Medication management post discharge

Whose job is it anyway?

Deirdre Criddle ~ Complex Care Coordinator Pharmacist SCGH
Dr Pradeep Jayasuriya ~ Practice Principal, Belgravia Medical Centre
What’s in a word?

“I believe the word ‘discharge’ is part of the problem,.. if you look it up in a dictionary, it implies “out of sight, out of mind” or no responsibility, or a process to make way for more beds.

In NSW at the Clinical Excellence Commission, we are trying to remove the word discharge from our medical lexicon unless of course it relates to an infected wound!”

Prof Clifford-Hughes
NSW Clinical Excellence Commission
June, 2014
Reframing the problem ~
Prof Clifford-Hughes

- ‘Transfer of Care’ could make a dramatic and far-reaching contribution to improving the planning at the time of transfer.

Prof Clifford-Hughes
NSW Clinical Excellence Commission
Changing the culture…

Clinical Handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients, to another person or professional group on a temporary or permanent basis.
Perennial problem with transitions of care

- The Joint Commission currently has standards, National Patient Safety Goals, survey activities, and educational services that address transitions of care.
- However these mechanisms have limited utility or reach.
- Current standards and survey processes address certain transition of care concerns within a healthcare setting, but neither “cross settings,” nor do they address what happens to patients after they leave a healthcare setting.

http://www.jointcommission.org/assets/1/18/hot_topics_transitions_of_care.pdf
2. Clinical Handover Process

6.3 Monitoring and evaluating the agreed structured clinical handover processes including:
- Regularly reviewing local processes based on current best practice in collaboration with clinicians, patients and carers
- Undertaking quality improvement activities and acting on issues identified from clinical handover reviews
- Reporting on results of clinical handover reviews at executive level of governance

Why?

► Evaluation establish if the policy, procedure and processes is efficient and determine if changes are needed to optimise performance and to identify areas for improvement.

► Reporting results should be fed back to the relevant committee or meeting about governance as health service organisation is responsible for ensuring that their systems for clinical handover are operational and effective.

Engagement of clinicians and patients and carers is important for ownership and successful implementation of clinical handover
Perennial problem with transitions of care ~ an international issue

HOT TOPICS IN HEALTH CARE

Transitions of Care: The need for a more effective approach to continuing patient care

http://www.jointcommission.org/assets/1/18/hot_topics_transitions_of_care.pdf
Root causes of ineffective transitions of care

- Communication breakdowns.
- Patient education breakdowns.
- Accountability breakdowns.

The Joint Commission: *The need for a more effective approach to continuing patient care*
http://www.jointcommission.org/assets/1/18/hot_topics_transitions_of_care.pdf
The core of the problem

• The period 7 to 10 days following hospital discharge is a vulnerable time associated with a significant risk of medication misadventure, especially in high-risk patients.

• Studies show ~ 50% of the adults discharged from hospital experience a medical error, with 19%-23% suffering an adverse event, most commonly an adverse drug event.

Medication related problems in transition

- Due to
  - discontinuity between hospitals and primary care physicians,
  - poor communication,
  - complex discharge instructions,
  - changes to the medication regimen, and
  - new self-care responsibilities.

Potential solutions from hospital

• Despite providing patients with best practice care from hospital pharmacists in medication education, medication errors post-discharge were not substantially reduced;
  • Pharmacist-assisted medication reconciliation
  • Tailored inpatient counselling by pharmacist
  • Provision of low-literacy adherence aids
  • Individualised telephone follow-up post-discharge

Unpacking the problem

- The impact of significant life 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.

*Ann Intern Med* 2013; **158**: 137.
Unpacking the problem ~ changing the focus

- Reduction of preventable medication related problems may require interventions focussed on closer discharge monitoring or home visits.
- Collaborative approach on discharge that includes and involves primary care
- Changing ‘discharge’ into ‘handover’
Potential solutions after discharge

- The final report for the Home Medicines Review Qualitative Research Project carried strong “widespread” unconditional support for post hospital discharge medication review;

- The need for a ‘rapid response’ HMR 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 HMRs to occur within approx 10 days of discharge (earlier if possible) and under the current model this is known to be close to unworkable.

Campbell Research & Consulting
Home medicines review program
qualitative research project final report 2008.
Developing sustainable solutions across transitions of care

• Early identification of risk factors including low literacy, recent hospital admissions, multiple chronic conditions or medications, and poor self-health ratings at admission and during the hospital stay ~ not just on discharge

Naylor MD, Sochalski JA: Scaling up: bringing the Transitional Care Model into the mainstream. The Commonwealth Fund, November 2010; Pub. 1453, Vol. 103
Stratified risk assessment

Adapted from Hospital Outreach in VIC and SA

Risk factors for medication misadventure include:

- Lives alone and manages own medicines (3 points).
- Cognitive impairment and manages own medicines (3 points).
- Multiple medications on admission (1.5 points).
- Recurrent admissions to hospital (e.g. 2 in 6 months (3 points).
- Changes in medications/dose during the admission (1.5 points).
- Clinical impression of the medical team that a post-discharge HMR is warranted (5 points).
- Other (1 point). e.g. using multiple GPs, English is a second language, having a low education, or a preference for alternative/complementary medications).

Patients who score 5 or more on screening assessment are considered ‘High Risk’ for medication misadventure.
Developing a screening tool

Validated tools are scarce, not user friendly

Excellent way of stratifying risk! – but do they over-estimate risk & under-estimate protective factors?

Risk stratification can ensuring only those most in need receive service – but have we got the balance right?
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Developing sustainable solutions across transition

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What our ‘experts’ thought about improving medication management post-discharge
Sustainable solutions

• Identify the “at risk patient” early ~ risk & protective factors

• Improve hospital staff awareness of primary care medication management services

• Support initiatives which engage clinicians across transitions of care for follow-up

• Ensure carers and patients are central to the transfer of care and understand who they can approach after discharge from hospital