Medication management post discharge: whose job is it anyway?
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Improving medication management across the continuum continues to be one of the greatest challenges in modern health care. The problems arising with medication management in the transition from tertiary to primary care have been well documented. With the projected increase in persons with chronic complex disease, medication-related problems are likely to escalate and will impact not only health professionals and the health systems but most importantly our patients too. The data is in, the problem seems perennial, but the solution may not be as elusive as it appears.

MEDICATION-RELATED PROBLEMS POST DISCHARGE – A READMISSION WAITING TO HAPPEN?

In a report focussed on positive ageing, it was identified that one-quarter of Australians with chronic health conditions did not receive clear instructions about symptoms to watch for and when to seek further care when discharged from hospital, and 15% did not know who to contact for questions about their condition or treatment after discharge. Adverse drug events, defined as injury due to a medication, affect 11% to 17% of patients during the first few weeks after hospital discharge. These problems are due to discontinuity between hospitals and primary care physicians, poor communication, complex discharge instructions, changes to the medication regimen and new self-care responsibilities. While hospitals strive for efficiencies through improved emergency access targets and reduced length of stay, readmission rates must be prioritised into quality measures when assessing the efficacy of hospital care. Numerous studies have identified that medication-related adverse events are at the very core of many hospital readmissions. These consequences of medication-related problems emphasise the most important point made by the Institute of Medicine in its landmark report on patient safety: ‘Systems and processes of care need to be redesigned to prevent and/or mitigate the impact of medical errors.’

MEDICATION EDUCATION ON DISCHARGE

Education regarding medicines and changes during hospital stay is important, and must underpin good discharge planning. However, this is clearly not the only important issue that requires consideration. Despite providing patients with best practice care from hospital pharmacists in medication education, Kripalani et al. found medication errors were not substantially reduced. The intervention consisted of 4 components: pharmacist assisted medication reconciliation, tailored inpatient counselling by a pharmacist, provision of low-literacy adherence aids, and individualised telephone follow-up after discharge. While this result challenges our perception of the problem, consideration must be given to contextual factors that are not immediately apparent. The impact of an event, such as a hospital admission should not be underestimated and may have had a significant influence on patients’ capacity to comprehend and retain information provided about their medications during their hospital stay. The authors concluded that a reduction in preventable medication-related problems may require interventions focused on closer discharge monitoring or home visits. Moreover, this study underscores the importance of a collaborative approach on discharge that includes and involves primary care, as ultimately the responsibility of the longitudinal care of patients will be in this arena.

TIMELINESS OF AN EARLY POST-DISCHARGE MEDICATION REVIEW

Since 2001, Home Medicines Review has been utilised as a means of improving medication management, where the reviewing pharmacist visits patients in their home through a general practitioner referral. However, the restrictive referral requirements were seen as a barrier to timely and accessible service early in the post-discharge period. The final report on the Home Medicines Review Qualitative Research Project in 2008 carried strong ‘widespread’ unconditional support for post-discharge medication review, in acknowledgement of this gap in care. The need for a ‘rapid response’ Home Medicines Review for post hospital discharge was the major reason for support for an option of referrals being made by the hospital. It is essential that
all possible barriers are removed to enable post hospital Home Medicines Reviews to occur within approximately 10 days of discharge (earlier if possible) and under the current model this is known to be close to unworkable.9

Despite the support, and call to action nationally and internationally, 7 years on we appear no closer to solving the problem of medication management across the care continuum. While there are many reasons cited for the delay in action in an area known to be a risk to patient safety, a constant is the lack of clinical governance. Who is responsible for care across the continuum for a patient recently discharged from hospital? The governance issue is inexorably linked to financing, and therefore becomes a political issue which may in part explain the inertia in finding and funding more appropriate models.

A COLLABORATIVE APPROACH URGENTLY NEEDED

Both internationally and at a local level across Australia there are pharmacists and medical practitioners in the tertiary and primary care settings working collaboratively for, and with their patients to improve medication safety across the care continuum.10–12 These collaborative leaders provide evidence that positive outcomes are possible. We need to translate this work into sustainable models that include all health professionals and importantly keep the patients’ needs at the centre of the process. The development of a successful, effective and cost-effective discharge planning process demands a systematised approach, where patients at high risk of medication misadventure are identified early and prioritised to receive a timely medication review. A number of validated tools have been used in the Australian setting across the care continuum10,11 to stratify known risk factors for medication misadventure such as being elderly, living alone, polypharmacy, multiple comorbidities, cultural and language barriers and cognitive impairment. Clinicians responsible for handover from hospital to primary care can ensure this perceived risk is documented and referral for a medication review is recommended to provide monitoring and a home visit from a pharmacist early in the post discharge period. The outcomes of post-discharge interventions should be communicated retrospectively if necessary (with the treating medical team) and prospectively (with the General Practitioner and Community Pharmacist), to resolve any medication-related problems identified during transition.

TIME FOR A NEW WAY OF WORKING

The Home Medicines Review model should be celebrated as a landmark service which was instrumental in establishing strong links and good working relationships between pharmacists and general practitioners in the community and providing evidence that quality medication reviews by pharmacists can substantially improve patient outcomes.13,14 It changed the way pharmacists, doctors and their patients worked together to improve medication management. However, to develop a model for post-discharge care of patients, there now needs to be a commitment and connection between acute and primary care. The next crucial step in the process is to engage hospital management to ensure their clinical pharmacists and medical practitioners take ownership for the post-discharge medication review referral. This can be achieved by defining the risk of medication misadventure on the discharge summary, and recommending referral for an early post discharge home medicines review for those identified as high risk. These hospital clinicians must be willing, collaborative participants in the process of resolving medication-related problems that may arise during transition. Only then will the ‘at-risk patient’ be assured of a timely medication review, provided by a pharmacist committed to working collaboratively across care transitions with the full support of all those involved in this episode of care.

The father of quality management, William Edwards Deming, stated ‘We are being ruined by best efforts. Best efforts will not substitute for knowledge. There is an excuse for ignorance, but there is no way to avoid the consequences’.15 There is an urgent need for action. To maintain the status quo is simply unacceptable. We are all responsible for medication management post discharge; however, our professional bodies must show leadership to enact the systems of care that our patients deserve. Together, we can make the care continuum a safer place for our patients to journey.

Competing interests

None declared.

REFERENCES


