Community pharmacist management of discharge medication summaries in primary care

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Transition of care, when a patient moves from one setting of care to another, is a period of high vulnerability for patients and one of the six most common areas of risk with medicines across health and adult social care services.[1–4] For example, after discharge from hospital, problems may arise when patients are not prescribed their usual medicines. Other known issues include transcribing errors, mistakes or omissions in discharge letters issued by hospitals to general practitioners (GPs), as well as delays in acting on the information provided in the discharge summary.[3–5] This can result in patients moving between care settings without a full understanding of any new medicines or changes to their existing medicines.

In general, community pharmacists are not routinely sent information on discharge medication for patients who have been in hospital, or even informed that patients have been admitted or discharged. However, evidence is emerging that involving community pharmacists in the process of medicines optimisation after hospital discharge can improve medicines reconciliation and patient safety, and may be associated with shorter hospital stays and lower readmission rates.[6–11] These reports of patient benefit resulting from communication with, and involvement of, the community pharmacist at discharge have appeared from different countries with different health systems, using different community pharmacist interventions.[11–14] A pilot scheme in the UK has shown that it is possible to transfer discharge information electronically from secondary care to allow community pharmacies to provide a follow-up consultation tailored to the patient's need.[10] It also indicated that patients may have lower rates of readmission and shorter hospital stays. Evaluation of the Discharge Medicines Review Service provided by community pharmacists in Wales suggested that the scheme was cost saving through reduced accident and emergency attendances, hospital admissions and drug wastage. Of more importance were the health benefits to patients that resulted from the avoidance of adverse events.[15]

Nevertheless, these and other unpublished UK-based studies of transfer of care around medicines (TCAM) projects have varied both in the electronic referral platforms used and how the service is delivered. For example, different patient cohorts were used as target groups, and there were different approaches to the use of telephone Medicines Use Reviews as an intervention offered by the community pharmacist. These UK evaluations are also not consistent in the framework they used or the data they collected, which makes firm analysis of the benefits problematic. Despite these uncertainties, there is the prospect that such schemes could help reduce the pressure on secondary care services and release value to the health system.

However, current performance across hospital trusts participating in TCAM services shows variable levels of both referral and community pharmacy completion rates (offering considerable scope for improvement). As yet, there is no structured information of the benefit levels that are likely to be achieved in different patient cohorts, and therefore the scale of the potential benefit offered by TCAM, while large, remains unknown. To improve the current performance, key areas need to be addressed. These include an understanding of which patient cohorts benefit the most; a support process in secondary care to enhance the referral rate (eg, improved technology that fits easily into the hospital pharmacy team workflow); and targeted investment within the community pharmacy contractual framework to deliver medicines optimisation after hospital discharge. There should also be an oversight function to monitor and support completion of referrals as well as evaluation and feedback to support quality improvement.

At the same time, it is important to recognise that another approach to the management of discharge summaries has emerged through the introduction of clinical pharmacists in general practice in England.[16] Evaluation of the pilot scheme identified that a large proportion of pharmacists were responsible for streamlining the discharge reconciliation process for patients. It was suggested that such work had a significant positive impact on patients and had the potential to reduce hospital readmissions. These findings need to be backed up by robust evidence of benefit to patients. A coordinated approach to the management of discharge summaries by community pharmacists and pharmacists working in general practice will be needed to avoid duplication of effort.

Although TCAM is one of the Academic Health Science Network priorities for national adoption and spread, it will need support from commissioners, GP practices, pharmacies and patients that a clinical handover service from hospitals to pharmacists in the community is wanted by all stakeholders.[17] Such a service should clearly define who does what for whom and when.

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