GUIDELINE: HOW TO PERFORM A MEDICATION COUNSELLING SES SION IN OLDER ADULTS PRIOR TO HOSPITAL DISCHARGE

Disclaimer: This guideline is developed by a multidisciplinary expert panel (pharmacists, geriatricians and nurses) on behalf of the Belgian Society for Gerontology and Geriatrics (BSGG). The guideline describes how medication counselling in older adults prior to hospital discharge should ideally be performed, based on the current scientific evidence and/or consensus among experts. However, the local hospital structure and possibilities should be taken into account when implementing this guideline.

Preconditions:

- Medication counselling should be regarded as an important component of a more comprehensive intervention. In that regard, it should preferably be integrated into an interdisciplinary and multifaceted intervention. The intervention should at least include the following components: medication reconciliation on hospital admission and at discharge, as well as a comprehensive medication review during hospital stay.
- Medication counselling can be carried out by different healthcare providers (e.g. pharmacists, geriatricians, nurses). All should be sufficiently trained to correctly provide the information. Similarly, active involvement in the inpatient care is a prerequisite.
- Information about medication reconciliation and the results of the medication review must be documented and should be readily available for the person who performs the counselling. Relevant information about the patient's attitude, experiences, knowledge etc. concerning their medications should also be documented. In addition, whether the patient is fully in charge of his medication intake or whether the medications are prefilled and/or administered by a caregiver or healthcare provider should be assessed and recorded shortly after admission.
- In addition, informing patients/caregivers about their medications should not be limited to the time of discharge. Patients/caregivers should be provided with tailored information throughout their entire hospital stay. Ideally, the counselling session should be planned at least 24 hours before hospital discharge in order to have sufficient time to prepare and perform the session.

Aim:

- To inform patients/caregivers, but also healthcare providers in primary care (general practitioner (GP), community pharmacist (CP), community nurse (CN)) about discharge medications to **ensure seamless pharmaceutical care**, to **reduce the risk of drug-related problems** and to **optimise medication adherence**.

Setting:

- Hospital (hospitalisation ward or ambulatory clinic).
- Older patient.
- Give priority to those patients who are themselves responsible for their medications or to the caregiver who administers the medications. There is an important role for the multidisciplinary team to prioritise patients for whom medication counselling should be performed.

©BSGG 2020

Preparation:

- Prepare an **up-to-date discharge medication list**:
    - Perform a medication reconciliation:
        - Check for unintended discrepancies between medications at discharge and at admission to ensure a correct medication list.
        - Check for unintended discrepancies between documents (e.g. discharge medication list, discharge document, prescriptions).
        - Report and resolve all unintended discrepancies.
    - Resubstitute all in-hospital used medications (hospital formulary products), back to the original medications that the patient used before hospital admission, to prevent confusion and duplication therapy.
- The discharge medication list should mention for every medication at a minimum:
    - Brand name (including dosage, dosage unit and pharmaceutical formulation)
    - Indication
    - Frequency of intake (per day, per week)
    - Time of administration (+ intake in relation with food when important)
    - Quantity + unit per administration
    - Route of administration
    - Mention stop date for medications with a fixed duration of therapy (e.g. antimicrobial agents, analgesics)
    - Any additional comments if necessary (e.g. storage, relevant reimbursement details, name of the hospital formulary product if substituted)
- **Describe or indicate all medication changes** which occurred during hospital stay (what is stopped, started or changed) and if possible the reason(s) for these changes.
    - For example, by the preparation of a pharmaceutical discharge form or by using colours to indicate what is new and what is changed on the discharge medication list.
    - Record all medications which were stopped (do not include these stopped medications amongst the active medications on the discharge medication list to prevent confusion).

©BSGG 2020

HOSPITAL LOGO					CONTACT DETAILS: address, phone number, email		
Patient's name:		Date of birth: DD/MM/YYYY			Printing date: DD/MM/YYYY		
	Brand name	**Indication**	**Frequency of intake**	**Time of administration**	**Quantity + unit of administration**	**Route of administration**	**Any additional comments if necessary**
NEW	*Alendronate 70 mg tablet*	*Osteoporosis*	*Once weekly: every Monday*	*7u, <u>without</u> food*	*1 tablet of 70 mg*	*Orally*	*Take with a full glass of water. Do not lay down 30 minutes after intake.*
NEW	*Steovit D3 1000mg/800IU tablet*	*Osteoporosis*	*Once-daily*	*20u*	*1 tablet of 1000mg/800IU*	*Orally*	
CHANGED	*NovoRapid FlexPen 100 IU/mL*	*Diabetes*	*Three times a day*	*8u – 12u – 18u*	*10 IU – 22 IU – 16 IU*	*Subcutaneously*	*Check glycaemic level before administration*
UNCHANGED	*Lantus SoloStar 100 IU/mL*	*Diabetes*	*Once-daily*	*20u*	*25 IU*	*Subcutaneously*	
UNCHANGED	*Zytiga 500 mg tablet*	*Prostate cancer*	*Once-daily*	*10u, <u>without</u> food*	*2 tablets of 500 mg*	*Orally*	
UNCHANGED	*Prednisolone 5mg*	*Prostate cancer*	*Twice-daily*	*8u – 18u, <u>with</u> food*	*1 tablet of 5 mg*	*Orally*	

STOPPED	*Acetylsalicylic acid 100 mg tablet*

©BSGG 2020

Procedure of the counselling session with the patient and/or the patient's caregiver:

- Identify whether the patient is in charge of his medication intake or whether the medications are prefilled and/or administered by a caregiver.
- Verify whether the patient/caregiver already received information related to his medications (e.g. from other healthcare providers) and try to evaluate what the patient/caregiver already knows about the discharge medication list.
- Use the discharge medication list during the counselling session with the patient/caregiver. This medication list should be clear and should use terms the patient/caregiver knows. Make clarifications when needed.
- Explain all medication changes and if possible the rationale when important for the patient/caregiver (the reason(s) why each medication listed was changed, started or stopped).
- Discuss the following topics **for medications which were started during hospitalisation** ('new medications') and **for medications wherefore additional information is desirable** (e.g. high-risk medications, medications leading to hospital (re)admission):
    - **Why?**
        - Provide information about the **indication.**
    - **How (much)?**
        - Provide information about the **frequency of intake** (per day, per week), together with the **quantity + unit, time and route of administration.**
    - **Extra?**
        - Provide, if applicable, **specific medication information**: e.g. therapeutic drug monitoring, inhalation techniques, nasal spray technique, administration of eye drops.
        - Provide information about the most frequent possible **side-effects** (adverse drug reactions, ADRs)
            - How they can be prevented,
            - How they can be recognised/detected,
            - What to do if they occur and,
            - When it is necessary to seek medical attention
        - Provide information about **specific requirements** (e.g. reimbursement via attestation, only available in hospital pharmacy).
- Discuss **stop date** for medications with a fixed duration of therapy (e.g. antimicrobial agents, analgesics).
- Emphasise the **importance of medication adherence** and the possible consequences of non-adherence.
    - Try to optimise adherence by identifying possible problems and suggesting tailored interventions (e.g. education to improve patient empowerment, optimisation of medication scheme, use of adherence aids (pillboxes, reminders)).
- Indicate to contact the CP or GP to know what to do when a **dose is missed.**
- **Ensure appropriate medication supply** to bridge the post-discharge period, until the patient/caregiver can receive the required medications from the community pharmacy.
    - Inform the patient/caregiver about the number of days' supply of each medication that was given at the time of discharge.

    - If applicable, indicate to which original medications the hospital formulary products correspond to.
    - Inform the patient/caregiver which medications were already administered on the day of discharge.
    - Provide information about the appropriate storage of the medications supplied.
- Ask for **feedback**: verify if the patient/caregiver finds the discharge medication list clear and complete.
    - Is anything missing according to the patient/caregiver?
    - Does the patient/caregiver have additional questions and/or has something to be repeated or explained once again?
- Confirm the patient's/caregiver's comprehension with the **teach-back** method, especially for newly started medications.
    - Ask the patient/caregiver to answer a specific question (for example 'When do you need to take medication X?') by use of the medication list, to detect any reading issues and to verify if patients/caregivers are able to read and interpret the medication list correctly.
    - Ask to demonstrate any new self-care tasks that the patient/caregiver will be required to carry out at home, such as using an inhaler or administering a subcutaneous injection.
    - Ask if the patient/caregiver desires additional written information (e.g. brochures).

Transfer of information

We strongly advocate for the implementation of an operational electronic health platform on which at least an up-to-date medication list is accessible for all healthcare providers in both community and hospital setting. Pending this we recommend:

- Make several copies of the discharge medication list and give them to the patient/caregiver.
    - Explain that these copies should be shown to all healthcare providers that should be informed (GP, CP, CN …) and encourage the patient/caregiver to always carry an up-to-date medication list. If something changes, this should be adapted to all copies and dated.
- Document the complete discharge medication list and all medication changes including the rationale in the patient's discharge letter that will be sent to the GP.
    - Add a summary of the medication review with consensus and proposed pharmacotherapeutic plan.
    - Record important points for follow-up of medication. For example, monitoring of certain parameters (e.g. blood glucose, blood pressure), monitoring of side effects (e.g. falls, sedation), tentative date of evaluation to consider stopping medication.
- Document that a counselling session was conducted in the patient's discharge letter and record all possible comments or recommendations based on the findings during the counselling session.
- Provide information for the patient/caregiver and primary healthcare providers how to contact the physician/pharmacist for more information.
- This transfer of information is essential to guarantee optimal post-discharge follow-up to further ensure good and persistent understanding of the discharge medication.

Contact: Andreas.Capiau@uzgent.be

Multidisciplinary expert panel: AERENS Sander (UZ Gent), BAEYENS Hilde (AZ Alma), CAPIAU Andreas (UZ Gent), DE COCK Anne-Marie (ZNA), GIELEN Evelien (UZ Leuven), GILARD Isabelle (UCL), HELLEMANS Laura (UZ Leuven), HIAS Julie (UZ Leuven), MERTENS Sarah (UZ Gent), NEEFS Jens (UZ Leuven), PEETERS Sofie (AZ Turnhout), PETROVIC Mirko (UZ Gent), QUITENS Charlotte (UZ Leuven), SENNESAEL Anne-Laure (UCL), SOMERS Annemie (UZ Gent), SPINEWINE Ann (UCL), THYS Ilse (UZ Leuven), TOURNOY Jos (UZ Leuven), VAN DE VELDE Caroline (UCL), VAN DER BRUGGEN Clémence (UCL), VAN DER LINDEN Lorenz (UZ Leuven), VAN SLYCKEN Evelien (UZ Gent), VANDER WEYDEN Liesbeth (UZ Leuven), VANMEENEN Margot (UZ Gent) , VELGHE Anja (UZ Gent), VERSLUYS Karen (UZ Gent)

©BSGG 2020