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| EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR | Professor George Rubin  
Director of Clinical Governance |
| AUTHOR | Julie Thompson on behalf of SESLHD Drug and Quality Use of Medicines Committee (D&QUMC) |
| POSITION RESPONSIBLE FOR THE DOCUMENT | D&QUMC Co-ordinator  
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| KEY TERMS | Medicine management processes, current medications, best possible medication history (BPMH), medication reconciliation, medication management plan (MMP), 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 |
1. POLICY STATEMENT

SESLHD Drug and Quality Use of Medicines Committee (D&QUMC) promotes high quality, safe, evidence-based and cost-effective medicine use across all SESLHD facilities. This includes aiming for continuity in medication management by following the Australian Pharmaceutical Advisory Council’s (APAC) Guiding principles to achieve continuity in medication management \(^{(1)}\) in SESLHD facilities. This procedure supports these principles where they are not guided by NSW Ministry of Health ‘Medication Handling in NSW Public Health Facilities’ PD2013_043\(^{(2)}\).

2. BACKGROUND

‘The key to safe and appropriate management of medicines is a coordinated approach that supports and encourages continuity.’ \(^{(1)}\)

NSW Ministry of Health ‘Medication Handling in NSW Public Health Facilities’ PD2013_043\(^{(2)}\) details the legislative requirements and policies on drug storage, supply, prescribing, dispensing and administration in NSW public health facilities. Additional processes and documentation outlined in this procedure are essential in order to achieve teamwork and continuity in medication management and prevention of adverse medication events.

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. ADR may commonly be referred to as an allergy.

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

**Best Possible Medication History (BPMH):** The most accurate list of a patient’s current medications taken prior to admission and verified from a second source.

**Health Care Record:**

Comprises patient information that is a combination of information stored in an electronic format and / or in the traditional paper format.\(^{(3)}\)

**Medication:** Any prescription or non-prescription medicine, complementary medicine, diagnostic agent or recreational substance.
Medication Management Plan (MMP): A standardised form to facilitate accurate documentation and communication of information related to medicines. This form is used to record medications taken prior to admission, changes to medication during admission up to discharge, medication issues and actions taken during the episode of care, and relevant information to inform future medication planning. The form must be stored with the active inpatient medication chart/s. A suitable electronic format may be used if available.

Medication Reconciliation: A formal process of verifying and clarifying a patient’s intended medication regimen by comparing the BPMH to the patient’s ordered medication and addressing all discrepancies.

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 Drug and Quality Use of Medicines Committee (D&QUMC) provide leadership for medication management within SESLHD and provide advice regarding medications to Clinical Quality Council.

3.2 Operation managers are responsible for resource provision to support continuity of medication management within SESLHD facilities

3.3 All staff have access to the Incident Information Management System (IIMS) to report incidents and near misses relating to all aspects of medication management

3.4 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.

3.5 Facility Drug and Therapeutics / Medication Safety Committees have responsibility to review all medication related incidents reported through IIMS, identifying trends and system errors, recommending and overseeing remedial actions, and reporting these to SESLHD Drug and Quality Use of Medicines Committee.

3.6 Facility Drug and Therapeutics / Medication Safety Committees are responsible for monitoring compliance with best practice, reviewing audits results and ensuring improvement plans are developed and implemented.
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 Pharmacists are responsible and accountable for dispensing medication in accordance with legislation, supporting and participating 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 any barriers to the patient’s ability to adhere to the prescribed medication regimen are identified, the appropriate action then taken to alleviate barriers, and fully support the medication management processes including documentation to achieve continuity of care. Particular care must be exercised with ‘at risk’ populations.

3.11 Medical officers and pharmacists have the responsibility to ensure patient’s current medications are reconciled and the reconciliation documented at admission, all transition points and discharge. At admission means completion by the end of the next calendar day after admission.\(^{(5)}\)

4. PROCEDURE

4.1 Best Possible Medication History (BPMH)
An accurate and complete medication history is to be obtained, documented on the Medication Management Plan (MMP) or National Inpatient Medication Chart (NIMC) and verified according to the process described in the National Medication Management Plan User Guide\(^{(4)}\) as early as possible in the episode of care, preferably within 24 hours of admission. This includes previous ADR history and should include the time of occurrence, medication name, and resultant symptoms or reaction recorded in the Health Care Record (paper and electronic).

4.2 Assessment of current medication management
From as early as possible and throughout each episode of care, current medicines are to be assessed to ensure the quality use of medicines. This assessment should be fully documented in the Health Care Record with issues and required actions documented on the MMP.
Assessments revealing adverse medicine events should be noted on the MMP and when relating to the current episode of care reported via IIMS and updated in the Health Care Record (paper and electronic).

When an adverse medicine event within the current episode of care is an Adverse Drug Reaction (ADR) it additionally must be:
- clearly documented in the Health Care Record (paper and electronic) including the medicine name, reaction type, onset, severity and management
- added to each active medication chart
- reported to the facility Drug and Therapeutics / Medication Safety Committee, and

As per SESLHD Procedure ‘Hybrid Health Care Records’ SESLHDPR/292 section 4.3 (3), “amendments must be completed in both the paper and electronic record management systems for consistency of data”.

Any new or suspected ADR must be reported and documented in this manner.

### 4.3 Medication Management Plan

A medication management plan should be developed based on information gathered from the Best Possible Medication History (BPMH) and assessment of medication management. It is a continuing plan within the context of overall management and should include actual and potential medication management issues identified, goals of medication management, and evidence based actions required to address issues and/or achieve goals. This should be documented on the MMP or NIMC and retained with the current medication chart/s.

### 4.4 Medication Reconciliation

Medication reconciliation should occur as soon as possible after admission and upon each transfer of care, including discharge. It is recorded on the MMP or NIMC.

### 4.5 Medication Information

Well timed medicine information, both verbal and written, must be provided to the patient/carer prior to discharge to enable safe and effective medication use. An accurate comprehensive current medication list, recent changes and advice regarding ongoing supply should be minimum inclusions in one clear and concise package with discharge medications and/or return of patient’s medications.

An entry outlining each occasion of supply must be recorded in the Health Care Record.
4.6 Transfer of Care

Comprehensive, clear and accurate medicine information must be provided to the health care provider in a timely manner when the patient is transferred to the next episode of care.

For inpatient transfer this may be facilitated by the MMP. The MMP must be retained in the Health Care Record at discharge.

At discharge this must comply with the minimum requirements stipulated in relevant policies including information on all changes to medicines, and a copy included in the Health Care Record.

5. DOCUMENTATION

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

- Health Care Record, including Electronic Medical Record (EMR)
- Medication Management Plan (MMP) or any suitable electronic alternative
- Incident Information Management System
- Medication charts, including the National Inpatient Medication Chart (NIMC) and any other specialised medication charts in use
- Adverse Drug Reaction Report Form
- Discharge summary or electronic Discharge Referral System (eDRS)
- Medication list (generated from iPharmacy)
- Personally Controlled Electronic Health Record (PCEHR)

6. AUDIT

At a minimum, current medicines are documented and reconciled (A) at admission and (B) at transfer of care between healthcare settings must be audited utilising indicator 3.1 (listed below) and reported to SESLHD D&QUMC annually.

The following Indicators for Quality Use of Medicines in Australian Hospitals\(^6\) may be selectively used for audit purposes as required:

- 3.1 Percentage of patients whose current medications are documented and reconciled at admission
- 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
5.7 Percentage of patients receiving sedatives at discharge that were not taking them at admission

6.2 Percentage of patients that are reviewed by a clinical pharmacist within one day of admission

Self-auditing to comply with National Safety and Quality Health Service Standards Medication Safety Standard 4(8) is encouraged.

7. REFERENCES

- Guiding principles to achieve continuity in medication management. Australian Pharmaceutical Advisory Council (APAC) July 2005
- NSW Ministry of Health ‘Medication Handling in NSW Public Health Facilities’ PD2013_043
- SESLHD Procedure ‘Hybrid Health Care Records’ SESLHDPR/292
- SHPA Standards of practice for clinical pharmacy
- Indicators for Quality Use of Medicines in Australian Hospitals: NSW Therapeutic Advisory Group, 2007
- Australian Adverse Drug Reaction Reporting System, Therapeutic Goods Administration
- National Safety and Quality Health Service Standards

8. REVISION AND APPROVAL HISTORY

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<tr>
<th>Date</th>
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