AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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Updating the Guiding principles to achieve continuity in medication management

Consultation paper

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Contents

Quality Use of Medicines and National Medicines Policy

The National Medicines Policy (NMP) underpins people's access, and use of medicines.

Quality Use of Medicines (QUM) is one of the central objectives of Australia's NMP. It focuses on:

- Selecting management options wisely
- Choosing suitable medicines if a medication is considered necessary, and
- Using medicines safely and effectively.

Medicines include prescription, non-prescription, and complementary medicines.

Three national QUM publications relating to medication management include[1]:

- Guiding principles to achieve continuity in medication management (July 2005)
- Guiding principles for medication management in residential aged care facilities (October 2012)
- Guiding principles for medication management in the community (June 2006)

Development of the original versions of the above guiding principles was overseen by the Australian Pharmaceutical Advisory Council, which has since been disbanded.

This consultation will focus on the guiding principle for achieving continuity in medication management. A Project Advisory Group has been convened to provide technical and strategic advice in updating the publication.

Due to the staggered timing of these reviews, the *guiding principles in residential aged care facilities* and *in the community* are subject to a separate consultation process that is currently underway.

[1] Publications relevant to the National Medicines Policy (NMP). Australian Government Department of Health. Available from https://www1.health.gov.au/internet/main/publishing.nsf/Content/Publications-16 Updated 08 May 2019 [Accessed 2 June 2021]

Updating national QUM publication

Purpose and scope

In July 2005, the Australian Pharmaceutical Advisory Council released the Guiding principles to achieve continuity in medication management (Guiding Principles). Since the Guiding Principles were published in 2005, the Australian healthcare landscape has evolved. While the breadth of activities related to medication safety in Australia is large, there remains opportunities to improve the integration of these efforts. Improved coordination is necessary, both between systems and between health professionals. There is a greater focus on the need for coordinated care and collaboration across multidisciplinary teams and the emerging role of digital health in facilitating medication safety at transitions of care.

The current version of the Guiding Principles includes 10 guiding principles, which collectively aim to promote 'safe and quality use of medicines and medication management' across the continuum of care. They recognise the importance of partnerships and a system-wide approach, with goals of:

- Achieving continued quality use of medicines in medication management between health care interactions, both in the inpatient and community settings;
- Employing a partnership approach to QUM, with a shared responsibility between governments, health care professionals, providers, consumers and their carers; and
- Outlining operating procedures and the positions or persons, working within the scope of their roles, who are responsible for implementing each step of the process.

The existing 'purpose and scope' for the Guiding Principles to achieve continuity in medication management will be addressed in the following document.

Background

In 2021, the Australian Commission on Safety and Quality in Health Care (the Commission) was engaged by the Australian Government Department of Health to review and update the Guiding Principles.

To further inform the process of updating the Guiding Principles, a literature review and environmental scan[2] was commissioned to identify areas of importance in the quality use of medicines (QUM) and medication safety landscape, in the context of for continuity in medication management.

The literature review and environmental scan[2] provided a summary of:

- Best practice evidence for medication management for continuity of care.
- Review and alignment of the current evidence with existing healthcare professional practice standards, guidelines, and the current guiding principles documents.
- Perceived gaps, benefits, or limitations of the literature review and environmental scan findings.

[2] Literature review and environmental scan: Review and update the Guiding principles to achieve continuity in medication management. A report prepared by the Faculty of Medicine and Health, School of Pharmacy, The University of Sydney. September 2021.

Areas of importance highlighted in the QUM and medicines safety landscape included the need for:[2]

- Greater interprofessional and intraprofessional communications to ensure continuity of effective, safe, and accurate medication management.
- Multidisciplinary collaborative practice agreements with shared responsibility and
- Accountability
- Quality processes for medication reconciliation and management
- Pharmacists to be integral in the medication reconciliation process upon admission to any new care setting
- A General Practitioner practice pharmacist-led model of care to help optimise medication management and reduce medication misadventures resulting in hospitalisations
- A greater focus on a person-centred approach including shared decision making
- Interoperable digital solutions for medication management
- Transitions of care tools and resources

Updating the guiding principles will also consider the framework of Australia's National Medicines Policy and the National Strategy for Quality Use of Medicines (NSQUM). The NSQUM outlines the 'key partners' who are responsible for achieving QUM. All these key partners need to be involved in developing and implementing interventions to improve QUM.[3] There are five key principles underpinning the NSQUM:

1. The recognition of the primacy of consumers and their views.
2. The notion of partnership between key participants.
3. The need for consultation, collaboration and multidisciplinary activity in the design, implementation, and evaluation of Quality Use of Medicines initiatives.
4. Support for existing Quality Use of Medicines activities and initiatives.
5. The need to adopt and embrace system-based approaches.

The update of the national QUM publication needs to consider the changes that have occurred throughout the healthcare environment, to ensure it remains relevant and fit for purpose. These changes, as highlighted in a 2020 paper,[3] include:

- **Person-centred focus:** the NSQUM already recognises that people are the focus of all interventions that improve medicines use. The review should include **a focus on vulnerable populations** – including older people (including aged care residents), Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds (including migrants and refugees), people with mental illness, disability or chronic conditions.

- **Medication safety:** monitoring risks associated with medicines is already included in the guiding principles, however, there needs to be an **increased focus on ways to prevent medication related harm** when updating the National QUM publications. Australian research has shown that more than 250,000 hospital admissions each year are due to harm from medicines. Half of them could be prevented with better medication management[3]. The WHO global patient safety challenge 'Medication without harm' aims to halve preventable medication related harm by 2023. Australia's response has similar objectives, including the goal to reduce avoidable medication errors, reduce adverse drug events and halve medication-related hospital admissions by 2025. These objectives align with the intent of Australia's 10th National Health Priority: Quality Use of Medicines and Medicines Safety.

- **Digital health:** use of digital health solutions such as My Health Record, electronic prescribing and electronic medication management has increased significantly since the current guiding principles documents were published.[3] The updated versions need to include **a greater focus on digital solutions for medication management**, including the use of telehealth.

[3] McLachlan A, et al. National Medicines Policy 2.0: a vision for the future. Australian Prescriber 2020;43(1):24-6.

Consultation process

How you can help?

The Commission is seeking input via SurveyMonkey™ from people receiving care, consumers, carers, clinicians, service providers and other stakeholders across the healthcare sector to inform the review and updating of the national QUM publication:

- Guiding principles to achieve continuity in medication management (July 2005)

The Commission is consulting with all stakeholders around Australia from **Monday 22 NOVEMBER 2021.**

Responses are due by **11:59pm AEDT MONDAY 20 DECEMBER 2021.**

Several topics of importance in the medication management landscape have been identified since release of the national QUM publications. Gaining the views and perspectives of stakeholders will be a critical aspect to updating the national QUM publication to ensure they are relevant and meet your needs. Below are the link to the consultation paper and the associated questions.

Guiding principles to achieve continuity in medication management consultation paper

Guiding principles to achieve continuity in medication management survey link

You will be asked a series of key questions about:

- The on-going relevance of each existing guiding principle
- The recommendations outlined against each of the guiding principles
- The modification, introduction of new, and, potential consolidation of guiding principles
- The format of the national QUM publication.

In addition, you will be asked whether you support (or not) the various recommendations that have been made within the consultation document.

Proposed featured themes in the Guiding Principles

The literature review and environmental scan[4] identified the important role that both collaboration, care-coordination and person-centred care play in continuity of care. Rather than stand-alone principles, these themes cross multiple areas in the Guiding principles to achieve continuity in medication management and require consideration for strengthening across the principles.

1. Collaboration and care-coordination within the health system

It is proposed that collaboration and care-coordination has a greater emphasis throughout the ten guiding principles in the national QUM publication. This will focus on improved collaboration and care coordination across health sectors and between healthcare providers – particularly when providing services for people with complex needs. Improved coordination has been shown to reduce the incidence of preventable hospital admissions, improve health and wellbeing and transitions of care, improve the interface between hospital and community providers, and provide additional support to caregivers[5].

Continuity in medication management across transitions of care requires a seamless transfer of information across care settings. Across the elements of transitions of care, the consumer/carer should be supported in navigating the journey across the continuum of care. The following elements are required[6]:

- Information transfer in collaboration with patients.
- Interdisciplinary collaboration between health care professionals.
- Complete, accurate and timely information transfer.
- Active coordination of information transfer.
- Interoperability of information systems.
- Use of standardised terminology e.g. medicines nomenclature.
- User-friendly system design.

Vulnerable populations may require additional strategies for care coordination and collaboration. For example, the national roadmap for improving the health of people with intellectual disability outlines that continuity of care and coordinated care is critically important for improving the health outcomes of people with intellectual disability. People with intellectual disability often need services from a wide range of health professionals, making the system complex to navigate, including for their families, carers, and support workers. Strong relationships and partnerships between health professionals and people with intellectual disability, their families and carers can help health professionals better understand the unique needs of their patients, support them to deliver effective person-centred care, and coordinate multidisciplinary team-based approaches. For example, the SLHD- Specialist Team for Intellectual Disability Sydney (STrIDeS) – Integrated Model of Care. The updated Guiding Principles could have a greater emphasis on strategies to support coordinated care in vulnerable populations.

Across all healthcare settings, a coordinated approach for the adoption of digital solutions is also required to facilitate interoperability. The principle of interoperability should be prioritised in the selection of digital health solutions for information storage and transfer, and to optimise effective medication management at care transitions. The literature review and environmental scan[4] specified the need for health disciplines to work collaboratively, facilitated by the existence of digital solutions with interoperability between health settings, settings and professions. It identified that interoperable digital solutions, including electronic medication management systems and electronic reconciliation,

[4] Literature review and environmental scan: Review and update the Guiding principles to achieve continuity in medication management. A report prepared by the Faculty of Medicine and Health, School of Pharmacy, The University of Sydney. September 2021.

appear to be effective in increasing the rate of medication reconciliation and reducing medication discrepancies across transitions of care.

A position statement by the Council of Australian Therapeutic Advisory Groups (CATAG) on the use of My Health Record by Australian public hospitals (2021), outlined the inclusion for a future and mature My Health Record to include interoperability with other digital health systems such as GP software, electronic medical records systems, secure messaging solutions, national healthcare provider directories and dispensing software. The Australian Government has allocated $45.5M in the May 2021 budget in supporting RACFs to implement the Electronic National Residential Medication Charts (eNRMC), as well as support the adoption of the *My Health Record* by June 2023. This is in response to Recommendation 68 of the final report of the royal commission into aged care quality and safety: Universal adoption by aged care sector of digital technology and *My Health Record*.

Recommendation:

1. That collaboration and coordinated care have a heightened focus across the ten principles by incorporating the following across the ten principles:
    a. Medication information transfer during transitions of care in collaboration with consumer/carer
    b. Interdisciplinary collaboration between health care professionals
    c. Complete, accurate and timely information transfer to supported coordinated care
    d. Interoperability of information systems
    e. User-friendly system design

2. Person-centred care

It is proposed that person-centred care should have a heightened focus throughout the 10 guiding principles in the national QUM publication. The patient is the one constant through all of their health care transitions and should be recognised as the key stakeholders in their health care. This is to ensure clinicians and members of the healthcare team involve patients in every step of their transitions of care, meet their information needs and share the decision-making about their treatment options (including whether using a medicine is the best option).

Patient centred-care will work towards being responsive to each person's individual needs, preferences, and values. People (and their carers) can be empowered by informing and educating them about the benefits and risks associated with medicines, as well as risk mitigation options. The NICE guidelines[6], the WHO Medication Safety in Transitions of Care technical report and the Commission's shared decision making resources outline strategies to involve people in the prescribing of medication decision making processes. The latter may also be operationalised via a process of multidisciplinary shared decision-making and ongoing communication between the individual (and carer) and their healthcare professionals.

A person-centred approach also acknowledges that individuals may have different and specific healthcare requirements, as the recipients of care. The adoption of person-centred health care acknowledges the need for a value-based approach in which the right care is provided to the right individual at the right time with the right results (clinical, economic, and humanistic outcomes).

Health literacy plays an important role in improving safety and quality of medication management, as well as cultural sensitivity in providing medication management services to Aboriginal and Torres

[6] National Institute for Health and Care Excellence. Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. 1 Guidance | Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence | Guidance | NICE. January 2009

Strait Islander peoples. A 2020 report on Consumer Health Literacy Segmentation and Activation Research Project identified and focused on four key 'vulnerable sub-populations':

- Older people (65 years and over)
- Aboriginal and Torres Strait Islander people
- Culturally and linguistically diverse (CALD) people
- People with low literacy and/or low health literacy

The Commission's National Safety and Quality Health Service (NSQHS) Partnering with consumers Standard is about actively working with people who use the healthcare system to ensure that care is safe, high-quality and meets people's needs. This Standard's focus is on 'person-centred care' and is supported by various resources including:

- Australian Charter of Healthcare Rights
- Informed consent
- Charter guide for people with cognitive impairment
- Information for consumers
- Decision support tools
- Health literacy
- Shared decision-making
- Person-centred care

Further to health literacy, is the key role of digital health literacy. The growth of digital health is rapid, with many advantages, but also threatens to exacerbate existing health inequalities experienced by individuals with lower levels of digital health literacy. Patient engagement with digital health systems such as their My Health Record (MHR) or electronic prescriptions relies on their digital health literacy, as well as their level of social support, and the responsiveness of healthcare providers. Both health literacy and digital health literacy are dynamic and influenced by context (e.g. illness, hospitalisation)[7]. Healthcare professionals should consider their patient's health literacy and digital health literacy to provide tailored support and promote engagement with digital health systems that may positively contribute to a person's health care[8].

Recommendation:

1. That person-centred care as outlined above has a heightened focus across the 10 guiding principles to ensure clinicians and members of the healthcare team involve patients in every step of their transition of care

[7] Pharmaceutical Society of Australia. Digital Health Guidelines for Pharmacists. https://www.psa.org.au/3d-flip-book/digital-health-guidelines-for-pharmacists-adha/. July 2021

[8] Literature review and environmental scan: Review and update the Guiding principles to achieve continuity in medication management. A report prepared by the Faculty of Medicine and Health, School of Pharmacy, The University of Sydney. September 2021.

Proposed additional guiding principle:

3. Patient Safety and Quality Systems:

The literature review and environmental scan[9] and the National Safety and Quality Health Service (NSQHS) Standards and the National Safety and Quality Primary and Community Healthcare Standards outline the importance of patient safety and quality systems. They outline that safety and quality systems should be integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients. It provides guidance on ensuring that patient safety and quality incidents are recognised, reported and analysed, and used to improve the care provided. In both standards, patient safety and quality systems refer to:

- Development of policies and procedures related to the continuity of medication management and take action to improve adherence to policies, procedures and protocols
- Implementation of measurement and quality improvement strategies related to the continuity of medication management
- Identification and risk mitigation strategies related to medication management.
- Incident, feedback and complaints management
- The identification of high-risk patient populations and social determinants of health
- The management of healthcare records that support continuity of medication management

The WHO patient safety solution on assuring medication accuracy at transitions of care outlines suggested actions to ensure quality systems are in place. It outlines that health-care organisations should have clear policies and procedures in place that require the clear assignment of roles and responsibilities for all steps in the medication reconciliation process, within a context of shared accountability.

Recommendation:

1. That a new **GP** titled **Patient Safety and Quality Systems** be added to the Guiding Principles publication**.**
2. That the new GP outlines the need for systems that are used to support and promote safe and effective transitions of care via the development of:
    - Policies and procedures
    - Measurement and quality improvement strategies
    - Risk management strategies
    - Incident, feedback, and complaints management
    - The identification of high-risk patient populations and social determinants of health
    - The management of healthcare records

[9] Literature review and environmental scan: Review and update the Guiding principles to achieve continuity in medication management. A report prepared by the Faculty of Medicine and Health, School of Pharmacy, The University of Sydney. September 2021.

Review of existing guiding principles

Guiding Principle 1 - Leadership for Medication Management

Governance ensures that everyone – from frontline clinicians, to managers, and members of governing bodies – are accountable to patients and the community for assuring the delivery of health services are safe, effective, of high quality and are continuously improving. Governance and leadership, which are fundamental to delivering healthcare services, establish and use clinical governance systems to improve the safety and quality of health care for patients.

Governance structures at transitions of care require effective leadership and a supportive culture e.g. organisational culture[10,11], clear guidance on who is responsible and accountable for care delivery, effective communication between healthcare providers within and across settings and ongoing processes for monitoring and evaluating care delivery with the view to continuous quality improvement in care delivery.

In its current form, **GP 1** focus on leadership to ensure that the systems exist and resources are provided to enable medication management across the continuum of care. **GP 1** could be reconfigured to have a heightened focus on the clinical governance, leadership and organisational culture to address the continuity of medication management. This could include the need for a health service organisation to:

- Ensure that they have safety systems in place with clearly defined roles and responsibilities, and that healthcare professionals are supported to transfer information about medicines accurately;
- Regularly monitor and audit the timeliness and safe transfer of medication information; and
- Share information about good and poor practice to help improve systems and to encourage a safety culture such as the timely sharing of discharge summaries to the consumer's general practitioner.

Each of the sectors across the continuum of care have their own clinical governance frameworks and standards, which outline best practice. The intent would be to ensure that health service organisations have governance systems in place to support clinicians in the safe transitions of care. This would include the need for the health service organisation to apply their respective standards (e.g. Royal Australian College of General Practitioners (Clinical Governance), National Safety and Quality Health Service (NSQHS) Standards- Clinical Governance Standard - Pharmaceutical Society of Australia Clinical Governance Principles for Pharmacy services) with a focus on the continuity of medication management. **GP 1** could incorporate each of the sectors clinical governance, leadership and culture principles.

The clinical governance frameworks and principles do not specify how a health service organisation should implement its clinical governance systems. However, across all standards and frameworks there is consistent messaging that requires clinical leaders and senior managers of health service organisations to implement systems for effective and structured transfer of care. Each health service organisation would need to implement strategies to meet the requirements of clinical governance that consider its local circumstances as well as consideration for the broader healthcare system.

As continuity of medication can involve care transitions that include movement of individuals from one healthcare system to another (e.g. state to national, primary to secondary), care being transferred to a

[10] Sawan M, Jeon Y-H, Chen TF. Shaping the use of psychotropic medicines in nursing homes: A qualitative study on organisational culture. *Social Science & Medicine.* 2018;202:70-78.
[11] Sawan M, Jeon YH, Chen TF. Relationship between Organizational Culture and the Use of Psychotropic Medicines in Nursing Homes: A Systematic Integrative Review. *Drugs and Aging.* 2018;35(3):189-211.

different health care professional or team, or a different level of care intensity (e.g. ICU to general ward) governance should include multidisciplinary representation from the different management structures. The AMA position statement on General Practice/Hospitals transfer of care arrangement outlines that this could be achieved by GP representation within individual hospital management structures, (e.g. Quality and Safety and Clinical Governance committees) to ensure general practice issues are regularly discussed and to allow for concerns of local GPs in their dealings with hospitals to be raised and addressed in an appropriate forum. This same principle could be applied to other disciplines, such as encouraging primary care or allied health representation on hospital management structures and vice versa. The updated **GP 1** would bring in the fundamental elements of establishing clinical governance to support the continuity of medication management as well as the need for better-coordinated and integrated governance across different healthcare settings.

In addition, the WHO Medication Safety in Transitions of Care technical report outlines that coordinated governance and leadership should be improved between hospitals (public and private), the community (general practitioner, pharmacist and other health care providers), residential care, patients/carers by:

- Collaboration with key stakeholders and defining clear goals;
- Developing a long-term strategy to achieve these goals; and
- Put in place governance arrangements to oversee implementation and progress.

Recommendations:

Alter the focus of **GP1** to:

1. **Clinical governance, leadership and organisational culture**
2. Have a broader more contemporary alignment with the concepts of clinical governance, leadership, and culture.
3. Incorporate coordinated governance and leadership between hospitals (public and private), the community (general practitioner, pharmacist, allied health and other health care providers), residential aged care facilities, patients/carers.

Guiding Principle 2 - Responsibility for medication management

Responsibility refers to being entrusted with or assigned a duty. In many instances, responsibility is assumed, in accordance with one's duties. Responsibility can be delegated as long as it is to someone who has the ability to carry out the task or function. The person who delegated the responsibly remains accountable, along with the person accepting the task or function.

It is recommended that the need for individual professional responsibility as outlined in the original **GP 2** be retained, and the updated **GP 2** incorporate allocating responsibility to the stages in the medication management pathway. The updated **GP 2** should differentiate between organisational and professional responsibility. The WHO Medication Safety in Transitions of Care Technical Report[12] assigns organisational responsibility to ensure there are systems and mechanisms to:

- Identify and allocate resources, both in workforce and Information Technology;
- Invest in research to inform understanding of problems and solutions, particularly where health care contexts differ from those studied to date;
- Plan, adapt, support and monitor improvement programmes; and

[12] Medication Safety in Transitions of Care. Geneva: World Health Organization; 2019 (WHO/UHC/SDS/2019.9).

- Develop mechanisms for education and training of health care professionals in quality processes and on the use of digital technology, to facilitate the continuity of medication management.

In accordance with the WHO technical report, consideration should be given to assigning responsibility and allocating workforce resources to perform the medication management elements in the Guiding Principles. There is a growing body of literature supporting the role of the pharmacist in conducting medication reconciliation and review in both the primary and hospital sectors.

It is also recommended that **GP 2** be expanded to incorporate responsibility around organisational governance. It could build on the current version and address specific gaps related to assigning:

- Responsibility for the implementation of routine use of validated measures of medication management services (e.g. quality indicators)
- Regular measurement of culture (e.g. validated measures of organisational culture, patient safety culture assessment tools) which applies both within and across sectors.

Recommendations:

That **GP 2** be retained and broadened to address organisational responsibility, specifically:

1. identify and allocate responsibility and resources, both in workforce and Information Technology
2. responsibility for the implementation of routine use of validated measures of medication management services (e.g., quality indicators)
3. regular measurement of culture (e.g., validated measures of organisational culture) and an approach to quality improvement, which applies both within and across sectors.
4. develop mechanisms for education and training for health care professionals in quality processes and the use of digital technology

Guiding Principle 3 - Accountability for medication management

Accountability refers to being answerable for one's actions, and the roles and responsibilities inherent in one's job or position. It is proposed that **GP 3** is merged with **GP 2** which focus on responsibility. In its current form, **GP 3** outlines the relationship between responsibility and accountability in that each health care provider is individually accountable for their assigned responsibilities and focuses on individual responsibility.

Due to the relationship between responsibility and accountability, it is proposed that the elements of **GP 3** be retained and combined with **GP 2**. It is also proposed that **GP 3** be inclusive of professional and organisation accountability. In this context professional accountability refers to the accountability of health care professionals to their colleagues, professional organisations, and to individuals. Organisational accountability refers to the structures and processes put in place to deliver medication management at transitions of care and to realise the intended outcomes of the care provided.

Recommendation:

1. That **GP 3** be combined with **GP 2** - Responsibility for medication management.
2. That the content in **GP 3** be retained and broadened to include organisational accountability

Guiding Principle 4 - Accurate medication history

The intention of the existing **GP 4** relates to documenting an accurate and complete medication history that can be used throughout an episode of care. In its current form, it focuses on activities related to building a Best Possible Medication History (BPMH).

However, medication reconciliation is a two-step process that goes beyond the BPMH within the hospital. It is the process whereby a health care professional in any sector partners with the patient to ensure accurate and complete medication information transfer at transitions of care[13] followed by reconciliation. Medication reconciliation consists of two parts:

1. Building the BPMH: the BPMH is obtained by following a systematic process of interviewing the patient, family and/or caregiver and verifying the history with at least one other reliable source of information to determine the complete and correct list of the patient's actual medication use at the time of the transition.
2. Reconciling the BPMH with prescribed medication: the BPMH is compared with prescribed medication, any discrepancies identified and resolved (with or by the prescriber), and changes documented, thus updating the medication list.

Transitions of care from hospital to the community or Residential Aged Care Facilities are periods of high risk for medication errors. Within the community sector, the Australian Government has funded medication reviews by pharmacists for over 20 years. The current program rules,[14] ratified in the 7th Community Pharmacy Agreement, fund collaborative Residential Medication Management Reviews or RMMRs (in-person or by telehealth during the COVID-19 pandemic) and Home Medicines Reviews (HMRs) with up to two follow-up reviews. The person's medical practitioner may request a subsequent review if deemed clinically necessary due to various criteria, including (but not limited to):

- *Discharge from hospital after an unplanned admission in the previous four weeks*
- *Significant change to medication regimen in the past three months*
- *Change in medical condition or abilities.*

Whilst the funding arrangements are an important aspect for medications reviews, along with the eligibility criteria, the focus within **GP 4** remains on the need to ensure that, given their complexity, each person's medicines are reconciled and are regularly reviewed. The review should also involve the multidisciplinary team and be a collaborative process between healthcare professionals and the consumer/carer. As part of the medication review and reconciliation process, the complex needs of each individual should be considered, and the review should be tailored accordingly.

Similarly, the transition of care into the hospital are also high risk periods for medication errors. Action 3.15 within the Primary and Community Healthcare Standards focuses on documenting a BPMH on presentation or as early as possible in the episode of care. Similarly, Action 4.05 and Action 4.06 within the NSQHS Medication Safety Standard focus on medication reconciliation, including the requirement to document the BPMH. In updating **GP 4**, consideration should be given to aligning with the intent of the above-mentioned actions in both the community and hospital, along with the PSA Guidelines for comprehensive medication management reviews and the Society of Hospital Pharmacists of Australia (SHPA) Standards of practice in geriatric for pharmacy services. Published in 2020, the SHPA standards of practice, include 'medication history and reconciliation' and 'medication review' as separate components of a geriatric pharmacy service.

Australia's response to the WHO Global patient safety challenge: Medication without harm highlights that minimising medication-related harm on admission to hospital starts with a BPMH. A BPMH is essential for:

- Ensuring continuity of medication management

[13] World Health Organization, Geneva. Medication Safety in Transitions of Care. WHO Patient Safety - Transition of Care - 2019
[14] Pharmacy Programs Administrator. Program Rules. Residential Medication Management Review. PPA; July 2021.

- Identifying medicine-related problems
- Identifying potential medicine-related discrepancies
- Informing the decision-making process
- Optimising the use of medicines.

Interventions increasing the role of pharmacists in medication management have been found to mitigate the incidence of medication errors and related adverse events[15]. A Partnered Pharmacist Medication Charting (PPMC) model was trialled across seven Australian hospitals, to increase the involvement of credentialed pharmacists in clinical decision making relating to medication management for acute care patients[15]. The PPMC model involved pharmacists leading the medication reconciliation and charting process for patients who were admitted to a general medicine unit. The multi-site implementation trial found fewer medication charting errors in patients who received the PPMC model[15].

Australia's response to the WHO Global patient safety challenge: Medication without harm advocates for the development of a tool to identify complex consumers who are at risk of hospital readmission early post-discharge. The hospital outreach pharmacy service is the subject of ongoing research in Western Australia (CoNeCT – Complex Needs Coordination Team, Sir Charles Gairdner Hospital). In this model, if a hospitalised consumer meets the high-risk criteria, then the CoNeCT clinical pharmacist coordinates a medication review once the patient returns home. Two of the criteria for eligibility are polypharmacy (five or more regular medicines daily) and/or taking a high-risk medicine (includes insulin, opioid analgesics, anticoagulants, and antipsychotics). Similarly, within the hospital, if medication reconciliation cannot be completed for all patients, patients most likely to obtain maximum benefit should be prioritised, as outlined in the SHPA Standards of Practice for Clinical Pharmacy Services.

The UK NICE quality standards outline the additional importance of coordinated care when caring for vulnerable populations[16]. Similarly, the Australian National roadmap for improving the health of people with intellectual disability outlines that continuity of care and coordinated care is critically important for improving the health outcomes of people with an intellectual disability. Medication reviews can be an important part of ensuring continuity of care, and care coordination. Medication reviews should also support the physical and mental health needs of the individual. For example, the National Roadmap identifies a short term action for the Australian Government Department of Health to collaborate with states and territories, experts and stakeholders, to lead work on the development of minimum and best practice quality standards for medical practitioners prescribing psychotropic medication to people with intellectual disability, and actions to ensure these standards are met (including where medication is being used as a chemical restraint in NDIS funded disability services).

Medication reconciliation requires access to a person's BPMH, including their most up-to-date medicines list. Whilst the goal of this process is stated within the current **GP 4**, this information could be further expanded either within this guiding principle and/or within health service organisation's respective policies, procedures, and guidelines. For instance, when verifying a person's current list of medicines, especially if they are newly admitted or there have been any recent changes in their care, helpful information sources include:

- their discharge summary from the most recent hospital admission
- a person's *My Health Record* including the Pharmacist Shared Medicines List
- General Practitioner or primary health care practitioner records
- their personal medicines list, for instance, on the MedicineWise smartphone app
- their medication chart from their RACF.

[15] Beks, H., Namara, K.M., Manias, E. *et al.* Hospital pharmacists' experiences of participating in a partnered pharmacist medication charting credentialing program: a qualitative study. *BMC Health Serv Res* **21,** 251 (2021). https://doi.org/10.1186/s12913-021-06267-w
[16] National Institute for Health and Care Excellence. Transition between inpatient mental health settings and community or care home settings. 1 (nice.org.uk). March 2017

The PSAs position statement on digitally empowered pharmacists encourages the use of digital health to support medication reviews and the continuity of care. It outlines that digital technology can effectively resolve major factors that contribute to medicine-related problems, such as gaps in communication and time delays in accessing information. It highlights that the availability of information through the My Health Record, electronic medication charts and electronic medical records facilitate completing and documenting a BPMH. The updated **GP 4** could encourage organisations to work towards the uptake of digital technology to support medication reconciliation and support optimal use for organisations who are further along the digital journey.

Admission to hospital or transition to a new care setting have the potential to occur outside of 'regular operating' hours as well as during emergencies, such as during the COVID-19 pandemic or the Australian bushfires (2019-2020). **GP 4** could be expanded to incorporate medication management at transitions of care during emergencies or outside of 'regular operating hours'. The expanding role of technology can facilitate 24/7 access to health information for consumers, clinicians and the broader multidisciplinary team.

Recommendation:

That **GP 4** be retained and be renamed **Medication Reconciliation** and:

1. the updated **GP 4** have a heightened focus on the two elements of medication reconciliation, a BPMH and reconciling the BPMH.
2. incorporates a person-centred care approach with a greater focus on coordinated care.
3. Incorporates evidence-based interventions to further facilitate medication reconciliation.
4. outlines strategies for prioritising patients for medication reconciliation if it cannot be completed for all patients.
5. integrates the role of digital technology in supporting medication reconciliation.
6. addresses medication management outside of 'regular operating hours', in 'emergency situations' and in regional and remote areas.

Guiding Principle 5 - Assessment of current medication management

A comprehensive medication review is a systematic and collaborative assessment of medication management for an individual person that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change. It includes the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste. The review usually follows the medication reconciliation in **GP 4.** It is proposed that the intent of the current **GP 5** which focuses on the assessment of all current medicines and how they are currently managed be retained; however, expand this to differentiate between the different transition of care settings and incorporate contemporary strategies that enhance medication reviews.

Each clinician involved in a person's care has the responsibility to use their specific knowledge, skills and expertise to ensure the safe and quality use of medicines by all consumers in their care. If risks with medicine use are identified early, it may prevent unnecessary escalation in care or hospital admission. Two-way ongoing communication should be maintained between the healthcare professional and the consumer/carer throughout the medication review process. Whilst a comprehensive medication review by a pharmacist is ideal, there may be situations where other clinicians need to consider and review the appropriateness of a medicine, suitability of its formulation, or a change in a consumer's situation or condition that prompts an 'ad hoc' review of their medicines. It is possible that this would prompt referral to their GP or contact with the consumer's pharmacist for advice and/or review.

As outlined in **GP4** the Australian Government has funded comprehensive medication reviews in the community as part of the 7th Community Pharmacy Agreement:[17]

- Home Medicines Reviews or HMRs (in-person or telehealth during the COVID-19 pandemic)
- MedsCheck and Diabetes MedsCheck (in-person or telehealth during the COVID-19 pandemic)

The Community Pharmacy Agreement acknowledges different contexts for the provision of professional services which include emerging situations such as, the response to the COVID-19 pandemic (e.g. utilisation of telehealth services for HMR) and the diversity of individuals within our population. This acknowledges that different individuals may have different needs and requirements and that professional services should be modified accordingly. It is recommended that the updated GP acknowledge that medication reviews at transitions of care may be different for different individuals.

In updating this guiding principle, consideration should be given to aligning with the PSA Guidelines for comprehensive medication management reviews. The updated **GP 5** will need to be flexible enough to adapt to changing funding rules for these services. Guiding principles for medication review and reconciliation should address polypharmacy and deprescribing.

The RACGP Silver Book, Part A, Medication management contains a series of 'consensus-based recommendations' for General Practitioners, including the need for medication review. The RACGP Silver Book also contains chapters on managing older patients with polypharmacy and deprescribing.

Since the guiding principles were released in 2005, the SHPA has released its Standards of Practice for Clinical Pharmacy Services. It outlines that the aims and objectives of a medication review is the assessment of a patient's current medication management. It aims to optimise therapy and outcomes by ensuring the safety and appropriateness of prescribed medicines, taking into account patient-specific factors including their medical condition and previous experience with medicines. It outlines best practice relating to the reviewing and subsequent documentation including:

- The key elements of a clinical review
- Therapeutic drug monitoring
- Adverse drug reaction management
- Comparing the patient's current medicines to their MMP and data from the medication administration record

The literature review and environmental scan[18] highlighted that transitions between high-risk wards (ICU, ED) to general wards, are periods of high risk for medication errors. A study by Dabliz et al[19] highlighted that medication errors occurred in 42% of patients on transition from the ICU to a general ward. Consideration should be given to prioritising the review of medications for patients transitioning between wards prior to their transition.

Across all sectors, use of digital health technology should be encouraged to facilitate and support medication reviews. The growth of Electronic Medical Records, Clinical Decision Support, Real Time Prescription Drug Monitoring Programs (PDMP),[20,21] the My Health Record (including Pharmacist Shared Medicines Lists) and telehealth.

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[17] Australian Government. Department of Health. Seventh Community Pharmacy Agreement. https://www.pbs.gov.au/info/general/seventh-community-pharmacy-agreement. 2020.

[18] Literature review and environmental scan: Review and update the Guiding principles to achieve continuity in medication management. A report prepared by the Faculty of Medicine and Health, School of Pharmacy, The University of Sydney. September 2021.

[19] Dabliz R, Poon SK, Fairbrother G, et al. Medication safety improvements during care transitions in an Australian intensive care unit following implementation of an electronic medication management system. *International Journal of Medical Informatics.* 2021;145:104325.

[20] Puac-Polanco V, Chihuri S, Fink DS, Cerda M, Keyes KM, Li G. Prescription Drug Monitoring Programs and Prescription Opioid–Related Outcomes in the United States. *Epidemiologic Reviews.* 2020;42(1):134-153.

[21] Martin HD, Modi SS, Feldman SS. Barriers and facilitators to PDMP IS Success in the US: A systematic review. *Drug Alcohol Depend.* 2021;219:108460.

Recommendation:

That the content of **GP 5** be retained and:

1. be renamed Medication Review to reflect contemporary terminology
2. reflects contemporary practice standards and guidelines
3. is broadened to be inclusive of the different types of transitions of care and the different high-risk populations
4. has a heightened focus on the use of digital health strategies

Guiding Principle 6 - Medication Action Plan

The existing **GP 6** outlines that the healthcare professional develop a Mediation Action Plan (MAP) for the use/management of medicines in collaboration with the consumer and/or their carer. The literature review and environmental scan[22] identified two major factors pointing to a need to revise this principle. First, there has been a significant advancement in digital health technologies and digitalisation of health information since 2005. Second, there is very limited evidence that MAPs have been formally established or are in use within Australian healthcare, beyond singular components such as medication reconciliation documentation and medication reviews. Solid evidence for both the use and effectiveness of the MAP, outside of Queensland, is lacking, because of poor implementation across Australian healthcare settings. In the contemporary setting, the development of a Medication Management Plan (MMP) is more widespread.

The SHPA has released its Standards of Practice for Clinical Pharmacy Services. An MMP is a continuing plan developed and used by healthcare professionals in collaboration with patients to develop strategies to manage the use of medicines for the patient. The MMP or equivalent may be used in inpatient, outpatient or non-admitted areas, emergency departments, subacute or for primary care. All healthcare professionals are responsible for documenting on the MMP regardless of the setting. It outlines the key elements as:

1. Interpreting patient-specific information
2. Identifying medicine-related problems
3. Individualising therapy
4. Documenting outcomes

In the community setting, the PSAs Guidelines for comprehensive medication management reviews outlines that the MMP prepared by the medical practitioner and should incorporate feedback on the recommendations made in the comprehensive medication management review report, actions taken by the medical practitioner with respect to treatment regimens and lifestyle adjustments, and agreed therapeutic goals. The MMP also documents when a follow-up is recommended by the accredited pharmacist and agreed by the medical practitioner. A coordinated collaborative case conference involving the medical practitioner, the pharmacist conducting the review and other health professionals may be required for addressing complex issues.

The RACGP Silver Book, Part A, Medication management includes chapters on deprescribing, Medication Management and Polypharmacy. Practice points for deprescribing advises:

[22] Literature review and environmental scan: Review and update the Guiding principles to achieve continuity in medication management. A report prepared by the Faculty of Medicine and Health, School of Pharmacy, The University of Sydney. September 2021.

- undertaking medicine reconciliation, while referring to hospital discharge records and medication management reviews,
- developing a medication management plan, and
- communicating this with other healthcare providers

The MMP should be developed in collaboration with the patient/carer and should remain patient-centred. The UK NICE guidelines and the NPS Prescribing Competencies Framework (2021) emphasises that patient/carer involvement in the development of a MMP and the decision-making process requires that healthcare professionals acknowledge patients' views about their condition, treatment and goals of care, and that both healthcare professional and patient have a role in making decisions about treatment. Principles from these guidelines could be incorporated into **GP 6** to ensure a greater person-centred focus.

Recommendations:

1. That **GP 6** be renamed to Medication Management Plan (MMP)
2. In development of the MMP, the consumer remains at the centre of the collaborative development of the MMP.
3. That elements of the MMP, as outlined in the existing GP 6, is retained, with specific reference to:
   - it be developed with the consumer and relevant health care professionals as early as possible in the episode of care
   - form an integral part of care planning with the consumer
   - be reviewed during the episode of care and before transfer
   - actual and potential medication management issues (problems and needs, including risk assessment) identified during assessment (see **GP 5**)
   - medication management goals addressed in collaboration with the consumer
   - actions/strategies in line with best evidence that are required to address the issues and achieve the consumer's medication management goals
4. That **GP 6** be broadened to integrate principles of a medication management plan in the community and hospital sector and reflect contemporary practice standards and guidelines.

Guiding Principle 7 - Supply of medicines information to consumers

The sharing of medicines information with consumers is an important part of the continuity of medication management and should remain in the updated version of the guiding principles. The current version of **GP 7** outlines the form, content, and resources available for the provision of information to consumers. It is proposed that these elements of **GP 7** be retained, however developed further to reflect the findings from the literature review and environmental scan and current professional practice standards and guidelines outlined below,

Information included in the updated guiding principles should align with the messages in Australia's response to the WHO global patient safety challenge, which state that:

- *there is a need to use technology to provide better medicines information to patients, so that they are better equipped to be shared decision makers in their medication management*

- *providing consumers with access to better medicines information promotes 'healthy challenge'*[23] *between consumers and their healthcare providers*
- *in order to provide appropriate health care, consumers and their health care providers need access to information so that they can make informed decisions about the benefits and risks of different treatments*
- *medication safety at transitions of care is improved when consumers understand their medicines and have access to their medicines information; and*
- *better communication of health information by health professionals to consumers can improve health literacy for consumers*.[24]

Australia's response to the WHO global patient safety challenge and the UK NICE guidelines[25] also outline person-centred strategies that support greater person involvement in the decision making process, such as *direct-to-consumer communications about primary care programs that raise awareness of self-care through promotion of:*

- *Simplified medication regimens*
- *Concordance with agreed medication regimen*
- *Medicine literacy*
- *Patient and carer engagement with safe use of their medicines.*

The Commission's Medication Safety Standard, in both the National Safety and Quality Health Service (NSQHS) Standards focusing on the hospital sector and the National Safety and Quality Primary and Community Healthcare Standards, provides guidance on how to provide people with information about their medicines. The NSQHS standards provides useful information to guide the provision of medicines information to people as they transition between care settings. Action 4.11 (*Information for patients*) and Action 4.13 (*Information and decision support tools for medicines*) within the Medication Safety Standard are most relevant to the provision of medicines information and medicines information resources. The National Safety and Quality Primary and Community Healthcare Standards, specifically Action 3.16 outlines the practice of providing person centred medication information. Within these Actions, the intent of each is defined along with reflective questions, key tasks and strategies for improvement.

The Commission's work on health literacy and partnering with consumers has highlighted the importance of understanding the diversity of people, tailoring strategies for vulnerable groups, and the importance of developing high-quality, easy to understand, health information to support effective partnerships.

The Commission's National standard for labelling dispensed medicines, aims to standardise the consistent presentation of medicine-related information across all consumer resources. Health literacy is fundamental for medicine-related information on labels to be appropriately understood and actioned by consumers. The standard has been developed to guide the format and content of medicine-related information on the dispensed medicine label. This will help to ensure that all consumers – particularly those with low health literacy levels – can locate and understand the information about how to take their medicines safely and effectively as they transition between settings.

Where possible, digital health methods should be used to support the supply of medicines information. The supplying of medicines information to a consumer in electronic form (e.g. electronic records) or telephone services (e.g. telehealth or electronic medication order), should ensure compliance with relevant legislation, guidelines and policies as well as the digital-literacy of the consumer.

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[23] *'Healthy challenge'* is meant to refer to people being equipped with information to be able to ask questions of their primary care provider about their medicines and play an active role in their medication management.
[24] Australian Commission on Safety and Quality in Health Care. Medication without harm – WHO Global Patient Safety Challenge. Australia's response. Sydney: ACSQHC, 2020.
[25] National Institute for Health and Care Excellence. Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. 1 Guidance | Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence | Guidance | NICE. January 2009

Medicine-related problems and risk of patient harm are minimised by maintaining a current medicines list with reasons for any changes. Consumers should continue to be supported in maintaining an up-to-date list of all their medicines. It should also be easily accessible for example their MedicineWise smartphone app. NPS MedicineWise have an accompanying consumer-focused resource to explain the importance of Keeping a medicines list. Continuity of medication management includes generating, maintaining, and communicating a current list of medicines and the reasons for changes when handing over care to another clinician or service provider.

Recommendation:

1. That **GP 7** is retained and renamed 'Share medicines information with consumer'
2. Ensure information within **GP 7** continues to align with all relevant professional practice standards and that the resource list in **GP 7** is updated
3. Adapt content within the Medication Safety Standard relevant to the provision of medicines information and medicines information resources to address transitions of care
4. Multimedia and multi-lingual resources are co-designed with consumers to be available to cater the needs of individualised groups.

Guiding Principle 8 - Ongoing access to medicines

The intent of the current **GP 8** is that the consumers and/or their carers should receive sufficient supplies of appropriately labelled medicines and information about how to obtain further supply of medicines. It is proposed that the content of **GP 8** be retained, and expanded to incorporate potential complexities associated with ongoing access to medicines and strategies to support uninterrupted access.

Health service organisations need to have policies, procedures, and guidelines in place to ensure the supply of medicines for a person is not interrupted, and adverse outcomes are avoided. In development of an MMP with the consumer, the plan for ongoing access to medicines should also be incorporated and considered prior to prescribing. This includes, but not limited to, how to manage and respond to:

- Situations where a new medicine or an urgent change to the dose of an existing medicine is prescribed (for instance, how changes to dose administration aids are managed)
- An unexpected local medicines shortage impacting on access within the hospital and/or community pharmacy
- How ongoing access should be managed if the prescribed medication is not listed on the Pharmaceutical Benefits Scheme (PBS) or the Special Access Scheme (SAS)
- Barriers to accessing medication in regional and remote areas.

As a result of the movement restrictions imposed during the COVID-19 pandemic, challenges to ongoing access to medicines in the Australian community were experienced. For instance, vulnerable and older people with chronic and complex conditions may not have been able to attend consultations with their health practitioner or visit their community pharmacy to have medicines prescribed and dispensed prompting an expansion of tele-health arrangements. However, there is a need to assess an individual's digital health literacy prior to consultation.

Pharmacies had difficulty sourcing brands of some medicines, with rural pharmacies particularly affected[26]. Initiatives put in place (including temporary ones) in response to this issue have included:

[26] Bell J, et al. Access to medications during the COVID19 pandemic. Australian Journal for General Practitioners 2020;49:530-2.

- as part of a telehealth consultation, prescribers permitted to send a digital image of an original prescription directly to the person's preferred pharmacy for dispensing.
- a pharmacist supplying a full PBS quantity (usually 30 days) of a previously prescribed Schedule 4 medicine, in case of immediate need when a person is unable to obtain a prescription to facilitate continuity of care
- home delivery services that support pharmacies (or other delivery services) to provide new or existing home deliveries medicines to vulnerable people up to once per month, including to people in RACFs
- pharmacists provided temporary permission, for eligible people, to deliver medication management reviews via telehealth arrangements.

The Interim Residential Care Medication Administration Chart (IRCMAC) was developed as a strategy to address continuity of medicines supply and reduce omissions of critical medicines and potential for readmission to hospital. Whilst uptake has not been universal across states and territories, from August 2018 South Australia (SA) introduced an Interim Medication Administration Chart (IMAC) for people transferring from SA hospitals to RACFs and the SA Prison Health Service. In addition, in Queensland (QLD) the Interim Medication Administration Record is used and valid for up to five days post-discharge from QLD hospitals until a long-term RACF medication chart can be updated by the person's general practitioner.

The changes and initiatives relating to electronic prescriptions, active ingredient prescribing, along with the implementation of the eNRMC, aim to reduce the complexities of the continuity of medicines supply at transitions of care. Also noted is the Australian Government's response to Recommendation 68[26] within the final report of the royal commission into aged care quality and safety. With the expected adoption of *My Health Record* by June 2023, there will be a need for RACFs to refer to and/or update information, including about a person's medicines, within the consumer's *My Health Record*.

A Dose Administration Aid service aims to promote medicine safety and the quality use of medicines by improving ongoing access to medicines, adherence, medication management, and reducing medication misadventure. A DAA (e.g. Webster pack) is a device that can be used as part of a coordinated approach to medication management. The two main guidelines on DAAs are the PSA Guidelines for pharmacists providing dose administration aids and the Pharmacy Board of Australia (PBA) *Guidelines on dose administration aids and staged supply of dispensed medicines*.[27] The PSA and Pharmacy Board guidelines highlight that provision of DAAs is a clinical service, not just a supply function. The guidelines make it clear that medication safety is paramount, and so pharmacists providing DAA services must follow robust processes of a high standard to ensure the safety of the person receiving care.

The importance of reconciling medicines the first time, and regularly thereafter, prior to packing a person's DAA is included. This process may begin shortly before discharge from hospital, if the treating multidisciplinary team assess the patient as benefitting from a DAA and a patient consents. Coordination between the hospital and community teams and in consultation with the patient/carer should take place to ensure continuity of care. The same principles should apply if commenced in the community. These are necessary steps to ensure a complete and accurate medicines list or medication profile that takes into account all prescription, non-prescription, complementary and alternative medicines a person is taking during any transition of care.

[27] Pharmacy Board of Australia. Guidelines on dose administration aids and staged supply of dispensed medicines. 2015. Available from: https://www.pharmacyboard.gov.au/codes-guidelines.aspx

Recommendations:

GP 8 be retained and incorporate:

1. a heightened focus on the communication with consumers for medication access:
    a. when they are prescribed a new medicine or have an urgent change
    b. during stock shortages
    c. for regional/remote areas
2. for regional/remote areas, strategies and tools to support uninterrupted medication supply on transfer to a RACF
3. a greater emphasis on the use of digital technology to improve access and continuity of care
4. information under appropriate labelled medicines in **GP 8**, be moved to provision of medicines information under **GP 9**
5. that **GP 8** has greater emphasis and more information on:
    a. the need for medication reconciliation prior to DAA packing for the first time, and after changes to medicines or hospital admission
    b. Resources for accessing medications for complex conditions such as, Special Access Scheme, depots, S100.

Guiding Principle 9 - Communicating medicines information

It is proposed that the content regarding the information required to be transferred in **GP 9** be retained. However, it is proposed that GP 9 be broadened to be inclusive of the different types of transitions of care as well as the method for the transmission of medicines information. Some of the frequent transition points in health care settings are[28]:

- Admission to hospital, community setting or primary care, where a medication history is taken, the inpatient prescription commenced and medications are started, changed or discontinued
- Transfer from one area within the hospital to another, particularly between units with a change in practice of documentation, such as a transition from paper to electronic medication records. This is often encountered from emergency department to intensive care unit, operating theatre to a clinical ward
- Referral from primary care setting to secondary/tertiary care
- Discharge from hospital, where a discharge prescription or instructions are issued; and
- Transfer from one hospital to another hospital or to a residential care setting.

Various digital health systems aimed at improving information documentation and the sharing of medicines information have already been implemented across Australia. Digital health strategies include active ingredient prescribing, electronic health records (including the My Health Record), electronic medication management (including administration records) and secure messaging.

Optimal care is provided when health disciplines do not act in isolation but in concert with each other, facilitated by the existence of digital solutions with adequate interoperability between sectors and different health professions. The principle of interoperability should be prioritised in the selection of digital health solutions for information storage and transfer to optimise effective medication management at care transitions. Ideally, digital health and medication management records held

[28] World Health Organization, Geneva. Medication Safety in Transitions of Care. WHO Patient Safety - Transition of Care 2019

within primary and secondary care software systems should be interoperable, be able to synchronise automatically and/or be accessible remotely and securely. Increased efforts have been directed at improving intra-hospital transitions of care, such as the eHealth NSW Transitions of Care (iTOC) project. The iTOC project is designed to deliver a safe solution that supports the effective and safe transfer of medication management information between Electronic Record for Intensive Care (eRIC) and eMeds.

With the growth of digital health strategies to facilitate continuity of care, there is a heighted focus on privacy and security of patient information. The PSAs Digital Health Guidelines for Pharmacists provides guidance on expected professional practice when using digital health systems, so that pharmacists can provide optimal patient outcomes, while meeting legal and ethical obligations relating to data access and stewardship.

It is critical to communicate the patient's current medicines list both with other healthcare professional and in collaboration with the patient, along with any medicine-related problems or adverse drug events that have occurred during care or as a result of a medication review, consistent with **GP 5** (Medication Review). A medicine-related problem may include a patient refusing or missing a dose of medicine or withholding a medicine as a result of an acute illness.

GP 9 should have a heighted focus on strategies to support the communication of medicines information that is timely, comprehensive and reflects the medication management plan. As mentioned in **GP 8**, the Interim Residential Care Medication Administration Chart (IRCMAC) was developed as a strategy to address continuity of medicines supply and reduce omissions of critical medicines and potential for readmission to hospital.

The national guidelines for the On-Screen Presentation of Discharge Summaries, aims to improve the on-screen presentation of discharge summaries and thereby improve the overall safety and quality of patients' continuity of care.

The draft of Australia's Primary Health Care 10 Year Plan 2022-2032 outlines that private primary care services, particularly general practices and psychologists, continue to provide a significant proportion of mental health care. It is therefore important that the updated **GP 9** addresses the interface between primary care and mental health services in a one-health system approach to ensure continuity of medication management.

Recommendations:

That the content of **GP 9** is retained and broadened to include:

1. The various types of transitions of care
2. Strategies to facilitate the sharing of information including such as:
    a. Digital technology
    b. National on-screen presentation of discharge summaries

Guiding Principle 10 - Evaluation of medication management

The existing **GP 10** expects the transferring health care provider to evaluate the medication management elements to ensure that the continuity of consumers' medication management has been achieved and take follow up action when required. Given that this expectation is inherent within a governance and quality improvement framework, it is proposed that a series of 'evaluation' questions

be adapted and adopted as ‘reflective questions’ within each individual guiding principle where relevant.

The existing **GP 10**, includes a list of questions that can be used by the health care provider to evaluate the application of each of the guiding principles. These ‘evaluation’ questions allow inter and intra-facility monitoring of the guiding principles implementation. These questions will be reviewed separately and updated according to their ongoing relevance once the final set of guiding principles are determined.

The option to adapt these as ‘reflective questions’ within each individual guiding principle should be considered. If adopted in this way **GP 10** could be renamed to evaluation and quality improvement and have a heightened focus on resulting action following reflection, and moved within the hierarchy to follow a revised **GP 1 and 2**.

Recommendations:

1. that **GP 10:**
    a. be renamed as ‘evaluation and quality improvement’.
    b. Have a heighted quality improvement focus
2. as it relates to organisational governance, it be moved up after **GP 3**
3. that the existing **‘**evaluation’ questions be adapted and incorporated as ‘reflective questions’ where relevant within each guiding principle.

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