Hospital to Community Pharmacy Handover: Can We Do More?

Negin Nasseh[1,2], Erin Dunn[3], Martin Canning[3]

1. The University of Queensland, School of Pharmacy; 2. Royal Brisbane and Women's Hospital Pharmacy Department; 3. The Prince Charles Hospital Pharmacy Department

Background

Clinical handovers are an integral component of transfer of care, as transition between care settings is a high-risk period.[1] It is estimated that over 50% of medication errors occur during transfer of care, and of these up to 30% have the potential to cause harm.[2] An effective approach to the mitigation of such harm is the implementation of, and adherence to, continuity of care initiatives.[3] The merit of such initiatives have repeatedly been demonstrated.[4,5] Hospital pharmacists have a unique opportunity to contribute to QUM by facilitating the optimal transfer of information to healthcare practitioners in the community.

Aim

- To gauge the attitudes of community pharmacists regarding clinical handover processes for patients discharged from hospital.
- To identify gaps in the current handover process and develop recommendations to enhance clinical handover to community pharmacists.

Methods

Local community pharmacists that received handover for patients using Dose Administration Aids (DAAs) from The Prince Charles Hospital (TPCH) were invited to participate in a 20 question, anonymous online survey. A link to the survey was emailed to community pharmacists, who were given two weeks to respond before the data was collated.

Clinical handover service provision gaps were identified by shadowing ward pharmacists during discharge prescription processing. Data was collected regarding how often community pharmacists were contacted, and what information was conveyed to them.

Results

Of the 52 pharmacies called, 44 agreed to participate (85%) and of those, 21 responded (40%). Figure 1 outlines the frequency which community pharmacists feel they receive handovers from TPCH, for DAA and non-DAA patients and Figure 2 shows the degree of community pharmacist satisfaction towards handovers for DAA and non-DAA patients.

Figure 1: How often community pharmacists feel they receive handovers from TPCH

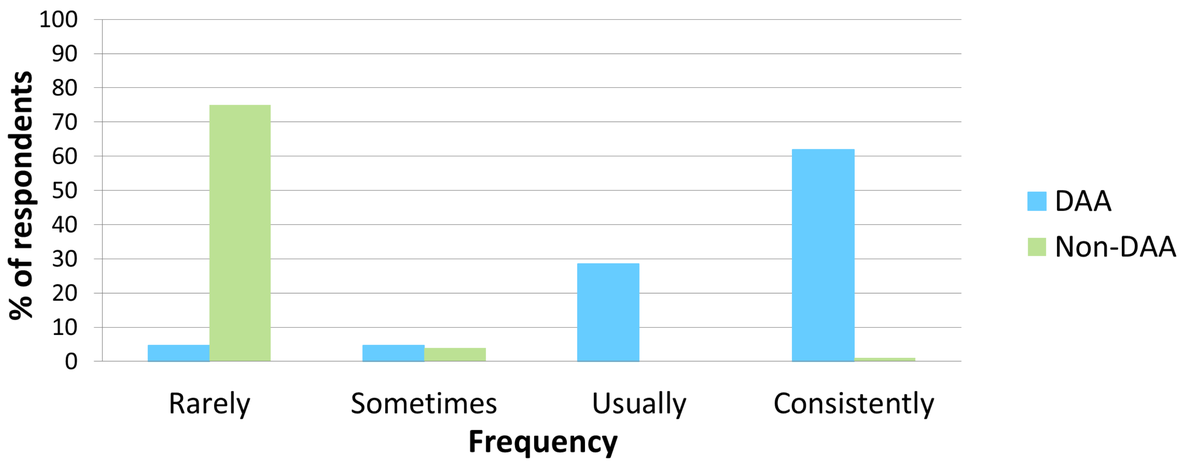


Figure 2: Community pharmacist satisfaction towards handovers for DAA and non-DAA patients

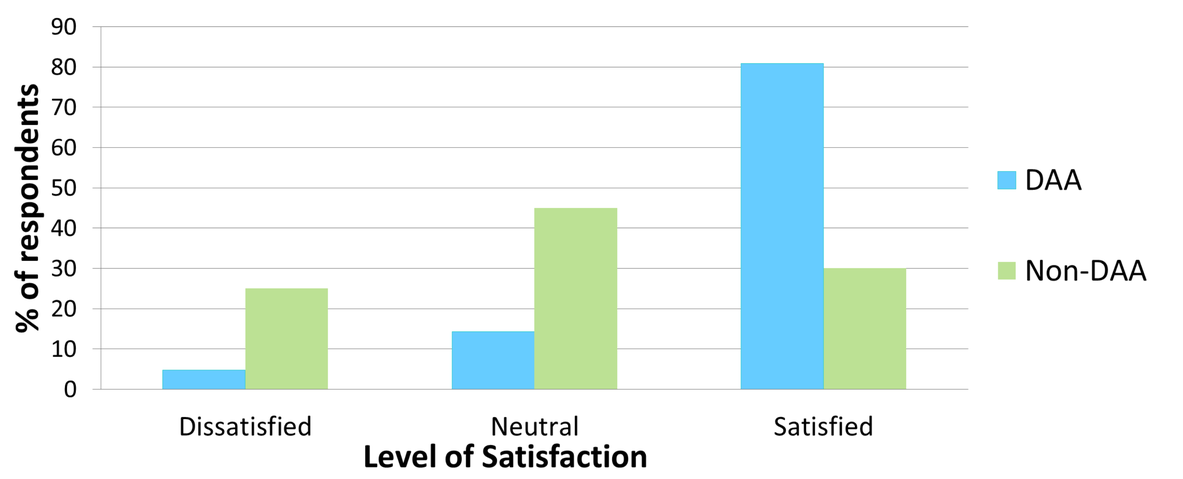
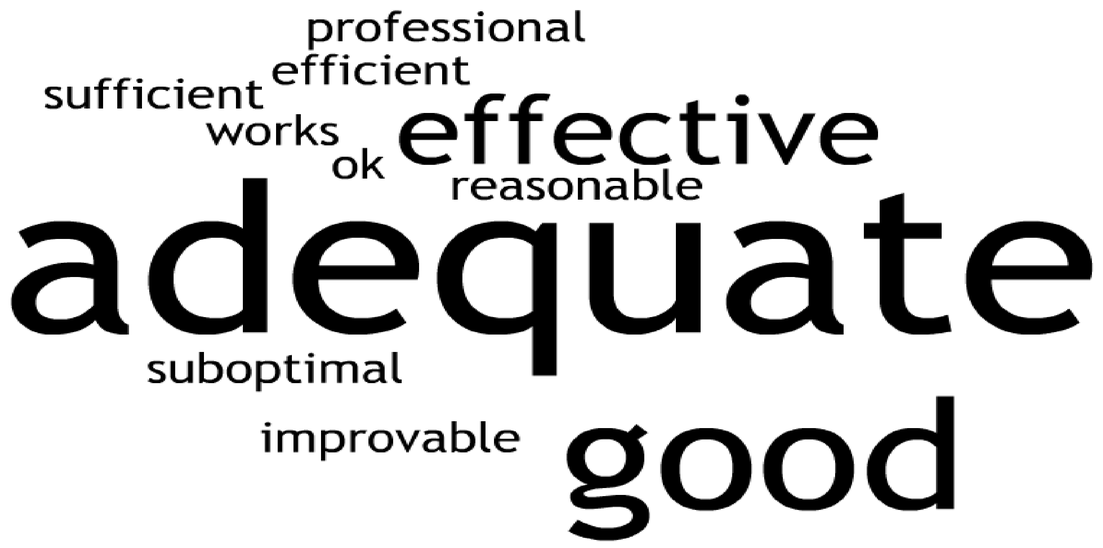


Table 1 outlines the percentage of pharmacists and desired clinical handover information requested by community pharmacists when asked for both DAA and non-DAA patients.

Information Requested by Community Pharmacists	% (DAA)	% (non-DAA)
Discharge Medication Record	**100**	**90**
PBS Prescription	**90**	**80**

Figure 3: WordCloud based on responses from community pharmacists, when asked to describe the handover process in one word.



Summary of Observation Results

20 discharges were observed, of which 9 were for DAA patients and 11 were for non-DAA patients

- 77% of DAA patients and 0% of non-DAA patients had a DMR sent to their community pharmacist
- Close to 100% of 'Ceased/Withheld' medication changes were explained on the DMR
- Less than 50% of 'Up/Down/New' changes were explained

Conclusion

TPCH's current clinical handover processes to community pharmacists are perceived as adequate but can be improved. Key recommendations include:

- Support effective clinical handover through electronic solutions which would automate provision of DMR's to patients nominated community pharmacy
- The provision of copies of the PBS discharge prescription to all patients' nominated pharmacies via fax or email (where relevant)
- Include additional clinical handover information to community pharmacies to explain changes for up/down/new medications (in addition to already included ceased/withheld information)

Overall, patients would directly benefit from an improved handover process which supports the judicious, safe, appropriate and effective use of medicines.

References

1. Claeys C, Foulon V, Winter SD, Spinewine A. Initiatives promoting seamless care in medication management: an international review of the grey literature. International Journal of Clinical Pharmacy 2013; 35(6):1040-52

2. SHPA guidelines Chapter 6: facilitating continuity of medication management on transition between care settings. Clinpharm SoP. 2013 Jun;43(2)

3. Layson-Wolf C, Morgan JA. Pharmacy Continuity of Care: What do Community Pharmacists Need from an Acute Care Hospital to Improve Continuity of Pharmaceutical Care? Journal of Disease Management & Health Outcomes. 2008;16(4):199–203.

4. Beadles CA, Voils CI, Crowley MJ, Farley JF, Maciejewski ML. Continuity of medication management and continuity of care: Conceptual and operational considerations. SAGE Open Medicine. 2014Oct;2.

5. Mant A, Rotem WC, Kehoe L, Kaye KI. Compliance with guidelines for continuity of care in therapeutics from hospital to community. The Medical Journal of Australia, 2001; 174(6):277-280

Contact Us

Negin Nasseh, Intern Pharmacist, negin.nasseh@health.qld.gov.au

Erin Dunn, Team Leader Pharmacist (General Medicine), erin.dunn@health.qld.gov.au

Martin Canning, Safety & Quality / Drug Use Evaluation Pharmacist, martin.canning@health.qld.gov.au

Queensland Government