Australian Commission on **Safety and Quality** in Health Care

Medication Management at Transitions of Care Stewardship Framework

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Executive summary

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed the Medication Management at Transitions of Care Stewardship Framework (the Framework) as part of its commitment to lead and coordinate national initiatives to reduce harm associated with transitions of care.

The Framework describes a stewardship approach to medication management at transitions of care (TOC) and is designed to be incorporated into existing systems, processes and clinical practice. It aims to:

- Establish a stewardship approach to medication management at TOC
- Support coordinated governance of medication management at TOC
- Promote and optimise safe and high-quality medication management at TOC
- Reduce medication-related harm and hospital readmission rates due to errors and miscommunication
- Improve communication between hospitals and primary and aged care to enable timely discharge planning and post-discharge medication management follow-up
- Ensure continuous improvement.

This Framework focuses on TOC that occur between hospital settings and primary and aged care settings, a period known to be especially high risk. The principles and elements of the Framework may be transferrable, with appropriate modification, to other TOC and pathways that occur within the primary and community care sector, and to other patient cohorts, such as people with disabilities.

Implementation of the Framework will be effective when it is tailored to the hospital's local context and incorporated into existing safety and quality frameworks. Clinicians and health managers are encouraged to customise the stewardship approach to suit their local resources and needs across the hospital, primary and aged care sectors. Implementation of quality improvement based on the Framework is intended to be incremental based on these local needs and priority areas.

The guidance provided in this publication should complement clinical judgement in accordance with the circumstances of the individual, their family and/or carer.

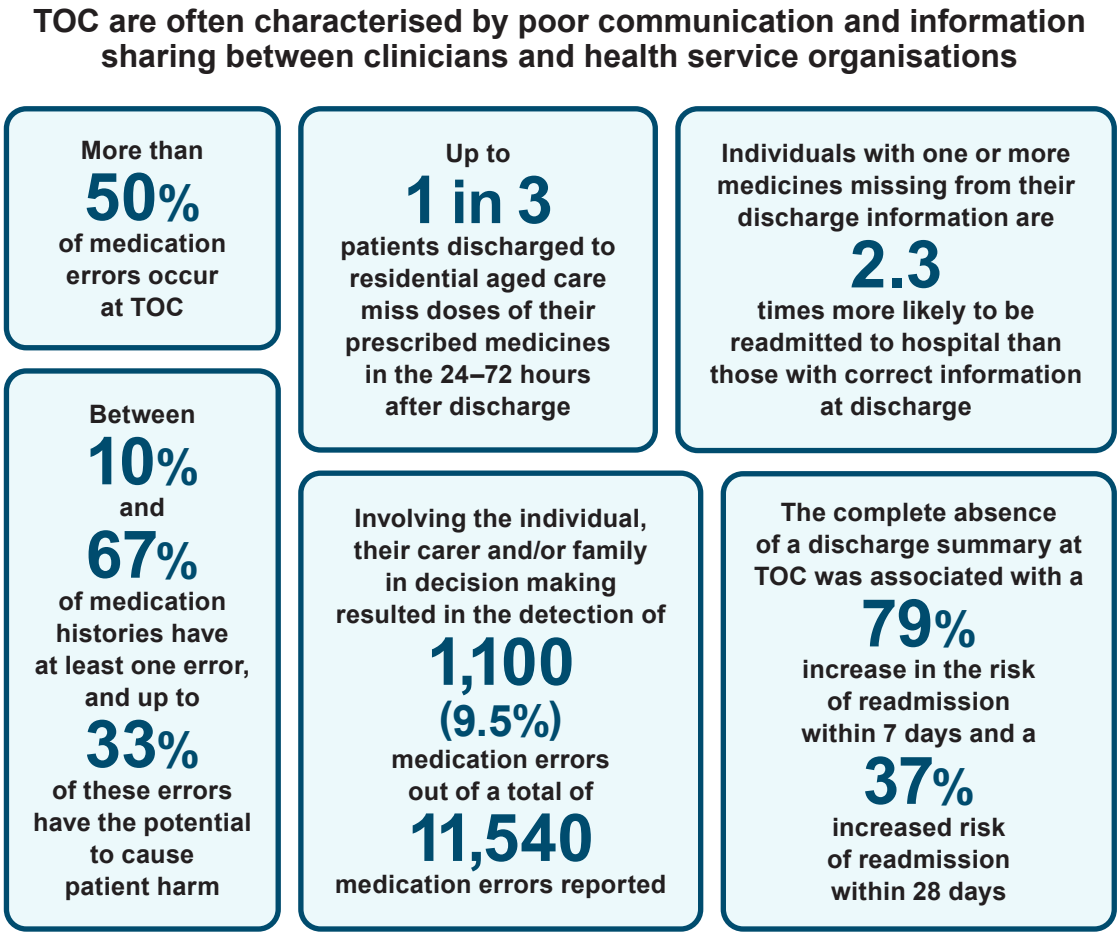
> In this document, 'individual' should be understood to include the patient, consumer or client and, if appropriate, their family and/or a carer who may be involved in decision making.

Rationale for medication management at transitions of care stewardship

A transition of care (TOC) is when all, or part, of an individual's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or for all their health care. It may be temporary or long term.[1]

Medication management at TOC is a period of high risk for medication errors and miscommunication, which can lead to harm (Figure 1).[2] In Australia, each year, more than 250,000 hospital admissions are attributed to medication errors, costing an estimated $1.4 billion.[3,4]

Figure 1 Why medication management at TOC stewardship matters – key statistics[5-14]



In response, the Commission has developed this Medication Management at Transitions of Care Stewardship Framework (the Framework). The Commission defines stewardship as the careful and responsible management of something entrusted to one's care. Medicines stewardship uses a strategic approach to support governance, interventions and tools that guide and optimise practice. It refers to programs aimed at improving prescribing and medication management at individual and population levels to reduce unwarranted clinical variation, ensure safe use of medicines, ensure efficient use of resources, and improve health outcomes.[15] In the Framework, stewardship refers specifically to a quality use of medicines continuous improvement program. A TOC stewardship approach provides opportunities to focus organisational resources, foster multidisciplinary collaboration, and improve coordinated care when individuals transfer between care settings.[16]

Australia's response to the third World Health Organisation Global Patient Safety Challenge – Medication without harm describes that establishing and implementing medication documentation and communication standards across all TOC can lead to reductions in both medication errors and adverse drug events.[6] Studies have promoted a TOC stewardship approach to address this priority area and reduce medicine-related readmissions and harm.[17]

Related standards and resources

The Framework complements and builds on an existing suite of standards and resources that foster integrated care and support safety and quality when individuals transfer between care settings. Clinicians and health managers seeking to drive local quality improvement in medication management at transitions of care are encouraged to draw on the wealth of information, evidence and guidance in the resources and standards described in Appendix 1 and linked where relevant throughout the document.

Framework overview

A literature review and environmental scan identified that, globally, no published studies or existing frameworks specifically describe stewardship of medication management at TOC.[16] Yet, medication management at TOC continues to pose safety risks, especially for vulnerable populations.[16] The Framework has been informed by evidence from other medicines stewardship initiatives, such as antimicrobial stewardship, and evidence for strategies identified to reduce medication errors at TOC, as summarised by two supporting evidence briefs (see Appendix 1).[18,19]

> Implementation of local medication management at TOC stewardship does not replace existing processes or systems, but does require cultural change and thus should use proven methodologies in behavioural and implementation science to embed clinical practice improvement in policies and procedures for local medication management at TOC.[15,16,20,21]

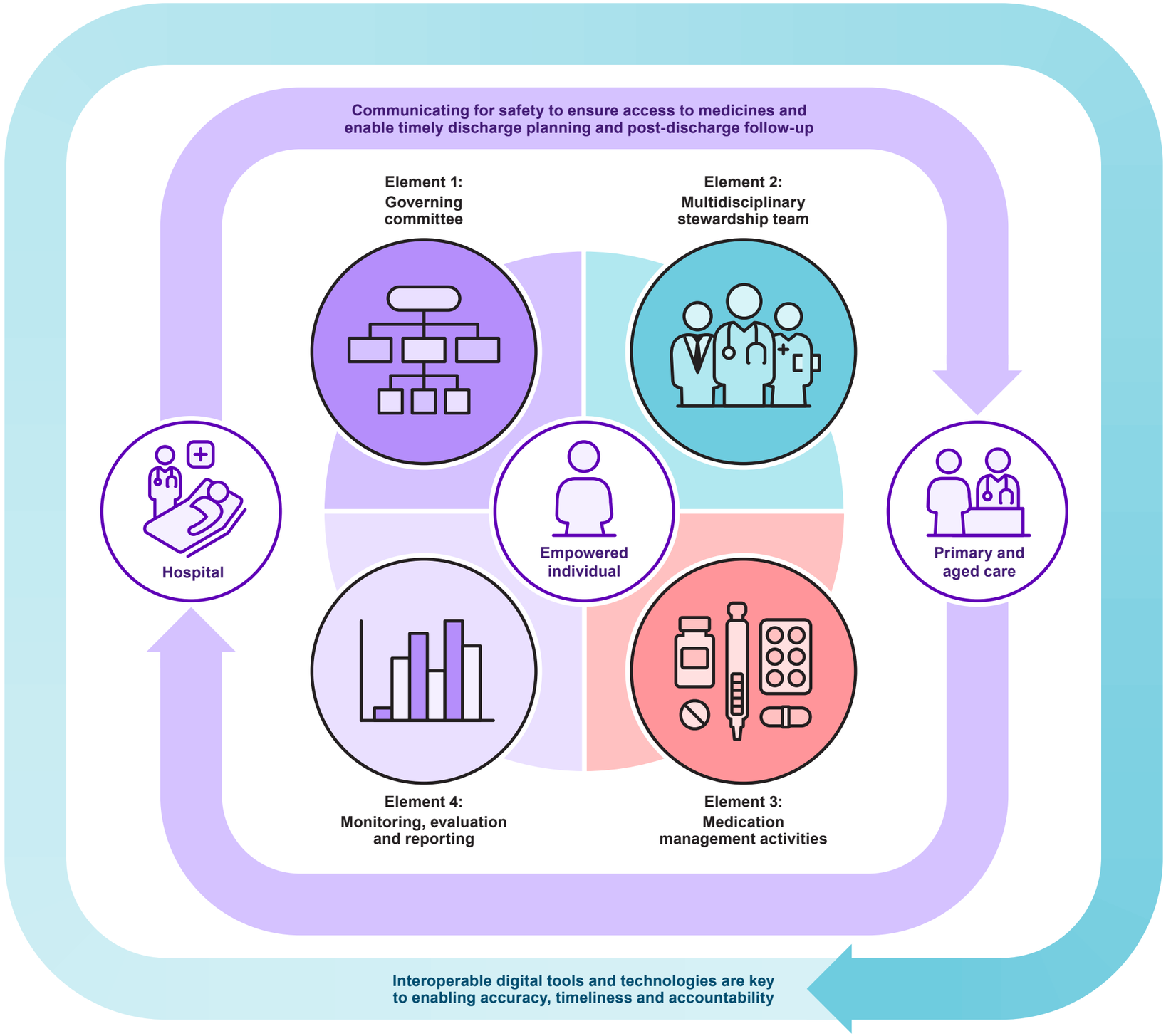
Scope

This Framework focuses on TOC that occur between hospital inpatient settings and primary and aged care settings; a period known to be especially high risk. That is, TOC that occur as part of an individual's hospital journey from admission, throughout the hospital stay, to discharge into primary or aged care settings, for effective follow-up care. However, the principles and elements of the Framework may be transferrable, with appropriate modification, to other TOC settings and pathways such as TOC that occur within the primary and community care sector, and to other patient cohorts.

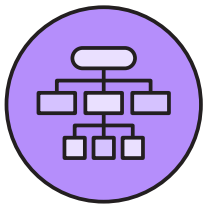
How to use the Framework

The Framework, comprised of four elements, is illustrated in Figure 2. It provides a systematic and person-centred approach for a hospital, encompassing coordinated interventions to optimise medication management at TOC.[16] Hospitals may use the Framework to guide the improvement of local medication management at TOC stewardship. Guidance on each element of the Framework and the enabling roles of person-centred care, communicating for safety and digital tools and technologies across each element are outlined below and summarised in Figure 3.

Figure 2 The Medication Management at Transitions of Care Stewardship Framework



A summary of the Framework elements

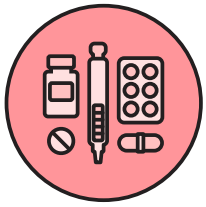


Element 1: Governing committee

Element 1 ensures there is effective leadership and clearly defined structures, accountability, roles and responsibilities. Operationalising the Framework requires clear governance roles and responsibilities, which are aligned to the most appropriate committee within the hospital's governance structure. In this Framework, the committee that assumes responsibility for stewardship of medication management at TOC is referred to as the 'governing committee'. It ensures there is appropriate engagement with internal and external stakeholders and that supporting policies and procedures are fit for purpose.

Element 2: Multidisciplinary stewardship team

Element 2 outlines the importance of a multidisciplinary team of clinicians to coordinate, lead and champion local medication management at TOC stewardship. They act as the link between the governing committee and hospital care teams, to support these teams to improve medication management at TOC.



Element 3: Medication management activities

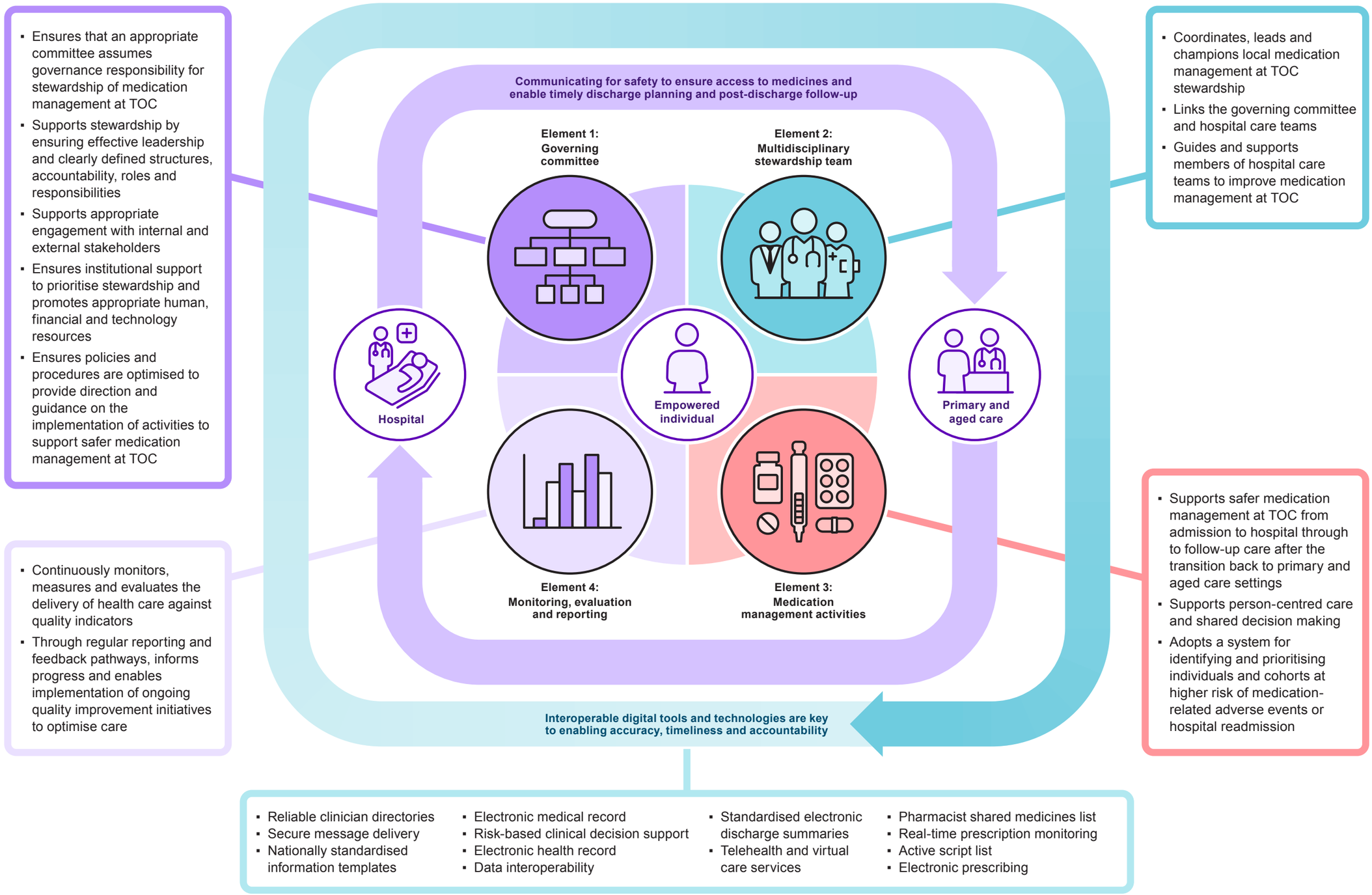
Element 3 describes medication management activities that support safer medication management at TOC – from admission to hospital through to follow-up after the transition back to primary and aged care settings. These activities are person-centred – determined by the individual's needs and preferences – and support shared decision making by engaging and empowering individuals, including their families and carer as appropriate, to participate in decisions about their care.

Element 3 also adopts a systematic approach to identify individuals and cohorts who are at higher risk of medication-related adverse events or hospital readmission and/or have complex medication needs. This supports appropriate prioritisation of medication management activities, alongside clinical judgement.

Element 4: Monitoring, evaluation and reporting

Element 4 promotes continuous monitoring, measuring and evaluation of care against locally determined quality indicators. This supports regular reporting and feedback pathways that track ongoing quality improvement initiatives that optimise care outcomes.

Figure 3 Guidance on the Framework elements[16]



Supporting enablers

The overarching enablers, outlined below, should be incorporated into the planning, design and implementation of all policies and strategies related to stewardship.

Person-centred care and shared decision making

Person-centred care is widely recognised as a foundation to safe, high-quality health care. It is care that respects and responds to the preferences, needs and values of individuals.[22]

Shared decision making is collaboration between an individual and their healthcare provider. It is about bringing together the individual's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person.[23] It is important to use empowering and inclusive language that is culturally appropriate and respectful of the diversity of Australia's people.

Communicating for safety

Early and ongoing collaboration and communication between clinicians and the individual underpin safe and high-quality TOC. Proactive and ongoing communication between clinicians and the individual across all care settings empowers the person to actively engage in their care.

> In this document, 'primary healthcare provider' refers to the clinician who is responsible for and coordinates an individual's care in the primary or aged care setting. This is usually the individual's regular general practitioner (GP) but may refer to other primary care clinicians when relevant.

Primary healthcare providers, especially a GP, are the key coordinators of individuals' care. For example, bidirectional communication between hospital clinicians and clinicians in the primary and aged care settings is essential to timely and effective transfer of care information. This supports timely discharge planning and post-discharge follow-up, such as timely access to medicines. Effective communication can be realised through connected digital systems, further enabled by written and verbal information exchange between clinicians.

Digital enablers

Interoperable digital tools and technologies are key to achieving accurate and timely clinical communication and accountability between clinicians and across care settings. While implementation of the Framework does not depend on the availability of digital solutions, digital maturity is considered a key factor in realising its full benefits.

Examples of digital tools and technologies that support TOC include accurate provider directories, secure message delivery, standardised electronic discharge summaries, electronic medical records (EMR), risk-based clinical decision support tools, national digital health infrastructure (such as My Health Record), data interoperability, telehealth and virtual care services, pharmacist shared medicines list, real-time prescription monitoring, active script list and electronic prescribing (see Figure 5).

Applying the Framework

The Framework provides a systematic approach to adopting stewardship of medication management at TOC by incorporating the approach into existing structures, policies and processes. This section outlines the key factors to consider when preparing to incorporate the Framework elements, followed by further guidance on the Framework elements.

Preparing to implement the Framework – Phase 1

Setting goals

The overarching goal of the Framework is to continuously improve safety and quality of medication management at TOC by embedding a stewardship approach. A health service organisation should determine its priorities and desired outcomes for improving medication management at TOC. The organisation should then identify specific goals and objectives that aim to achieve these and decide on relevant performance measures or quality indicators to track progress.

Establishing governance arrangements

Governance is the set of relationships and responsibilities established by a health service organisation between its governing body, executive, clinicians, individuals receiving care and consumers to deliver safe and high-quality health care.

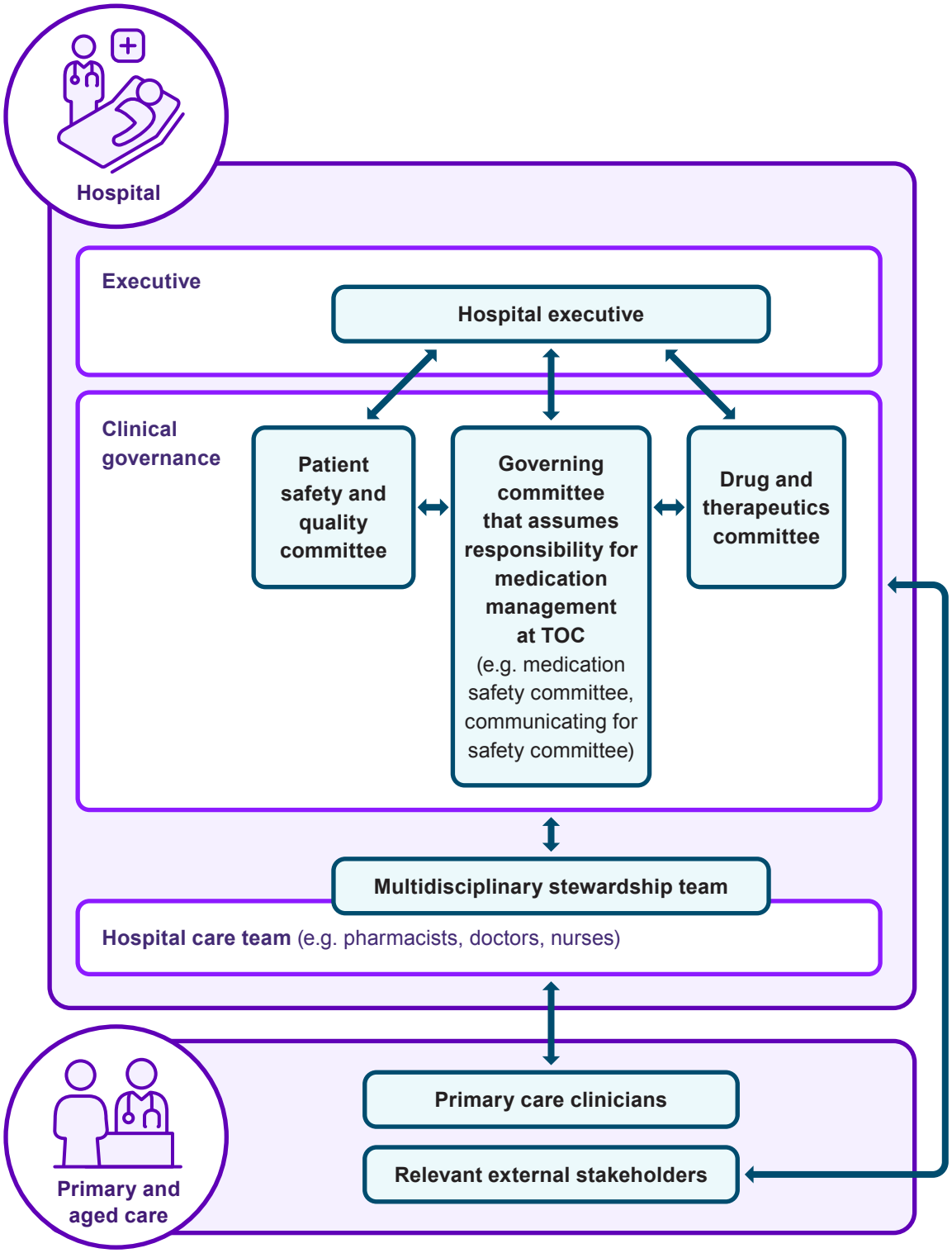
The National Safety and Quality Health Service (NSQHS) Medication Safety Standard[24] outlines that a health service organisation should:

- Ensure there are systems for effectively managing medication safety, and that resources are allocated to implement these systems
- Ensure there are processes for the regular review of current and future medication safety risks, and for reporting and acting on incidents involving medication errors
- Review reports on the effectiveness of the medication safety system.

Stewardship of medication management at TOC is best supported when it is incorporated into existing safety and quality frameworks and reports through the organisation's governance structure. It is expected an existing committee will assume responsibility for stewardship of medication management at TOC (see Element 1). This committee is referred to in this Framework as the 'governing committee' and it should have clearly defined operational and reporting lines to the executive, the peak safety and quality committee (or equivalent), and the drug and therapeutics committee (or equivalent). Figure 4 provides an exemplar of how medication management at TOC stewardship may be incorporated into a hospital's governance structure.

Good health outcomes rely on effective governance processes and systems that involve stakeholders across an individual's care continuum.[25] Governance in health service organisations therefore requires both executive and clinical leadership.[26] Governance should be linked to frontline care through a multidisciplinary stewardship team of clinicians (see Element 2). This team will lead and champion stewardship among hospital care teams and provide the connection between clinicians and the governance structure.

Figure 4 Exemplar of a hospital governance structure, incorporating medication management at TOC stewardship



Establishing leadership

Prioritising safe and high-quality medication management at TOC will help ensure the executive team and the clinical governance unit maintain accountability for stewardship objectives. Executive and clinical leaders can promote a safety culture by demonstrating their own commitment to safety and providing resources to help teams improve (Box 3 and Figure 5).[26]

The success and sustainability of the stewardship initiative depends on the support and leadership of the executive, senior management and senior clinical workforce.[26] Specific leadership roles of the governing committee and the stewardship team are discussed in Element 1 and Element 2, respectively.

Preparing to implement the Framework – Phase 2

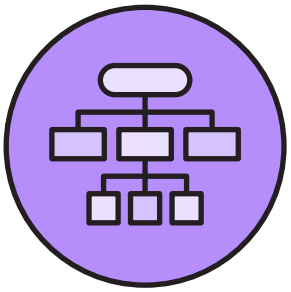
Planning for local implementation of stewardship activities should be customised for the individual health service, and consider local needs, resources, risks and stakeholder priorities. Key planning steps are to assess readiness (through an initial assessment, needs analysis and risk assessment) and determine priority areas. Table 1 outlines a planning approach to be considered by the governing committee and stewardship team before implementing the Framework.

Table 1 Planning considerations before implementing the Framework

Step	Planning consideration	Description
1	**Initial assessment**	An assessment of: • current performance of medication management at TOC processes • human, financial and information technology resources available or accessible • organisational culture, including the level of executive commitment and support[26] This will establish baseline performance, inform a needs analysis, and enable progress to be measured
2	**Enabling performance**	A needs analysis compares current performance with desired performance and helps identify and prioritise what changes will enable improvement The assessment of current performance will be informed by data related to medication management at TOC, such as data on medication misadventure and hospital readmissions. The desired future state is described by the goals and objectives (see above) Once these are defined, the organisation can determine what processes, resources and behavioural changes are required to achieve the objectives
3	**Structures and processes required**	A needs analysis based on the initial assessment will determine what (new or improved) structures and processes are required A risk assessment should also be used to ensure risks associated with new or changed structures and processes are mitigated and existing processes are not disrupted

Table 1 Planning considerations before implementing the Framework (continued)

Step	Planning consideration	Description
4	**Organisational readiness**	Organisational culture, encompassing the attitudes and behaviours that characterise the organisation, may influence readiness to adopt the Framework and affect the prospects of success[26] Assessing organisational readiness will help identify perceived barriers or resistance to staff engagement and implementation This will enable measures to be planned and implemented to overcome these obstacles[26]
5	**Risk assessment**	Action 1.10 of the NSQHS Clinical Governance Standard requires health service organisations to identify and manage risks effectively.[27] Hospitals should use a risk management approach (informed by *Australian/New Zealand Standard AS/NZS ISO 31000:2018 Risk Management*[28]) to mitigate risks that arise from local stewardship A risk assessment using the information gathered from the initial assessment and needs analysis, as well as the review of local policies and procedures (see Element 1), will help the stewardship team identify: • established roles and services that support medication management at TOC as part of providing standard care • elements of the Framework that are missing from current practice • priorities for action
6	**Determining priority areas**	Matching interventions to local priorities ensures and demonstrates that plans are locally focused and achievable Once the priority areas and objectives have been determined, the plan to implement priority stewardship activities should be developed and documented (see Element 3 for more information). This will ensure transparency among all involved stakeholders. It will also help gain executive agreement to establish and implement medication management at TOC stewardship within assigned resources.[26] Proposed practice changes should be reviewed and endorsed by the governing committee



Element 1: Governing committee

As outlined above, the Framework is designed to be implemented within a hospital's existing medicines governance group and governance structure (which may comprise, for example, a drug and therapeutics committee, medication safety committee, communicating for safety committee). Element 1 of the Framework establishes a set of roles and responsibilities to be assumed by the most appropriate committee within the hospital's governance structure.

The committee that assumes responsibility for medication management at TOC stewardship is referred to in this document as the 'governing committee'. The governing committee is responsible for the implementation and ongoing oversight of stewardship of medication management at TOC, including reviewing and advising on the effective and efficient management of available resources and risks.

Composition

The starting point for the composition of the governing committee is the membership of the existing committee that assumes responsibility for medication management at TOC stewardship. An assessment of the composition of the governing committee should be made based on the required roles and responsibilities and need for stakeholder engagement (discussed in the following two sections). It may be desirable or necessary to introduce new skillsets or stakeholders to represent broader perspectives and interests.

Roles and responsibilities

In general, the governing committee is responsible for:

- Reviewing and updating the committee's terms of reference to reflect a focus on adopting a stewardship approach to drive improvements in the organisation's medication management at TOC
- Overseeing ongoing stewardship implementation
- Regularly reviewing local datasets to identify outcomes, trends and opportunities for improvement
- Identifying target areas and priority actions to improve stewardship activities
- Reviewing and developing relevant policies and guidelines
- Reviewing committee membership to ensure appropriate internal and external stakeholder engagement
- Establishing or using existing formal communication and engagement channels with relevant external stakeholders from primary and aged care
- Evaluating and reporting on the progress and effectiveness of implementation, including achieving defined outcomes, against the committee's terms of reference
- Monitoring medication-related incidents and potential risks and taking any necessary management actions in response.[16,26]

Leveraging stakeholder engagement

Stakeholder engagement improves medication management at TOC, and encourages internal and external advocacy for medication management activities.[16] These stakeholders should be involved in collaborative planning and decision making.[16] Stakeholder roles and responsibilities should be documented in local policies and procedures.

Regular engagement is required with both internal stakeholders (for example, clinicians, executives) and external stakeholders (for example, representatives from other care settings and consumer representatives).[16] Membership of the governing committee should include appropriate internal and external stakeholders. When appropriate and practicable, shared governance between the Local Hospital Network and Primary Health Network should be considered.

External stakeholders may include GP representatives or GP liaison officers, which would act as a conduit to engage and inform GP colleagues. As outlined in Table 2, it may include other clinicians from primary care or aged care settings, and non-clinician representatives with relevant authority and expertise from other care settings or government entities.[29]

Table 2 Suggested external stakeholder representatives for the governing committee

Proposed representative	Rationale for inclusion as a member of the governing committee
Aboriginal and Torres Strait Islander health liaison officer	Address the needs of Aboriginal and Torres Strait Islander individuals, ensuring culturally safe practices
Allied health professionals (for example, social workers, occupational therapists)	They play a crucial role in supporting medication adherence, educating individuals on safe medication use, and managing any social or functional challenges that may affect medication management
Community pharmacist representative (including credentialed pharmacists)	They are essential for medication review and reconciliation, patient education and ongoing medication management post-discharge
Culturally and linguistically diverse communities health liaison officer	Address the needs of their communities, including ensuring culturally safe practices
Home care or community nursing services representative	They provide insight into the challenges and needs of people who receive home-based care and medication support
Nurse practitioners (primary or community care)	They provide care continuity, support medication administration, and often coordinate with other healthcare providers in primary and community care settings
Patient or consumer advocate	They ensure the Framework remains person-centred and responsive to individuals' needs and concerns
Residential aged care home representative	A representative familiar with procedures at residential aged care homes can help smooth transitions and ensure continuity of care for individuals transitioning to or from these facilities

Executive leadership

The overarching role of the governing committee is to provide leadership and oversight of adoption of a stewardship approach to medication management at TOC. It also engages with the executive to ensure support for stewardship at the highest level of the organisation (the governing committee is likely to include a member of the executive team, who may act as executive sponsor for implementing stewardship). Some specific leadership roles played by the governing committee (and/or executive) are described in Box 1.

Box 1 Governing committee leadership roles[26]

- Prioritising and promoting medication management at TOC stewardship as a strategic safety and quality goal of the organisation
- Ensuring that the clinical governance framework and quality improvement systems and processes relating to medication management at TOC stewardship within the organisation are robust, and that the Framework is incorporated into the organisation's safety and quality strategic and operational plans and organisational priorities
- Providing institutional support for resourcing to optimise effectiveness, build capability and capacity, and ensure improvement strategies are sustained[16,20]
- Facilitating availability of appropriate resources for stewardship (human, financial and technological), and supporting the stewardship team (see Element 2) to operate within the clinical governance framework
- Supporting the stewardship team in promoting accountable clinical practice across the organisation
- Ensuring that clinicians receive appropriate orientation on medication management at TOC stewardship at the start of their employment in the organisation, and ongoing education and training regarding medication management at TOC
- Issuing formal statements that the facility supports efforts to improve medication management at TOC stewardship
- Including medication management at TOC stewardship duties in job descriptions and annual performance reviews at all levels
- Ensuring that workforce members from relevant departments have commitment to contribute to medication management at TOC activities
- Ensuring participation from clinical groups that can support medication management at TOC activities

Policies and procedures

Health service organisations should ensure their policies and procedures guide clinicians on stewardship activities to support safe medication management at TOC.[16] These policies and procedures should reflect state or territory requirements, be informed by internal and external stakeholder engagement and reflect key stakeholder priorities.[16] These policies and procedures should clearly define the:

- Processes and activities to support medication management at TOC[16]
- Structure and composition of the stewardship team and its accountabilities, roles and responsibilities (see Element 2)
- Processes or protocols to screen, assess and prioritise individuals according to risk, along with specific medication management activities (see Element 3)
- Locally determined quality indicators to evaluate implementation of medication management at TOC stewardship (see Element 4).

Policies and procedures should be regularly reviewed to ensure guidance remains current and reflects the nuances in different clinical requirements according to the source and destination of TOC.[16]

Element 2: Multidisciplinary stewardship team

Element 2 of the Framework establishes:

- The multidisciplinary team and their roles and responsibilities
- Resources for consideration when establishing stewardship activities
- A communication and education plan.

Establishing the team

The formation of a multidisciplinary team of clinicians to champion stewardship is recognised as a core element of stewardship. Element 2 of the Framework establishes this team, its responsibilities and suggested activities.

Oversight and championing from a multidisciplinary stewardship team provides a holistic system perspective that helps ensure stewardship achieves its intended aims and can be sustained. The multidisciplinary stewardship team serves as the intermediary between the hospital's governance structure and individual clinicians.

Box 2 The stewardship team is not a treatment team

The stewardship team members sits between the governing committee and clinicians. Its role is to lead and champion stewardship activities. It works to raise awareness of stewardship, achieve buy-in and identify education and training needs within the organisation.

The stewardship team do not, however, in their role as stewardship leaders and champions, intervene with care teams or the care of an individual. Clinicians and teams caring for individuals remain responsible for providing safe and high-quality care, using their clinical judgement and discretion. This includes empowering individuals, their families and carers to participate in their medication management at TOC.

Composition

The composition of the stewardship team should reflect local needs and available resources.[16] Membership may overlap with membership of the governing committee and should include the suggested positions outlined in Box 3.

As with the governing committee, the overarching role of the stewardship team is to provide leadership. Some specific leadership roles played by the stewardship team are described in Box 3.

Box 3 Multidisciplinary stewardship team leadership roles[26]

- Identifying a suitable lead to be the director in medication management at TOC stewardship (ideally a senior medical lead)
- Identifying a suitable clinical champion(s) (ideally a senior pharmacist) to be the leader(s) in medication management at TOC stewardship implementation. In hospitals without an on-site pharmacist, this role may be performed by a network pharmacist, a dedicated senior nurse or a junior medical officer with suitable experience. Alternatively, a nurse specialising in medication management or TOC, with necessary support and training, could be appointed to coordinate medication management at TOC activities
- Enabling the director and clinical champion(s) to work with the executive to ensure that the executive is engaged and invested in the goals of medication management at TOC stewardship, in order to provide sufficient executive support
- Using other champions to enhance communication and collaboration for improving medication management at TOC, including:
  - Specialist senior medical professionals (for example, those working in geriatrics or cardiology)
  - Junior medical professionals
  - Pharmacists
  - Nurses
  - Other allied health staff as appropriate
- Reviewing workflows and processes to identify which experts are available and best placed to lead and manage medication management at TOC stewardship across a health network. (Networked stewardship often requires leadership and resources dedicated to the support of remote facilities)

Roles and responsibilities

Roles, responsibilities and accountabilities of stewardship team members should be clearly defined and may extend in scope beyond the local organisation. Suggested responsibilities include[16]:

- Work with the governing committee to plan and adopt stewardship of medication management at TOC, establish goals, and optimise existing and new policies, procedures and guidelines, including systems and workflows for out of hours and weekends
- Facilitate awareness, education and training for hospital clinicians and other staff and, if appropriate, primary care clinicians
- Advocate for medication management at TOC stewardship
- Monitor, evaluate and report performance against defined indicators for quality and safety
- Provide direct feedback to clinical areas and support improvement
- Regularly monitor and maintain appropriate risk stratification processes and escalate concerns or risks to the governing committee.

The stewardship team has an overarching view of stewardship and its performance. They are well positioned to identify and understand risks, so it is a key responsibility to escalate such issues to the governing committee.

Nevertheless, **all clinicians** are responsible for escalating concerns or risks to the governing committee or via business-as-usual processes.

Resources required

Once the governing committee and stewardship team have been established, the resources required to successfully carry out stewardship activities require careful consideration. The needs analysis conducted in the planning stage will compare the resources available or accessible to the resources required. Relevant resources include the capacity of the workforce to participate in medication management at TOC stewardship activities, supporting policies and guidelines, audits and data collection processes, and digital infrastructure.[26]

Although the Framework does not require mature digital infrastructure for successful implementation, health service organisations are encouraged to embed safe and quality digitally enabled care to strengthen effective communication across clinical disciplines and improve medication management at TOC. While it is acknowledged that digital maturity is variable, paper-prominent medication management is not considered to be best practice.[30] Primary Health Networks should also be engaged to determine the tools and resources that can be provided to primary care services to assess digital readiness. Outlined below are examples of how leveraging digitally enabled care as a resource can support medication management at TOC stewardship activities.

Leveraging digitally enabled care as a resource

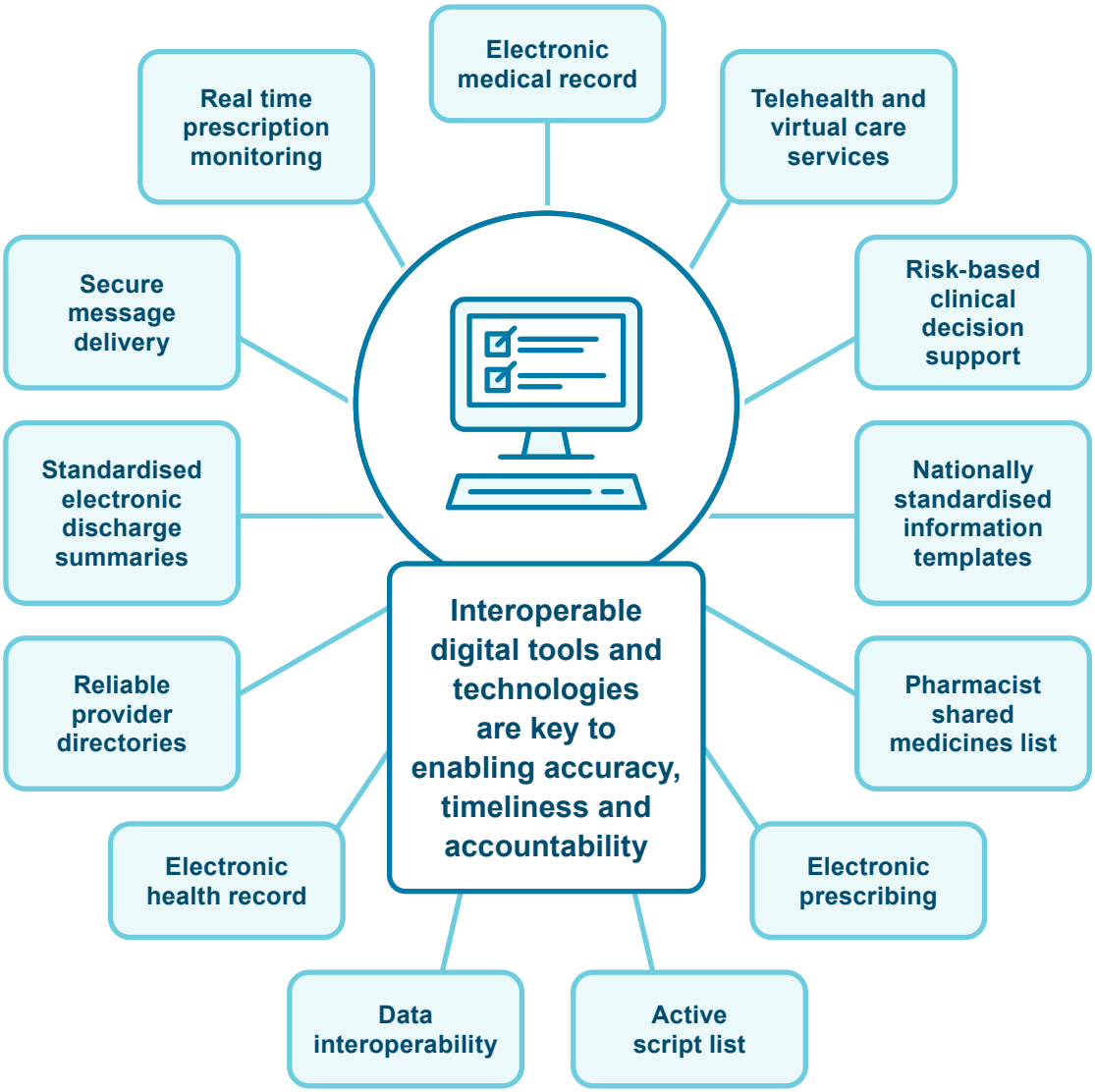
The safe implementation and use of digital tools and technologies to deliver digitally enabled care has been shown to empower clinicians to enhance decision making and actively manage various health conditions.[16]

> While implementation of the Framework does not depend on the availability of digital solutions, digital maturity is considered a key factor in realising its full benefits.[30]

The Framework has been developed to align with the *National Digital Health Strategy 2023–2028*[31] and the *Strategy Delivery Roadmap*.[32] Several foundational initiatives in digital health that are to be delivered or enhanced in the near term (2024–2028) are significant to safety and quality in health care.[31,32] The Commission recognises the ongoing and expanding national agendas driving improvements in health infrastructure and interoperability that will support this Framework.

Digital maturity varies nationally. Organisations that use the Framework will need to consider their digital capability when prioritising activities under each of the Framework's elements. For example, an electronic medical record system can enable seamless information exchange across different healthcare settings. In addition, establishing robust interfaces between systems, such as EMR systems, My Health Record and electronic National Residential Medication Chart systems, will enable real-time access to patient information and improve coordination among healthcare providers. Figure 5 presents key digital enablers.

Figure 5 Digital health initiatives that enable seamless information exchange



Adopting digitally enabled stewardship

To facilitate safer transition of medicines information, a combination of direct verbal and electronic information transfer methods should be used.[16] Table 3 presents a list of digital tools that can be used to help implement the Framework. Consideration should be given to the on-screen design and usability of digital tools, which can improve clinician usability and reduce cognitive burden.

Further digital enablement should focus on adopting:

- National terminologies and information structures, for example Australian Medicines Terminology[33], for creating accurate and reusable medicines information across the health system
- An enduring, comprehensive and secure record system to document, communicate and provide access to information about an individual's care[34]
- Directly messaging discharge summary data securely to the individual's primary healthcare provider (usually a GP) or primary care setting (using secure message delivery), accompanied by real-time verbal communication. Clinical documentation,

such as discharge summaries, should be available in near real time at the point of TOC. This will ensure effective communication and professional accountability between care providers about an individual's care plans during and after TOC.

- Adopting national healthcare identifiers[35] such as 'organisation', 'healthcare provider identifier – organisation and individual' and 'individual healthcare identifier'.

Table 3 Suggested digital tools that support local medication management at TOC stewardship

Digital tool	Description	Enhanced functionality when maturity is reached	Potential applications and benefits
Electronic Medical Records (EMR)	A digital platform for sharing an individual's health information within a health service organisation[16]	Standardisation, consistency, transparency and ease of sharing to optimise documentation and communication of an individual's health information among the healthcare team	Streamlined discharge medication reconciliation process through the availability of nationally standardised templates for documenting discharge summaries, best possible medication histories, individuals' medication management plans and GP letters[16]
Electronic medication management (EMM) systems	A digital system that can govern the medication cycle to increase quality and safety, including reducing prescribing and dispensing errors and the number of preventable medication-related adverse events[16]	Embedding of EMM systems by health service organisations to improve the accuracy, visibility and legibility of medical information, thereby improving communication among clinicians. The Commission has developed guidance on the safe implementation of EMM systems[36]	Reduced preventable adverse medication events, and medication prescribing and dispensing errors[36]
Electronic Healthcare Records (EHRs), such as the My Health Record	An online electronic repository through which an individual can easily access, manage and share their health information securely[37]	An individual's EHR will be accessible by all treating clinicians across care contexts, providing one avenue for improving timely access to current and clinically relevant information[37]	Optimised medication safety at TOC through EHRs that are maintained and updated by all appropriate stakeholders involved in an individual's care, which will reflect their accurate medication usage across TOC

Implementation

Successful implementation of medication management at TOC stewardship requires a multifaceted intervention strategy.[16] Proven methodologies in behavioural change and implementation science should be adopted to overcome resistance to change and improve clinical practice.[15] For example, a sequential, structured method of implementing focused stewardship activities may be appropriate. Implementation should include a thorough communication and education plan as outlined in Table 4.

Table 4 Suggested communication and education plan

Implementation strategy	Description	Activities
Develop a communication plan	A robust, clear communication plan should include strategies to raise awareness and increase clinician understanding of medication management at TOC stewardship and its objectives	• Promoting stewardship activities and achievements during Medication Safety Week • Promoting stewardship via hospital-wide communication channels (for example, a newsletter or the intranet) • Creating posters, lanyards and computer screensavers • Using local nursing, medical, pharmacy and other allied health champions to advocate for stewardship and support its implementation • Holding a launch event • Integrating medication management at TOC stewardship into existing local events such as medication safety forums and grand rounds.
Educate the workforce	Education should reinforce that stewardship processes must consider discharges occurring out of hours and on weekends and should be ongoing[16,26]	• Regular training and education sessions should be provided for staff to increase their awareness and understanding of medication management at TOC • Gaps in clinical knowledge should be identified and guidelines developed to educate the workforce about stewardship activities • Training and education may be integrated with clinician orientation, regular continued education sessions and grand rounds, and may extend into the primary and aged care settings • Smaller facilities, including rural and remote hospitals, private facilities and residential aged care homes, may need to draw on communication and education resources available in the larger organisations in their network[26]

Element 3: Medication management activities

Element 3 of the Framework establishes:

- Communicating for safety strategies
- A systematic risk-based approach to prioritise individuals for interventions
- Activities to support safe and high-quality medication management at TOC, from admission to hospital through to post-discharge follow-up.

Together, these build towards a model of care that optimises medication management at TOC.

Studies have demonstrated that multi-strategy interventions have the greatest effect on clinical outcomes.[16] The Framework proposes a set of high-level stewardship activities, based on frameworks and programs already in use.[16,18,20,21] These activities do not replace existing initiatives, but rather are intended to work with and complement them.

The proposed activities recognise that collaboration and communication – among the care teams, and with the individual and their family and/or carer – underpin safe and high-quality TOC.[16] These are further enabled and increased by digitally mature health infrastructure and systems.[7]

Across all activities, it is essential that stewardship activities are person-centred and the individual's informed consent is obtained and documented, and that clinicians abide by relevant privacy and confidentiality legislation, rules and policies.

Communicating for safety

Safe and high-quality medication management at TOC requires effective, two-way communication and handover between all clinicians involved in the individual's care[16] and between healthcare providers and the individual – from admission to hospital through to post-discharge follow-up (Box 4).[38]

Prior to any targeted medication management at TOC activities being undertaken, the governing committee should advise on the most appropriate verbal and written communication and documentation processes for all stages of Element 3. This should be reflected in local policies and procedures.[39]

These should cover all activities such as:

- Documentation of risk status on admission
- Documentation of medication management reviews, medicines lists, discharge summaries and post-discharge follow-up as well as guidance on verbal contact that may occur at the discretion of the clinician
- Communication with the primary healthcare provider and documentation in the individual's healthcare record.

Hospitals should implement systems to engage individuals early in their admission and support them to participate in TOC throughout their episode of care. Participation should be tailored to the individual's wishes and should include careful consideration of the individual's health literacy, language barriers and culture.[40] Post-discharge follow-up should be discussed and agreed plans, with consent from the individual, should be documented in the individual's healthcare record and discharge summary.

Box 4 The primary healthcare provider

Clear, timely and effective clinical communication between the hospital care team and the individual's primary healthcare provider is critical to safe and high-quality TOC. The governing committee should establish policies and processes to guide this communication. The clinician may use clinical judgement when initiating contact with the primary healthcare provider throughout an episode of care. Established processes should guide communication in the lead-up to TOC and communication should continue, as a minimum, up to discharge from hospital, and beyond when appropriate, to ensure effective clinical handover and continuity of care.

Risk stratification and prioritisation

Establishing a systematic risk-based approach to prioritise individuals

The governing committee should establish a systematic approach, using predefined criteria, to support clinicians in identifying and prioritising individuals and cohorts for targeted stewardship activities. Those may include individuals:

- At higher risk of medication-related adverse events during or after TOC
- At higher risk of medication-related hospital readmission after TOC
- With complex medication needs.

They may also include:

- A focus on specific wards or specialties, based on local readmission rates and/or the hospital's risk assessment
- A focus on high-risk populations as identified by the literature – for example, individuals who are older, have low literacy, have complex medicine regimens, have a history of mental health, are an Aboriginal or Torres Strait Islander person, or are a member of a migrant population.[16,41-43]

This may involve the use of a standardised risk stratification tool. To date, no high-quality studies have demonstrated if risks of adverse medication outcomes are reversible and if readmissions could be prevented by the use of any such tool. Further, few of the tools focus on medications or use medication-related variables to predict risk.[16]

Targeted and individualised strategies should be given to high-risk cohorts to better facilitate care planning, resulting in smoother TOC[16], improved safety and quality of care, reduced readmission rates and maximised resource efficiency.[16]

> Risk stratification and prioritisation to support stewardship should not disrupt existing effective care arrangements. For example, an established heart failure service within a hospital would typically continue to handle the medication management of individuals with heart failure.

As a guide, Box 5 and Box 6 present a list of individual patients and groups of patients, respectively, who are most at risk of medicines-related problems and more likely to have poor TOC experiences, respectively.[42,43]

Box 5 Patients most at risk of medicines-related problems per AdPha's Standards of Practice for Clinical Pharmacy Services[42]

Maximum benefit from clinical pharmacy services is likely to be obtained for patients most at risk of medication misadventure, for example, patients who have at least one of, but not limited to, the following characteristics:

- Have medication misadventure as the known or suspected reason for their presentation or admission to the health service organisation
- Are aged 65 years or older
- Take 5 or more medicines
- Take more than 12 doses of medicines per day
- Take a medicine that requires therapeutic monitoring
- Take a high-risk medicine
- Have had clinically significant changes to their medicines or treatment plan within the last 3 months
- Have suboptimal response to treatment with medicines
- Have difficulty managing their medicines because of literacy or language difficulties, dexterity problems, impaired vision or hearing, confusion/dementia or other cognitive difficulties
- Have impaired or fluctuating kidney or liver function (for example, pregnancy, sepsis)
- Have problems using medicine delivery devices or require adherence aids
- Are suspected or known to be non-adherent with their medicines
- Have multiple prescribers for their medicines
- Have been discharged within the last 4 weeks from or have had multiple admissions to a health service organisation
- Are in locations where they have limited access to their treating team, or the clinical specialty they are admitted under.

Source: Dooley et al. (2024) © 2024 Advanced Pharmacy Australia. Reproduced with permission 2025.

Box 6 Patient groups who are more likely to have a poor TOC experience per AdPha's Standard of Practice for pharmacy services specialising in transitions of care[43]

The following groups of patients may be more likely to have a poor transition of care experience and adverse medication outcomes:

- People affected by polypharmacy
- People with chronic and complex conditions
- People with serious mental health conditions
- People with dementia or other forms of cognitive impairment
- Culturally and linguistically diverse groups
- Aboriginal and Torres Strait Islander Peoples
- People who access medicines through the Closing the Gap PBS Co-Payment Program or the Remote Area Aboriginal Health Services Program
- People who live in rural and remote areas
- People who are socially isolated
- People who are transient, have unstable housing or have no fixed address
- People without a regular general practitioner
- People with multiple specialists/prescribers
- People with a disability (especially intellectual disability)
- People living in residential care/nursing home
- People with previous hospital presentations or admissions (especially if medicines-related)
- People transitioning out of prison/incarceration
- Young people who are transitioning from paediatric to adult care
- People discharged from hospital without pharmacist input.

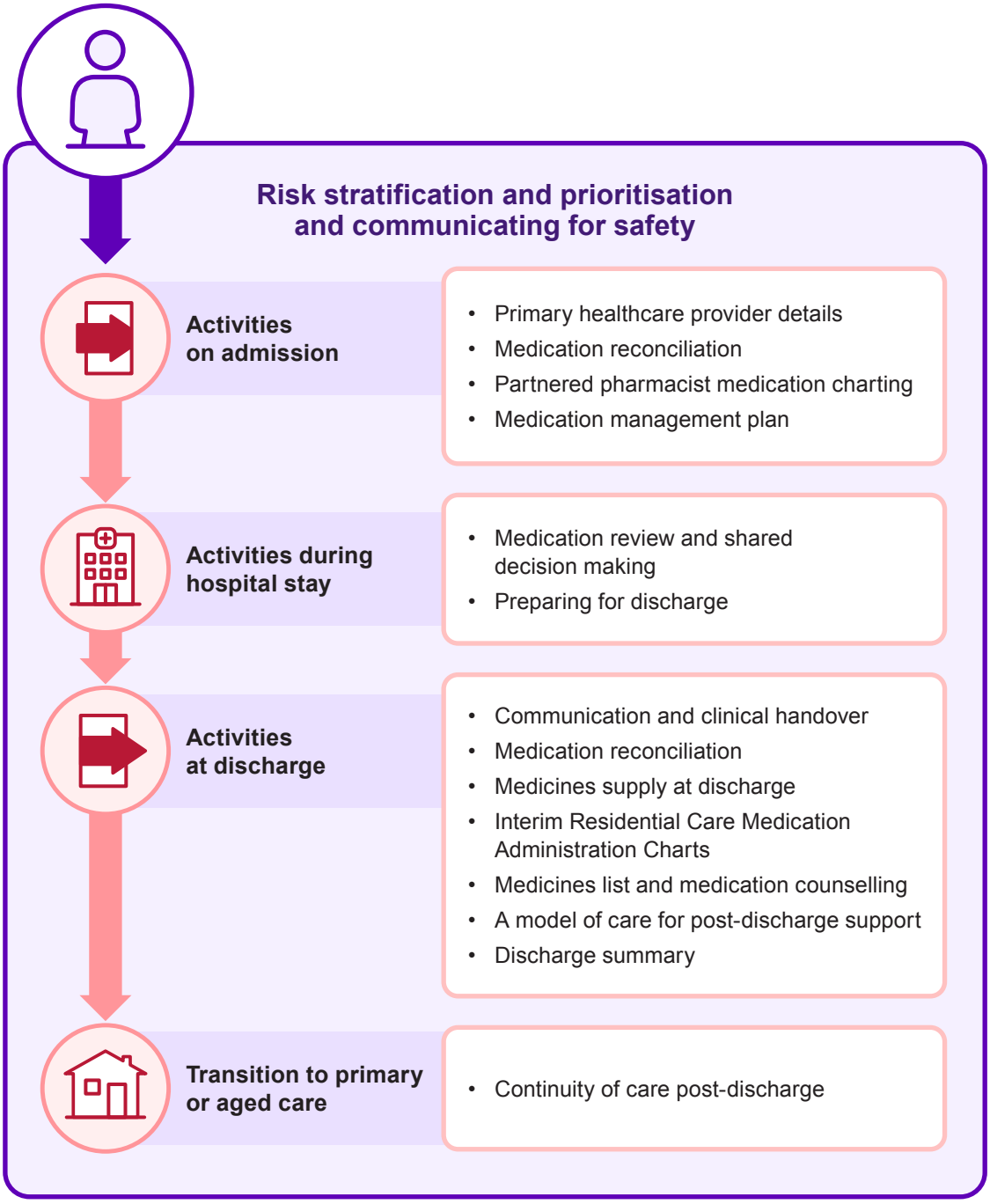
Source: Phillips et al. (2024)

Once the risk stratification and prioritisation process has been established, the clinician responsible for completing the risk assessment should be identified locally. This could be the emergency department pharmacist, ward pharmacist or another suitably qualified clinician, such as medical or nursing staff. After-hours arrangements and staffing in rural or remote hospitals should be considered in formulating this process.

The approved process should be documented in local policies and procedures, and its performance should be monitored to enable improvement over time.

While it is considered best practice to complete all activities outlined below (Figure 6) for all individuals admitted to hospital, in accordance with the *National Medicines Policy*[7], medication management strategies should target known risk areas such as individuals classified as 'high risk'.

Figure 6 Element 3: Medication management activities



Activities on admission

Conduct clinical assessment

When an individual is admitted to hospital, the responsible clinician should assess their risk in accordance with the agreed predefined criteria, and document when individuals are assessed as 'high risk' (according to the local risk stratification approach) in their healthcare record. They should also communicate with the responsible pharmacist and broader treating team to prioritise the clinical review of these high-risk individuals.[16]

Clinicians are expected to apply clinical judgement[44] to identify individuals who, though 'low risk', may benefit from targeted stewardship initiatives.

Clinical judgement is a key component of clinical decision making and clinicians are expected to apply professional clinical judgement when performing clinical interventions and in managing associated risks.[44]

An individual's risk status may change during their admission, and it may be appropriate to reassess the individual during their episode of care and/or at discharge. Any change in risk status should be documented in their healthcare record, communicated to the hospital team and communicated via the discharge summary at TOC.

Obtain primary healthcare provider details

Primary care clinicians are crucial to the continuity of medication management for individuals, especially at TOC.[16] Hospitals should have processes to collect, confirm and document the details of an individual's primary healthcare provider (usually their GP) – and, where relevant, other providers such as their community pharmacy – upon or as soon as possible after admission.

The Framework is primarily designed based on engagement with a primary healthcare provider (usually a GP).

The Framework acknowledges that an individual's health care, including the medicines they are taking, may not always be managed by a single GP or general practice, and that other clinicians may be involved.

Individuals without a regular GP or community pharmacy should be strongly encouraged to nominate a GP and community pharmacy for the hospital team to liaise with throughout their episode of care.[7,45] In addition, a note should be made in the healthcare records of individuals who see multiple GPs or specialists, or obtain their medicines from multiple community pharmacies, as they are at increased risk of miscommunication and medication misadventure.

Early and ongoing primary care collaboration

Using their discretion and clinical judgement, and depending on agreed stewardship processes, it is recommended that the responsible clinician consider making early contact with the primary healthcare provider (usually a GP or practice) of individuals who have been assessed as 'high risk' or have complex needs. Following the individual's consent, this provides an opportunity for the clinician to inform the primary healthcare provider that the individual is an inpatient and that they may require follow-up by their primary care team post-discharge. The provider may also be advised to expect a phone call at the point of discharge to discuss recommendations for collaborative comprehensive medication management review post-discharge. This will be in addition to a written discharge summary and upload to My Health Record and aims to facilitate GP coordination and follow-up post-discharge. These communications should be documented in the individual's healthcare record.

This process provides primary healthcare providers the opportunity to 'flag' specific individuals in their systems for urgent review and follow-up post-discharge. It allows providers to seek clarification on any queries about the individual's clinical condition and to update their records accordingly. This ensures that providers are better prepared and informed about the individual's status and expected needs (including collaborative comprehensive medication management review) post-discharge.

Medication reconciliation

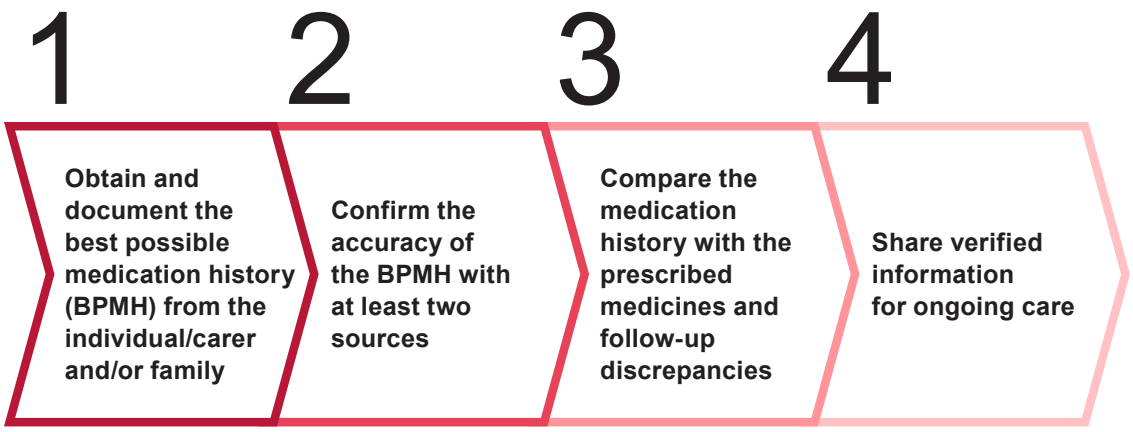
Medication reconciliation involves identifying and resolving any discrepancies between prescribed medicines and medicines being taken, including any complementary or traditional medicines. The process begins by obtaining a best possible medication history (BPMH). A more detailed explanation of the process can be found in the *Guiding principles to achieve continuity in medication management*[46] and is summarised in Figure 7. These steps need to be completed on presentation or as early as possible in the episode of care.

Medication reconciliation and BPMHs are associated with significant reductions in medication discrepancies, particularly when led by a clinical pharmacist.[16] Medication reconciliation should also occur at each TOC[16,47], including:

- During intrahospital transfers, such as the transfer of an individual from the intensive care unit to a general inpatient ward
- When an individual's care, including their medication, is discussed during multidisciplinary rounds, case conferences or consults conducted by multiple treating teams
- When an individual is discharged from hospital to the primary or aged care setting.

The governing committee should determine the most appropriate model to embed for the completion of BPMHs for high-risk individuals. Although usually led by a pharmacist, medication reconciliation requires a multidisciplinary approach that also includes doctors, nurses and the individual.[47]

Figure 7 Keys steps in medication reconciliation[46]



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Digital tools and systems integrated into workflows are associated with significant improvements in the documentation of medication-related information and significant reductions in medication discrepancies across TOC.[16] Where available, they should be used to obtain and document medication histories and perform medication reconciliation.

Partnered pharmacist medication charting

Partnered pharmacist medication charting (PPMC) involves credentialed pharmacists working closely with medical practitioners to undertake a medication review, and chart medicines for nursing staff to administer.[48] When in accordance with local state and territory legislation, hospitals should consider integrating PPMC into their policies and procedures. This enables the ward pharmacist, on agreement with the treating team, to prepare the individual's medication chart, following medication reconciliation. PPMC within 24 hours of hospital admission has been shown to significantly reduce medication errors by over 62%[37,63,64] and length of hospital stay from a median of 4.7 days to 4.2 days.[37,64]

Medication management plan

A medication management plan (MMP) is a living document that describes strategies to manage the individual's use of medicines.[46] It is tailored to the individual and should list issues identified during the assessment of their current medication management and goals of medication management. The MMP is developed and maintained by clinicians, in collaboration with the individual. It should be developed and documented as early as possible in the episode of care and then reviewed and updated regularly, including at discharge and at each TOC.

It should combine information, such as medication reconciliation, assessment of current medication management (including any issues identified and any complementary medicines the individual may be taking), clinical review, therapeutic drug monitoring and other relevant information.[46]

The MMP is integral to care planning for the individual and is intended for use by, and sharing among, the individual and their healthcare providers.

Activities during hospital stay

Medication review and shared decision making

Ongoing review of an individual's MMP throughout their episode of care is key to minimising problems and optimising therapeutic outcomes, and aligns with the requirements of the NSQHS Medication Safety Standard.[49] The hospital should choose a well-structured medication review model suited to its local context, and document the process in local policies and procedures.

Individuals who are assessed as 'high risk' should be prioritised for regular medication reviews. Strategies include:

- Treating teams should discuss with the individual their medication options, including evidence-based recommendations and any changes, such as medicines that have been added or ceased. All individuals should be given the opportunity to ask questions of the treating team and the wider multidisciplinary team about their medicines.
- Hospitals should consider incorporating a focused discussion on medication management into existing multidisciplinary case conference schedules, especially for individuals who are 'high risk', have complex needs or are managed by multiple teams. If possible, the hospital pharmacist involved in the individual's care should participate in these stewardship rounds/case conferences.

Preparing for discharge

Planning for discharge should begin as soon as an individual enters the hospital's care.[50] The assessment that an individual is ready for discharge should be clearly documented in the individual's healthcare record. The hospital care team should also speak with the responsible pharmacist to facilitate discharge preparations, including medicines supply at discharge.

The setting into which the individual is discharged must be considered to ensure the appropriate handover of their health information. If details of an individual's primary healthcare provider (usually a GP), community pharmacy and other relevant primary care clinicians were not obtained or confirmed on admission, these should be obtained and entered in the individual's healthcare record. These details should be double-checked and reconfirmed before discharge. Individuals who have not nominated a regular GP or community pharmacy should be strongly encouraged and supported to select one for the hospital team to liaise with throughout their hospital stay and at discharge.[7,45] If an individual newly enters residential aged care home or a respite facility on discharge, it should be documented in their healthcare record. Capturing the details of associated community pharmacies for interim or ongoing medicine supply, when relevant, is also important because this may differ from the individual's original community pharmacy.

Activities at discharge

Communication and clinical handover at discharge

The NSQHS Communicating for Safety Standard[39] emphasises structured clinical handover processes to ensure effective communication among clinicians. It requires health service organisations to ensure patient safety by embedding effective systems to communicate and document critical information.

Effective communication and, hence, the quality of care at discharge are underpinned by standardised and structured clinical handover processes that actively involve clinicians in the hospital and primary and aged care settings.[51] Effective clinical handover processes ensure all relevant participants know the minimum information that needs to be communicated at handover, the purpose of the handover, the format to use, and how responsibility and accountability are transferred.[40]

The use of structured information templates should be considered (for example, templates for documenting BPMHs, medication reconciliation – which must occur at every transition of care – MMPs, clinical handover notes and discharge summaries).[16] However, streamlining this approach remains challenging because of differences in local hospital practices and clinician preferences.[16] In addition, different parts of a hospital often use different electronic systems that are not interoperable, which may increase the risk of inaccurate transfer of health information.

> The Commission's *Electronic Medication Management Systems – a guide to safe implementation*[52] and the *National Medication Management Plan*[53] provide guidance on a nationally standardised approach to medication management.

Health information at discharge should be transferred in real time and encompass a combination of interpersonal communication and electronic information transfer. Hospitals should have secure and reliable electronic systems to exchange information with the primary healthcare provider (usually a GP or GP practice) and other providers. Digital maturity, including the capability to transfer health information electronically via secure messaging, is a key factor for success in realising the Framework's benefits and supporting desired clinical outcomes. Interoperability standards that enable real-time transfer of information about an individual's care are needed. These standards should include appropriate compliance measures.[7]

Until reliable, structured electronic messaging systems between the hospital and the individual's primary healthcare provider (usually their GP or general practice) are available, the hospital care team should consider best-practice principles and apply clinical judgement and discretion in communications with the primary healthcare provider. All communication from the hospital to primary healthcare providers should be streamlined and documented in local policies.

> The *Guiding principles to achieve continuity in medication management* provide guidelines to support clinicians to collaborate and to communicate medicines-related information, particularly at TOC.[46]

Medication reconciliation

Medication reconciliation at discharge is effective in identifying, resolving and preventing medication problems. The ward pharmacist (where possible) in collaboration with the medical team should reconcile the individual's planned discharge medicines list against admission medicines (as listed in the BPMH), the most current medicine administration record, and new medicines planned to start upon hospital discharge. Any unwarranted variation, including any clinical, regulatory or ongoing supply issues should be addressed.

Medication reconciliation at discharge can be supported by implementing digital tools, such as medication reconciliation and clinical decision support systems. Hospitals must establish robust and transparent processes for the development, use, review and update of these tools.[16]

Hospitals must consider interventions that reduce the risk of errors in medication information in discharge summaries.

- Collaborative preparation of discharge summary medicines information by the responsible pharmacist and medical practitioner has been shown to reduce the risk of transmission of incorrect information.[16]
- An Australian trial reported an absolute risk reduction of 46.5% in having at least one medicine error when pharmacists complete the MMP in the discharge summary.[54]

Combining medication reconciliation at discharge with interventions such as follow-up and home visits may enhance clinical effectiveness, and reduce hospital readmissions and emergency department visits.[16]

Medicines supply at discharge

The governing committee should embed robust processes to guide medicines supply at discharge and associated communication at TOC between the hospital team, individual, primary healthcare provider (usually their GP) and residential or community aged care providers. Safe and high-quality care requires that individuals have timely and uninterrupted access to their medicines following discharge:

- Medicines supply should be planned early and logistically coordinated between the individual's hospital and primary or aged care teams. Medicine supply options should be openly discussed and collaboratively decided with the individual, and then documented in their healthcare record.
- Hospital pharmacists should work with the individual to ensure any plans during discharge do not cause avoidable financial or other barriers to medicine access, and they should supply medicines in accordance with local policies and procedures.
- An adequate supply of medicines should be provided to the individual upon discharge, based on the time it will take the individual to see their primary healthcare provider (usually a GP) and/or obtain medicines in the primary or aged care setting post-discharge.
- If assessed as necessary for the individual, the ward pharmacist should contact and liaise with the nominated community pharmacy to arrange ongoing supply of medicines post-discharge. The ward pharmacist may also need to arrange for a dose administration aid to be prepared by the hospital or community pharmacy on discharge.

More information on discharge planning for individuals being transferred to aged care settings can be found in the *Guiding principles for medication management in residential aged care facilities*[55] – Guiding Principle 9: Documentation of medication management and Guiding Principle 12: Continuity of medicine supply including in an emergency.

Box 7 describes the potential use of electronic prescribing and Box 8 describes considerations for medicine supply at discharge for specific cohorts.

Box 7 Electronic prescribing

When appropriate, electronic prescriptions should be prepared and sent by the hospital team to the individual, via SMS or email, or to their nominated pharmacy.

Electronic prescribing aims to provide convenience and choice to individuals while improving Pharmaceutical Benefits Scheme (PBS) efficiency, compliance and medication safety.[56]

While electronic prescribing is now widely available in the community setting for PBS supply, nationwide implementation will:

- Streamline medication management
- Facilitate uninterrupted access to and supply of medicines
- Ensure that all healthcare providers have real-time access to an individual's prescription history, thereby facilitating smoother transitions between different health settings.

The Commission acknowledges the ongoing collaboration between the Australian Government Department of Health, Disability and Ageing and the Australian Digital Health Agency on electronic prescribing to support its widespread uptake across Australia.

Box 8 Discharge of Aboriginal and Torres Strait Islander individuals

Closing the Gap in Aboriginal and Torres Strait Islander disadvantage is a national priority that the Australian Government and all state and territory governments are committed to addressing.[57] The NSQHS Standards include key actions required of health service organisations to improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people.

Hospital pharmacists should collaborate with First Nations hospital liaison officers, Aboriginal and Torres Strait Islander health workers, other Aboriginal and Torres Strait Islander health services and nominated kin and community members to enable person-centred decision making about an individual's care and their medication management.[58]

Hospital pharmacists should be aware of and be able to advise on relevant funding programs that support access to medicines (for example, the Closing the Gap Pharmaceutical Benefits Scheme Co-payment Program).[58]

More information can be found in the Pharmaceutical Society of Australia's *Guidelines for pharmacists supporting Aboriginal and Torres Strait Islander peoples with Medicines Management*.[58]

Interim Residential Care Medication Administration Charts

An Interim Residential Care Medication Administration Chart (IRCMAC) provides continuing medicines orders for up to seven days. IRCMACs, accompanied by supplies of medicines, enable residential aged care home staff to continue medication until the individual's own prescriber reviews and prescribes ongoing treatment.[16]

The involvement of a multidisciplinary team, pharmacist-led medication reconciliation, and the provision of accurate discharge information, including an IRCMAC, have been identified as improving continuity of medication management during transitions of care from hospital to a residential aged care home.[55] The use of IRCMACs has significantly reduced the proportion of individuals with missed or delayed doses in the 24 hours post-discharge.[16]

Hospitals should have local policies and procedures outlining the requirements and accountability for the provision of IRCMACs.

> Hospitals and residential aged care homes are encouraged to refer to the *Guiding principles for medication management in residential aged care facilities*.[55]

Medicines list and medication counselling

At discharge, the individual should receive various documents.

- A medicines list, ideally reconciled by the pharmacist, included with the individual's discharge summary
- A patient-friendly medication list prepared by the responsible pharmacist (reconciled against the medicines list in the discharge summary). This can be independent of or part of their discharge summary, per action 4.12 of the NSQHS Medication Safety Standard.[24] Where necessary, the medicines list should be explained to the individual. This list could be a pharmacist shared medicines list which could also be uploaded to their My Health Record following consent[59]
- Any other relevant medicines information, tailored to their needs or specific situation (for example, transfer to a residential aged care home), in accordance with relevant policies, procedures and guidelines.[24]

> Principle 8 of the *Guiding principles to achieve continuity in medication management* lists tools to support individuals to obtain medicines lists and manage their medicines.[46]

A model of care for post-discharge support

Integrated care

Safe and high-quality care post-discharge relies on shared responsibility and accountability between clinicians in the hospital, primary and aged care settings, and the individual, their family and/or carer. Stewardship does not end at discharge.

The hospital's governing committee should design a model of care that is specific to medication management post-discharge and considers the specific needs of their patient cohorts. It should reflect what services are available, or could be developed, and what activities would be appropriate to improve medication management when individuals transition to primary or aged care settings. The model of care should be designed to extend care beyond discharge. The model should include facilitating and arranging access to collaborative comprehensive medication management review and other follow-up services, establishing clear communication processes and supporting ongoing continuity of care.

The model of care developed by the governing committee to support individuals following discharge should:

- Consider the resources available within the hospital and primary and aged care settings
- Consider what existing specialised outreach medication management services or interventions should be targeted to individuals who are at high risk or have complex or other special care needs, and what other services could be introduced based on local context
- Consider federally funded and other external programs that can be recommended by the hospital or referred to by the individual's primary healthcare provider to support post-discharge medication management (Box 9)
- Integrate medication interventions into a multicomponent management approach involving a team of clinicians[16]
- Assign clinicians responsibility and accountability to optimise communication and documentation of the individual's health information and required follow-up
- Consider involving family, carers and social and community supports
- Consider advance care planning, which may begin in the hospital or outpatient setting and include engaging hospice services (if appropriate)[60]
- Ensure approaches are adaptable to novel strategies, programs and advancements
- Consider the financial, cultural and geographical accessibility of care services, including the availability of interpreter services in primary care settings, to identify which post-discharge medication review services may be considered for local implementation (for example, resource constraints may require rural and remote health service organisations to engage experts who work across multiple sites, or consider virtual or telehealth services).

Box 9 Examples of services that support post-discharge medication management[16,61]

- Early post-discharge GP consultation
- Medication reconciliation
- Community pharmacists providing MedsCheck or Diabetes MedsCheck[62]
- Comprehensive medication management review such as home medicines review (HMR[63]), residential medication management review (RMMR[64]) or an aged care on-site pharmacist[65] review
- Review by embedded pharmacist roles within the aged care, primary care (for example, general practice pharmacist[66]), and disability care settings[16]
- Medication management reviews by pharmacists integrated into Aboriginal Community Controlled Health Services[67]
- Post-discharge follow-up services (for example, via telehealth)[68]
- Hospital outreach medication review services[61]
- Outpatient clinic review

Hospitals seeking to ensure continuity of care through collaborative comprehensive medication management review post-discharge can obtain guidance from:

- Box 9
- Box 10 (for an example of a model centred around post-discharge consult)
- AdPha's Hospital-initiated medication review – Hospital pharmacy practice update[61], which provides detailed information about possible pathways for referrals to HMRs, RMMRs and hospital outreach medication reviews
- AdPha's Standard of Practice for pharmacy services specialising in transitions of care[17], which describes best-practice pharmacy services at transitions of care.

Expert opinion on the barriers and enablers to implementing Hospital-initiated post-discharge medication reviews in Australia can inform its broadscale implementation to reduce harm when 'high-risk' individuals transition from hospital to primary care and aged care.[17]

Health service organisations should refer to AdPha and the Royal Australian College of General Practitioners' (RACGP's) medication management at TOC resource kit.[69-72] This kit includes three resources tailored for hospitals and general practices promoting best practices in collaborative care to ensure seamless continuity in medication management. It also offers a dedicated resource for consumers to empower them to actively participate in their medication management at TOC.

Further communication to support the model of care

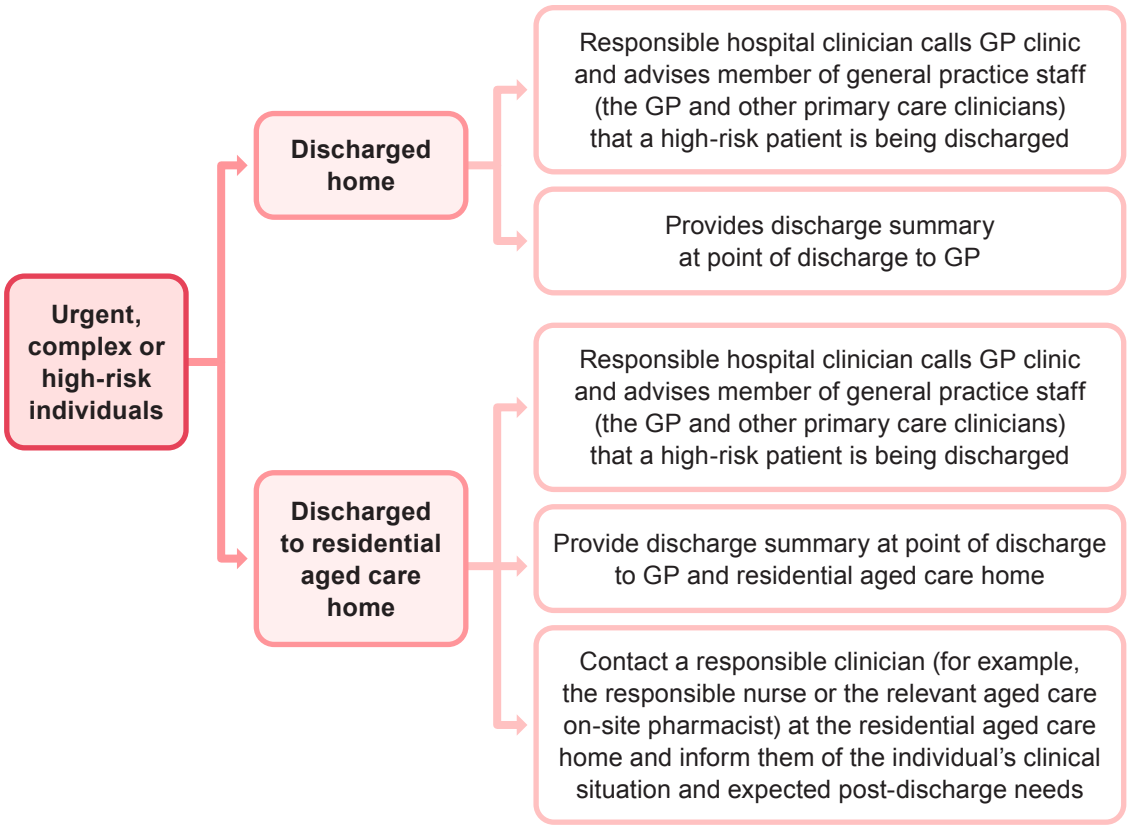
The hospital team should include any recommendations for collaborative comprehensive medication management review post-discharge in the discharge summary (see Discharge summary for more detail).

The governing committee should formulate guidance for clinicians on how to discuss priority follow-up reviews with primary healthcare providers, while also allowing for clinician judgement and discretion. Direct discussion between the hospital team and the individual's primary healthcare provider is supported by AMA's position statement on TOC.[10] For example, the governing committee may establish that, for individuals who are 'high risk' or have complex needs, the hospital team should supplement written advice by discussing their recommendations with the primary healthcare provider (usually a GP) verbally. This would:

- Ensure effective communication of care plans between care providers
- Enable hospital clinicians to confirm the primary healthcare provider has received the discharge summary
- Give the primary healthcare provider the opportunity to 'flag' the individual in their system, promptly refer them to recommended services, and provide appropriate and timely follow-up care.

Figure 8 outlines a suggested typical process for communicating urgent, complex or high-risk individuals' discharge information.

Figure 8 A suggested typical process for communicating urgent, complex or high-risk individuals' discharge information



Example model for post-discharge support

Box 10 provides an example of post-discharge follow-up care by the hospital team.

Box 10 Example of a model centred around post-discharge follow-up care by the hospital team

The responsible pharmacist (or other suitably qualified clinician) undertakes a follow-up consultation with all 'high-risk' individuals (at a minimum) within the immediate post-discharge period.

Post-discharge follow-up consultations, for example, via telehealth, led by the hospital team should include at a minimum[16]:

- Collaborative post-discharge medication management review with the individual, focusing on priority issues for follow-up as outlined in the discharge summary
- Answering any medicine-related queries
- Resolving any medicine-related issues, including liaising with the community pharmacy for any issues related to medicine supply
- Medication adherence support
- Non-pharmacological advice (such as symptom monitoring, lifestyle, diet and exercise plan, and wellbeing and self-care advice).

Before discharge, the ward pharmacist and medical team should discuss with the individual what the follow-up consultation will focus on, including the most appropriate person to participate in the consultation (that is, the individual receiving care, depending on capacity, their family and/or carer or the nurse responsible for their care if they are discharging to a residential aged care home).

Findings and recommendations from the consultation should be documented in a dedicated standardised form in the individual's healthcare record and sent to the individual's primary healthcare provider (usually their GP) via secure messaging. If possible, this should also be uploaded to the individual's My Health Record.

To enable ongoing management, the responsible pharmacist should liaise with and escalate any concerns to relevant clinicians, such as GPs, community pharmacists and nursing staff caring for individuals in residential aged care homes.

Further information and examples are available at:

- The ASPIRE Trial systems approach to enhancing community-based medication review[73]
- Safer Care Victoria's Safer Care Victoria's Safer Medicines at Transitions of Care project[74]
- The Pharmaceutical Society of Australia Guidelines for Comprehensive Medication Management Reviews.[75]

Applying the model of care

Clinicians involved in the discharge of an individual from a hospital setting should be aware of the hospital's model or care and consider the individual's situation and plans for the post-discharge period. This includes the setting into which the individual will be discharged and the availability of follow-up primary care services.[60]

The care team should:

- Discuss post-discharge follow-up services with individuals who are assessed as 'high risk', have complex needs or would otherwise, in the clinician's judgement, benefit from a post-discharge medication review or services. Examples of these services are outlined in Box 9
- Arrange and, when necessary, book relevant post-discharge appointments for individuals before their discharge
- Outline post-discharge follow-up service(s) in the discharge summary; depending on the local context, it may also be appropriate to consider verbal follow-up.

Discharge summary

A discharge summary is critical to well-coordinated and effective clinical handover.[46]

> The Commission's *National Guidelines for On-Screen Presentation of Discharge Summaries* list what should be included, along with recommendations to ensure information is clear and unambiguous.[76]

Among other information, a discharge summary should include:

- An overview of the individual's hospital journey
- An MMP, including any commenced medicines and their indication, and ceased medicines and the reasons for ceasing
- An overview of the individual's post-discharge care plan, including any recommendations for follow-up medication management services
- Relevant contact details to enable primary and aged care providers to obtain clarification where necessary.[76]

Note that the above guidance is general in nature. Additional medicines information (not covered in the Commission's guidelines) may often be required in the discharge summary for specific cohorts or those transferring to different settings.

To facilitate continuity of care and information sharing, an individual's discharge summary should be:

- Provided to the individual at the time of discharge
- Distributed via secure messaging to their primary healthcare provider (usually a GP)
- Distributed to other healthcare providers in the next care setting (for example, community pharmacies, residential aged care homes)
- Uploaded to the individual's My Health Record (if they have one).[7]

In a digitally mature environment, well-designed and interoperable digital systems facilitate transfer of health information, including discharge summaries. This would improve communication between healthcare providers when individuals transition across the health system, enabling effective care during and post transition.[7,77] For example, enhanced digital maturity would support identification of an individual's elected community pharmacy and ensure they receive a copy of a discharge summary, ideally by secure electronic transfer.

To encourage continuity of care, the hospital team should:

- Ensure the individual has a clear plan for follow-up post-discharge. Advise the individual to follow-up with their primary healthcare provider (usually their GP) and other appropriate primary care clinicians in accordance with their post-discharge care plan
- Book a timely follow-up appointment with the individual's primary healthcare provider (usually a GP) or other clinicians as appropriate, if relevant.[7]

The receiving clinician is expected to review completed discharge summaries in a timely manner, so they are well prepared to receive the individual for ongoing management and care post-discharge.

Transition to primary or aged care

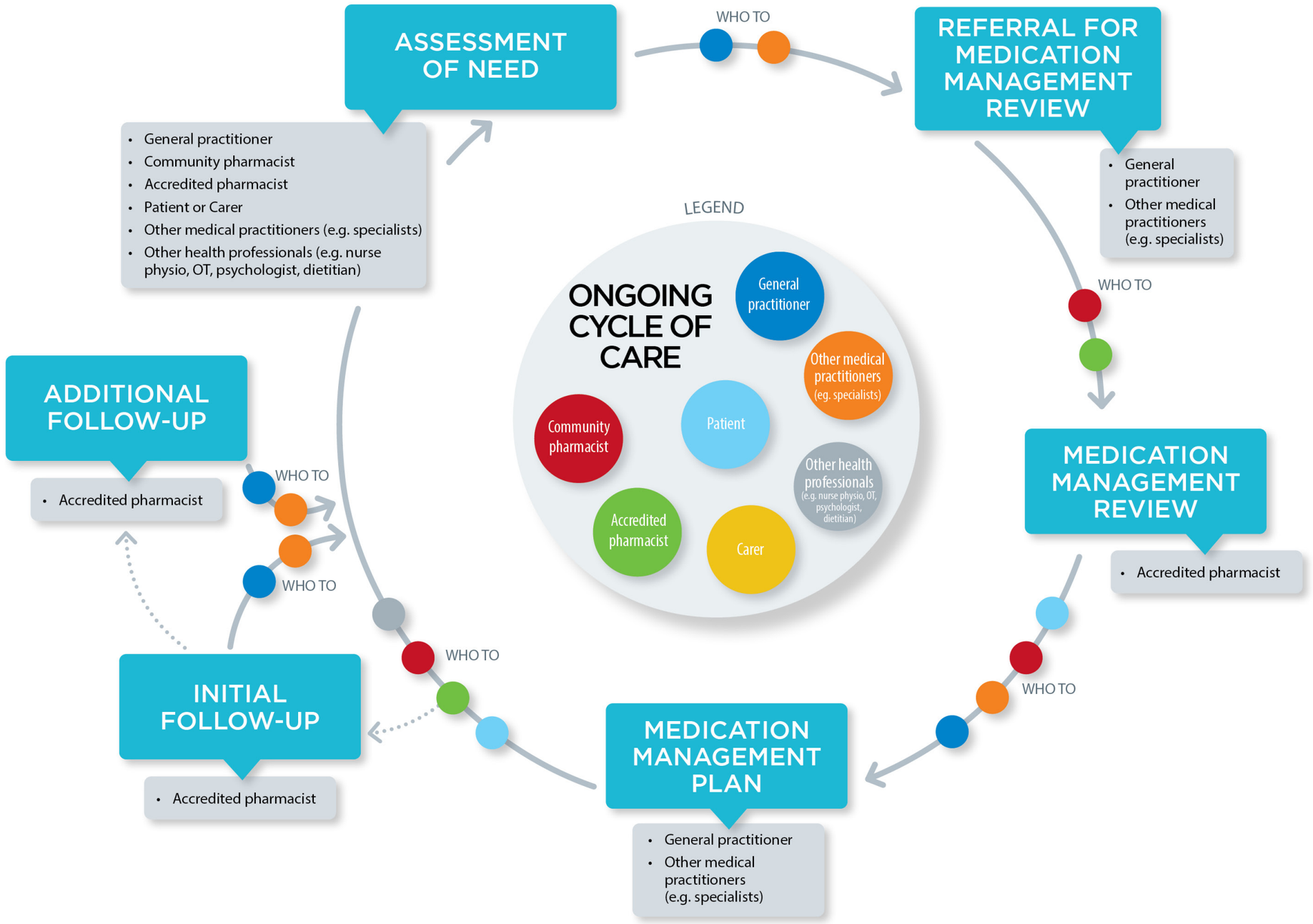
Hospital care teams are co-responsible for ensuring individuals receive appropriate follow-up care and services post-discharge.

Continuity of care post-discharge

All individuals should receive continuity of care through regular follow-ups with their primary care team. This includes appropriate and timely referral to medication management review services – such as HMRs, RMMRs and aged care on-site pharmacists, especially if recommended by the treating team in the discharge summary – follow-up of these services, and GP-led multidisciplinary case conferences. When possible, associated findings and recommendations reports should be uploaded to the individual's My Health Record to ensure effective ongoing communication.

The Pharmaceutical Society of Australia's Medication Review Cycle of Care (Figure 9) provides further guidance for clinicians to ensure issues are managed through appropriate pathways post-discharge[78], and that GPs regularly update each individual's medicines list in their systems and the individual's My Health Record. This will ensure transparency, accuracy of medicines information and continuity of care. It may also be helpful to consider the use of MyMedicare – a voluntary patient registration model that aims to formalise the ongoing relationship between individuals and their general practice, GP and primary care teams.[79]

Figure 9 The Pharmaceutical Society of Australia's comprehensive medication management review cycle of care[78]



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Element 4: Monitoring, evaluation and reporting

Routine monitoring, evaluation and reporting against predetermined quality indicators and outcomes is essential to measure and manage performance and promote continuous quality improvement. The governing committee should determine objectives and performance measures as part of planning for adopting the Framework.

Feedback pathways

Reporting of performance supports continuous improvement and the sustainability of stewardship. Feedback pathways for reporting to executives, stewardship sponsors and governing committee(s) may include[16,26,80]:

- At least quarterly reporting of performance against locally determined quality indicators and outcomes
- Publication of an annual report that summarises stewardship performance and quality improvement initiatives.

The following feedback pathways are recommended for communicating performance outcomes with clinicians[16,26,80]:

- Regular and direct feedback to individual clinicians and clinician leads on stewardship implementation outcomes
- The use of various modes of communication, such as presentations to staff during grand rounds, case studies and dissemination of formal reports.

Identification of areas requiring improvement should guide clinician education and training. Refined stewardship activities should be incorporated into local policies and procedures to embed them into usual practice.[16,80]

Quality indicators

Safety cannot be measured directly, so a range of measures are used as quality indicators.[81] These measures can be built into the hospital's performance framework and reported against the NSQHS Medication Safety Standard and Communicating for Safety Standard criteria. The necessary data collection should be an integral component of implementation from the outset.

The quality of health care across organisations can be assessed and compared using the six domains of healthcare quality (safety, timeliness and accessibility, effectiveness and appropriateness, patient-centred care, efficiency and equity).[82] The types of quality measures can include structure, process and outcome measures[83] along with balancing measures. Specific measures – based on the literature[16] – that may be relevant to safe medication management at TOC are suggested in the following subsections (see Table 5, Table 6, Table 7 and Table 8). Hospitals should assess these measures for appropriateness and relevance when designing their context-specific approach to evaluation.

Structure measures

Structure measures assess the effectiveness of systems and processes to provide high-quality care. They can help hospitals determine whether they have appropriate governance, lines of reporting, policies, systems and workforce in place[3], and whether appropriate resources are available.

Table 5 Suggested structure measures[16]

Focus	Suggested measures
Governance	• A hospital governing committee is responsible for overseeing, monitoring and reviewing medication management at TOC stewardship • Member(s) of the executive team support medication management at TOC stewardship • The hospital provides the human, financial and technology resources needed for timely and safe TOC
Local policy and protocols	• The hospital has a policy to support the transfer of care of individuals when they are discharged, covering systems, procedures and the roles, responsibilities and accountabilities of clinicians to support medication management during TOC • The hospital has a policy to support appropriate risk stratification and prioritisation protocols of individuals identified as at higher risk of poor transitions (for example, individuals identified as having a higher risk of hospital readmission or those with complex or high-risk medicine regimens) • The hospital provides clinicians involved in individual referrals with information on available services to support safe medication management at TOC

Table 5 Suggested structure measures (continued)

Focus	Suggested measures
Multidisciplinary stewardship team	• The hospital has a multidisciplinary stewardship team in which each member is aware of their roles, responsibilities and accountabilities • Leadership of the multidisciplinary stewardship team has professional accountability for the outcomes of stewardship implementation and expertise in medication management at TOC • The stewardship team has appropriate senior and executive sponsorship
Documentation and communication	• The hospital has templates to support clear and consistent documentation (before and during TOC) and clinical handover • The hospital has processes to ensure the timely transfer of essential TOC information to key stakeholders
Appropriate broader connections	• There is evidence of local arrangements that support effective connections and communication channels between the hospital and its network of primary care clinicians • There is evidence of systems that support outpatient follow-up, including collaborative comprehensive medication management review post-discharge
Monitoring, evaluation and feedback	• The hospital routinely collects and analyses data on the processes and outcomes of TOC to evaluate effectiveness and identify areas needing change • The hospital provides affected clinicians with feedback on stewardship outcomes and provides educational resources and training to improve safe medication management at TOC

Process measures

Process measures can help determine whether systems are performing as planned and whether they are effective. Process measures may be:

- Part of a quality improvement cycle
- Used on an intermittent basis as part of the evaluation of an intervention.

When instituted as regular audits and reported back to affected clinicians, process measures can help sustain stewardship activities.

The development of process measures should involve clinicians from various disciplines to ensure ownership by relevant clinical groups.

Table 6 Suggested process measures[16]

Focus	Suggested measures
Medication reconciliation at hospital admission	• Proportion of individuals for whom a BPMH and medication reconciliation are completed and documented within 24 hours of admission • Accuracy of medication reconciliation at admission and discharge • Evidence of multidisciplinary collaboration in medication-related admission processes • Proportion of individuals for whom a documented MMP is started during admission and finalised before TOC • Measures from the National Quality Use of Medicines Indicators for Australian Hospitals[84], selected to suit the local context
Medication reconciliation at hospital discharge	• Proportion of individuals for whom a medication reconciliation upon hospital discharge has been completed and documented using the correct tool for documentation • Evidence of review of discharge prescriptions for appropriateness and accuracy • Evidence of reconciliation of verified discharge prescriptions against discharge medication lists (discharge summaries, patient-friendly medication lists and IRCMACs) to ensure consistency • Evidence of a clear plan and justification for all medications on medication lists in discharge summaries (including decisions to continue, discontinue or withhold) • Accuracy of medication lists in discharge summaries • Proportion of individuals with medication discrepancies or problems resolved before discharge • Evidence of multidisciplinary collaboration in medication-related discharge processes

Table 6 Suggested process measures (continued)

Focus	Suggested measures
Documentation and communication	• Evidence of structured clinical handover processes for intra- and inter-hospital transfers that support continuity of medication management • Proportion of discharge summaries with clear documentation of the clinician(s) responsible for ongoing care following discharge • Proportion of discharges where critical information is transmitted at the time of discharge to the next care setting or clinician continuing care • Proportion of individuals discharged to residential care homes who were provided with an IRCMAC • Percentage of hospital records accurately listing the individual's usual GP or general practice • Percentage of hospital records accurately listing the individual's usual community pharmacy
Individual, family and carer education and discharge planning	• Evidence of local systems that engage the individual, their family and/or carer in discharge planning • Proportion of individuals who receive a patient-friendly medication list and individualised medicines counselling at the time of discharge • Proportion of individuals discharged with an adequate supply of medicines until follow-up with the next healthcare provider, as appropriate • Evidence of a process to measure the individual's understanding of their medicines
Medication management after hospital discharge	• Percentage of individuals who have a scheduled medication management follow-up service or appointment at the time of discharge, as clinically appropriate • Proportion of individuals who receive a telehealth consultation and/or collaborative comprehensive medication management review within defined time frames post-discharge, as clinically appropriate

Outcome measures

Outcome measures reflect the impact of an intervention on the health status of the target group. Although outcome measures may seem to represent the 'gold standard' in measuring quality, outcomes may be the result of numerous factors beyond a hospital's control, and these must be accounted for.

Although reduced hospital readmissions due to medication misadventure would be the most easily measured outcome, in isolation it may not indicate improvements in individual outcomes; a range of other safety and quality outcome measures also must be monitored. Relevant outcomes to be monitored include improved individual health outcomes, patient safety and costs.

Table 7 Suggested outcome measures[16]

Focus	Suggested measures
Clinical outcomes	• Number of unplanned hospital readmissions within 30 days of discharge • Proportion of individuals revisiting the emergency department within a defined time frame following discharge • Proportion of individuals with medication discrepancies or errors identified after TOC • Proportion of individuals experiencing a medication-related adverse event within a defined time frame following discharge • Percentage change in medication error incident reporting before and after implementation of the Framework

Balancing measures

Implementation of medication management at TOC stewardship may give rise to unintended consequences, both good and bad. Balancing measures provide insight into these effects.

Table 8 Suggested balancing measures[16]

Focus	Suggested measures
Patient and carer satisfaction	• Proportion of individuals satisfied with their experience and care provision during TOC and their understanding of the care plan, including the management of their medicines
Clinician satisfaction	• Proportion of clinicians satisfied with the standard of information provided in transfer of care summaries and related clinical outcomes

Appendix 1: Related standards and resources

The Commission

- NSQHS Standards[85], especially:
  - Clinical Governance Standard[27]
  - Partnering with Consumers Standard[86]
  - Medication Safety Standard[24]
  - Comprehensive Care Standard[87]
  - Communicating for Safety Standard[39]
- Principles of safe and high-quality transitions of care[34]
- Clinical Care Standards[88], including the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard[89], Quality statement 9 – Transitions of care
- Antimicrobial Stewardship in Australian Health Care[26], chapter 2
- Evidence briefing on strategies to facilitate safer medication management at transitions of care[18]
- Evidence briefing on digital approaches to facilitate safer medication management at transitions of care[19]

Australian Government Department of Health, Disability and Ageing

- National Medicines Policy 2022[90]
- Guiding principles to achieve continuity of medication management collection[46]

Advanced Pharmacy Australia

- Clinical pharmacy standards[42]
- Standard of practice for pharmacy services specialising in transitions of care[43]

Australian Digital Health Agency

- Connecting Australian Healthcare: National Healthcare Interoperability Plan 2023–2028[91]
- Strategy delivery roadmap[32]

NSW Agency for Clinical Innovation

- Transition Care Network resources[92]

NSW Therapeutic Advisory Group

- Transitioning Young People on Complex or High Cost Medicines from Paediatric to Adult Care Services: Guiding Principles and Supporting Resources[93,94]

Australian Medical Association

- General Practice/Hospitals Transfer of Care Arrangements position statement[7]

Appendix 2: Developing the Framework

In 2023, the Commission engaged the University of Sydney, Faculty of Health and Medicine, School of Pharmacy, to undertake a literature review and environmental scan[16] to identify current best-practice evidence on medication management at TOC.

No published studies or existing frameworks or policy documents were identified that described stewardship specifically focused on medication management at TOC. The proposed Framework is based on evidence from other medicines stewardship initiatives, evidence of potentially effective strategies to reduce risk during TOC, and expertise of the authors and contributors.

Some of the proposed elements outlined in this Framework have been adapted from the Commission's Antimicrobial Stewardship in Australian Health Care.[21]

The development of the Framework involved:

- Consultation with peak organisations, and internal and external experts, involved in medication management at TOC
- Analysis of relevant documents and published literature
- Targeted consultations with members of the healthcare workforce, including prescribers, nurses and pharmacists.

The Commission was supported by an expert project advisory group (Table 9) which provided strategic and practical advice to inform the development of the Framework.

Project oversight and governance was also supported by the Commission's Health Services Medication Expert Advisory Group, Medicines Safety and Quality Advisory Committee, Digitally Enabled Care Advisory Committee and Primary and Community Healthcare Advisory Committee.

Table 9 The expert project advisory group membership and affiliations

Member name	Position	Organisation	State
Associate Professor Chris Freeman (Chair)	Associate Professor of Safe and Effective Medication Research	The University of Queensland	Qld
Dr Alexander (Cuong) Do	Medical Registrar	Council of Doctors in Training, Australian Medical Association	Qld
Ms Kerry Fitzsimons	Manager, Medicines and Technology Unit, Patient Safety and Clinical Quality Directorate, Clinical Excellence Division	Department of Health Western Australia	WA
Dr Robert Herkes	Chief Medical Officer	Ramsay Health Care Australia	NSW

Member name	Position	Organisation	State
Dr Shane Jackson	Community pharmacist and national board member of the Pharmaceutical Society of Australia	Pharmaceutical Society of Australia	Tas
Mr Daniel Lalor	Director of Pharmacy	The Canberra Hospital and Health Services, ACT	ACT
Ms Jo Lewis	Nurse practitioner	Australian Primary Health Care Nurses Association	SA
Emeritus Professor Teng Liaw	Emeritus Professor and Consultant in Clinical Informatics and Digital Health	School of Population Health, University of New South Wales	NSW
Dr Isobel Morse	GP and Medical Specialist, Digital Health Consultant	Department of Health Tasmania	Tas
Ms Nina Muscillo	Program Lead, Safety and Quality (Single Patient Digital Record)	Clinical Excellence Commission, NSW	NSW
Ms Katie Phillips	Chair, Transitions of Care and Primary Care Specialty Practice Stream	Advanced Pharmacy Australia	n/a
Professor Rashmi Sharma	Clinical Associate Professor	School of Medicine and Psychology, Australian National University	ACT
Associate Professor Christine Slade	Consumer Representative	University of Queensland	Qld
Mr Mike Stephens	Director, Medicines Policy and Programs	National Aboriginal Community Controlled Health Organisation	ACT
Ms Jacquie Wiley	Director, Nursing and Clinical Services	St Andrew's Hospital, Adelaide	SA
Ms Kylie Wright	District Director, Clinical Governance	Illawarra Shoalhaven Local Health District, NSW	NSW

n/a: Not applicable.

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- Aboriginal Health Council of Western Australia
- Advanced Pharmacy Australia
- Aged and Community Care Providers Association
- Alpine Health
- Australian and New Zealand College of Anaesthetists
- Australian College of Nurse Practitioners
- Australian College of Nursing
- Australian Digital Health Agency
- Australian Medical Association
- Australian National University
- Australian Primary Health Care Nurses Association
- Bamford Community Care
- Beaufort & Skipton Health Service
- Bendigo Health
- Brisbane North Primary Health Network
- Central Gippsland health
- Clinical Excellence Commission
- Department of Health New South Wales
- Department of Health Tasmania
- Department of Health Western Australia
- East Melbourne Primary Health Network
- Eastern Palliative Care
- Gowan & Associates Pty Ltd
- HealthShare Victoria
- Hunter New England Local Health District
- Illawarra Shoalhaven Local Health District
- Kimberley Region
- Mallee Track Health and Community Services,
- Medication Services Queensland Health
- Medicines Australia
- Monash Health
- National Aboriginal Community Controlled Health Organisation,
- National Allergy Council
- National Paediatric Medicines
- New South Wales Ambulance
- North Western Melbourne Primary Health Network

- Peninsula Health
- Pharmaceutical Defence Limited
- Pharmaceutical Society of Australia
- Pharmacy Guild of Australia
- Queensland Aboriginal and Islander Health Council
- Ramsay Health Care Australia
- Rehabilitation Medicine Society of Australia and New Zealand
- Royal Australasian College of Surgeons
- Royal Australian College of General Practitioners
- Royal North Shore Hospital
- Safer Care Victoria
- Sir Charles Gairdner Hospital
- South Australia Health
- South Australia Pharmacy
- Southern New South Wales Local Health District
- St Agnes Parish Care and Lifestyle
- St Andrew's Hospital Adelaide
- St Vincent's Hospital Sydney
- Sydney Pharmacy School, The University of Sydney
- The Australasian College for Emergency Medicine
- The Australian College of Nurse Practitioners
- The Canberra Hospital and Health Services
- The Royal Australasian College of Physicians
- The University of New South Wales
- The University of Queensland
- Victorian Therapeutics Advisory Group
- Western Australia Country Health Service
- Western Victoria Primary Health Network
- Westmead Hospital
- Women's and Children's Health Network.

Abbreviations

Abbreviation	Definition
AMA	Australian Medical Association
BPMH	best possible medication history
EMR	electronic medical records
HMR	home medicines review
IRCMAC	Interim Residential Care Medication Administration Chart
MMP	medication management plan
NSQHS	National Safety and Quality Health Service
PBS	Pharmaceutical Benefits Scheme
PPMC	partnered pharmacist medication charting
RMMR	residential medication management reviews
TOC	transitions of care

Glossary

The glossary includes definitions from the Commission's glossary and the *Australian Government Department of Health, Disability and Ageing Guiding Principles glossary*[95], and adds definitions specific to the Framework.

Term	Definition
Aboriginal Community Controlled Health Services	Primary healthcare services initiated and operated by the local Aboriginal community to deliver holistic comprehensive and culturally appropriate health care to the community that controls it, through a locally elected Board of Management.
Aboriginal health	Aboriginal health means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life.'
Accountability	Being answerable for one's actions, and the roles and responsibilities inherent in one's job or position.
Active ingredient prescribing	Active ingredient prescribing using standardised terminology increases consumer understanding of their medicines, assists health literacy and communication, and increases the uptake of generic and biosimilar medicines. The active ingredient is the approved pharmaceutical ingredient in a product, substance or compound that produces its biological effect in the body.
Adverse drug reaction	A noxious and unintended response to a medicine, which occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function. An allergy is a type of adverse drug reaction.
Adverse event	An incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event.
Aged care transfer summary	A document type in the My Health Record which enables residential aged care providers to digitally capture residents' health information for transfer to another health facility, such as a hospital.
Allergy	Occurs when a person's immune system reacts to substances within the environment called allergens. Allergens are harmless for most people. Typical allergens include some medicines, foods and latex. An allergen may be encountered through inhalation, ingestion, injection or skin contact. A medicine allergy is one type of adverse drug reaction.
Appropriate care	Appropriate care should see that patients receive the right type and amount of care, in the right place, at the right time. The care offered should also be based on the best available evidence.

Term	Definition
Assessment	A healthcare professional's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the healthcare professional's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.
Audit (clinical)	A systematic review of clinical care against a predetermined set of criteria.
Best possible medication history	A list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.
Best practice	When the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients.
Carer	A person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program. For Aboriginal and Torres Strait Islander people, there may be a collective approach to carer responsibilities. Confirming who is responsible for different aspects of care is important for ensuring that carer engagement is effective.
Clinical assessment	A clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's findings. These findings include data obtained through laboratory tests, physical examination and medical history; as well as information reported by carers, family members and other members of the healthcare team.
Clinical communication	The exchange of information about a person's care that occurs between treating clinicians, patients, carers and families, and other members of a multidisciplinary team. Communication can be through several different channels, including face-to-face meetings, telephone, written notes or other documentation, and electronic means.

Term	Definition
Clinical decision support tool	Tools that can help clinicians and consumers draw on available evidence when making clinical decisions. The tools have several formats. Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists). Electronic clinical decision support systems link patient-specific information in electronic records with evidence-based knowledge to generate case specific guidance messages through a rule or algorithm-based software. This includes computer-assisted diagnosis and therapy systems.
Clinical governance	An integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. It is the set of relationships and responsibilities established by a health service organisation between its governing body, executive, clinicians, patients and consumers, to deliver safe and quality health care. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high-quality health care.
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.
Clinical information system	When referring to software that stores and manages information collected directly from equipment and clinician inputs. Examples include patient administration systems, laboratory information systems, picture archive and communication systems, electronic medical records and electronic healthcare records
Clinical leaders	Clinicians with management or senior leadership roles in a health service organisation who can use their position or influence to change behaviour, practice or performance. Examples are executives, directors of clinical services, heads of units and clinical supervisors.
Clinician	A trained health professional, including registered and non-registered practitioners, who provides direct clinical care to patients. Clinicians may provide care within a healthcare service as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health professionals, paramedics and other professionals who provide health care, and students who provide health care under supervision.
Collaboration	In the context of medication management, collaboration is a process whereby individuals and healthcare providers share their expertise and take responsibility for decision making. Accomplishing collaboration requires that individuals understand and appreciate what it is they, and others, want to contribute to the ‘whole’.

Term	Definition
Community care or service provider	Provider of a health and community care service in the community.
Complementary and alternative medicines (CAM)	CAMs include herbal, vitamin and mineral products, nutritional supplements, homeopathic medicines, traditional Chinese medicines, Ayurvedic medicines, Australian Indigenous medicines, and some aromatherapy products regulated under the *Therapeutic Goods Act 1989*. Other terms sometimes used to describe CAMs include 'natural medicines' and 'holistic medicines'.
Comprehensive care	Health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the patient's health issues on their life and wellbeing, and are clinically appropriate.
Consultation	Occurs when people seek information or advice and take into consideration the feelings and interests of all of the members of the medication management team.
Coordinated governance	Occurs when public, private, acute and primary sectors across align their efforts to implement an agreed solution to the transnational problems encountered during continuity of medication management and do so in accordance with guiding principles and fundamental norms that ensure such governance is broadly regarded as legitimate. For example, this could involve primary care or allied health representation on hospital clinical governance structures and vice versa to ensure there is consistency and alignment between strategies.
Deprescribing	The process of tapering or stopping medicines, which aims to discontinue potentially inappropriate medicines, minimise inappropriate polypharmacy and improve a person's health outcomes. Also referred to as 'de-escalation'.
Discharge summary	A collection of information about treatments, procedures and other interventions that a patient has received during their stay in a hospital. The document may vary depending on to the healthcare setting, and whether or not the patient is admitted. The summary is developed during their stay and issued as at the time of discharge or as soon as possible afterwards.
Diversity	The varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.
Dose administration aid (DAA)	A device or packaging system such as blister packs, bubble packs or sachets for organising doses of medicines according to the time of administration.

Term	Definition
Effective clinical communication	Two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information. Effective communication is critical to, and supports, the delivery of safe patient care.
Electronic healthcare record	An online electronic application or repository that contains a consumer's health information, which can be sourced from one or more healthcare organisations.
Electronic medication management (eMM)	Can refer to prescribing systems, such as GP desktop systems or hospital clinical information systems that have electronic ordering, decision support systems such as evidence-based order sets, dispensing systems, ordering and supply solutions or electronic medical records including medication charts in the acute and primary care sectors.
Electronic National Residential Medication Chart (eNRMC)	A comprehensive and accurate electronic record of an individual consumer's medicines for people living in residential care facilities. Information requirements within this record are (at a minimum) consistent with the Instrument of Approval for PBS National Residential Medication Charts.
Electronic prescribing	Prescriptions that are issued and dispensed in an electronic system, without the use of a paper-based document at any point.
Electronic prescription	A digital version of a paper prescription. A digital link can be sent by a healthcare provider to a person to store on their digital device (for example, a smart phone) until they need to access it for dispensing by a pharmacist.
Embedded pharmacist	A pharmacist who is fully integrated within the care team and wherever medicines are used – including within primary care, residential care and other settings where medicines are prescribed, supplied and administered to people.
Environment	The physical surroundings in which health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, consumers, visitors and the workforce.
Episode of care	A phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principal clinical intent changes or when the patient is formally separated from the facility.
Evaluation	A critical appraisal or assessment, a judgment of the value, worth, character, or effectiveness of something; measurement of progress. A broad view of evaluation in health care includes three approaches, directed toward structure, process and outcome, depending on the focus of evaluation and the criteria or standards being used.

Term	Definition
Governance	The set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.
Governing body	A board, chief executive officer, organisation owner (proprietor), partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a healthcare service or health service organisation.
Health care	The prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.
Health literacy	There are two components to health literacy: individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.
Healthcare identifier/ individual healthcare identifier	A healthcare identifier is a unique number that ensures healthcare providers can accurately match records to the person they are treating. The Healthcare Identifiers Service is a national system for identifying individuals, healthcare providers and organisations, using a healthcare identifier. An Individual Healthcare Identifier (IHI) is a unique 16-digit number used to identify an individual for health care purposes. As part of the HI Service, every Australian resident has a unique IHI.
Health care service/ Health service organisations	Used to describes acute, primary and community healthcare services, as well as other services involved in the delivery of health care. Healthcare services are delivered in a wide range of settings and vary in size and organisational structure. These range from owner-operated services, where a single clinician is also responsible for administrative and management operations, to complex organisations comprising of many clinicians, a supporting workforce, management and an overarching governing body.

Term	Definition
Higher risk (patients at higher risk of harm)	A patient with multiple factors or a few specific factors that may result in their being at greater risk of harm from health care or the healthcare system. This may include people with chronic clinical conditions, language barriers, or low health literacy. Other factors may also affect a person's risk of harm such as being of Aboriginal and Torres Strait Islander descent, from a Culturally and Linguistically Diverse background or identifying as lesbian, gay, bisexual, transgender and intersex (LGBTI+).
High-risk medicines	Medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating. At a minimum, the following classes of high-risk medicines should be considered: • Medicines with a narrow therapeutic index • Medicines that present a high risk when other system errors occur, such as administration via the wrong route.
Home medicines review (HMR)	An Australian Government-funded service in which the medical practitioner and the accredited pharmacist both participate in the medication review process, consistent with the business rules for Item 900 of the Medicare Benefits Schedule. *See also* **medication review**.
Hospitals	Public and private acute and psychiatric hospitals, freestanding day hospital facilities, and alcohol and drug treatment centres. Includes hospitals specialising in dentistry, ophthalmology, and other acute medical or surgical care. May also include hospitals run by the Australian Defence Force and correctional authorities, and those in Australia's offshore territories. Excludes outpatient clinics and emergency departments.
Incident	An event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss.
Inclusive language	Language that is culturally appropriate and respectful of the diversity of Australia's peoples.
Individual	In this Framework, 'individual' refers to a patient or patients (a person or people who are actively receiving health care; for example, a person being treated in a hospital or being cared for by a general practitioner or specialist) and people who provide them with support including family, carers, partners, friends, healthcare advocates and the general community.

Term	Definition
Informed consent	A process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care, which may include watching and waiting. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.
Integrated care	Is where all parts of the health system work together to deliver person-centred care that is seamless, comprehensive, coordinated, and efficient across the continuum of care. Integrated care is a multidisciplinary collaboration, where each sector takes responsibility for the patient across the entire health care system.
Interim residential medication administration chart (IRCMAC)	A standardised medication chart for use on an interim basis when patients are transferred from hospital to a residential aged care home (RACH). Also referred to as an interim mediation administration chart. It supports continuity in medication management and enables RACH nurses to document administration of medicines until a review occurs.
Local context	The particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the health service organisation's function, size, resources, patient cohorts and organisation of care regarding service delivery mode, location and workforce.
Local Hospital Network	States and territories each have different descriptions of the governance structure providing health services. These include local health networks, local hospital networks, local health districts, boards and area health services. Where the term 'local hospital network' is used, it refers to the description of any of these terms as relevant to states and territories (see meteor.aihw.gov.au/content/index.phtml/itemId/491016).
Medical/ healthcare record	A record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. Information in a healthcare record can be sourced from multiple healthcare organisations.
Medication chart	A tool to document a record of the prescriber's clinical intention for a person's treatment, an order for the pharmacist to dispense a person's medicine, and a record of administration of the medicine to the person.
Medication management	Practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.

Term	Definition
Medication management plan (MMP)	An MMP is a continuing plan for the use and management of medicines developed in collaboration with the patient. The MMP records medicines taken before admission and aids medication reconciliation throughout the patient's episode of care. It is a record of patient-specific medicines-related issues, actions taken to resolve issues and medication management goals developed during the episode of care. All health professionals are responsible for documenting on the MMP regardless of the setting. The MMP or equivalent may be used in inpatient, outpatient or non-admitted areas, emergency departments, subacute or for primary care.
Medication reconciliation	A formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.
Medication review	A systematic assessment of medication management for an individual patient 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 medicines-related problems and reducing waste. Medication review may be part of medication reconciliation. *See also* **home medicines reviews (HMRs)** and **residential medication management reviews (RMMRs)**.
Medication safety	Is about reducing medication adverse events and errors by establishing and using systems to ensure: • Clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use • Consumers are informed about medicines, and understand their own medicine needs and risks.
Medicine	A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.
Medicine-related problem	Any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease specific, laboratory test–specific and patient-specific information. Medicine-related problems include issues with medicines such as: • Underuse • Overuse • Use of inappropriate medicines (including therapeutic duplication) • Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test) • Noncompliance.

Term	Definition
Medicines governance group	Has responsibility for medication management, including formally reporting to the organisation's clinical governance or managers. This is usually a drug and therapeutics committee, or a committee with a similar name and intent (for example, quality use of medicines committee, medication safety committee, medication advisory committee [MAC]).
Medicines list	Prepared by a healthcare professional, a medicines list contains, at a minimum: • All medicines a patient is taking, including over-the-counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included. • Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions; for each allergy or adverse drug reaction, the medicine name, the reaction type and the date on which the reaction was experienced should be included. Ideally, a medicines list also includes the intended use (indication) for each medicine. It is expected that the medicines list is updated and correct at the time of transfer (including clinical handover) or when services cease, and that it is tailored to the audience for whom it is intended (that is, individual or healthcare professional).
Medicines or medication literacy	The degree to which individuals can obtain, comprehend, communicate, calculate and process patient-specific information about their medicines to make informed medicines and health-related decisions in order to safely and effectively use their medicines, regardless of the mode by which the content is delivered (for example, written, oral and visual).
MedsCheck	A service provided within a community pharmacy and consists of a review of a patient's medicines to improve the patient's understanding of their medicines and ultimately, patient outcomes. The service aims to support self-management by evaluating a patient's knowledge about their medicines, addressing any problems the patient has identified with their medicines, and advising the patient about the best way to utilise and store their medicines.
Minimum information content	The content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.
Model of care	The way care is delivered to support the safe and timely treatment of patients through their health care.
Multidisciplinary stewardship team	In the Framework, a team of clinicians appointed by the governing committee to link frontline clinicians with the committee structure, and promote and lead stewardship of medication management at transitions of care. The team is not a treating team. Rather it promotes stewardship and stewardship activities, and identifies clinician training and education needs. The team includes a champion for medication management at transitions of care stewardship.

Term	Definition
My Health Record	The secure online summary of a consumer's health information, managed by the system operator of the national My Health Record system (the Australian Digital Health Agency). Clinicians are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.
Outcome	The status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.
Person-centred care	An approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care. Also known as patient-centred care or consumer-centred care.
Pharmacist shared medication medicines list (PSML)	A list of medicines that may include those prescribed by your doctor, non-prescription medicines including over-the-counter and complementary medicines (such as vitamins or herbal medicines) you may take. This list will include details on how and when you take your medicines at the time the list was created. Pharmacists can upload a PMSL to a person's My Health Record.
Point of care	The time and location of an interaction between a patient and a clinician for the purpose of delivering care.
Policy	A course or principle of action adopted or proposed by an organisation or individual.
Polypharmacy	The use of multiple medicines to prevent or treat medical conditions. It is commonly defined as the concurrent use of five of more medicines by the same person. Medicines include prescription, complementary and non-prescription (or over-the-counter) medicines.
Primary care	The first level of care or entry point to the healthcare system, such as general practice clinics, community health practice (for example, clinics, outreach or home visiting services), ambulance services, pharmacists or services for specific populations (for example, Aboriginal or refugee health services).
Primary Healthcare Networks	Independent organisations working to streamline health services – particularly for those at risk of poor health outcomes – and to better coordinate care so people receive the right care, in the right place, at the right time.
Primary healthcare provider (usually a GP)	The healthcare professional/clinician who is responsible for and coordinates an individual's care in the primary and aged care settings. This is usually the individual's regular GP but may refer to other primary care clinicians where relevant.

Term	Definition
Procedure (organisational)	The set of instructions to make policies and protocols operational, which are specific to an organisation.
Program	An initiative, or series of initiatives, designed to deal with a particular issue, with resources, a time frame, objectives and deliverables allocated to it.
Protocol	An established set of rules used to complete a task or a set of tasks.
Provider directories	Provider directories are online lists that help find and access information about healthcare providers and services, particularly for individuals and healthcare professionals. They can include details like contact information, specialties, locations, and services offered.
Quality improvement	The efforts of the individuals, the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development. Quality improvement activities may be undertaken in sequence, intermittently or continually.
Quality use of medicines	Quality use of medicines is: • Selecting management options wisely • Choosing suitable medicines if a medicine is considered necessary so that the best available option is selected • Using medicines safely and effectively to get the best possible outcome.
Regularly	Occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. The interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.
Residential aged care home (RACH)	A special-purpose facility that provides accommodation and personal care 24 hours a day, as well as access to nursing and general healthcare services, and assistance towards independent living, for senior Australians who can no longer live in their own home. All government-funded aged care facilities must be approved providers and meet quality standards.
Residential medication management review (RMMR)	A collaborative medication review provided by an accredited pharmacist in accordance with a program funded by the Australian Government for eligible people receiving care within a government-funded RACH, consistent with the business rules for Item 903 of the Medicare Benefits Schedule. *See also* **medication review**.
Responsibility	Being entrusted with or assigned a duty or charge. In many instances, responsibility is assumed, appropriate with one's duties. Responsibility can be delegated as long as it is delegated 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. Responsibility is about accepting the tasks/functions inherent in one's role.

Term	Definition
Risk	The chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.
Risk assessment	Assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.
Risk management	The design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.
Safety culture	A commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.
Screening	A process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.
Shared decision making	Discussion and collaboration between a patient or consumer and their healthcare provider. The process aims to bring together the patient/consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person.
Stewardship	The careful and responsible management of something entrusted to one's care It uses a strategic approach to support governance, interventions and tools that guide and optimise practice. Medicines stewardship refers to programs to improve prescribing and medication management at individual and population levels to reduce variations in practice, ensure safe use of medicines, ensure efficient use of resources, and improve health outcomes. In the Framework, stewardship refers specifically to a quality use of medicines continuous improvement program.
Structured clinical handover	A structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate.

Term	Definition
System	The resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system: • Brings together risk management, governance, and operational processes and procedures, including education, training and orientation • Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials • Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures. The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.
Telehealth	Health services delivered using information and communication technologies, such as videoconferencing or phone calls.
Timely (communication)	Communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.
Transitions of care	A transition of care is when all or part of a person's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or all of their health care. It may be temporary – to manage a brief illness, or long term – due to a permanent change in health status. Transitions of care may occur within and between healthcare locations, settings, care delivery types, levels of care and involve a range of health care providers.
Treating team	The team of clinicians providing care to the individual. In the Framework, the treating team is responsible for delivering medication management activities (Element 3 of the Framework) to the individual or performing them for the benefit of the individual. The treating team's medication management activities are informed by the policies and processes formulated by the governing committee and by the leadership of the multidisciplinary stewardship team (which is not directly involved in delivering care).
Virtual care	Any interaction between a patient and clinician, or between clinicians, occurring remotely with the use of information technologies.
Workforce	All people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* **clinician**.

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