Commonwealth Department of Health and Family Services

National guidelines to achieve the continuum of quality use of medicines between hospital and community

Australian Pharmaceutical Advisory Council
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APAC
AUSTRALIAN PHARMACEUTICAL ADVISORY COUNCIL

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Australian Pharmaceutical Advisory Council
MDP 83
GPO Box 9848
CANBERRA ACT 2601

Ph (02) 6289 7491
Fax (02) 6289 8846

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Background

Hospital pharmaceutical care aims to provide a continuum for the quality use of medicines during the period of a patient's entry into and treatment within hospital, and re-entry into community or residential care settings. The care needs to be individualised for each patient and involves cooperation and coordination between health care workers and services within and outside the hospital, the patient, and his or her carers.

An essential aspect for ensuring the quality of pharmaceutical care involves establishing standards of practice which define the standard operating procedures necessary to achieve appropriate care. This includes identifying the persons or positions responsible for implementing each step of the process.

The following guidelines for ensuring continuity of pharmaceutical care between hospital and community settings have been developed by the Australian Pharmaceutical Advisory Council (APAC), a national body composed of the peak organisations involved in pharmaceutical issues. The guidelines consist of broad principles upon which standard procedures for individual institutions or settings can be based. They do not relate to in-hospital medication as such, as this is covered by other guidelines used by hospitals.

Obviously, pharmaceutical care is but one component, albeit a major one, of good clinical practice and treatment. The quality use of medicines is a part of total patient management during the hospital admission, stay, and discharge; however, the importance of medication management to many patients is central to successful health outcomes. Further, in view of the increasing trend for earlier discharges, the need to ensure continuity of care in relationship to drug therapy is likely to have a significant impact on quality health outcomes. It is part of a patient's right to expect that the continuity of care is planned prior to admission and discharge and that the management plan is appropriately coordinated.

APAC recommends that the discharge process should be part of a quality assurance program which is linked to accreditation programs, hospital standards, patient health charters and Medicare agreements. Consumer rights, including the right to privacy, need to be taken into account throughout the process.

The following guidelines are intended as a broad set of principles to assist hospitals in developing and implementing standard procedures to ensure continuity of medication management through hospital admission and treatment and post-discharge. APAC plans to monitor the implementation of these guidelines, and evaluate their impact.

Definitions

The American Hospital Association has provided the following definition of discharge planning:

> Successful discharge planning is a centralised, coordinated, interdisciplinary process that ensures all patients have a plan for continuing care after they leave the hospital. The plan should reflect both the patient's and the family's internal social, emotional, medical, and psychological needs and assets. The transition from the hospital is often more threatening than the actual hospitalisation, and a plan must exist not only to provide for a continuum of care, but also to address the patient's immediate needs following discharge.
>
> Discharge planning is the process by which health care professionals, patients, and families collaborate to ensure that patients have access to services after they are discharged from the hospital. For some patients, the necessary services will enable them to regain, maintain, and even increase the level of functioning achieved in the hospital. For others, patient teaching can serve this function. For yet others, a drastic change in life-style and an array of services may be required, as is so for palliative care.

(American Hospital Association, *Introduction to Discharge Planning for Hospitals*, USA, 1983)

The Council on the Ageing (COTA), in noting this definition, has stated that:

> Management support of discharge processes, and of those staff implementing the discharge processes, is essential if hospitals are to respond to throughput incentives without compromising quality of care.

COTA has also provided its own definition of discharge planning:

> Discharge planning is the process through which people, hospital and community based services can work together to establish structures and networks which facilitate care across a range of services required. Discharge planning is central in planning and organising continuity of care.

(Council on the Ageing (Victoria), *Removing the Boundaries: Hospital Discharge Practices and Older People Returning to the Community*, Melbourne, 1994)

Principles

The following principles aim to achieve continuity and quality of pharmaceutical care between hospital and community settings, including residential care. It should be noted that the term 'patient' in this document refers to the patient and/or carer.

The guidelines are intended to:

- provide a benchmark against which operational standards of practice can be developed by hospitals and State, Territory and Commonwealth health or community service programs; and
- be used as a criterion for acceptable standards of practice for:
  - patient charters,
  - publicly funded projects in relevant areas, or
  - defining performance standards for publicly funded programs.

Individual hospitals should have a written policy as to who is responsible for collecting full and accurate information about patients' medication, and ensuring continuity of medication management.

Hospitals should also implement strategies to ensure that policies developed at the management level are acted upon at the clinical level. For example, random audits of discharge plans could be undertaken to measure what actually happened against the policy, either in entirety or against selected criteria.

To monitor and maintain standards, the ongoing education of coordinators and discharge planners is indicated.

Principle 1

It is the responsibility of the admitting institution to ensure the development and coordination of a medication discharge plan for each patient. The person responsible for coordinating the development, implementation, and monitoring of the medication discharge plan, including medication supply and medication information, should be identified as soon as practicable after admission.

It is the responsibility of that person to coordinate planned discharge management and to ensure that all components of the discharge plan are completed to ensure discharge in a timely fashion.

Medication discharge planning should commence on admission for elective admissions, but it is acknowledged that where admissions are through accident and emergency departments, this may not be practicable.

Principle 2

Hospital staff should obtain an accurate medication history, including prescription and over-the-counter medicines and other therapies such as herbal products, at the time of admission.

Development of a medication profile for each individual should be promoted as a 'positive health' habit. Good communication between general practitioners, hospital staff, community nurses, and carers is needed.

Community education is required so that general practitioners, community health workers and patients are aware of the need for patients to bring all relevant information and their current medications to the pre-admission clinic or to the hospital at the time of admission. This should

include prescription, over-the-counter and herbal products, including ophthalmic preparations, skin care products, analgesics and aperients, and medications used on an intermittent (p.r.n.) basis.

Medication histories obtained at the time of admission are often inaccurate, and standard procedures should assist in improving the quality of the information obtained. A standard national admission form developed by the professional medical organisations, incorporating a section dealing with medication history including adverse reactions, would be ideal. Such a form could become incorporated into professional standards. However, it is recognised that many admissions are through accident and emergency departments, and are therefore made without a referral.

Procedures for obtaining medication histories by hospital health professionals should be incorporated within the policies of the hospital. The information gathered should include brand name, dosage, and reason for taking (as many medications have multiple indications), and length of time on the medication. It is also useful to ask about any recently ceased medications.

Hospital staff need to be skilled in obtaining a medication history, and have knowledge of and access to comprehensive information about medications, including drug names. The role of clinical pharmacists is central, and ideally, a team approach between clinical pharmacists, medical practitioners, and nursing staff should be taken.

Hospitals should actively seek from patients a current medication profile, obtained from their medical practitioner and/or community pharmacist/s prior to admission. The Royal Australian College of General Practitioners' health summary form is a useful model for this purpose. In certain circumstances, eg admissions from residential care institutions, it will be necessary to obtain a medication record from that institution.

It must be recognised that a record from the patient's usual general practitioner may not always reflect full current medication use or those medications used on an intermittent (p.r.n.) basis. In addition, a history regarding social drug use (eg alcohol, tobacco and illicit drugs) should be obtained from the patient.

Attention should be paid to issues arising from day surgery, such as the impact of any medication on the ability to drive motor vehicles or operate machinery.

Material which will assist the development of policies in this area has been developed by bodies such as the Society of Hospital Pharmacists of Australia and the Royal Australian College of General Practitioners.

Principle 3

Hospital staff should evaluate the current medication at the time of admission, in consultation with the patient's general practitioner, with a view to:

- **identifying the appropriateness and effectiveness of current medication, and rationalising current medications if appropriate;**
- **paying particular attention to any problems associated with current drug therapy including any possible relationship with the current medical condition; and**
- **documenting allergies and any previous adverse drug reactions.**

Guidelines should be established for medication review. The quality of the information obtained from patients will be determined by the quality of the interviewing/reviewing techniques and the knowledge and skills of the reviewer. The Society of Hospital Pharmacists of Australia has developed a detailed set of principles for this activity (see reference list).

In order to ensure quality assessments, the persons undertaking these evaluations should have an adequate knowledge base in drug therapy and must have access to appropriate drug information resources.

There should be an assessment of the appropriateness of the dose, route, or dosage form of medicines for the particular patient and circumstance, together with an assessment of any inappropriate use or misuse of drug therapy.

Assessment of compliance with medication regimens is needed. This could include a check of the prescription record regarding the frequency of repeats, and compared to the recommended dosage schedule. Particular attention should be paid to any incapacity of the patient which could limit the ability of the patient to manage their medication.

It should be ensured that hospital policies on use of the patient's own medication exist and are implemented. The hospital should not dispose of the patient's own medications without reference to the patient.

As lifestyle factors such as diet may influence response to drug therapy, a review of such factors should be made.

It would be useful to identify any patient with a known allergy, through provision of a bracelet or similar mechanism, to ensure that patient is not exposed to the medication.

Principle 4

During the hospital stay, treatment plans relating to the probable medication management during the stay and where applicable at discharge should be developed in consultation with the patient and/or carer. Hospital staff should negotiate with the patient issues relating to treatment and the development of a discharge plan, and these discussions should be documented in the patient's notes. This plan should form part of the overall care plan or critical pathway.

- **The use of interpreters may be required to ensure good communication with people from non-English speaking backgrounds.**
- **To enable the discharge process to be successful, there needs to be effective communication and coordination between all relevant parties in the hospital environment.**
- **Where appropriate, community health providers, especially the patient's general practitioner, should be consulted.**
- **Carers should also be consulted where appropriate.**

Informed decision-making by the patient regarding new medication should be ensured. Guidelines relating to this activity have been discussed in the NHMRC *General guidelines for medical practitioners on providing information to patients*, and in patient charters.

- Where possible, the provision of written information such as Consumer Medicine Information (CMI) should be part of the process. The difficulty of providing CMI in some hospital situations, such as accident and emergency, is acknowledged.
- Attention should be paid to the cost implications for the patient of any drug therapy and this should form part of the consultation.
- More specific information may be required regarding drugs provided under the Special Access Scheme or as part of a clinical trial.

As part of the management plan, the assessment of patients should take into account the following essential elements in order to develop appropriate strategies:

- The ability of the patient to self administer medication should be assessed. Physical factors such as the ability to read labels, to properly use administration devices (eg inhalers), to open containers, and to identify contents of medication, should be assessed. The patient's ability to use a specific

dose form (eg patients with dysphagia) should be assessed. Simple strategies can often be implemented to overcome these difficulties, eg print size on labels, different dosage forms such as liquids or dispersible tablets, use of drug administration aids, medication cards, and written instructions for complex regimens.

- It is necessary to identify whether any assistance in drug administration by community care workers or residential care workers will be required following discharge, and to ensure that these services are organised.
- Factors influencing the patient's knowledge about the medication and the ability to comply with medication regimens should be identified. This may involve cognitive and attitudinal factors. Any prior history of poor compliance should be identified and factors influencing such behaviour should be addressed. Particular issues include the patient's knowledge about their medication regimen, confusion between brand names, cultural attitudes and behaviours.
- The patient's financial status and their ability to meet the cost of therapy should be taken into account, to ensure that cost is not an impediment to compliance with recommended therapy.

Implementation of drug therapy should be accompanied by the use of appropriate education programs.

- Such programs should include individual patient counselling with Consumer Medicine Information or other written information, use of audio and video tape recordings, drug administration aids, and particular instructions regarding certain forms of administration such as eye drops.

Principle 5

Prior to discharge, pre-discharge medication review and dispensing of adequate medication should take place in a planned and timely fashion. Adequate medication means sufficient medication to carry the patient through to the next arranged review (by their general practitioner, outpatient clinic, or some other arrangement), or to complete the course of treatment.

If patients are discharged with inadequate supplies of medication, this can compromise quality of care for the patient. Supply of the medication from the hospital facility must be adequate to ensure continuity of medication is not interrupted by the inability to obtain further ongoing supplies if required, within a reasonable timeframe.

Prior to discharge, a review of the medication to be taken in the post-discharge context should occur (including issues such as the cost of medications, and the availability and supply of clinical trial medication).

Prescriptions should be written in a timely manner to ensure that patients are not waiting unnecessarily for the medication to be dispensed.

Communication with the community doctor and/or pharmacist/s prior to discharge may be necessary to avoid specific difficulties of supply. Hospital pharmacists should alert hospital medical staff when a medicine, which is not available as a Pharmaceutical Benefit Scheme (PBS) item, has been recommended as a discharge medication. This is especially important when prescribing for patients on healthcare benefits who may not be able to afford to continue the use of non-PBS medication.

Principle 6

At the time of discharge, each patient should be provided with a discharge folio containing relevant information such as Consumer Medicine Information, a medication record, patient/carer plan, and information on the availability and future supply of medication.

Both verbal and written information should be provided covering areas such as generic and brand names of medications, purpose and action, dose and administration schedule, instructions on missed dose, special directions and precautions, common side effects and action to take, interactions and storage requirements.

Hospital medications should be listed generically, but trade names should also be indicated. Multiple drug names are a significant cause of confusion for patients as well as clinicians. Hospital clinicians and pharmacists should recognise that the medications in their dispensaries may not be widely prescribed and dispensed in the community, or even readily available, outside a hospital setting.

In particular, patients should be counselled in regard to details of medication which is no longer needed, and its relationship with any new medication. This will minimise the common problem of patients becoming confused due to changes in medication and in brands of medication during the hospital admission.

In many cases, patients will already have received Consumer Medicine Information for the medication they are taking. This needs to be checked so there is no unnecessary duplication.

If both the hospital and the patient's general practitioner prepare medication lists without reference to one another, the patient may be provided with multiple medication lists which are not identical. The hospital should liaise with the patient's general practitioner regarding the patient's medication list at discharge, to ensure that a correct current list is compiled and used by all parties.

Specific information on entitlements under the Medicare and PBS systems should be provided, together with an indication of costs of any medication not covered under the PBS.

The folio should include details regarding any specific tests that need to be undertaken to monitor drug therapy, eg anticoagulant therapy, together with instructions about how to get these tests done.

Principle 7

No patient should be discharged from hospital until the details of the admission, medication changes (including additions/deletions) and arrangements for follow up have been communicated to the healthcare provider(s) nominated by the patient as being responsible for his or her ongoing care.

Hospitals should develop systems that enable the provision of information in a timely manner.

Information to the patient's health care providers should include details of the medication management during the hospital stay, any reported adverse drug reactions, and any specific needs with respect to drug management. This communication can occur through a number of routes, eg electronic transfer and e-mail. However, the method of delivery of information must take into account privacy and confidentiality issues. If the initial contact is by telephone, a printed or electronic copy of the medication list should be forwarded to the patient's health care provider at the time of discharge.

The discharge coordinator must ensure that the required assistance of any home or residential care provider has been organised and that information about this is provided to the patient at the time of discharge.

Patients deemed at risk of medication misadventure should be identified and followed up in the immediate post-discharge period.

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