

Continuity of medication management from hospital discharge to primary care in Central Australia

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Background: Continuity of medication management can be described as the accurate transfer of medicines information across different health care settings. Pharmacists within the health care team play a primary role in ensuring that this service is being provided to patients. When a patient is admitted to hospital for treatment or care, there are often alterations made to a patient's regular and often longstanding medication regimen. Revised chronic medication regimens are typically intended to be continued after discharge from hospital in the community or primary care setting.

Aim: To identify if alterations made to a patient's medication regimen in the hospital setting reflect what is dispensed in the community/primary care setting in rural and remote Central Australia.

Method: Retrospective chart audit. Data from inpatient records, specifically discharge medications were matched with records for the same patient with dispensing records in community pharmacies or electronic health records 4-6 weeks after discharge. Inconsistencies were noted and match rates examined.

Results: When pre-admission medications, examined from inpatient records, were compared with those recorded at discharge, 56/57 (98.2%) of patients had changes to chronic medication therapy. From the data collected 40.4% (23/57) of patients' hospital discharge prescriptions exactly matched dispensing history records in the community setting 4-6 weeks post discharge. The development of Medication Management Plan by a clinical pharmacist did not show a significant relationship with the continuation of discharge medication care or to the provision of discharge summary (Chi-Square test: $p=0.238$, $p=0.585$ respectively). Discharge summaries were more likely to be forwarded to primary care providers if the patient received their ongoing medication from an urban or remote Aboriginal Health Service ($p=0.001$). This may be due to the introduction and use of specialised electronic health records in the Northern Territory. Such specialised electronic health records enable effective communication between different health care providers working across large demographic areas and in relatively isolation.

Conclusion: Communication and collaboration between hospital and primary health care providers needs to be improved to minimise DRPs for patients in the period directly following discharge from hospital. The availability of Electronic Health Record systems in rural and remote health settings may improve continuity of care.