SUMMARY 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 unforeseen 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.