EDITORIALS

A TRANSITION PERIOD IS A PERIOD BETWEEN TWO TRANSITION PERIODS

Many readers of the Journal would struggle to describe the work of George Stigler, a Nobel Laureate from the early 1980s, apparently known for his playful sense of humour, and who is said to have penned the line used as the title for this editorial. Although Stigler was an economist (a calling not necessarily known for the whimsical nature he was said to possess), the sentiment encapsulated in his words is insightful. Although ubiquitous in health systems, for many years now it has been known that transitions in health care are potentially dangerous moments, where incomplete, inaccurate or tardy transfer of information can have dire consequences. Although we tend to focus upon specific episodes where the transition of care occurs, as Stigler’s observation rightly highlights, this approach is to some extent illusory, in that an individual’s health status and associated health needs are essentially in constant transition. For all that modern strategies such as the use of sophisticated information technology platforms have been advocated as a means to improve the quality of information transfer at the interfaces of health care, it is all too clear that very commonly, things do not go as planned when a person is admitted to hospital from a community-based setting, or from residential aged care. Equally, mistakes are prone to happen when a patient is discharged from hospital, and because the initial discharge destination (e.g. a respite or rehabilitation facility) is not necessarily the final part of the transitional journey, the implications of errors may become compounded in subsequent movements.

The sources of medical error and sub-optimal care that arise in transitional settings are many and varied. Instructions for important follow-up investigations may be omitted. Attention to simple strategies such as the need for pre-operative fasting may be neglected. Normal follow-up appointment bookings may fail to eventuate. Relying upon busy junior medical staff to complete a heavy load of time-critical handover tasks creates the potential for important deadlines to be missed. However, among all of the things that can go wrong, one recurrent theme appears to emerge as a common factor in serious hand-over problems – issues related to the timely, accurate and complete transfer of information about medication therapy.

Data from the Australian Institute of Health and Welfare reveal that in 2014–15 there were more than 10 million separations from Australia’s hospitals (combined public and private). Based on these figures, it is possible to make some broad extrapolations that allow a rough estimate of the extent of the issues relating to medication-related problems arising at interfaces of care. Excluding about 60% of these admissions (which were same-day separations), and doubling the result to account for the associated admissions, there were at minimum about 8 million interfaces of care that year (not taking into account inter-unit transfers within hospitals, or multiple site transfers where hospital discharge is not to the patient’s final destination). If we then assume that each interface involves the transfer of a minimum of five elements of medication-related information (probably rather conservative, given that this information needs to address drug selection, dosage, administration route, monitoring and more), it is evident that something in the order of 40 million medicines information elements must annually change hands each in these exchanges. Although the numbers are impressive, the statistics take on far greater meaning when the human impact is considered. The woman who is now profoundly disabled by a massive stroke that happened because anticoagulation suspended prior to surgery was not restarted knows well the impact associated admissions, there were at minimum about 60% of these admissions (which were same-day separations), and doubling the result to account for the associated admissions, there were at minimum about 8 million interfaces of care that year (not taking into account inter-unit transfers within hospitals, or multiple site transfers where hospital discharge is not to the patient's final destination). If we then assume that each interface involves the transfer of a minimum of five elements of medication-related information (probably rather conservative, given that this information needs to address drug selection, dosage, administration route, monitoring and more), it is evident that something in the order of 40 million medicines information elements must annually change hands each in these exchanges. Although the numbers are impressive, the statistics take on far greater meaning when the human impact is considered. The woman who is now profoundly disabled by a massive stroke that happened because anticoagulation suspended prior to surgery was not restarted knows well the impact of miscommunication at the transfer of care, and will live with that impact for the rest of her life.

In this edition of the Journal we see the publication of several pieces that address strategies to achieve better medication management at the interfaces of hospital care. It is very clear that pharmacists have a key role to play in ensuring that information about drug therapy is transferred accurately and completely when people are admitted to and discharged from hospitals as well as other settings. As a profession with a role that is uniquely centred on appropriate care in the use of medications, pharmacy can and should assume a leadership role in this area. Having started this editorial with a quote, it seems appropriate to end the same way. The scientist O.A. Battista said that ‘an error doesn’t become a mistake until you refuse to correct it’. Pharmacists must accept the challenge and work to prevent errors in the transfer of medicines information – not to do so would indeed be a mistake.
Conflict of interests statement

The author declares that he has no conflicts of interest.

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DIGITAL HEALTH INITIATIVES SUPPORT CONTINUITY OF CARE

Evidence demonstrating the advantages provided by many digital health systems and processes has grown to such an extent that they may almost be considered part of an expected standard of care. Patients can access their health portal via a smartphone application to schedule appointments or request repeat prescriptions. Shared care records allow care providers to share documentation of activities and note management recommendations. Secure transfer of prescription information reduces the risk of errors, and will soon render handwritten paper prescriptions or medication charts obsolete.

The expansion of professional roles for pharmacists, particularly in community pharmacy and general practice settings, has placed greater importance on the documentation of what the pharmacist has identified and their advice for ongoing management. While many digital health initiatives are developing within pharmacists’ common practice settings of community pharmacies, hospitals and general practices, a question exists of what ‘pharmacist care’ information is being proactively shared.

The New Zealand Government’s revised Health Strategy published in 2016 includes a key theme of a ‘Smart System’.

1 This theme focuses on the need for a health system that innovates, improves, monitors and evaluates what we are doing, and the sharing and standardisation of ‘better ways of doing things’.

Health portals are supporting patients to access and maintain their medical records, schedule appointments, view lab results and request repeat prescriptions. As at June 2017, just over 400 000 New Zealanders have registered for portal access via a smartphone application or secure web login. Systems are also being utilised to collect health data, and share information through eReferrals and shared care plans that aim to smooth a patient’s journey, and offer a greater role in setting their own health goals, supported by the multidisciplinary team.

The pharmacy profession has been at the forefront of many of the ‘eHealth’ initiatives being implemented by the Ministry of Health. The New Zealand Electronic Prescribing Service (NZePS) provides a secure exchange of prescription information between prescribing and dispensing systems, although still requiring a physical bar-coded paper prescription.

3 This has been expanded further in hospital care where ‘electronic prescribing and administration’ (ePA) systems cover the entire hospital medicines cycle, including prescribing, review and dispensing of medication orders, and administration of medicines.

4 A range of quality and safety benefits are provided by these systems, including the reduction of errors of interpretation or transcription of prescription information, real-time decision support, and integration with other management systems such as electronic discharge summaries and e-medicines reconciliation. However, in many respects, these electronic systems appear to be developed and implemented with a focus on how they meet the needs of the particular care setting, as opposed to any over-arching need for how to best support the patient and their health needs (and information) as they move between their home and various care settings. Patients expect health professionals involved in their care to know about them and their health needs. Yet pharmacists are still required to conduct medicines reconciliations, when a single shared medication record could automatically document all prescribed and over-the-counter medicines that make up a patient’s treatment regimen.

Pharmacists in many areas of the country can view electronic discharge and medicines reconciliation summaries for patients, which can support medication counselling and provide clarity when treatment has been changed. Some hospitals also employ a discharge liaison pharmacist specifically to facilitate the transition of care (and some will soon gain their pharmacist prescriber authorisation). However, the knowledge of the ward pharmacist, who has contributed to the specialised care of a patient during their acute hospital stay, is seldom passed on to their community pharmacist who will provide the ongoing care and support to keep the patient living well (and the reverse also being true). Some regions still question the need for pharmacists to view these records, while other regions not only permit