FINAL REPORT

Medication management and dementia in the acute care sector and during care transitions

Dementia Collaborative Research Centre
Assessment and Better Care

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Background

People with a diagnosis of dementia may be prescribed medication for dementia or more likely, for their co-morbidities. Care transitions are associated with medication problems such as unintentional medication discrepancies, preventable adverse events, little or no discharge planning, lack of an informative discharge summary and unforseen medication access problems. These problems can be detrimental to patient safety and so may lead to extended recovery periods, hospital readmissions or aged care admissions. People with a diagnosis of dementia are a particularly vulnerable patient group due to their cognitive impairment impacting upon medication self-management and so are expected to be more at risk of having problems with their medication. Strategies to optimise medication management in this group during transfer of care are therefore important for the patient and would help minimise the costs incurred by the health system. This project aims to explore medication processes that occur during acute care episodes and in care transitions for people with a diagnosis of dementia and to make recommendations to improve practice.

Methods

Semi-structured interviews were conducted from a purposive sample of stakeholders from acute and primary care concerning hospital medication discharge and admission processes for patients with a dementia diagnosis. Content analysis of the transcripts was undertaken to identify major concepts and themes.

Results

Between February and July 2012, fifty-one participants were recruited from urban and rural sites in NSW and ACT. These comprised carers (relatives/friends), consultant physicians, nurses (from transitional services, wards, aged care/respite facilities), pharmacists (hospital, transitional and community), occupational therapists, general practitioners and Alzheimer's Australia staff. Themes identified were: medication reconciliation; no modified planning for care transitions; underutilisation of information technology; multiple prescribers; residential aged care facilities and medication reviews by pharmacists. Subthemes were access to appropriate staff; identification of dementia; blister pack dose administration aids and staff training. Good practice was centred on individual champions with established communication networks.

Conclusions

Medication management is sub-optimal for people with a diagnosis of dementia during care transitions. The identified gaps in medication processes may compromise safety of people with a diagnosis of dementia. Effective systems and co-ordination between the person with dementia, carers, acute and primary care healthcare providers are required to achieve high quality care during care transitions rather than a reliance on individual champions. Mechanisms to identify people with a diagnosis of dementia on the hospital medication chart should be utilised to prompt appropriate communication. Initiatives such as home medicines reviews, outreach or transitional health care professionals, co-ordinated electronic healthcare records,
structured communication and improved training are required to reduce the risks associated with medications in care transitions for all people with a diagnosis of dementia. Suggested improvements included accessible and practical dementia training for all staff, modified planning for all individuals over 80 years in hospitals, support for care provision outside normal working hours, shared electronic healthcare records within and external to hospital and dementia aware healthcare workers working at the primary care-acute care transition.

Background

Dementia is the leading cause of disability in Australians aged over 65 years. Dementia prevalence in Australia is predicted to increase from 266,574 in 2011 to 942,624 in 2050. People with dementia have a high demand for health care so the rise in number of people with a dementia diagnosis will be associated with increasing social and economic costs.

People with dementia are likely to be admitted to hospital. Over 25% of people aged 50 and over with dementia are likely to enter hospital during a one year period, compared to 12% of those without dementia. Care transitions involve a move between or within any formal health care setting including hospitals, primary care and residential aged care services. There is a need to better understand care transitions for people with dementia, particularly as they relate to medication management.

People with a diagnosis of dementia may be prescribed medication for dementia or for their co-morbidities. Problems with activities of daily living, a decreased capacity for decision making, confusion, disorientation, communication problems and reliance on carers (paid or family) make managing medication challenging for patients with a diagnosis of dementia. People with a diagnosis of dementia will experience multiple care transitions as the disease progresses and their vulnerability places them at increased risk of having medication-related problems.

Problems with medication such as unintentional medication discrepancies, preventable adverse drug events, poor selection of medication, no discharge summary and supply problems have been identified in care transitions for patient groups that have not focused on dementia. These problems can be detrimental to patient safety and so may lead to hospital readmissions or aged care admissions. People with a diagnosis of dementia are a more vulnerable patient group due to their cognitive impairment affecting their ability to self-manage their medication and so are expected to be more at risk of having problems with their medication. Specific dementia friendly strategies for medication management to ensure safe, high quality transfer of care are therefore important. To date there has been limited investigation of this issue.

Poor communication between healthcare providers during care transitions can contribute to medication related problems. A prospective study that contacted 400 patients within 5 weeks following discharge from a tertiary hospital in USA found that
19% of patients had an adverse event, mostly drug related (12.5%). The majority of drug adverse events were preventable or modifiable and were most commonly due to poor communication between the hospital and the patient or primary care provider (general practitioner or community pharmacist). Strategies suggested to prevent adverse events were assessment and communication of unresolved problems at the time of discharge, patient education regarding medications and other therapies, monitoring of drug therapies after discharge, and monitoring of overall condition after discharge.

**Methods**

In this qualitative study two researchers conducted semi-structured interviews using a set of seeding questions on topics concerning medications and care transitions for people with a diagnosis of dementia. The participants were a purposive sample of stakeholders from acute and primary care. The interviews were audio-recorded then transcribed verbatim for face-to-face interviews, or notes were taken during the interview if conducted by telephone. The transcripts were checked for accuracy by the researcher who conducted the interviews. Thematic analysis of the data was undertaken independently by the two researchers to reduce bias and any disagreements were resolved by discussion. Human Research Ethics Committee approval was obtained from the University of Canberra, The Australian Capital Territory (ACT) Government Health Directorate and South Eastern Sydney Local Health District – Northern Sector.

This project aims to explore medication processes that occur during acute care episodes and in care transitions for people with a diagnosis of dementia and to make recommendations to improve practice.

**Results**

Between February and July 2012, fifty-one participants were recruited from one urban site in Australian Capital Territory (ACT), two urban sites in New South Wales (NSW) and one rural site in NSW. These comprised carers, consultant physicians, nurses (from transitional services, wards, aged care/respite facilities), pharmacists (hospital, transitional and community), occupational therapists, general practitioners (GPs) and Alzheimer's Australia staff. Each participant was allocated a code. Forty-nine of the interviews with participants were audiotaped and then transcribed. For two participants, the researcher took notes during the interview that included verbatim quotations.

The care transitions that were identified were discussed in both directions (see Table 1).
Table 1: Care transitions identified

<table>
<thead>
<tr>
<th>Home</th>
<th>Public hospital</th>
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<tr>
<td>Home</td>
<td>Private hospital</td>
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<tr>
<td>Home</td>
<td>Aged Care Facility</td>
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<td>Aged Care Facility</td>
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<td>Specialist outpatient</td>
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<td>Specialist outpatient</td>
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<td>Public hospital ward/department</td>
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<td>Public Hospital</td>
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The methods of communication utilised for medication were face-to-face, by telephone and via letter or care plan (these can be delivered by mail, electronically, by fax or hand-delivered). Qualitative analysis identified six themes and four sub themes (see Table 2). These are described in the following text with comments italicised.

Table 2: Themes and sub themes identified

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub themes</th>
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<tr>
<td>Medication reconciliation</td>
<td>Access to appropriate staff</td>
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<tr>
<td>No modified planning for care transitions</td>
<td>Identification of dementia</td>
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<td>Blister pack dose administration aids</td>
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<td>Training</td>
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<td>Access to appropriate staff</td>
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<td>Underutilisation of Information technology</td>
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<td>Multiple prescribers</td>
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<td>Residential Aged Care facilities</td>
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<td>Access to appropriate staff</td>
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<td>Medication Review by Pharmacists</td>
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Medication reconciliation

When a person with a diagnosis of dementia is admitted to hospital, establishing their current medication regimen is important for informed clinical decision making. It can be challenging to undertake medication reconciliation, the process of obtaining and verifying a complete and accurate list of a patient’s current medication, for this group of patients. They may not be able to provide an accurate medication history themselves, their carers may not be present and they may not have brought medication into hospital. On contacting the GP for the medication list, there was frustration that the written information provided by the GP was not accurate. Reasons for this included GPs failing to regularly update the medication list in their patient database, the patient having multiple GPs, multiple specialists prescribing for the patient or that previous discharge information was inaccurate. A regular community pharmacist was acknowledged as the most reliable source of information about a patient’s current medication regimen but they were rarely consulted.
It's a dementia patient, they don't know. You can't just read the label on the box and assume that's what they take because it's not. (Respondent 47)

Often they have all the medicines that the patient was ever on so the doctor will just print off. They don’t do data cleaning so it will all come in. And often we do find things that are charted that really the patient isn’t on anymore (Respondent 24)

[The Community Pharmacist is] Most accurate, that’s where I would go, if I can speak to the local pharmacy. (Respondent 4)

The hospitals in the study all employed pharmacists, the healthcare professional that is specifically trained in medication. The hospital pharmacists have prioritised medication reconciliation. Reliance on hospital pharmacists to perform this task, or any task including modified planning for people with a diagnosis of dementia, is compromised by lack of access due to restricted working hours (usually Monday to Friday) and variability of pharmacist services between hospitals. This can lead to other allied healthcare professionals without specific medication training taking on roles relating to medication.

Sometimes the occupational therapists get a bag, here are the medications and you’ve got to sort it. (Respondent10)

No modified planning for care transitions

The identification of people with a diagnosis of dementia and other types of cognitive impairment in hospital was cited as a challenge especially where people with a diagnosis of dementia were not located on a ‘Geriatric Medical Ward’. Solutions suggested included introducing cognitive screening tools at admission for all patients over a certain age, more health professionals and care providers being trained to screen for cognitive impairment, blanket modified planning for all elderly individuals and using a symbol to alert practitioners and carers that this is a patient with a diagnosis of dementia or cognitive issues.

During a hospital admission, switches of medication between brand and generic need to be managed carefully. They can cause anxiety to carers and people with a diagnosis of dementia who struggle with changes of complex medication regimens. The supply of medication from acute care in addition to their existing supplies from the community pharmacy can cause confusion and misadventure. This did not occur in the rural area where all discharge medication was supplied solely by the patient’s usual community pharmacy. Systems that use recognised ‘green bags’ to transfer medication between care settings, the continuous use of patient’s own medication and self administration in hospital were suggested as potential solutions to this issue.

They come out on a generic medication of every single medication they were on plus extras and they end up completely bewildered and overwhelmed, and they go “I’ll just not take any of it.” (Respondent 51)

Insufficient quantities of medication supplied from hospital can cause issues. Where less than 7 days are supplied problems occur if the patient isn’t well enough to
attend the GP surgery, if the discharge information hasn’t arrived at the GP or if the patient cannot get an appointment with their GP.

3 or 5 day appointment with the GP comes up some of them are tired and they cancel it and so then what can happen is they revert back. (Respondent 3)

Timely planning for discharge may be difficult in public hospitals due to pressures to have short lengths of stay and the rule that patients can only stay in the Emergency Department (ED) for four hours before being admitted to hospital or discharged home. This leads to patients with cognitive issues not being allocated sufficient counselling time by staff prior to discharge. It is even more challenging for these patients when they are discharged outside of usual working hours without a family member or carer. These issues are associated with a greater degree of medication related risk.

At 5pm with 3 pages of discharge medications, new initiations of warfarin, new Webster paks™, they are actually really unsafe discharges. (Respondent 4)

Problems with the accuracy or appropriateness of medication information provided to GPs on hospital discharge were identified. There can be difficulty establishing whether changes to medication on discharge are intentional. Participants were frustrated that medication discharge information can lack explanations for changes and this causes problems for ongoing care of the patient. Respondents frequently linked this to the role junior doctors played on discharge, with responsibility for writing up medications for discharge usually falling to the most junior person on the team often with a limited exposure to the patient and the care aims. In the rural site, fewer issues were reported and this was attributed to the role that hospital pharmacists have in writing a discharge medication summary. There was support for the medication changes from the discharge letter being sent to the community pharmacy in order to facilitate follow up of medication issues but this rarely occurs except where a blister pack dose administration aid (Webster-Pak™ or MedicoPak™) is required.

The person who knows the patient least well is writing the instruction manual for further treatment and that’s not right (Respondent 36)
Something has been ceased on the ward and they have actually got it on their discharge summary or vice versa they’ve started it and it hasn’t been put on the discharge summary (Respondent 40)

Blister pack dose administration aids may facilitate a person with dementia to manage their own medication or be supported by a carer. Blister packs generally contain an individual’s tablets or capsules dispensed into a weekly pack with four unit dosing times per day. The data included reports where these aids were initiated without assessment of an individual’s ability to use a blister pack dose administration aid. Where a device has been initiated, there was concern about the expense of the devices, the potential for errors, the lack of formal ongoing monitoring and the safety of outsourcing the supply of dose administration aid to a central packing location.
You do need to have a, in my opinion, fairly high degree of cognition to work out what days, what dates and then have the wear-with-all to be able to push the medications (Respondent 10)

They are getting them back half used and you think what’s the point in keep sending them. We had a dementia client. She had a build up of 6. Why would you keep delivering? (Respondent 38)

Discharges where the patient will be reliant on paid carers to monitor medication require more liaison and planning in terms of timescale and dosing schedules. There were issues around communication with medication related care package providers during care transitions for people with a diagnosis of dementia.

It might take a package provider three days to get carers back into the home. (Respondent 16)

Merge all the meds together so they’re one time a day, and then you can get a paid carer to go in and support them, rather than trying to find a paid carer to go in three times a day, which is virtually impossible. (Respondent 16)

We don’t find out that they’re in there until a service needs to be cancelled, or they’re about to be discharged (Respondent 16)

Good practice centred on individual champions with good communication networks. These included workers that supported people with a dementia diagnosis post hospital discharge, during hospital admission and in avoiding hospital admissions. Within the hospital there were clinical nurse consultants to support people with a diagnosis of dementia. Transitional care pharmacists can support people with a diagnosis of dementia to receive appropriate medication during care transitions.

Underutilisation of information technology

Participants expressed frustrations with the current IT systems. There are multiple different unlinked systems (for example in the emergency department, mental health, hospital wards, GPs, pharmacists) in use leading to data that is not shared. An example where this may cause a problem is if a drug was suspected to cause an admission, this would not be transferred to all the systems in hospital so this information may not be available to clinicians during the admission or in a subsequent admission. This may lead to prescribing of an unsuitable medication and harm to the patient. Restricted access to IT systems was described. This can mean that some information relevant to patients cannot be shared, for example, their cognitive state or their correct medication. An example where this is an issue which can potentially cause harm is where the clinical pharmacist in the hospital dispensary has identified a problem with the discharge prescription and agreed a change to the medication with the ward doctor but only the ward doctor can alter the discharge communication to the GP. If the ward doctor does not change the discharge letter, the incorrect information will be sent to the GP.

If we identify an error in that discharge prescription, a dose or we want a dose change and we say to the doctor, you’ve got to go back and change the
Multiple prescribers

Where there are multiple prescribers, problems can occur with care transitions. It was reported that little information was shared between the private and public hospitals. The communication between specialists and GPs had caused problems for some participants. Delays in treatment have been caused by the communication method from specialists to the GP being a letter. An advocate that coordinated care was offered as a potential solution to the problem of multiple prescribers. Information technology (IT) was cited as an area where improvements could be made to facilitate better communication between prescribers and other healthcare professionals. There was support for a mandatory electronic healthcare record with automatic updating every time a change to medication is made.

If everybody has an electronic record coded to their Medicare number … every time you as the pharmacist changes it or me as the doctor changes it, that automatically quickly alters it. (Respondent 12)

Residential Aged Care facilities

Medication problems for people with a diagnosis of dementia were identified in care transitions from acute care to Residential Aged Care facilities (RACF). The RACF require specific documents in order to give medication. Problems were described where these were not provided. Staff members from RACFs were frustrated about the lack of or inaccurate information received from hospitals whereas hospital pharmacists had difficulties with the variable clerical and clinical requirements from the different RACFs. In one of the urban sites, a GRACE CNC (Geriatric Rapid Acute Care Evaluation Clinical Nurse Consultant) is employed and one of her roles is to make sure that medication information is transferred between RACF and acute care. There was also support for transfer of information in a ‘yellow envelope’ or bag.

We’ve got to go through all this mucking around, phoning, faxing, faxing, phoning and then get a delivery. That’s what holds up the administration of medication. And it could be 24, 48 hours perhaps longer before we get the medication. (Respondent 43)

Every nursing home has their own chart and they won’t accept another nursing home’s med chart (Respondent 45)

Training about medications was raised in the context of RACFs as a significant proportion of the workforce has limited training relating to medications. A number of respondents from RACF commented on negative attitudes to dementia that may adversely influence the quality and safety of patient management generally, and particularly during transitions of care. Training could help to change these attitudes.

I said to the staff it’s really important that he’s having his Lasix™ they weren’t able to demonstrate that they understood (Respondent 5)
Doctors are very results driven and they look at aged care and the related problems, dementia included, as fairly tedious, boring, a waste of time because they are going to die anyway (Respondent 43)

Medicine Reviews by pharmacists

Pharmacists frequently interact with GPs with regards to dementia care within two government-funded schemes, the Residential Medicines Management Review (RMMR) and the Home Medicine Review (HMR). These have been promoted as a way to support patients with medication around the time of care transitions. Accredited pharmacists have undertaken specific training to conduct this enhanced role. Participants expressed mixed opinions on the clinical relevance of the RMMR and HMRs as there was little recognition of the dementia specific issues faced by the patients and carers.

There was concern that RMMRs are lacking in specific clinical benefit when national companies provide a generalized service to Aged Care Facilities rather than adapting the service for dementia patients. Similarly there were pharmacist concerns about HMRs including that the patient is unknown to the accredited pharmacist so there is no prior understanding or rapport of the patient’s history compared to the regular community pharmacist or local GP. In some cases older patients may not be receptive to HMRs because they tend to have a higher level of trust in doctors than pharmacists.

Generationally, they trust their doctors. They won’t trust a pharmacist to the same degree. (Respondent 16)

Discussion

Principal findings

People with a dementia diagnosis, like other members of the community, require a range of health interventions as they transit across the entirety of the complex healthcare system. Health care systems are confusing and risky for these individuals. There is little practical recognition within the health system of these patients’ specific needs or vulnerabilities. Medication management is particularly sub-optimal for these people and errors in the process of prescribing and administration add significantly to community, hospital and residential care costs.

The identified gaps in the care transition medication processes may compromise the safety of dementia patients. The lack of an ongoing systematic approach to achieve a high quality medication communication process during care transitions for dementia is a clinical governance issue. Integrated dementia care pathways that coordinate between the patient, carers, hospital staff and primary healthcare providers together with enhanced pharmacy services are required to consistently achieve safe care transitions rather than the observed reliance on individual champions or random chance.
Dementia champions identified included specialist transitional staff such as aged care services in emergency team (ASET) nurses, dementia CNCs and geriatric rapid response acute care evaluation (GRACE) nurses.8 These positions are not funded in every locality and even where there are dementia champions, they may not be involved in all care transitions due to cost or availability. Specialist transitional workers do try to resolve medication problems during care transitions but medication is only one of their foci. Utilisation of pharmacists, the healthcare professional that is specifically trained in medication, could achieve better outcomes but their involvement in care transitions is variable.9

Pharmacists can support people with a diagnosis of dementia during care transitions in many different ways. These comprise medication history taking on admission, medication reconciliation,6,7,10 assisting with medication adherence, discharge medication counseling,6 information sharing with community pharmacies,4 preparing interim RACF medication administration chart11 and conducting post-discharge follow-up such as telephone calls or visits which may include a HMR.6,12 The most comprehensive pharmaceutical care model described in the literature is the pharmacist transition co-ordinators.6 These pharmacists supply medication-management summaries from hospitals to primary care providers (RACF, GPs and community pharmacists), complete a comprehensive medication section on the discharge summary, arrange timely medication reviews by accredited community pharmacists and participate in case conferences with general practitioners.6 Pharmacist transition co-ordinators have demonstrated that they improve health outcomes for patients transferred from hospitals to RACF so could be expected to be beneficial for all patients with a diagnosis of dementia in any care transition. We advocate that all public hospitals employ pharmacist transition co-ordinators to target and support people with a dementia diagnosis and their carers. Additionally the pharmacist transition co-ordinators need to recognise that it is not always families or care facilities that regularly care for these patients.

Structured communication for a comprehensive clinical handover with respect to medication at transitions of care can be achieved by utilizing lists or by completing care pathways and then sharing them in a timely fashion with appropriate care providers. A standardised patient transfer form may assist with the communication of advanced directives and medication lists and that pharmacist-led review of medication lists may help identify ceased, omitted or indicated medications on transfer.13

Recognition of patients with dementia is required in order for the management of their medications to be modified appropriately. Identification and communication of dementia diagnosis was poor in our study hospitals. There is some hesitancy in the community about sharing information about mental health in general and dementia specifically. Community engagement is required to heighten the recognition by the community in general that medications combined with cognitive impairment has risks14 that need to be recognized and managed with the patient, carers and health professionals. Previous research recorded that dementia was documented in medical notes for less than half of admissions in NSW hospitals.8 Increased screening for dementia in hospital together with a positive result triggering an above bed visual alert may be useful to promote appropriate modified medication management. Alerts are often used in hospitals when patients have risks that are not
easily observed, such as difficulty hearing, poor vision, falls, nil by mouth. A visual
cognitive impairment identifier, an abstract graphic, has been well received by staff
and carers in Victoria as part of a hospital-wide educational package to identify
dementia and modify care accordingly.\textsuperscript{15} An alternative in the interim is that
medication management in hospitals is modified to be dementia friendly for all
individuals over 80 years. A threshold of 80 years is suggested for modified planning
as dementia prevalence increases with age, from around 3\% at 70-74 years to
above 12\% at 80-84 years and to over 31\% at 90-94 years.\textsuperscript{1}

Identifying an accurate medication record is acknowledged as one of the biggest
challenges during care transitions and this could be resolved by better use of IT
across the different sectors. The National E-Health Transition Authority (NEHTA) has
been tasked to co-ordinate the adoption of systems such as e-referral and e-
discharge in Australia\textsuperscript{16} and these should facilitate accurate transfer of medication
information between healthcare providers. Disappointingly the evidence for improved
safety following implementation of e-discharge\textsuperscript{17} and electronic medication
management systems\textsuperscript{18} is equivocal. The ease of use of these systems has been
acknowledged to limit effectiveness.\textsuperscript{17,18} A core role of healthcare professionals
should be updating IT databases. Development of user-friendly electronic systems
that link hospitals with GPs, specialists with GPs, RACFs with hospitals, community
pharmacies with hospitals are essential to improve medication management during
care transitions.

An initiative which has the potential to resolve the described medication problems
that occur due to electronic healthcare information not being shared between
hospitals, medical practitioners, pharmacies and RACF is the Australian eHealth
record.\textsuperscript{19} This is an electronic summary of an individual patient’s health information,
giving healthcare providers access to patient information such as medications, test
results, discharge summaries and allergies. Individuals with a dementia diagnosis
who lack capacity can nominate an authorised representative to manage the record
on their behalf. To date the impact of the eHealth record has been limited because it
is opt-in and the uptake by both healthcare providers and Australian citizens has
been poor. If joining eHealth became mandatory, this initiative would realise its
potential to improve continuity of care in transitions for all Australians.

The Australian Commission on Safety and Quality in Health Care recommends that
all hospital staff should receive appropriate dementia education and training.\textsuperscript{20} Research has identified that more dementia training is required.\textsuperscript{21-23} Various modes
of training delivery have been described that include online,\textsuperscript{24} DVDs,\textsuperscript{23} didactic,\textsuperscript{15} and
paper-based.\textsuperscript{23} These packages appeared to improve carer satisfaction\textsuperscript{15} staff
knowledge\textsuperscript{21,22} and confidence\textsuperscript{15,21} but it is unclear whether they improved clinical
outcomes or contained a medication component. Mapped patient journeys with
respect to medication across care transitions may promote a greater understanding
of the systems in other sectors and the potential risks. We suggest that staff training
needs to be accessible and include non-clinical staff.

The inferior health care service provided to patients outside of normal working hours
seems to contribute to medication management issues during care transitions. Poor
service by out-of-hours GPs has been linked to higher hospital admissions from
RACF in the United Kingdom.\textsuperscript{25} ASET is a NSW initiative that aims to facilitate better
care and management of older people in ED by referring to appropriate hospital or primary care services. These ASET health professionals have a positive effect on patient care during care transitions but this service is limited by part-time working so that core hours are not covered. International standard timeframe for medication reconciliation is within 24 hours but many hospitals in Australia do not have a 7 day a week pharmacy service. Increasing service provision by these key healthcare professionals should improve medication management for patients with a diagnosis of dementia during care transitions.

Strengths and limitations

Strengths of this study were that the personal perspectives of a range of personnel (urban and rural) dealing with medication during care transitions reported provide useful insights into the challenges, which may be addressed by the suggested improvements. The results however may not be generalisable across Australia given our study was conducted in two states and recruited informants that have a commitment to dementia. People with a diagnosis of dementia were not recruited because ACT law prevents individuals that lack capacity from participating in research. This limitation on participation by people with dementia raises complex ethical questions, relating on the one hand to the protection of vulnerable groups but on the other to the right of vulnerable groups to have their voices heard in this and similar kinds of research projects.

Implications for practice

This report recommends the following

- Involving pharmacists in care transitions. This may be achieved by using pharmacist transition co-ordinators.
- Structured communication pathways. These should include routine information provision to community pharmacies and routine information provision to aged care facilities
- Modified planning for all individuals over 80 years
- Adoption of better strategies to better identify people with dementia
- Automatic updating of medication whenever changes are made on an electronic healthcare record that is accessible to all practitioners involved in a patient’s care
- Accessible staff training that addresses the care needs of the cognitively impaired (not just provided for geriatric wards but all areas of clinical care)

Conclusion

Communication between the range of care providers is required for seamless transfer of care with regard to medication. To enable this to be achieved communication between care givers and health services (both acute and community based) is required to be well co-ordinated, documented and readily available especially after hours. Mindfulness by all health professionals of the challenges confronting both care receivers and givers in navigating the health system and its complexity, needs to be supported by communication pathways that keep all informed
of past and future health and social issues relevant to individuals with dementia and those who care for them.
REFERENCES


