Editorial

Discharge medication

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There are many barriers to the transfer of a patient's medication history between the hospital and the community. It is just as important to have good information on discharge as it is to have an accurate medication history when the patient is admitted. Discharge summaries may be illegible, inaccurate and inconsistent in the use of generic and trade names. Timely transfer of discharge information is also a challenge. Telephone calls are helpful for discussing changes to medications, but must be used in conjunction with a written list of discharge medications. There is currently limited use of fax and email to transfer discharge medication information. Many hospitals issue a limited supply (3–5 days) of medication, so the patient may need another prescription before the general practitioner receives the discharge summary by conventional mail.

There is a need to transfer more information than a list of current drugs. Changes made to treatment and the reasons for those changes should be communicated. This should include information about drugs which have been tried and found to be ineffective or to have caused adverse reactions. Specialist knowledge about the use of medications (for example, the need to monitor for adverse drug reactions) and about compliance should also be transferred. The hospital staff must communicate with the community pharmacist if a blister pack is needed (increasingly required in residential aged care) and with the family or community nurses if they are needed to assist with drug administration.

Trials of interventions to improve the transfer of drug information from the hospital to the community have been disappointing. We found that hand-held medication cards given to patients were infrequently used and often inaccurate.[1] A South Australian study of patients discharged from hospital to residential care used a pharmacist to co-ordinate medication management transfer summaries, timely medication reviews by community pharmacists, and case conferences with physicians. These interventions prevented a post-discharge decline in the quality of prescribing (measured by the Medication Appropriateness Index) and prevented worsening of pain, but had no effect on adverse drug events, falls, mobility, behaviour or confusion eight weeks after discharge.[2] In Sydney, workshops and audits were used to improve the exchange of medication information between hospitals and general practitioners. The intervention increased the proportion of general practitioners receiving discharge summaries directly by fax from 2% to 27%.[3] However, only 29% of general practitioners reported receiving a discharge referral which included the reasons for changing medications.

Healthcare agreements between the Commonwealth and state governments aim to implement the Australian Pharmaceutical Advisory Council's guiding principles for achieving continuity in medication management.[4] To implement the 'provision of a sufficient supply of medicines in a planned and timely way', public patients in most states will soon receive up to one month's supply of medication through the Pharmaceutical Benefits Scheme (PBS) on discharge from hospital. Medications can be prescribed in hospital and, where possible, dispensed from the hospital pharmacy.

Provision of a PBS prescription on discharge will allow time for the discharge summary to reach the general practitioner by mail before a new prescription is required. However, issuing PBS prescriptions from the hospital requires training of junior medical officers and an investment of their limited time, in

In this issue…

The importance of communication as a component of prescribing is underlined in several articles. Sarah Hilmer and Susan Ogle suggest that communication could be improved when patients are admitted to or discharged from hospital. This is illustrated in the two 'Medicinal mishaps'. Treatment summaries are also useful for travellers, as discussed by Nick Zwar.

Asthma can be exacerbated by travel so it is important for people to take their regular medication. Christine Jenkins considers how to use inhaled corticosteroids to control asthma.

Controlling neuropathic pain can be challenging. Rob Helme reminds us that drugs are just one part of management.

Drugs have a central role in treating leukaemias. Ian Kerridge explains how therapy is changing as our understanding of these diseases increases.

addition to writing medication lists on discharge summaries. In our hospital, discharge prescriptions are screened by clinical pharmacists and errors are detected for about 12% of patients.[5] Issuing PBS prescriptions from the hospital will require new systems to check discharge drugs and to transfer instructions about their use.

Accurate, timely transfer of discharge medication information from the hospital to the community requires co-operation between doctors, pharmacists and nurses in the hospital and in the community. Lists of discharge medications should be typed to improve legibility and include reasons for any changes. The drugs must be ordered in time for the pharmacist to check them, dispense them (or organise dispensing in the community) and provide the patient with the information to manage their medications. There should be timely transfer of the discharge information by as many routes as possible to the patient and/or carer and the general practitioner. The community pharmacist needs to know if a blister pack is required and the community nurse needs to be informed if administration is required. Medication cards can provide the patient with their own record on discharge.

Electronic systems can transfer computerised discharge summaries and medication lists rapidly by fax or email, but require new processes for checking and correcting discharge prescriptions. The Commonwealth Government has trialled a 'MediConnect' record for consenting patients.[6] An electronic medication list was stored by Medicare Australia and could be added to and accessed by doctors, pharmacists and hospital staff. The findings will be implemented as part of the 'HealthConnect' strategy for electronic health information. However, for all records, paper or electronic, accuracy depends upon timely and accurate data entry. For example, it is important that electronic prescribing records are updated to reflect changes in treatment. Ultimately the most useful and accurate record of patients' medications may be the 'plastic bag' or basket (Fig. 1) containing all their drugs, including discharge medications.[1]

Fig. 1

Medicines brought to a geriatric outpatients clinic by a patient

References

1. Atkin PA, Finnegan TP, Ogle SJ, Shenfield GM. Are medication record cards useful? Med J Aust 1995;162:300-1.
2. Crotty M, Rowett D, Spurling L, Giles LC, Phillips PA. Does the addition of a pharmacist transition coordinator improve evidence-based medication 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.
3. Mant A, Kehoe L, Cockayne NL, Kaye KI, Rotem WC. A quality use of medicines program for continuity of care in therapeutics from hospital to community. Med J Aust 2002;177:32-4.
4. Australian Pharmaceutical Advisory Council. Guiding principles to achieve continuity in medication management. Canberra: Commonwealth of Australia; 2005. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding [cited 2006 May 12]
5. Duguid M, Gibson M, O'Doherty R. Review of discharge prescriptions by pharmacists integral to continuity of care. J Pharm Pract Res 2002;32:94-5.
6. http://www.mediconnect.gov.au [cited 2006 May 12]

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Letters

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Assisting Aboriginal patients with medication management

Editor, –The article 'Assisting Aboriginal patients with medication management' (Aust Prescr 2005;28:123–5) included many useful suggestions. However, one of the most important barriers facing people with chronic ill health was only mentioned in passing, namely medication co-payments. A particular sub-group of the Aboriginal population is severely affected by co-payments. These are the growing number who normally live in remote communities but move temporarily or permanently into capital cities. By moving, they lose access to free medications provided under Section 100 (*National Health Act 1953*). Due to the high burden of chronic disease experienced by Aboriginal