LETTER TO THE EDITOR

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HOSPITALIZATION DRUG REGIMEN CHANGES IN GERIATRIC PATIENTS AND ADHERENCE TO MODIFICATIONS BY GENERAL PRACTITIONERS IN PRIMARY CARE (1)

Dear Editor,

In the recently published paper by Rouch et al (1) the Authors comment that communication processes at the interface between secondary and primary care, particularly with community pharmacists, must be strengthened to improve seamless care. They note that in their study, despite virtually all community pharmacists wanting to be made aware of drug regimen changes during hospitalization, in fact they were frequently left out of the medication loop.

There are limited reports of how different systems can be used to support the smooth transition of medication information to community pharmacies at discharge (2, 3, 4) and strategies for improvement in care have been suggested (5), though implementation will depend on many factors including the health system, technology, incentives for providers and community pharmacy, and national direction and support for this to happen.

At our hospital, we commenced faxing discharge medication details to community pharmacies in mid-2013 in line with national guidance (6), though more recently moving, as have others (7), to an electronic platform for communication. We are currently averaging just under 200 transitions (or transfers) of care messages a month to community pharmacy, though there is much scope for us to increase this number.

The Authors note that medication regimens frequently change over the course of a hospitalisation. Interestingly, their paper appears not to identify discrepancies and medical errors at point of discharge as a major concern (8). This is argued to be due to collaboration in their hospital between geriatricians and hospital pharmacists and because justifications for drug regimen changes were systematically provided in discharge letters. Recognising that hospital doctors, especially juniors who do most of the discharge writing at our hospital, do not always describe in the discharge letter why medicines have changed, our hospital pharmacists attempt to capture such changes in 'discharge medication review notes' on our electronic prescribing system, which then flow into the e-discharge letter for the GP, and also into the communication to community pharmacy (if patients have so consented, though this can be a rate limiting step in our process).

Though we are all working towards having safe systems in place for managing information and supply of medicines across care providers, seamless care is still some way away.

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