Facilitation of Transition of Care between Outpatient Diabetic Clinic and Community Pharmacies
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INTRODUCTION

Pharmacist-led interventions have shown to decrease drug-related problems (DRPs) and improve clinical outcomes especially during the transitioning between different healthcare settings.\(^1\)

Patients are particularly prone to medication errors during transitioning, as medical data can get lost. This threatens patient safety by increasing the possibility of losing critical clinical information leading to delay of care and inappropriate monitoring.\(^2\)

AIM & OBJECTIVES

To develop and implement a pharmaceutical care service at the outpatient setting for diabetic patients

The objectives of this study were:
• Perform medicine reconciliation to identify drug therapy problems (DRPs)
• Develop a Transition of Care Document using the comprehensive list which was compiled during the medicine reconciliation

METHOD

Patients attending Mater Dei Hospital outpatients and satisfied the inclusion criteria were eligible to participate in the study

<table>
<thead>
<tr>
<th>Patient’s data collected using a designated Data Collection Sheet</th>
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<tbody>
<tr>
<td>• Medicine reconciliation performed</td>
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<tr>
<td>• DRPs were identified and classified into six categories according to Pharmaceutical Care Network Europe(^4)</td>
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A Transition of Care document was compiled using the patient’s current medication list gathered during the medicine reconciliation denoting either

| Change in treatment |
| No change in treatment |

Pharmacist interventions performed were grouped into four categories

| Verbal intervention – when patients required educational advice |
| Written advice – when a change in treatment was required |
| Required both verbal and written advice |
| No intervention needed |

RESULTS

Number of pharmacist interventions (N=104)

- Verbal intervention
- No intervention
- Written advice given to physician
- Required both verbal and written advice

Identified DRPs (N=194)

- Lack or misinterpretation of information
- Insufficient awareness of health and disease
- Inappropriate timing of administration and/or dosing intervals
- Non-adherence to treatment
- Suggested an add-on treatment
- Treatment not according to guidelines

CONCLUSION

The Transition of Care document developed in this study was used to list a complete and updated list of current prescription and non-prescription medications to the community pharmacist with whom the patient is registered to collect his/her regular chronic medications on the national health service scheme.

The implementation of this developed pharmacist-led Transition of Care service was shown to be relevant to the outpatient diabetic group as demonstrated by the identified DRPs, which is a service innovative to our healthcare system.

Acknowledgements

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REFERENCES


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