SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Medicine: Continuity of Management and Documentation
TYPE OF DOCUMENT	Procedure
DOCUMENT NUMBER	SESLHDPR/267
DATE OF PUBLICATION	February 2022
RISK RATING	High
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 1 – Governance for Safety and Quality in Health Service Organisations (1.2, 1.3, 1.9) Standard 4 – Medication Safety (4.1, 4.6, 4.7, 4.8, 4.12, 4.13, 4.14)
REVIEW DATE	February 2024
FORMER REFERENCE(S)	N/A
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FUNCTIONAL GROUP(S)	Medicine
KEY TERMS	Medicine management processes, current medications, best possible medication history (BPMH), medication reconciliation, medication management plan, transfer of care, discharge, adverse drug reactions (ADR), quality use of medicines (QUM)
SUMMARY	A systems approach to facilitate teamwork and continuity in medicine management processes to: 1. Accurately obtain, verify, document and reconcile a patient's current medications on admission and at each transfer of care 2. Accurately document and report adverse drug reactions (ADR) 3. And be available at the point of care.

Medicine: Continuity of Management and Documentation

SESLHDPR/267

1. POLICY STATEMENT

SESLHD Quality Use of Medicines Committee (QUMC) promotes high quality, safe, evidence-based and cost-effective medicine use across all SESLHD facilities. This includes aiming for continuity in medication management for all inpatients of SESLHD facilities in accordance with the National Safety and Quality Health Service Standards [(1)]. This procedure should be read in conjunction with NSW Health Policy Directive - PD2013_043 - Medication Handling in NSW Public Health Facilities [(2)] and NSW Health Policy Directive PD2020_045 High-Risk Medicines Management [(3)].

2. BACKGROUND

'The key to safe and appropriate management of medicines is a coordinated approach that supports and encourages continuity.' [(4)]

NSW Health Policy Directive PD2013_043 - Medication Handling in NSW Public Health Facilities [(2)] details the legislative requirements and policies on storage, supply, prescribing, dispensing and administration of medications in NSW public health facilities. Additional processes and documentation outlined in this procedure are essential in order to achieve effective continuity in medication management and prevention of adverse medicine events through a multidisciplinary approach.

2.1 Definitions

Adverse Drug Reaction (ADR): An appreciably harmful or unpleasant reaction, resulting from an intervention related to the use of a medicinal product, which predicts hazard from future administration and warrants prevention or specific treatment, or alteration of the dosage regimen, or withdrawal of the product. The term ADR is inclusive of drug allergies.

Adverse Medicine Event: Any unwanted event relating to the administration of a medicine. This may include but is not limited to dose omission, side effects and ADR.

At admission: By the end of the next calendar day after admission.

Best Possible Medication History (BPMH): A medication history obtained using a systematic approach, based on information source(s) with high reliability and comprehensiveness, and which may therefore be reasonably assumed to be an accurate and complete reflection of the medicines a patient was taking prior to admission. Wherever possible, a BPMH should involve a patient / carer interview and confirmation with at least one other source (e.g. patient's own medicines, GP, community pharmacist, etc.).[(10)]

eMM System: An electronic Medication Management system approved for use in the facility.

eMEDs System: The Cerner eMM system used for inpatient medication management across SESLHD acute facilities, except in intensive care areas.

Health Care Record: Comprises patient information that is a combination of information stored in an electronic format and / or in the traditional paper format.(3) Information recorded in electronic medication management systems forms part of the patient's overall Health Care Record.

Medication: Any prescription or non-prescription medicine, complementary medicine, diagnostic agent or recreational substance.

Medication Management Plan: In accordance with the Australian Commission on Safety and Quality in Health Care Advisory A16/04(4), a medication management plan is defined as including at a minimum the following components:

1. Provision of current and comprehensive medicines management information at transfers of care
2. Inclusion of a current and comprehensive list of medicines and explanation of changes in the patient's discharge summary
3. Provision of a current and comprehensive list of medicines to the patient / carer at discharge.

Actions taken by all members of the multidisciplinary team in consultation with the patient / carer, including documenting a BPMH, recording changes to medication during admission and documenting medication issues and actions taken during the episode of care will ensure that completion of a medication management plan can be effectively achieved.

Medication Reconciliation: A formal process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care, the verified information is transferred to the patient and next care provider.

Medication Review: A systemic assessment of a patient's medication management with the aim of optimising the quality use of medicines and minimising medication-related problems. It is a multidisciplinary responsibility that ensures the ongoing safe and effective use of medicines at all stages of the medication management pathway. (10)

NIMC: National Inpatient Medication Chart

Quality Use of Medicines: Selecting management options wisely, choosing suitable medicines if medicine is considered necessary, and using medicines safety and effectively.

3. RESPONSIBILITIES

3.1 SESLHD Quality Use of Medicines Committee (QUMC) provides leadership for medication management within SESLHD and provides advice regarding medications to the Clinical and Quality Council.

3.2 **General Managers or their delegates** are responsible for resource provision to support continuity of medication management within SESLHD facilities

3.3 **Facilities** are responsible for ensuring that a risk management approach is taken to implement strategies to support continuity of documentation for medication management. This should include a documented plan that clearly defines consumers at heightened risk of medication-related harm.

3.4 **Facility Safe Use of Medicines Committees (or delegated sub-committees)** have responsibility to review all medication related incidents reported through IMS+, identifying trends and system errors, recommending and overseeing remedial actions, and reporting these to SESLHD Quality Use of Medicines Committee.

3.5 **Facility Safe Use of Medicines Committees (or delegated sub-committees)** are responsible for monitoring compliance with best practice, reviewing audit results and ensuring improvement plans are developed and implemented.

3.6 **All staff** are responsible for reporting medication-related incidents and near misses in the Incident Information Management System (IMs+)

3.7 **Medical staff** are responsible and accountable for their prescribing practice and participation in medication management processes including documentation and monitoring outcomes. This includes recording or updating of allergy status.

3.8 **Nursing staff** are responsible and accountable for administration of medicine and participation in medication management processes including documentation and monitoring outcomes. This includes recording or updating of allergy status.

3.9 **Pharmacy staff** are responsible and accountable for dispensing medication in accordance with legislation and supporting and participation in medication management processes including documentation and monitoring outcomes. This includes recording or updating of allergy status.

3.10 **Medical staff, pharmacists, nursing staff, patients and carers** should collaborate to ensure that:

- All changes to the patient's medications are discussed, understood, agreed and documented.
- Any barriers to the patient's ability to adhere to the prescribed medication regimen are identified and appropriate action is taken to alleviate barriers.
- All patients have a medication management plan completed.
- Patient's own medications are reviewed prior to discharge to determine whether they should be returned, relabelled or confiscated and destroyed, with the consent of the patient or carer.

3.11 Medical staff and ward pharmacists have the responsibility to ensure that:

- A BPMH is recorded at admission.
- Patients' current medications are reconciled at admission, all transfers of care and at discharge.
- All intentional changes to the patient's medications are documented throughout the admission and at discharge.
- All discrepancies identified on reconciliation are documented, followed up and resolved.
- All actual or potential medication-related issues, including AME's, and required actions are documented and addressed appropriately.

4. PROCEDURE

4.1 Documentation of Best Possible Medication History (BPMH)

At admission a BPMH is to be obtained and documented in the 'Document Medication by Hx' section of the eMEDs system (where used) or other designated place as agreed by the facility. The source(s) used to obtain the information must be documented using the compliance comments.

4.2 Documentation of Adverse Drug Reaction (ADR) history

The patient's previous ADR history must be confirmed and documented or updated, including reaction details (noting the specific medication, symptoms of the reaction and when the reaction occurred).

4.3 Assessment of current medications on admission

There should be a clear plan for all the medications documented in the patient's medication history. Intention to continue of discontinue each medication should be indicated through use of the 'Admission Conversion' tool in the eMEDs system (where used). A full explanation for all intentional changes to the pre-admission medications must be documented in the Health Care Record by the attending medical team and communicated to the patient where possible. The indication field in the eMM system or on the NIMC should be used to document the reason for prescribing each medication.

4.4 Medication reconciliation on admission

Medication reconciliation should occur for all patients at admission. Any discrepancies identified must be documented in the Health Care Record, followed up and resolved as appropriate.

4.5 Medication review during admission

All changes to the patient's current medications should be made in consultation with the patient/carer and documented in the Health Care Record by the attending medical team, including a full and clear explanation for the change. In addition, the indication field in the eMM system or NIMC should be used to document the reason for prescribing new medications. Actual or potential medication-related issues and required actions identified

by pharmacists should be documented as clinical interventions in the eMEDs system or other agreed place as defined by the facility.

4.6 Management of Adverse Drug Reactions

Actual or suspected ADRs should be clearly documented in the Health Care Record, and where appropriate, reported via IMs+.

When a new or suspected ADR occurs within the current episode of care it must be:

- Communicated to the patient / carer and next health care provider / GP on discharge
- clearly documented in the Health Care Record (paper and electronic) including the medicine name, reaction type, onset, severity and management
- added to any active paper-based medication charts
- reported to the facility Drug and Therapeutics / Medication Safety Committee, and
- reported to the TGA's Australian Adverse Drug Reaction Reporting System[5] (directly at: https://www.ebs.tga.gov.au/ebs/ADRS/ADRSRepo.nsf?OpenDatabase, or via MIMs at: www.mimsonline.com.au/Search/ADRSNotification.aspx), either by the identifying clinician, or by an agent on their behalf.

As per SESLHD Procedure SESLHDPR/292 - Hybrid Health Care Records section 4.3 [6], *"amendments must be completed in both the paper and electronic record management systems for consistency of data".*

4.7 Provision of medication information

Appropriate medication information must be provided to the patient/ carer throughout the admission to enable them to make informed decisions about their medicines; and to ensure safe and effective medicines use. This information should be provided to patients in verbal and written form as appropriate, and occasions of information provision should be documented in the Health Care Record.

4.8 Transfers of care

At all transfers of care, comprehensive, clear and accurate medication information must be provided to the next care provider at the time of transfer or as soon as possible after.

At all transfers of care, both the sending and receiving teams should perform medication reconciliation, including review of the BPMH and the pre-and post-transfer medications. Any intentional changes to the patient's medications made at transfer must be documented in the health care record and any discrepancies identified must be documented, followed up and resolved as appropriate.

4.9 Patient discharge

At discharge the medical officer should determine the most appropriate discharge medication regimen for the patient by reviewing the BPMH, current inpatient medications and information documented in the Health Care Record. All changes to the patient's medication regimen should be communicated to ongoing care providers in the discharge summary. The ongoing plan for the medications should be communicated, including

review dates and monitoring requirements. Where short-term opioids are prescribed for pain management, the need for timely review should be highlighted.

Where involved in the patient's discharge, the pharmacist must review the BPMH and reconcile current inpatient orders to ensure that the medication list in the discharge summary and/or the discharge prescription contain accurate and comprehensive information. Any discrepancies identified must be followed up and resolved as appropriate. Following discussion with the prescriber, pharmacists may update the discharge summary in accordance with SESLHDPR/327 – Medicine: Utilising medication information from the electronic Medical Record (eMR) in the electronic Discharge Referral Summary (eDRS) for medication supply at discharge [(7)].

On discharge from hospital, patients should be provided with a clear explanation of any changes that have been made to their medicines and the ongoing plan for their medications. Most patients should be provided with an updated list of medicines in a format they can understand, noting that this is considered mandatory for 'high-risk' patients in accordance with individual facility business rules. Advice regarding ongoing supply should be provided.

Patient's own medications should be reviewed at discharge to determine whether they should be returned, relabelled or confiscated and destroyed. Patient or carer's consent must be obtained prior to confiscation or disposal of patient's own medications, including Schedule 8 medications [(2,8)]. Where consent is not granted by the patient or carer, the matter should be escalated to a medical officer suitably qualified to assess:

- The patient's continuing risk of self-harm (e.g. where the patient has been admitted with deliberate self-poisoning)
- The patient's decision-making capacity [(8)].

Where the medication is no longer appropriate but the patient or carer does not provide consent for disposal, and a suitably qualified medical officer has deemed the patient capable of decision-making, the dispensing label on the medication should be crossed out, dated and recorded as stopped prior to returning the medication to the patient [(8)].

5. DOCUMENTATION

All documentation must be accurate and fully completed according to applicable policies and professional standards.

Health Care Record, including electronic medical records
Incident Information Management System (IMs+)
Medication charts, including the National Inpatient Medication Chart (NIMC) and any other approved specialised medication charts in use
Approved eMM systems
Adverse Drug Reaction Report Form
Discharge summary or electronic Discharge Referral System (eDRS)
Patient-friendly medication list (generated from iPharmacy or eMM system)

6. AUDIT

The following National Quality Use of Medicines Indicators for Australian Hospitals[9] may be used for auditing compliance with National Safety and Quality Health Service Standard 4: Medication Safety[1]. At a minimum, the documentation and reconciliation of current medications at admission must be audited utilising indicator 3.1 [Percentage of patients whose current medications are documented and reconciled at admission] and reported to SESLHD QUMC annually.

Other examples of indicators for assessing compliance with Continuity of Management and Documentation include:

3.2 Percentage of patients whose known adverse drug reactions are documented on the current medication chart
5.3 Percentage of discharge summaries that include medication therapy changes and explanations for changes
5.4 Percentage of patients discharged on warfarin that receive written information regarding warfarin management prior to discharge
5.5 Percentage of patients with a new adverse drug reaction (ADR) that are given written ADR information and a copy is communicated to the primary care clinician
5.6 Percentage of patients with asthma that are given a written asthma action plan at discharge and a copy is communicated to the primary care clinician
5.9 Percentage of patients who receive a current, accurate and comprehensive medication list at the time of hospital discharge
6.2 Percentage of patients that are reviewed by a clinical pharmacist within one day of admission
7.3 Percentage of patients who receive written and verbal information on regular psychotropic medicines initiated during their admission

The Clinical Excellence Commission (CEC) Continuity of Medication Management Program[10] provides additional alternative audit tools.

The regular use of eMEDs reports EM002, EM003 and EM008 by facilities is encouraged audit compliance with this procedure.

7. REFERENCES

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards
2. NSW Health Policy Directive PD2013_043 - Medication Handling in NSW Public Health Facilities
3. NSW Health Policy Directive PD2020_045 High-Risk Medicines Management
4. Guiding principles to achieve continuity in medication management. Australian Pharmaceutical Advisory Council (APAC) July 2005
5. Australian Adverse Drug Reaction Reporting System, Therapeutic Goods Administration
6. SESLHDPR/292 - Hybrid Health Care Records
7. SESLHDPR/327 – Medicine: Utilising medication information from the electronic Medical Record (eMR) in the electronic Discharge Referral Summary (eDRS) for medication supply at discharge
8. NSW Health Safety Notice 008/18: Return of Patient's Own Medications, July 2018
9. National Quality Use of Medicines Indicators for Australian Hospitals: NSW Therapeutic Advisory Group, 2014
10. Clinical Excellence Commission Continuity of Medication Management

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
May 2013	Draft 0.1	Julie Thompson, D&QUMC Coordinator. Reviewed by Drug and Quality Use of Medicines Committee 09May2013 Reviewed by D&QUMC Pharmacy Directors Subcommittee 14May2013
May 2013	Draft 0.2	Julie Thompson, D&QUMC Coordinator. Incorporate revisions requested by D&QUMC Pharmacy Directors Subcommittee 14-17May2013. Release to LHD Draft for Comment process.
July 2013	Final Draft	Julie Thompson, D&QUMC Coordinator. Incorporate revisions from Draft for Comment process as reviewed and approved by Drug and Quality Use of Medicines Committee 11July 2013 Forward as final draft to policy officer.
Sept 2013	1	Approved by SESLHD Clinical Quality Council
Dec 2013	1.1	Reviewed and revised by Julie Thompson, D&QUMC Coordinator. Updated links, references and incorporated feedback from Quality Manager regarding documentation of adverse drug reactions.
Feb 2014	1.1	Reviewed and endorsed by SESLHD Drug and Quality Use of Medicines Committee
April 2015	2	Reviewed and revised by Julie Thompson, D&QUMC Coordinator at request of Clinical Governance Unit to require use of MMP and incorporation of recently released CEC toolkit. Reviewed and endorsed by SESLHD Drug and Quality Use of Medicines Committee (9 April 2015)
May 2015	2	Updated procedure endorsed by Executive Sponsor
March 2018	3	Reviewed and updated to align with eMM processes
May 2018	3	Major Review. Incorporated feedback from QUMC Pharmacy Subcommittee, Medication Safety Pharmacists group and Executive Sponsor.
May 2018	3	Draft for Comment
July 2018	3	Endorsed by SESLHD Quality Use of Medicines Committee Endorsed by SESLHD Clinical and Quality Council
February 2019	4	Minor update endorsed by Executive Sponsor to include details around appropriate return of patient's own medications at discharge in accordance with NSW Health SN:008/18
March 2019	4	Approved by Quality Use of Medicines Committee and Clinical and Quality Council.
January 2022	5	Minor Review terminology and definitions updated by Erica Wales, QUM Lead Pharmacist.
February 2022	6	Approved by Executive Sponsor. Approved by SESLHD Quality Use of Medicines Committee.