liaison with the patient/carer and other health professionals (e.g. GP, community pharmacists, other primary health professionals) facilitates the continuity of a patient's medication management. Patients may have multiple prescribers including non-medical prescribers. This communication may be via the patient's discharge summary, medication management plan (MMP), electronic health record or equivalent.

A key aspect of facilitating the continuity of medication management is to ensure the patient has affordable and continued access to the medicines they require to support their MMP.

Ideally, an outreach or community liaison pharmacist would be available to facilitate patient transfer from hospital. See *SHPA Standards of Practice for the Community Liaison Pharmacy Practice*.[8]

OBJECTIVE AND DEFINITION

Objective

The pharmacist's role in facilitating transition between care settings is to achieve continuity of medication management for the patient. The care settings may include hospital, residential aged care and community services. The patients may be admitted, ambulatory or residential.

Definition

Facilitating the continuity of medication management at transition involves pharmacist activities performed on discharge or transfer that ensure:

- patients receive the correct medicines and have ongoing access to medicines
- verified, patient-specific, medicines-related information is provided to all relevant persons involved in the patient's ongoing care
- patients at risk of medication misadventure are followed up, monitored and receive adherence aids, if required.

EXTENT AND OPERATION

Planning for transition between care settings should commence on admission and be ongoing during the episode of care. All patients should have access to information about their medicines. Medicines information should be supplied to the patient/carer and other relevant health professionals as required during the episode of care.

If all steps of facilitating medication management on transition cannot be completed for every patient, prioritise those who are most likely to benefit from the service. Patients most at risk of medicines-related problems include those who:

- have medication misadventure as the known or suspected reason for their presentation or admission to the health service organisation
- are aged 65 years or older
- take 5 or more medicines
- take more than 12 doses of medicines per day
- take a medicine that requires therapeutic monitoring or is a high-risk medicine
- have clinically significant changes to their medicines or treatment plan within the last 3 months
- have suboptimal response to treatment with medicines
- have difficulty managing their medicines because of literacy or language difficulties, dexterity problems, impaired sight, confusion/dementia or other cognitive difficulties
- have impaired renal or hepatic function
- have problems using medication delivery devices or require an adherence aid
- are suspected or known to be non-adherent with their medicines
- have multiple prescribers for their medicines
- have been discharged within the last 4 weeks from or have had multiple admissions to a health service organisation.

POLICY AND PROCEDURE

Patient's confidentiality and personal wishes must be respected. Obtain patient consent before sharing their information with other health professionals. Encourage patients to contact their hospital pharmacist at any time, even after discharge or transfer, as they may require further information despite comprehensive counselling. The name and contact number of the hospital pharmacist or the organisation's pharmacy service should be made available to the patient/carer.

Manage Patient's Medicines and Communicate with Patient and/or Carer on Transition

Patients/carers should receive sufficient supplies of appropriately labelled medicines for ongoing treatment. Where it is not hospital policy to supply medicines on discharge, prescriptions should be provided. The pharmacist needs to ensure that the patient can access supplies in a timely manner for uninterrupted dosing.

Communication with the patient/carer on transition is important to ensure any remaining issues are resolved or communicated to the new team and to reinforce information provided during the admission or episode of care.

- Reconcile medicines on transition, see *Chapter 1: Medication reconciliation*.
- Reconcile discharge/transfer medication orders with:
  -current medication orders (on all medicine charts)
  -medication history taken on admission
  -patient's own medicines
- Discuss with the patient/carer the medicines that need to be supplied or sourced on discharge or transfer. Annotate on the MMP which medicines need to be supplied on discharge.
- Return patient's own medicines where appropriate. Remove ceased medicines for destruction with the patient's permission. Document the details of medicines returned, re-labelled or removed.
- Check that the medicine orders meet legal and local prescribing requirements.
- Provide patient with the medicines that they require together with an accurate and complete list of their medicines or discharge medication record.
- Provide patient/carer with instructions on how to get further supplies of their medicines after discharge or transfer.
- Provide verbal and written medicines information including information on changes to their medicines, CMIs, details regarding the further supply of medicines and other information required for ongoing care. See *Chapter 5: Providing medicines information*.
- Provide information about adherence aids.
- Discuss the need for follow-up either at home, residential care, outpatients or non-admitted settings.

If the patient refuses to consent to the removal of ceased medicines then separate the ceased medicines from the current medicines and clearly label them as ceased and no longer part of the current therapy.

Liaise with Other Health Professionals on Transition

Obtain patient consent and then communicate all medicines-related information in a timely manner to the patient's GP, community pharmacist, residential care provider or other health professional. The method and extent of communication will vary depending on the needs of individual patients, and the available time and resources.

There should be communication with the community pharmacy to facilitate continued supplies of the medicines.

Provide the following information to all involved in the patient's care in accordance with the *Guiding Principles to Achieve Continuity in Medication Management,* Guiding principles 8 and 9:[1]

- details of medicines prescribed on discharge or transfer, a contact name within the hospital and a telephone number
- verified list of all the patient's medicines beginning at the episode of care, changes made during the episode of care and a detailed rationale of these changes
- monitoring requirements for ongoing management of the patient's medicines
- information regarding the patient's need for periodic medicines review. Include recommendations on the need for a Home Medicines Review, Residential Medication Management Review, MedsCheck, Diabetes MedsCheck or other review process to support the patient's MMP including:
  -post acute care follow-up
  -outpatient or non-admitted medication review
  -hospital-in-the-home
  -post-discharge outreach or liaison services for those at high risk of medication misadventure
- sufficient information about obtaining supplies of ongoing medicines after transition, including special packaging requirements
- reported adverse drug events and adverse drug reactions during the episode of care
- information regarding assistance required
- an interim medication chart (if available) for patients discharged to residential care facilities.

Document the information provided and who it has been transferred to on the MMP or directly in the patient's health record. See *Chapter 13: Documenting clinical activities*.

Post-Discharge Follow-Up of Patients at High Risk of Medication Misadventure

The potential benefits of post-discharge follow-up include:

- reduced readmission rates due to adverse drug reactions and medicines-related problems
- improved patient knowledge about medicines through ongoing counselling to improve medication adherence
- improved patient satisfaction with discharge care
- enhanced continuity of care and improved communication and interaction with GPs and other health professionals
- reduced medicine stockpiling.

Identify high-risk patients in consultation with the interdisciplinary team and arrange appropriate follow-up for the immediate post-transfer period, e.g. MedsCheck, Diabetes MedsChek, outpatient or non-admitted review. Prioritise patients most at risk of medicines-related problems who have risk factors as above in Extent and Operation.

Identify patients who will have difficulty in obtaining medicines, e.g. combination of the Pharmaceutical Benefits Scheme and the Special Access Scheme.

Table 6.1 lists the competencies and accreditation frameworks that are relevant to this chapter.

References

1. Australian Commission on Safety and Quality in Health Care. Safety and quality improvement guide. Standard 4: medication safety. Sydney: The Commission; 2012.

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5. Crotty M, Rowett D, Spurling L, Giles L, Phillips P. Does the addition of a pharmacist transition coordinator improve evidence-based management and health outcomes in older adults moving from the hospital to a long term care facility? Results of a randomized, controlled trial. Am J Geriatr Pharmacother 2004; 2: 257-64.

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7. Stowasser DA, Collins DM, Stowasser M. A randomised controlled trial of medication liaison services-patient outcomes. J Pharm Pract Res 2002; 32: 133-40.
8. Society of Hospital Pharmacists of Australia Committee of Specialty Practice in Rehabilitation. SHPA standards of practice for the community liaison pharmacist. Aust J Hosp Pharm 1996; 26: 570-2.
9. Society of Hospital Pharmacists of Australia. Clinical competency assessment tool (shpaclinCAT version 2). In: SHPA standards of practice for clinical pharmacy services. J Pharm Pract Res 2013; 43 (suppl): S50-S67.
10. Australian Pharmacy Profession Consultative Forum. National competency standards framework for pharmacists in Australia. Deakin: Pharmaceutical Society of Australia; 2010.
11. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney: The Commission; 2011.

Table 6.1 Competencies and accreditation frameworks
Relevant national competencies and accreditation standards and shpaclinCAT competencies
shpaclinCAT[9]
Competency unit 1.5 Discharge/transfer facilitation
1.5.1 Reconciliation of medicines on transfer between care settings 1.5.2 Provision of information for ongoing care 1.5.3 Continuity of supply 1.5.4 Liaison with community primary care healthcare providers
Competency unit 1.6 Patient education and liaison
1.6.1 Need for information 1.6.2 Cultural and social background 1.6.3 Provision of information to patient and/or carer 1.6.4 Provision of information regarding non-pharmacological therapies
Competency unit 2.3 Provision of therapeutic advice and information to health professionals
2.3.1 Provision of accurate information 2.3.2 Provision of relevant and usable information 2.3.3 Provision of timely information
Competency unit 2.4 Communication
2.4.1 Patient and carer 2.4.2 Pharmacy staff 2.4.3 Prescribing staff 2.4.4 Nursing staff 2.4.5 Other health professionals
Competency unit 2.5 Personal effectiveness
2.5.1 Prioritisation 2.5.3 Efficiency 2.5.4 Logic 2.5.5 Assertiveness 2.5.6 Negotiation 2.5.7 Confidence
Competency unit 2.6 Team work
2.6.2 Interdisciplinary team
Competency unit 2.7 Professional qualities
2.7.2 Confidentiality 2.7.4 Responsibility for patient care
National competency standards framework for pharmacists[10]
Standard 1.1 Practise legally
3 Respect and protect consumers right to privacy and confidentiality 4 Support and assist consumer consent
Standard 1.3 Deliver 'patient-centred' care
1 Maintain primary focus on the consumer 2 Address consumer needs
Standard 2.1 Communicate effectively
1 Adopt sound principles for communication 2 Adapt communication for cultural and linguistic diversity 3 Manage the communication process 4 Apply communication skills in negotiation
Standard 4.3 Dispense prescribed medicines
3 Assist consumer understanding and adherence
Standard 7.1 Contribute to therapeutic decision-making
4 Support and assist consumer self-management
National safety and quality health service standards[11]
Standard 4 Medication safety: continuity of medication management
4.12 Current comprehensive list of medicines and the reason for change
Standard 4 Medication safety: communicating with patients and carers
4.15 Provide current medicines information