The safety and continuity of medicines at transitions of care for people with heart failure

B. Fylan[a], G. Armitage[a], L. Breen[a], P. Gardner[b], H. Ismail[a], I Marques[a], A. Blenkinsopp[a]

[a] University of Bradford
[b] University of Leeds
Email: b.fylangwynn@bradford.ac.uk

Introduction: Avoidable harm associated with medicines is widespread – particularly at care transitions – and unintended discrepancies in patients' medicines after discharge from hospital affect more than half of all patients. Patients with heart failure are frequent service users (including readmission to hospital), and susceptible to deficiencies in medicines management. Heart failure is responsible for approximately 5% of medical admissions and the readmission rate within 3 months of discharge may be as high as 50%.[1]

Aim: The Improving Safety and Continuity of Medicines management at Transitions of care (ISCOMAT) study is an NIHR-funded programme of research in patients with heart failure. The first work package, described here, aimed to map and evaluate current medicines management pathways across care transitions, describing the core characteristics of best practice and effective systems at each stage.

Method: Mixed-methods research collecting data centred on patients' journey out of hospital and back home exploring current practice relating on heart failure. NHS REC approval was obtained (16/NS/0018). Following a process of informed consent, data were collected from patients (n=16) in four health economies in England using semi-structured interviews conducted shortly after their discharge from hospital and again after two and six weeks and included video recording. Non-participant observation was conducted on cardiology wards in the four areas to understand predominant systems employed by the hospitals to deliver information to patients and to primary care. Interviews with staff in hospitals and primary care explored policy, practice and systems across the transition. Data were analysed using integrative 'parallel mixed' analysis.

Results: Several themes emerged that described the resilience of the system that manages patients' medicines across the whole pathway. Spatial dimensions – including local working conditions – impacted on staff who managed transfers. Process efficiencies and effectiveness, including the degree of staff training and policy awareness, both enhanced and hindered communication with patients and health care professionals (HCPs) in primary care. The system did not allow staff to assess the impact of the management of medicines at discharge across the transition into primary care. Patients themselves were found to have different levels of knowledge and confidence in their medicines once back at home and, where their pathway included this, to value the care co-ordination functions of heart failure nurses. Primary care staff operated varying systems for managing discharge communication and implementing recommendations and some reported positive outcomes from integration of practice pharmacists into the system.

Conclusions: To our knowledge this is the first UK study of medicines management along the patient's journey from hospital into primary care for patients with heart failure. A whole pathway analysis has enabled a detailed understanding of resilience in each part of the healthcare system. These findings will be used in the co-design of an intervention to improve medicines management in the next phase of the research.

1 Sutherland K. (2010). Bridging the Quality Gap: Heart Failure. Health Foundation, London.