

How to improve medicines management at the primary/secondary care interface

How can pharmacists help improve medicines management at the interface between primary and secondary care? **Clare Bellingham** investigates

The fact that patients have problems with medicines as they move between primary and secondary care is hardly news. Research in this area dates back over 10 years and it has been on pharmacy's agenda for at least as long. What is remarkable is that the problem has yet to be solved. Examples of good practice exist but, in general, patients crossing the interface are not offered seamless care. Perhaps this is why medicines management across the interface was picked as the theme of this year's Primary Care Pharmacists' Association conference, held in London last week.

Taking medicines will always involve some risks. But it is the fact that patients are more at risk of things going wrong with medicines when they move between care settings that is important, explains Catherine Duggan, director of the academic department of pharmacy, Barts and the London NHS Trust. This is true even when the medicines are being used correctly. Speaking at the PCPA conference, Dr Duggan said that the point at which patients are most vulnerable is straight after discharge from hospital. Some of the problems that patients encounter are outlined in the Panel below.

What underlies all these difficulties is a lack of communication. Although the profes-

sionals working in each sector are independently doing their best for the patient, their ability to offer optimal care is restricted by their lack of knowledge about what has happened in the other care setting.

What does the research say?

Dr Duggan has been involved in research examining medicines management at the interface for a number of years. She told the conference that many changes to prescribed medicines are unintended. At admission to hospital 11 per cent of medicines had unintended changes and this rose to 46 per cent at discharge. "These discrepancies are dependent on either different labelling or supply systems, or breakdown in communication between secondary and primary care," she said. "Communication across the sectors should be routine practice yet only 4 per cent of those questioned report that they do this."

Plenty of research has shown that giving discharge information to community pharmacists improves patient care. For example, in one study, for every 19 pieces of information given to a community pharmacist, one re-admission is prevented. "Pharmacists on both sides of the interface are enthusiastic to improve communication. The trouble is that they often do not know how to do this," said Dr Duggan. "We do have examples of good practice, but they are neither widespread, nor uniform, nor routine."

And therein lies the rub. Although the research exists, the problem is a lack of implementation. Why is this the case? Dr Duggan suggests a number of problems. There is a gap between research and policy and practice, she says. The same pilots are being repeated in different localities rather than moving on to the next level, and people are unsure how to implement roles. She also thinks that there is a lack of understanding of roles and responsibilities, a lack of communication between sectors and a lack of agreement over what should or can be done.

"Discharge planning is not always dealt with at organisational level: it may not be seen as either a primary care responsibility or a secondary care responsibility," Dr Duggan says. But organisations do have to address this. Last year's Government document, "Discharge from hospital: pathway, process and practice", sets out principles of good practice and guidance for organisations.

Good practice

What should be happening? Routine discharge planning should be in place at all hospitals and standards should be set for

Better communication is needed

information transfer, suggests Dr Duggan. "Information should be sent out to GPs and community pharmacists, perhaps using a four-layer copy form. But one huge issue is ensuring that these forms are legible," she says. "Having a plan rather than a TTA [to take away prescription] that can communicate what changes have occurred and the reasons for these changes might be better," she adds. "It all comes down to improved communication."

In some places, hospitals and primary care trusts have got together to fund joint posts to improve medicines management over the interface. In Huntingdonshire, they have gone one step further and appointed a medicines management team that works across the primary and secondary care settings (see **Vision for Pharmacy**, p217).

Another pharmacist in a new interface role is Stuart Richardson. He is a senior clinical pharmacist employed by Kensington and Chelsea PCT but he spends his time evenly between the PCT and Chelsea and Westminster Hospital. "My role is to provide a link between the hospital and PCT so as to facilitate medicines management across the interface and to lead on clinical issues relating to older people within each setting," he explains. He is in the process of developing a comprehensive GP referral pathway to improve the information that the hospital gets at admission. At the other end, he is designing a computerised template to use for electronic discharge prescriptions. "This will standardise the information provided and will include concordance issues as well as details on compliance aids and reasons for changes to medicines," he explains. It is hoped that this information will be sent to community pharmacists as well as GPs.

Common problems

The medicines a patient is discharged from hospital on are rarely the same as those they were taking before admission. What problems can arise?

- The hospital receives inaccurate information when the patient is admitted so incorrect medicines are prescribed for the patient
- Patients leave hospital with a week's supply of new medicines but it can take longer until the GP is informed of changes: in the meantime the pre-hospital medicines might have been prescribed again
- If different brands of the same drug are used, patients might take both not realising that they are doubling the dose
- Patients think that medicines prescribed in hospital are different from those prescribed by their GP so take both
- GPs do not receive clear explanations for medication changes from the hospital so revert to pre-admission drugs
- Clinically unnecessary changes to medicines can be made if a patient is prescribed a drug that appears on the hospital formulary but not the primary care formulary (and vice versa)

Similar initiatives are under way at Hull Royal Infirmary, where Paul Kendrew is a primary/secondary care interface pharmacist. He spends half his time working on interface issues and the other half as a ward-based pharmacist. He is involved in introducing an "immediate discharge letter" which is sent from a short-stay acute admissions ward to a patient's GP on discharge. "It provides information about the diagnosis, medical history and the medicines the patient is taking, including an explanation of why new medicines have been started," he comments. A pilot study of faxing discharge prescriptions from the hospital pharmacy to patients' GPs to overcome problems with delays in discharge letters reaching GPs is also under way.

But even if this type of working is not possible — and there are difficulties in geographical areas where patients are referred to more than one hospital and where a hospital provides services for a number of PCTs — there are still opportunities to improve care at the interface.

Community pharmacy roles

Improving care over the interface does not just involve hospital and primary care pharmacists: there is a role for community pharmacists too. Claire Jones, assistant head of NHS service development at the National Pharmaceutical Association, says: "Now is a key time for community pharmacists to get involved because of the emphasis on delayed discharge from hospital, implementation of the single assessment process and a drive to move forward on intermediate care.

"There are various services that community pharmacists can offer, from monitoring the difference between hospital discharge information and prescribing by GPs to performing medication reviews in patients' homes." Speaking at the PCPA conference,

Ms Jones suggested that if community pharmacists had a copy of the discharge prescription from the hospital they could compare it with prescriptions from the patient's GP and contact the GP if they identified any discrepancies. A medication review service could be added to this for patients at high risk of medicines-related problems.

Examples of good practice do exist. Some hospitals refer patients who need ongoing support, such as monitored dosage systems, to a specified community pharmacy. This way the patient knows where to go for help once discharged from hospital and the community pharmacist is better placed to provide support because the hospital has provided relevant information. Similarly, some PCTs fund community pharmacists to review patients that the hospital has identified as being in need of medicines support. One system that has been in operation for some time is K-med. The system, set up at Kettering General Hospital, involves a medication summary (including explanation for changes) being sent to GPs and community pharmacists.

Similarly, a scheme led by East Riding and Hull LPC involves discharge information for high risk patients being faxed to community pharmacists. The pharmacist then reviews the patient's medication at home, liaises with the patient's GP, produces a care plan and provides ongoing monitoring. The service has just started and a full audit is planned.

It is difficult to see how these systems can work without addressing one contentious issue: should patients be registered in community pharmacies? "Yes," says Dr Duggan. The argument given against registration is that it restricts patient choice. However, Dr Duggan says: "Patients tend to choose to go to the same pharmacy. Even in London, research shows that 89 per cent of patients stick to the same pharmacy." She adds that patients do not even think about going to a GP other than their own.

Another real problem that many community pharmacists face is getting the funding to provide new services. How should they go about this? "The first thing pharmacists should do is approach the PCT to see what the local priorities are and make the case that community pharmacist involvement in the discharge process can make a difference to patient care," Ms Jones says. In the future, other opportunities might exist, such as offering a local pharmaceutical service or a supplementary service under the new pharmacy contract.

When approaching a PCT for funding, pharmacists need to:

- Carry out the research into the evidence-base for the proposed service and use this to support the application
- Make sure the service targets local need and the PCT priority areas
- Describe the service, what it aims to achieve and how it will be monitored
- Clearly present the benefits (eg, patient benefits, safety improvements, meeting

PCT targets and cost savings) and costs of the service (eg, resources, training)

- Start with a small pilot but try to get an advance agreement to roll-out the service if the pilot is successful

The Royal Pharmaceutical Society is in the process of producing a toolkit called "Discharge planning and medicines" to help improve medicines management at the interface. The toolkit will be launched in the spring. Dr Duggan has played a crucial role in the development of the toolkit. She explains: "It aims to use research evidence, policy documents, expert opinion and examples of good practice to develop standards. We are at the stage of collating examples of good practice from each sector and each specialty to inform our recommendations for good practice." When this has been done, standards can be developed. "Once these standards have been set, local implementation strategies can be agreed and implemented. Then good practice can become a baseline for trusts in primary and secondary care," she adds. This can only be a good thing for patients.

Which interface?

There is a general assumption that the interface at which problems arise is that between primary and secondary care. However, it is worth considering the interface between health and social care, according to Beth Taylor, principal pharmacist at London Specialist Pharmacy Services.

Speaking at the PCPA conference, Ms Taylor said that many of the tasks associated with taking medicines are carried out by people other than health professionals. She emphasised the importance of the role of social care. "Prescribing and dispensing medicines are the only tasks that have to be carried out by health professionals," she said. Tasks that could be undertaken by others included requesting repeat prescriptions, collecting medicines, administering medicines, monitoring medicine use, disposing of unwanted medicines, encouraging self-medication and training patients. This raised issues around the training that social workers have in medicines management, particularly since social workers might have to assess patients' ability to cope with their medicine regimen. "Staff in care homes and domiciliary care welcome advice on medicines management. They need some sort of basic guidance about medicines," Ms Taylor said.

In April 2004, the single assessment process (SAP) for older people has to be implemented. "The SAP is a way of providing single, joined-up assessment for people with complex needs in health and social care," she explained. This is so patients do not have one assessment after another in each area of health and social care.

"In the future, more care will be provided through integrated teams. There will be a greater choice for patients about how they want to access services," she added. "Pharmacists need to think about how they engage with all teams at all levels to support medicines management services."

Possible solutions

Some possible solutions to improving medicines management across the interface are:

- Discharge information, including an explanation of the discharge prescription, is faxed from the hospital to the GP, community pharmacist and primary care pharmacist
- Patients at risk of medication problems after discharge are identified in hospital and then referred to a named pharmacist or technician to follow-up at home
- Patients are helped to self-administer medicines in hospital so they get used to their new medicines before they are discharged
- Discharge planning starts as early as possible in the hospital stay, even before admission for planned procedures, and should involve a multidisciplinary approach
- Joint formularies between primary and secondary care are used to help prevent medicines being changed purely because they are not on the formulary