SESLHD PROCEDURE COVER SHEET

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KEY TERMS	Medicine management processes, current medications, best possible medication history (BPMH), medication reconciliation, roles & responsibilities, medication management plan, transfer of care, discharge, adverse drug reactions (ADR), quality use of medicines (QUM)
SUMMARY	Define roles and responsibilities in completion of medication management tasks across in scope SESLHD inpatient sites. 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. Review medications throughout admission to ensure safety and optimisation of care. 4. Engage patients and carers in shared decision-making regarding medication management

Contents

1. POLICY STATEMENT

SESLHD Drug and Therapeutics Committee (DTC) 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 in scope 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 PD2022_032 - Medication Handling [2] and NSW Health Policy Directive PD2024_006 - High-Risk Medicines Management [3] and the National Safety and Quality Health Service Standard 4: Medication Safety [1].

2. SCOPE:

When commencing an episode of care for a patient who is likely to be admitted as an inpatient to one of the following SESLHD facilities:

- Prince of Wales Hospital
- Royal Hospital for Women
- St George Hospital
- Sydney Hospital & Sydney Eye Hospital
- The Sutherland Hospital
- SESLHD Mental Health Inpatient Services

3. BACKGROUND

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

NSW Health Policy Directive PD2022_032 - Medication Handling [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.

3.1. Definitions

Admitting Medical Officer (AMO): is the consultant, surgeon, or specialist medical practitioner under whom the patient is being admitted.

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.

Medicine allergies and ADRs can be classified as:

- Known – those that have been previously experienced by the patient before their episode of care
- New – those that are experienced by patients during their episode of care and have not been previously experienced or documented.

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.

Authorised Clinician: For the purposes of this document an authorised clinician is a health professional who has received appropriate training in the completion of medication management tasks within their scope of practice.

Authorised Prescriber: a health professional approved by the facility to directly prescribe medications (e.g. medical officer or nurse practitioner), but only in accordance with any practice conditions imposed by the person's place of employment and the endorsements, notations and conditions on the person's health practitioner registration (such as a nurse prescribing in line with a standing order).

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 information source (e.g. patient's own medicines, patient medication list, community pharmacist, GP etc.) [5]. The BPMH should also include an assessment and documentation of any previous medication related allergies/ADRs including timing and details of the reaction. For low-risk patients, if a clinician is confident that a medication history obtained using a single information source is complete and accurate and does not require further verification, this may be signed off as a Best Possible Medication History.

Checkpoint 1: A review within 24 hours of admission by the admitting medical team, to determine the current medication history and reconciliation status for each patient under their care, with an action plan documented to ensure completion if not already complete.

Checkpoint 2: Monitoring the status of pending pharmacist referrals for medication history/reconciliation for high-risk patients to ensure completion within agreed timeframes.

Checkpoint 3: Monitoring the status of pending pharmacist referrals for medication review for high-risk patients to ensure completion within agreed timeframes.

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.

eMR: Within this procedure, eMR relates to the Cerner electronic medical record used for documentation of the Health Care Record across SESLHD acute facilities.

eTOC: electronic Transfer of Care

eHOC: electronic Handover of Care

Health Care Record: Comprises patient information that is a combination of information stored in an electronic format and / or in the traditional paper format [6]. Information recorded in electronic medication management systems forms part of the patient's overall Health Care Record.

High Risk/Complex Patient: A patient identified as being at high-risk of medication related harm or who has a complex medication history due to a either combination of risk factors or identification through use of a risk modelling tool.

Certain medical, medication, social and environmental factors may increase a patient's risk of medication misadventure within the hospital setting or may increase complexity and time required to confirm an accurate medication list.

The following are commonly identified risk factors:

- Age >65 years
- >8 regular medications
- Renal or hepatic impairment
- High risk medications (e.g. **A**nti-infectives, **P**otassium and electrolytes, **I**nsulin, **N**arcotics (opioids & sedatives), **C**hemotherapeutic agents, **H**eparin and other anticoagulants)
- Time critical medications (e.g. Anticonvulsants, medications to treat Parkinson's Disease)
- Multiple chronic comorbidities
- Complex medication regimen (e.g., transplant patients or patients receiving chemotherapy treatment, medications obtained overseas)
- Non-English-speaking background/interpreter required
- Lives alone
- Known/suspected poor medication compliance
- Difficulty managing medications at home due to factors such as dementia, cognitive impairment, or dexterity problems, literacy or language barriers or impaired sight
- Multiple prescribers
- Medication related admission to hospital
- Re-admission to hospital within 4 weeks of discharge
- Transitions of care – e.g., transfer from ICU to general ward

- Developmental disability - people with developmental conditions are at higher risk of being represented across multiple risk domains. On admission, people with developmental conditions are at higher risk of inconsistent record keeping, or with absent pharmacological information. Subsequent transfer of care to the community (e.g. into NDIS service settings) may potentially compromise the medication reconciliation process.

Initial Medication History: The first attempt at documentation of a medication history after a patient presents to hospital. When the initial medication history is taken all attempts should be made to verify the medication list with the patient/carer plus at least one additional information source. The information obtained and status of the medication history should be documented as per section 5.1.

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

Medication Management: Collective term to include BPMH, medication reconciliation and medication review activities.

Medication Reconciliation: A dynamic, 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 [5].

Medication Review: A systematic 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 [5]. Issues identified and outcomes should be made in the partnership with patients and documented in the health care record.

Types of Medication Review:

- Medication Order Review (address issues relating to individual medication orders/validity)
- Medication Adherence Review (Patient interview to identify actual medicines use and technique)
- Clinical Medication Review (comprehensive review of a patient's conditions, medicines and appropriateness)

Medication Safety Committee (MSC): Facility level Safe Use of Medicines, Medication Safety or otherwise named Committee responsible for promoting and supporting the safe use of medicines, facility level monitoring and evaluation of medication related incidents and ensuring compliance with the National Safety and Quality in Healthcare Medication Safety Standard (Standard 4) [1].

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.

Referral: is a documented request for review by another clinician or health professional.

4. ROLES & RESPONSIBILITIES: COMPLETION OF MEDICATION MANAGEMENT TASKS:

The **Admitting Medical Officer** is ultimately responsible for ensuring a Best Possible Medication History is completed (including assessment and documentation of any known allergies/ADRs), Medication Reconciliation occurs at all transitions of care and Medication Reviews are completed based on a patient's clinical needs and minimising the risk of medication-related problems.

Authorised prescribers may only prescribe medications for patients under their care. Authorised prescribers are responsible for ensuring that medication orders comply with NSW Health Policy Directive PD2022_032 [2] requirements, formulary requirements, and are clinically appropriate within the context of the patient's current medical condition, allergy history and other prescribed treatments.

Pharmacists are responsible for proactive review and completion of medication management tasks, prioritising high risk/complex patients.

A process for referring high risk/complex patients for pharmacist review is available to medical officers, midwives, nurses and allied health clinicians. Referral criteria is defined for each site/service. Pharmacists will review referrals, accept those that meet the criteria and of which the pharmacist has capacity to undertake. The pharmacist will inform the referrer if the referral is not accepted.

For patients admitted to Intensive Care Units, the medication history should be documented within Cerner eMR as per section 5.1 of this procedure. Admission reconciliation should occur via line-by-line comparison of the documented medication history against all medication orders within the electronic Record of Intensive Care (eRIC). Documentation of admission reconciliation and medication reviews should follow an approved process endorsed by the site Medication Safety Committee.

4.1. Best Possible Medication History (BPMH) & Admission Reconciliation

4.1.1 Initial Medical Officer (or pharmacist, nurse practitioner or another authorised clinician) responsibilities:

- Completing an initial medication history including assessment and documentation of any known allergies/ADRs as per section 4.2.

- Documentation of the medication history within the Document Medication by Hx section of the eMR, including for patients who take no regular medications.
- Completing the checkbox (see below) to indicate if the medication history is complete (unticked = BPMH) or incomplete (ticked = further verification of the medication history is required).

- Where a medication history is documented as 'incomplete' – document within the clinical notes, what further actions are required to verify the medication history.
- Completing a pharmacist referral for high-risk or complex patients where a BPMH was not achievable during the initial clinician's review.

4.1.2 Initial Authorised Prescriber responsibilities:

- Using the Admission Reconciliation function in eMR to reconcile the medications a patient was taking at home, prior to their hospital admission. Reconciliation involves using the green "Play" and red "Stop" buttons to decide which medications should be continued on admission and charted on the Medication Administration Record (MAR). (Refer to Admission Reconciliation QRG)
- Documenting in the clinical record the reason for any changes made to the medications the patient was taking at home, prior to admission to hospital.

In the case of an emergency where medications are required to be prescribed PRIOR to completion of BPMH and medication reconciliation OR patient is transferred PRIOR to BPMH and medication reconciliation being completed, these tasks must be completed at the earliest opportunity, within the first 24 hours of admission. If use of the Admission Reconciliation function is deemed unsuitable in this situation, then reconciliation should occur manually by line-by-line comparison of the BPMH against all current inpatient orders.

4.1.3 Admitting medical team responsibilities:

- **Checkpoint 1 (within 24 hours of admission):** Reviewing and confirming the status of the initial medication history and admission reconciliation within the Medication List or Orders tab of the eMR for the current admission and making a plan for completion if not already achieved.
- If no medication history has been documented or the medication history is incomplete (requires further verification), it is the responsibility of the admitting medical team to either:
  - Complete a BPMH and document this within the Document Medication by Hx section of the eMR, unticking the 'leave medication history incomplete – finish later' box if an accurate and complete medication history has been confirmed.
  - Order a pharmacy consult for 'Medication History/ Reconciliation' if unable to complete AND the patient is deemed to be high-risk or complex.

- Reviewing the patient's home medications in the context of their current presentation and clearly documenting within the Health Care Record, the plan for medication management within hospital including the rationale for any intentional medication changes.
- Ensuring allergies/adverse drug reactions have been investigated and documented in the allergy section of the eMR as per section 4.2.
- Utilising the Admission Reconciliation function in the eMR to action any required changes to the medication chart resulting from any changes made to the initial medication history.
- **Checkpoint 2:** Monitoring of referrals made to pharmacy for Medication History/ Reconciliation and following up to ensure response or completion within one working day.

4.1.4 Heads of Department responsibilities:

- Ensuring systems are in place within their department to ensure that **Checkpoint 1** is completed within 24 hours of admission for all patients admitted to their service.
- Reviews to demonstrate compliance with this policy.

4.1.5 Pharmacist responsibilities:

- Proactively identifying high-risk/complex patients for completion of BPMH, admission reconciliation, and allergy/ADR history as per section 4.2.
- Monitoring and responding to referrals for completion of BPMH and admission reconciliation within agreed timeframes.
- Where a referral is not accepted, or not able to be completed within the agreed timeframes, the pharmacist is responsible for communicating directly with the admitting team as soon as possible (including follow up to ensure response received) and documenting the resulting agreed plan within the Health Care Record.
- Communication with the relevant medical teams and follow up to ensure any identified medication related problems are resolved as soon as possible.
- Documentation of any medication plans agreed with the treating medical officer(s) as a result of identified medication related problems or potential for optimisation of therapy.
- Follow up to ensure that recommendations have been actioned, or documenting the rationale in the case of a recommendation not being accepted or actioned.
- **Checkpoint 2:** Referrals for Medication History/Reconciliation in high-risk/complex patients are completed or responded to:
  - By close of business for referrals received before 12:00pm
  - Within 24 hours, for referrals received after 12:00pm

Table 1.0 Responsibility for responding to pharmacy referrals across SESLHD sites

Facility	Mon – Fri	Sat-Sun
Prince of Wales Hospital	Site Pharmacy service	Medication Management Team
St George Hospital	Site Pharmacy service	Medication Management Team
Royal Hospital for Women	Site Pharmacy service	Medication Management Team
The Sutherland Hospital	Site Pharmacy service	Medication Management Team
Sydney/Sydney Eye Hospital	Site Pharmacy service	No clinical pharmacy service available

4.1.6 Director of Pharmacy responsibilities:

- Ensuring systems are in place within their department to ensure that **Checkpoint 2** is completed within agreed timeframes.

4.1.7 Nurse/Midwife responsibilities:

- Royal Hospital for Women – refer to Appendix B Royal Hospital for Women medication history workflow for obstetric patients presenting to the Birthing Unit.
- Supporting BPMH completion by facilitating access to information sources (e.g. patient's own medication lists, ensuring patient own medications are stored as per policy).
- Communicating to the relevant medical officer/pharmacist, information obtained from patient/carers regarding medications or medication related problems.
- Obtaining and documenting allergy/ADR history information as per section 4.2.
- Maintaining working knowledge and compliance with storage and handling of medications.
- Ensuring physical assessment information is documented to support safe prescribing (e.g. height, weight, observations etc).
- Ordering a pharmacy consult for 'Medication History/ Reconciliation' if the patient is deemed to be high-risk or complex AND BPMH not completed within 24 hours of admission, AND/OR is admitted under inpatient midwifery care.
- **Checkpoint 2:** Monitoring the status of pending pharmacist referrals for high-risk patients and prompting relevant staff to ensure completion of referrals including resolution of any documented issues resulting from reviews.

4.1.8 Nurse/Midwife Unit Manager/Team Leader responsibilities:

- Ensuring systems are in place so that **Checkpoint 2** – monitoring and tracking of referrals for high-risk patients via the Electronic Patient Journey Board – is incorporated into daily ward meetings or processes.

4.2. Adverse Drug Reactions

To minimise the risk of preventable harm from adverse drug events, it is critical to ensure that clinicians understand their responsibility to maintain accurate records of known and new adverse drug reactions and to ensure checks are performed before prescribing, dispensing or administering medicines.

Accurate assessment, documentation and communication of patient allergies/ADRs is a responsibility of all clinicians involved in patient care.

4.2.1 Take and Document Allergy/ADR History

- The initial authorised clinician to review the patient is responsible for taking an allergy/ADR history and documenting this in the appropriate section of the eMR (as per eMEDS – Adding Allergy Status QRG) and on any paper charts.
- The assessment of any known allergies/ADRs should include where possible the following information:
  - The name of the medicine/causative agent
  - When the reaction occurred
  - Details of the reaction and
  - Any treatment/management required

4.2.2 Check for Allergies/ADRs continuously

- All **authorised prescribers** are responsible for checking the patient's allergy/ADR history and assessing the safety of any new medication **prior to prescribing.**
- All **authorised clinicians** are responsible for checking the patient's allergy history **prior to administering or dispensing** any medication, fluid or therapeutic product and before performing any therapeutic interventions.
- All **authorised clinicians** are responsible for updating the allergy section of the eMR and any paper based medication charts whenever any new allergies/ADRs are identified and/or when new/additional information becomes available.

4.2.3 New Allergies/ADRs

All **authorised clinicians** are responsible for:

- Communicating details of any new allergies/ADRs to the patient/carer and next health care provider/GP on discharge.

- Clearly documenting in the Health Care Record (paper and electronic) the medicine name, reaction type, onset, severity, and details of any management provided.
- Addition of the ADR to any active paper-based medication charts.
- Reporting to the facility Medication Safety Committee, and
- Reporting the ADR to the Therapeutic Goods Administration (TGA). This can be done by submitting an online form to the Adverse Event Management System (AEMS) at Home - Adverse event reporting or by notifying Pharmacy of the ADR who may submit the TGA report on the clinician's behalf. TGA reporting may also be performed by clicking on the 'Report an Adverse Reaction' link within eMIMS Medicines Information pages.

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

4.3. Medication Reviews:

4.3.1 Admitting Medical Team responsibilities:

- Regularly reviewing the medication chart for every admitted patient under their care (e.g. during every ward round). This may include paper charts (e.g. pain management infusions) or medications recorded in other electronic systems (e.g. MOSAIQ). At each review, considering the appropriateness and optimisation of medications in the context of the patient's current condition and treatment goals.
- Responding to changes in medication related risk by ensuring a medication review is completed within 24 hours of a change in risk being identified (for example identification of a medication related problem by a pharmacist/nurse or use of an electronic risk monitoring tool) by either:
  - Completing a medication review or
  - Referring the patient for medication review by a pharmacist or specialised stewardship team if appropriate.
- Checkpoint 3: Monitoring referrals made for pharmacist medication review and following up to ensure response or completion within 24 hours.
- Complete relevant medication order reviews when prescribing or changing a patient's medications.
- Acknowledge, make and document decisions regarding recommendations made by pharmacists, specialised stewardship teams or other health professionals.
- Involve the patient and/or carer in care decisions that are being recommended as a result of medication review activities.
- Document completed medication reviews in the patient's medical record including when no changes are necessary.

4.3.2 Pharmacist responsibilities:

- Proactively identifying high-risk patients for ongoing medication reviews
- Checkpoint 3: Actively monitoring referrals and ensuring referrals are completed or responded to within 24 hours (during pharmacy business hours).
- Providing ongoing medication reviews throughout admission for identified high-risk patients
- Documentation of any relevant issues identified within the eMR using an appropriate note type (as per Pharmacy Documentation Guidelines)
- Completion of the Pharmaceutical Review task each time a medication review is performed, including when no issues are identified.
- Communication with the relevant medical teams and follow up to ensure any identified medication related problems are resolved as soon as possible.

4.3.3 Nurse/Midwife responsibilities:

- Documentation of physical assessment information and escalation of any issues impacting medication management (e.g. new allergies, adherence issues, intolerance of medication form (syrup, tablets etc) or significant change in weight etc).
- Completion of medication review activities appropriate with their clinical training and scope of practice (e.g. a Nurse Practitioner performing clinical medication reviews for medications relevant to their specialisation, a relevant Clinical Nurse Consultant assessing a patient's inhaler technique or insulin management etc.)
- Referring patients that are at high risk of medication-related problems (by risk criteria or by discretion) for medication review by the attending medical team, a pharmacist or a specialised stewardship team.
- Checkpoint 3: Monitoring the status of any pending referrals for high-risk patients via the Electronic Patient Journey Board and prompting relevant staff to ensure these are completed and any issues resulting from reviews are resolved.

4.4. Transfers of care

4.4.1 Medical Officer responsibilities:

- At all transfers of care, both the sending and receiving teams are to perform medication reconciliation, including review of the BPMH and the pre-and post-transfer medications prescribed.
- Any intentional changes to the patient's medications made at transfer must be comprehensively communicated. Changes must be documented in the health care record and relevant staff notified (e.g. nursing staff arranging the transfer) to ensure the latest correct information is shared with the patient on transfer. Any discrepancies identified must be documented, followed up and resolved as soon as possible.

- If medications are required during transfer, the sending medical officer is responsible for printing and checking an Offline Medication Administration Chart and handing over this information to all clinical staff involved in the transfer as per eMR QRG Patient Transfer Print .
- On transfer of patients from ICU to a general ward, medication reconciliation is to be performed by the discharging medical officer via use of the eMR electronic Transfer of Care (eTOC) functionality. The electronic Handover of Care (eHOC) document should be available for review in Cerner eMR when a patient is transferred to a general ward.
- When receiving a patient who has been transferred from ICU to a ward, ensure that medication reconciliation is performed by either a pharmacist or medical officer, via review of the eHOC, any paper medication charts, medication history documentation and relevant medical notes.

4.4.2 Pharmacist responsibilities:

- Proactively identifying and performing medication reconciliation for patients at high risk of adverse medication events due to transfer between care locations.
- Monitoring and responding to referrals for high-risk patients identified who require transfer reconciliation.
- Documentation of any relevant medication issues identified within the eMR using an appropriate note type (as per Pharmacy Documentation Guidelines).
- Communication with the relevant medical teams and follow up to ensure any identified medication related problems are resolved as soon as possible.

4.4.3 Nurse/Midwife staff responsibilities:

- Documentation of physical assessment information to support safe reconciliation.
- Ensuring printed transfer documents reflect the latest information where electronic prescribing does not flow between care settings.
- Monitoring the status of any pending referrals for high-risk patients and prompting relevant staff to ensure these are completed and any issues resulting from reviews are resolved.

4.5. Discharge Reconciliation

4.5.1 Admitting Medical Team responsibilities:

- Documentation of the rationale for any changes to the patient's usual medications in the discharge summary. This can be documented in either the free text of the document or in the special instructions field for each medication during discharge reconciliation.

- Documentation of any further planned changes and/or monitoring requirements related to medications within the discharge summary.
- Communication to discharge nurse/ midwife/ pharmacist of any changes or concerns regarding discharge medications to ensure clear messaging to patient/carer.
- Ensuring the discharge medication list and explanation of any changes has been provided to the patient/carer and the next care provider.
- Ensuring the patient is provided with information to support ongoing supply of relevant medications after discharge.
- Referral to pharmacy for high-risk patients requiring a patient medication list at discharge.
- Referral to community liaison pharmacy services (where available and with patient consent), for ongoing medication management support in the community.

4.5.2 Pharmacist responsibilities

- Performing discharge reconciliation by proactive review of identified high-risk patients, and for any patient where medication is being supplied via the inpatient pharmacy on discharge.
- Documentation of any issues identified through discharge reconciliation using an appropriate note type in the eMR as per Pharmacy Documentation Guidelines.
- Communication of any discrepancies identified through discharge reconciliation to the appropriate medical officer and follow up to ensure resolution.
- Provide a patient-friendly medication list for identified high-risk patients and any other patient that is deemed suitable, where possible/appropriate.
- Support medical officers in ensuring the discharge medication list and explanation of any changes has been provided to the patient/carer and the next care provider.
- Provide discharge medication counselling where possible/appropriate.
- Identify appropriate patients who may benefit from medication review or additional medication support in the community. Obtain patient consent and actively refer consented patients for review by district community liaison pharmacists.

4.5.3 Nurse/Midwife responsibilities

- Supporting discharge reconciliation efforts undertaken by medical officers and pharmacists. This should include checking that patients/carers have been provided with a list of medicines they can understand and an explanation of any changes.
- Monitoring and checking that any outstanding medication review referrals have been completed prior to discharge.
- Ensuring discharge medications or prescriptions required for continuity of medication management have been provided to the patient/carer prior to discharge.

- Review of patients own medications at discharge to determine if they should be returned, relabelled, confiscated, or destroyed in accordance with the SESLHDPR/758 - Patients' Own Medications (POMs) – Handling and Storage in Hospital.

4.6. Provision of medication information

4.6.1 All Clinicians responsibilities:

- Actively involving the patient and carer(s) whenever possible in conversations regarding changes to medications to enable them to make informed decisions about their medicines; and to ensure safe and effective medicines use. Discussions regarding changes to medications should wherever possible occur at the time that changes are made and should be documented within the Health Care Record.
- Providing information on management of any new medications including possible adverse effects, monitoring requirements and ongoing management plans.
- Providing information to support patients with ongoing supply of medications.
- Providing information to patients in verbal and written form as appropriate, and documentation of information provided in the Health Care Record.

5. DOCUMENTATION OF MEDICATION MANAGEMENT TASKS

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

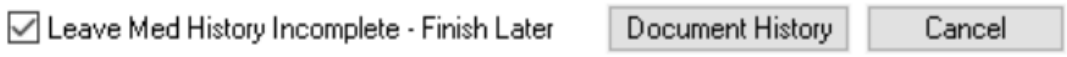
- Health Care Record, including electronic and paper medical records
- Incident Information Management System (IMs+)
- Medication charts, including the National Inpatient Medication Chart (NIMC) and any other approved specialised medication charts in use
- Approved eMM systems
- Adverse Drug Reaction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

5.1. Documentation of a Medication History:

Should be performed using the 'Document Medication by Hx' section of the electronic medical record for admitted patients. The status of a medication history can be viewed in the Medication List tab of the eMR.

For the purposes of documentation, communication, and reporting within the eMR:

The ‘Leave Med History Incomplete – Finish Later’ check box, is to be utilised as a marker for the status of a medication history. Within SESLHD acute facilities, the default status for medication histories is incomplete.



Incomplete Medication History: Leaving this box ticked indicates that the history is ‘incomplete’ and further confirmation of the medication history is required.

Best Possible Medication History: Unticking this box indicates that the medication history is ‘complete’, and meets the definition of a BPMH as set out in section 3.1.

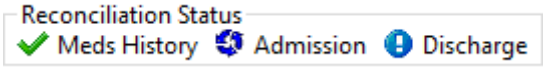
The preferred workflow for documentation of medication history information in the Cerner eMR is by using the ‘Document Medication by Hx’ function. Once entered, the partial or complete medication history can be imported automatically in General Exam Adult eMEDs and General Exam Paediatric eMEDs note types (or manually into any note type using the ‘Medication History (eMEDs) smart template (Refer to QRG Importing the Documented Medication by History into any Progress Note).

Where this is not possible and a medication history has been documented initially as free text within a document, we encourage staff to utilise the ‘Tear Off’ function (in the Action Toolbar of the eMR) to allow the medication history to remain visible while transcribing into the ‘Document Medication by Hx’ section of the eMR.

5.2. Documentation of Medication Reconciliation

Medication reconciliation by authorised prescribers, is documented through use of the ‘Admission Reconciliation’ and ‘Discharge Reconciliation’ functions within the eMR.

The status of reconciliation can be viewed within the Medication List or Orders tab of the eMR.



Where reconciliation has not yet been commenced there is a blue circle with white exclamation mark; a blue recycle icon identifies the process is in progress; and a green tick indicates that that step is complete.

Documentation of medication reconciliation by pharmacists, is via use of specific note types as outlined in Pharmacist Documentation Guidelines SESLHD.

5.3. Documentation of Medication Reviews

Medical Officers: In progress notes.

Pharmacists: By completion of the Pharmacy Medication Review task in eMR (indicating that the pharmacist has completed a medication order review for all orders on the MAR at that time), and/or in a relevant note type as per the Pharmacy Documentation Guidelines.

5.4. Referral for Pharmacist Review:

In ED: is to be requested by adding a Pharmacist Review HP set event. This generates a mortar and pestle icon within the 'To Do' column of the patient board.

Outside of ED: is to be ordered via the 'consult to pharmacy' function within the electronic medical record (refer to QRG eMEDS – Ordering Pharmacy Consults).

5.5. Response and actioning of Pharmacist Referrals

Pharmacy consults can be actioned by pharmacists by "ticking" the relevant task on the Census Task List Tab or the Task List tab. When a task is "ticked" or completed, the pharmacy consult will move to the next stage (e.g., Acknowledged to In Process to Complete).

The status of the consult can be viewed at any time via the Census Task List or Task List (pharmacists only) or the PHM column on the ward's Electronic Patient Journey Board (if this has been configured).

If a pharmacy consult is not appropriate and/or cannot be actioned by a pharmacist, the consult should be cancelled using the "Orders" tab in eMR. To do this, find the original order under the 'Consults' section, right click on the order then select 'cancel/discontinue'. Cancelling an order should only occur after discussion with the relevant referring medical team.

Referrals made within FirstNet should be completed by the relevant pharmacist after the review is complete by changing the status to 'complete'. If a FirstNet referral has not been actioned prior to the patient transferring to an inpatient ward, the system will automatically generate a pharmacy consult order that includes the name of the original requestor and the date/time.

6. ROLES AND RESPONSIBILITIES: GOVERNANCE OF MEDICATION MANAGEMENT:

- **SESLHD Drug and Therapeutics Committee** (DTC) provides oversight and governance for medication management within SESLHD and provides advice regarding medications to the Clinical and Quality Council.
- **General Managers or their delegates** are responsible for ensuring adequate staffing and equipment are available to support the continuity of medication management within SESLHD facilities in compliance with this procedure.
- **Facilities** are responsible for ensuring that a risk management approach is taken to implement strategies to support continuity for medication management.

- **Facility Medication Safety Committees** (or delegated sub-committees) are responsible for:
  - Reviewing all medication related incidents reported through IMS+, identifying trends and system errors, recommending and overseeing remedial actions, and reporting these to SESLHD Quality Drug and Therapeutics Committee.
  - Monitoring compliance with this procedure.
  - Reviewing facility level results for the compliance measures outlined below as provided monthly by the Medication Management Team to the Medication Safety Committees for evaluation.
  - Any additional reporting and audits required at departmental level.
  - Managing risks associated with reported rates, feedback of results to relevant departments and ensuring improvement plans are developed and implemented, and reporting quarterly to the SESLHD DTC.
- **All clinical staff** are responsible for reporting medication-related incidents and near misses in the Incident Information Management System (IMS+) and for compliance with this procedure.
- **Directors of Pharmacy** or their delegates are responsible for monitoring pharmacist completion rates of BPMH, medication reconciliation, medication review and completion of referrals. Ensuring a service model to meet the requirements of pharmacists within this procedure. They are responsible for escalation to the site Medication Safety (or however named) committee, any risks or issues related to compliance of pharmacy services with this procedure.
- **Medication Management Team** are responsible for monitoring and reporting of district wide completion rates for BPMH and medication reconciliation tasks, and pharmacist completion of Medication History/Reconciliation referrals. Escalation of any identified risks associated with completion of these tasks to the district DTC.

6.1. Medication Management Compliance measures provided by the Medication Management Team:

- Facility BPMH completion rate (all clinicians)
- Facility Admission Reconciliation rate (by Medical Officers & Pharmacists)
- Facility completion rate for pharmacist referrals – overall rate and completion within timeframes set out in this policy.

7. AUDIT

The following National Quality Use of Medicines Indicators for Australian Hospitals [8] 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.

The Clinical Excellence Commission (CEC) Continuity of Medication Management Program [5] provides additional alternative audit tools.

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

8. REFERENCES

[1] Australian Commission on Safety and Quality in Health Care, “National Safety and Quality Health Service Standards,” [Online]. Available: https://www.safetyandquality.gov.au/standards.

[2] NSW Health, “Policy Directive Medication Handling PD2022_032,” 11 August 2022. [Online]. Available: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2022_032.pdf.

[3] NSW Health, “Policy Directive High-Risk Medicines Management PD2020_045,” 17 November 2020. [Online]. Available: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_045.pdf.

[4] Australian Government Department of Health and Aged Care, “Guiding principles to achieve continuity in medication management,” November 2022. [Online]. Available: https://www.health.gov.au/sites/default/files/2022-11/guiding-principles-to-achieve-continuity-in-medication-management.pdf.

[5] Clinical Excellence Commission, “Continuity of Medication Management,” [Online]. Available: https://www.cec.health.nsw.gov.au/keep-patients-safe/medication-safety/cmm.

[6] “SESLHDPR/292 Hybrid Health Care Record Procedure,” August 2021. [Online]. Available: https://www.seslhd.health.nsw.gov.au/policies-and-publications/functional-group/71.

[7] Australian Government Therapeutic Goods Administration, “Australian Adverse Drug Reaction Reporting System,” [Online]. Available: https://www.ebs.tga.gov.au/.

[8] Australian Commission on Safety and Quality in Health Care, “National Quality Use of Medicines Indicators for Australian Hospitals,” 2014. [Online]. Available: https://www.safetyandquality.gov.au/sites/default/files/migrated/SAQ127_National_QUM_Indicators_V14-FINAL-D14-39602.pdf.

[9] NSW Health, “Safety Notice 008/18 Return of Patients' Own Medications,” 25 July 2018. [Online]. Available: https://www.health.nsw.gov.au/sabs/Documents/2018-sn-008.pdf.

9. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
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.

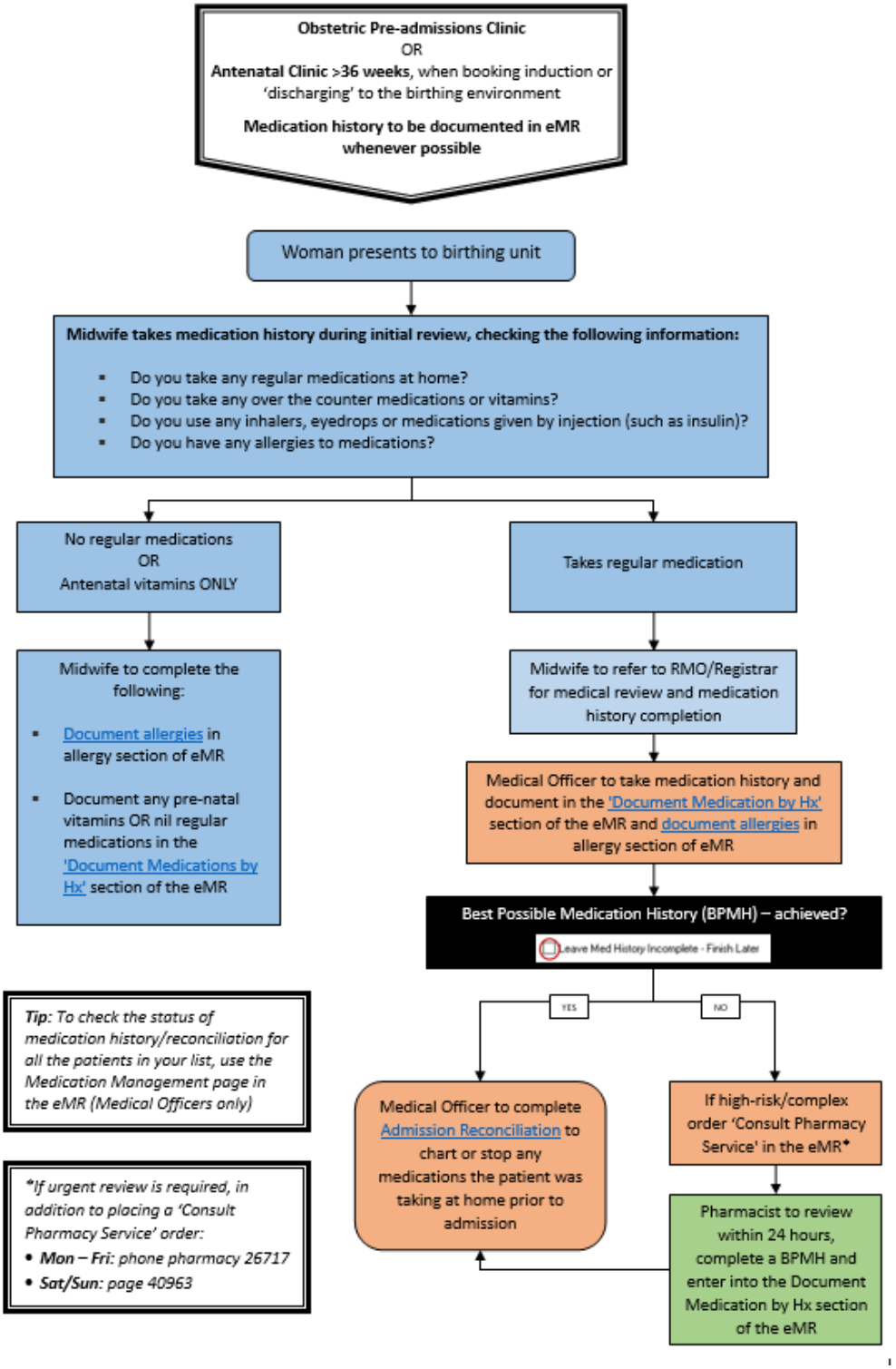
December 2023	7.0	Major review to clarify roles and responsibilities for clinicians in delivery of medication management tasks and standardisation across SESLHD sites. To be tabled at SESLHD Drug and Therapeutics Committee and SESLHD Clinical and Quality Council.
June 2024	7.1	Update to wording for medication history documentation for patients in Intensive Care Units. Update to High-Risk list to specify APINCH medications, addition of link to SESLHDPR/758. Addition of SESLHD Mental Health Inpatient Services to scope of document.
August 2024	7.2	Addition of developmental disability to list of risk factors for medication harm. Additional wording in Initial Clinician, Medical Officer and Pharmacist responsibilities in BPMH & Admission Reconciliation section to specify assessment and documentation of Adverse Drug Reactions. Addition of Appendix B Royal Hospital for Women Medication History Flowchart for Obstetric patients presenting to the Birthing Unit.
21 November 2024	7.3	Minor review. Update to allergy/ADR section and moved earlier in document. Addition of table of contents. Updated definitions of Authorised Clinician and Authorised Prescriber. Updated wording in document summary and policy statement to provide clarity that only in-scope SESLHD sites are covered by this procedure. Approved at SESLHD Drug and Therapeutics Committee.

10. APPENDIX A: SUMMARY OF ROLES AND RESPONSIBILITIES IN MEDICATION MANAGEMENT ON ADMISSION

Patient presents to hospital	Admission to treating team	Inpatient stay
Initial medical officer to review patient (OR Pharmacist, NP or Authorised Clinician).	**Medical Officer – Admitting Team**	**Medical Officer – Admitting Team**
• Take **initial medication history** & document in Document Medication by Hx section of eMR. • Completing the checkbox to indicate if further verification of the medication history is required. ☑ Leave Med History Incomplete - Finish Later Document History • Authorised prescribers only: Utilise Admission Reconciliation function to chart any medications required that the patient was taking at home. • Document in eMR notes, the reason for any medication changes. • High risk/complex patients - complete referral to pharmacy if BPMH not achievable during initial review.	• **Checkpoint 1:** Within 24 hours of admission, review the medication history & reconciliation status & plan for completion if not already achieved. • If medication history is incomplete or not done, either complete a BPMH or refer to pharmacy if high-risk/complex patient and unable to complete. • Utilise the Admission Reconciliation function to make any required changes to the medication chart based on updated medication history. • **Checkpoint 2:** Monitor BPMH/Med Rec referrals made to pharmacy and follow up to ensure completion within one working day.	• Regularly review the medication chart for all admitted patients under their care • Document completed medication reviews • Document & action decisions relating to medication recommendations made by other clinicians (e.g. pharmacists) • Respond to changes in medication related risk by: • Completing a medication review and/or • Referring to pharmacy for high-risk/complex patients • **Checkpoint 3:** Monitor Medication Review referrals made to pharmacy and follow up to ensure response or completion within 24 hours.
Pharmacist	**Pharmacist**	**Pharmacist**
• Proactively identify high-risk patients for completion of BPMH and admission reconciliation • **Checkpoint 2:** Monitor BPMH/Med Rec referrals and respond within agreed timeframes. • Actively communicate and follow up any identified issues to ensure resolution.	• Proactively identify high-risk patients for completion of BPMH & admission reconciliation. • **Checkpoint 2:** Monitor BPMH/Med Rec referrals & respond within agreed timeframes. • Communicate with the treating team if a referral is not accepted or cannot be completed within agreed timeframes. • Actively communicate & follow up any identified issues to ensure resolution.	• Proactively review identified high-risk patients daily (Mon-Fri). • **Checkpoint 3**: Monitor Medication Review referrals & respond within 24 hours (during business hours). • Actively communicate and follow up any identified issues to ensure resolution.
Nurses/Midwives	**Nurses/Midwives**	**Nurses/Midwives**
• Supporting access to medication history source information and physical assessment • Communicating to medical/pharmacists medication related issues identified • **Checkpoint 2:** Monitoring the status of BPMH/Med Rec referrals and prompting relevant staff to complete	• Supporting access to medication history source information and physical assessment • Communicating to medical/pharmacists medication related issues identified • **Checkpoint 2**: Monitoring the status of BPMH/Med Rec referrals and prompting relevant staff to complete	• Support for or completion of medication reviews within scope of practice • Referring to the medical team or pharmacist where adherence or other issues are identified • **Checkpoint 3:** Monitoring the status of Medication Review referrals and prompting relevant staff to complete

All clinicians are responsible for actively involving the patient and carer(s) in conversations regarding changes to medications to enable informed and shared decision making and safe and effective medicines use. All clinicians are responsible for effective and proactive communication with other clinicians/health care providers to optimise continuity of care.

11. APPENDIX B: ROYAL HOSPITAL FOR WOMEN MEDICATION HISTORY FLOWCHART FOR OBSTETRIC PATIENTS PRESENTING TO THE BIRTHING UNIT:



Flowchart endorsed by RHW Medication Safety Committee on 20/08/24