FREQUENTLY ASKED QUESTIONS

Standard 4: Medication Safety

Medication safety is an important element of many of the NSQHS Standards. When considering medication safety policy, you should also consider related principles in NSQHS Standards:

- Standard 1: Governance for Safety and Quality Health Service Organisations
- Standard 2: Partnering with Consumers
- Standard 3: Preventing and Controlling Healthcare Associated Infections
- Standard 5: Patient Identification and Procedure Matching
- Standard 6: Clinical Handover.

Governance and systems for medication safety

Health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.

1. How can appropriate governance arrangements be implemented within the limitations of staffing and resources?

Drug and Therapeutics Committees (DTCs) have an important role in policy development and oversight, developing the medication safety quality improvement plan and monitoring quality improvement activities. DTCs and medication safety sub-committees should work with the health service’s safety and quality unit and Executive to implement NSQHS Standard 4. Medication safety can be integrated within the health service organisation’s corporate and clinical governance and organisational strategic or risk management plans. By undertaking a risk assessment/gap analysis, medication safety activities can be prioritised according to risk.

Small hospitals should link with local health network/district DTCs (where they exist)/private hospital safety and quality network for governance arrangements and access to policies, audit tools and other resources.

2. What processes should a small rural hospital with no onsite pharmacist implement in order to achieve medication safety standard?


The Guide also lists a number of resources to support implementation of the Standard. Further resources are available from the Commission’s website both within the accreditation program and the medication safety program.

The starting point should be to map existing medication management processes and governance arrangements against the standards. This will help identify areas where there are gaps between the standard and the medication management system, and where activities need to be focussed.
The next key activity is to undertake an assessment of the medication management system by using the Medication Safety Self Assessment tool available from the NSW Clinical Excellence Commission [www.cec.health.nsw.gov.au/programs/mssa](http://www.cec.health.nsw.gov.au/programs/mssa) This will further help to identify and prioritise the areas on which to focus medication safety activities, and subsequently to develop an action/quality improvement plan to address areas for improvement. Reviewing medication incident reports may also assist to prioritise activities. The Safety and Quality Implementation Guide (item 4.5.2) outlines some quality improvement activities that are mandatory requirements. Strategies 1-3 would apply to a small rural health service.

Small hospitals are encouraged to work with other hospitals in their Local Health Network, and to participate in the Drug and Therapeutics Committee in the network. The Commission has set up networks of health services that will be part of the first wave of health services to be accredited to the NSQHS Standards. The network meetings are held via teleconference and Webex, and provide an opportunity to discuss the NSQHS Standards as well as network with similar services. Health services can be involved in this network by registering interest with the Advice Centre via the Commission website at the following link [www.safetyandquality.gov.au/our-work/accreditation/accreditation-newsroom/advice-centre/](http://www.safetyandquality.gov.au/our-work/accreditation/accreditation-newsroom/advice-centre/).

3. How can we increase the uptake of the NPS medication safety course e-learning modules to address the need for workforce training on safe medication practice?

Encourage staff to undertake the NPS MedicineWise medication safety course e-learning modules as a continuing professional development (CPD) activity. The modules are endorsed by the Australian College of Nursing and accredited by the Australian Pharmacy Council and attract CNE and CPD points. In 2014, NPS MedicineWise will be able to provide health service organisations with completion figures for the modules, enabling organisations to monitor staff participation rates.

4. Is a hospital formulary a mandatory requirement?

Hospitals should have a list of the medicines (formulary) that have been approved by the DTC (or equivalent governance group) for use in the facility. This should include restrictions placed on the prescribing of any of the medicines. It is best practice that the list, including prescribing restrictions, is accessible to staff throughout the hospital, where possible in electronic format.

5. Is the use of ‘related specialist and ancillary charts in hospitals’ mandatory or recommended?

The use of the National Inpatient Medication Chart ([NIMC (acute)](http://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard4_Oct_2012_WEB.pdf) public hospital version) and the private hospital version is required in all hospitals using paper-based medication charts. Use of the related specialist charts is also required, including:

- NIMC (long- stay) public hospital version
- NIMC (long-stay) private hospital version
- NIMC (paediatric) public hospital version
- NIMC (paediatric) private hospital version
- NIMC (paediatric long-stay) public hospital version
- NIMC (paediatric long-stay) private hospital version
- NIMC (GP e-version) for use by general practitioners prescribing for inpatients using GP prescribing software
- NIMC for public day procedure services

Where private day procedure services choose to use a modified version of the NIMC, a risk assessment should be used to assess the chart and supporting processes (such as education to staff) prior to implementation. Any risks identified through the risk assessment must be addressed.

Other (ancillary) charts which meet relevant jurisdictional and legislative requirements may be used in conjunction with the NIMC, examples include NIMC Clozapine and charts for managing patient-controlled analgesia.

6. Is the standard NIMC the only chart that meets the National Standards, or can we continue to use a modified version?

Hospitals using a modified version of the NIMC should check whether their modifications comply with the NIMC Local Management Guidelines produced by the Commission


If the changes do not comply, transition to the standard NIMC is required.

7. We use an electronic medication management system, how can we meet the requirement to use nationally standardised charts?

The mandatory requirement for use of NIMC applies to those health services using paper medication charts. Health services with electronic medication management systems (EMMS) are not required to use the NIMC. However, as a minimum, the EMMS should reflect the core functional and technical features outlined in Electronic Medication Management Systems: A Guide to Safe Implementation Second Edition, and be working towards the desirable features. The guide is available from


8. Is it mandatory to use the NIMC in intensive care units.

The National Inpatient Medication Chart (NIMC) was designed to improve the prescribing and documentation of regular medicines, stat and PRN doses in hospitals and should be used, and is used, in ICUs for this purpose. The benefits of the safety features contained in the NIMC, and gained from using a standard chart with which all prescribers are familiar, should be available to critically ill patients.

However there is a range of medicines prescribed in ICUs for which the NIMC is not appropriate e.g. infusions, medicines requiring titration etc and hospitals need to have specialised charts in place to safely prescribe and record the administration of these medicines.


9. How can a rural facility achieve compliance with the requirement to use the NIMC where the GPs use their prescribing software to transfer medication orders electronically to the hospital?

The Commission released a four page A4 version of the NIMC specifically for inclusion in GP electronic prescribing software several years ago. It permits GPs to issue NIMC-compliant medication orders using A4 single-sided printing. Several GP software suppliers have incorporated the NIMC-compliant chart in their software. Information about the chart, including a user guide, is available from
Hospitals should liaise with their GPs regarding the upgrading of software and transitioning to a system and version that supports the generation of the four A4 page NIMC. Implementing the NIMC should be a priority. Actions towards achieving this should be listed in the organisation’s risk register, including a collaborative approach working with the GPs to achieve an electronic system for medication management which includes medication history, administration, reconciliation and management plans. Information on implementing electronic medication management systems is also available from the Commission’s website www.safetyandquality.gov.au/wp-content/uploads/2011/01/EMMS-A-Guide-to-Safe-Implementation-2nd-Edition-web-version.pdf.

Concerns related to functionality and compliance need to be included in an organisational risk register with strategies for addressing issues with software proprietors.

10. How many identifiers are required on patient labels applied to medicines dispensed by the pharmacy department?

**TWO** identifiers are required on labels of medicines dispensed by the pharmacy to individual patients. Given that the process of dispensing is in the context of other patient identification requirements in the NSQHS Standards, two identifiers is considered sufficient for dispensed medicines. However **THREE** approved patient identifiers are specified in Standard 5: Patient Identification and Procedure Matching to correctly match patients with their intended care, including user-applied labelling of injectable medicine containers such as syringes and bags with additives.

11. What is the recommended approach for assessing the medication management system?

All hospitals should use a validated, structured assessment method - the Medication Safety Self Assessment Tool for Australian Hospitals (MSSA) - to assess the safety of their medication management system irrespective of organisation size and whether public or private. The assessment should be completed by a multidisciplinary group and be reassessed every three years. All questions must be answered. Where a facility does not have the resources to provide a function, this may indicate a gap in the safety of their medication management system.

Day procedure services should undertake a gap analysis using the accreditation workbook and/or the monitoring tool available from www.safetyandquality.gov.au/publications/nsqhs-standards-monitoring-tool-for-hospitals-excel-2007/. It is not necessary to undertake a risk assessment, develop risk registers or develop action plans at individual unit level. However hospitals with oncology or haematology services should complete the MSSA for Oncology.

From the assessment, identify areas that are done well and collate evidence to demonstrate this, identify areas for improvement, prioritise according to risk, develop an action plan, and implement and evaluate improvements.

All problems identified during the assessment do not have to be actioned immediately. Areas for improvement should be prioritised according to level of risk and incorporated into an action plan. The Commission provides a risk matrix tool on its web site at www.safetyandquality.gov.au/our-work/accreditation/accreditation-newsroom/

12. Can hospitals that use a non-conforming medication chart enter data into the NIMC database?

Hospitals using a medication chart that has been modified from the NIMC should check whether their changes comply with the NIMC Local Management Guidelines produced by the Commission www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/quality-assurance-and-an-issues-register/

If the changes do not comply, transition to the standard NIMC is required.
Hospitals using non-conforming medication charts cannot enter data into the NIMC Audit System. However, they can use the NIMC Audit Spreadsheet for their own use to monitor compliance with those NIMC safety features reflected on their non-conforming chart.

13. What is required to authorise the clinical workforce to prescribe, dispense and administer medicines?

An annual check of registration is the minimum requirement to verify that the clinical workforce is authorised to prescribe, dispense or administer medicine. The Australian Health Professionals Registration Authority is required to notify employers of professionals with conditions on their registration. They also provide a service to employers that allows regular access to public information about practitioners they employ. Health service organisations should have a mechanism for managing the communication of this information to the relevant personnel in the health service organisation.

Where high risk procedures are performed e.g. chemotherapy prescribing, administration, or additional skills are required for a procedure e.g. administration of IV or intrathecal chemotherapy, staff will require additional training, qualifications or competency assessments. Health service organisations should maintain registers or records of staff qualified to perform procedures and have a process for checking specialist practice qualifications or other professional recognition if it is a requirement. Particular medicines and specialty areas of practice requiring registers of qualified practitioners are a local and/or state decision.

The medication authorisation system items 4.3.2 and 4.3.3 do not relate to approvals to use drugs such as Individual Patient Use/SAS items. They relate to health practitioners managing medicines having the skills and competence to prescribe/Dispense or administer a medicine in accordance with state or territory legislation and within their scope of practice. For further information, see page 20 of the Safety and Quality Improvement Guide for NSQHS Standard 4 Medication Safety.

14. How should organisations approach incident monitoring? Can they use pharmacist intervention data?

Health service organisations can chose to report pharmacy intervention data as well as incident monitoring data to their Medication Safety or Drug and Therapeutics committees as a routine agenda item. Intervention data can provide information on “near misses” that can be useful for identifying issues in the medication management system.

Health service organisations need to establish systems for analysing and investigating the reported data to identify trends and developing an action plan to address any of risks identified.

15. Is it necessary to collect data routinely on quality improvement activities?

Data does not have to be collected routinely on an ongoing basis, nor is it necessary to audit every item continuously. Health service organisations should take a risk management approach to selecting items for auditing and measuring quality improvement, with a focus on areas of risk for the organisation that are likely to cause harm e.g. high risk medicines/areas, areas of poor performance identified in the MSSA or through medication incident reports. Once there is enough data to demonstrate process improvement, and the process is stable, health service organisations can stop auditing in that area and move to another area identified as requiring improvement.

Where there are insufficient resources to collect indicator data routinely, health service organisations should prioritise auditing to those areas identified as highest risk to patients. Data can be collected as part of routine care, by monitoring a small number of patients such as ten to twenty patients per month (five per week) on an ongoing basis using the model of quality improvement promoted by the Institute for Healthcare Improvement at www.ihi.org.

Health service organisations are not expected to use the Global Trigger Tool solely to monitor adverse events related to medicines. However, where the tool is routinely used in a health service organisation as part of the overall quality and safety program information on any medication-related adverse events...
identified in the process should be used to identify risks in the medication management system and
monitor improvements resulting from any actions taken to reduce these risks.

16. Are there any indicators available to measure quality and safety of medicines use and
systems?

Health service organisations are encouraged to use the Quality Use of Medicines Indicators for
Australian Hospitals as indicators of medicines use safety and quality.¹ They include indicators suitable
for monitoring activities directly related to specific items in Standard 4. A revised version of the
indicators will be available in early 2014, and will include additional indicators for continuity of
medication management and mental health.

Health service organisations can also use the South Australian Health Department’s APAC Key
Performance Indicators for Continuity of Medication Management.²

17. When auditing compliance following implementation of medication safety strategies,
what percentage of patients should be audited? Will small, frequent audits targeted to high
risk patients or processes be acceptable or are organisation wide audits required?

There is no requirement to audit a specified percentage of patients or in specific clinical areas for
action item 4.5.2. Health services are not required to conduct organisation wide audits. The aim of
auditing is to measure the effect of quality improvement activities undertaken and to quantify the
scope of potential risk. Small, more frequent, audits targeted at high risk patients, medicines or
processes are appropriate. Audits of five patients per week (10 to 20 per month) using time series or
run charts will provide a good indication of improvement. Results can then be presented in the form of
dash boards, see www.ihi.org.

Where a specific issue has been identified from incident reporting or other sources, a health service
organisation may chose to undertake an organisation wide audit to provide a snapshot of the problem
and to guide selection of appropriate strategies and actions to minimise risk.

18. Are the medication safety alerts, e.g. for potassium and vincristine, mandated or
recommended?

National medication safety alerts for potassium and vincristine are mandatory and the
recommendations contained in the alerts should be actioned in all health service organisations using
those medicines.

19. Is the use of barcode scanning in inpatient and outpatient dispensing mandatory?

Health service organisations should use barcode scanning in their pharmacy dispensing processes. The Guidelines for Dispensing of Medicines issued by the Pharmacy Board of Australia in 2010, state
"Pharmacists are to use barcode scanners when dispensing medicines at dispensing stations in
pharmacies and pharmacy departments". The Pharmacy Board of Australia has confirmed this will
become a mandatory requirement.

The Commission recommends that health service organisations not currently using barcode scanning
should be actively planning to introduce barcode scanners in both inpatient and outpatient dispensing
processes. Delay in implementing this important patient safety intervention involves risks for patients,
for the health services managing care and the healthcare professionals delivering care. In the interim,
and if there are delays in implementation due to software issues, health service organisations should
undertake a risk assessment of their dispensing processes and put strategies in place to reduce the
risk of dispensing errors which would otherwise be mitigated by barcode checking.
20. Do the National Recommendations for Use-applied Labelling of Injectable Medicines, Fluids and Lines apply to Day Procedure Services?

Yes. In day surgery services the Labelling Recommendations apply in the open practice environment outside of the operating room, including preparation and recovery areas. They also apply in the perioperative area where the Australian/New Zealand Standard: User-applied labels for use on syringes containing drugs used during anaesthesia (AS/NZS 4375) is not applicable.

Pre-printed and coloured labels used to identify drugs in syringes used during anaesthesia should comply with the anaesthetic labelling standard, ISO 26825:2008 (Anaesthetic and respiratory equipment- User-applied labels for syringes containing drugs used during anaesthesia – colours design and performance.) This is consistent with the Australian and New Zealand College of Anaesthetists Guidelines for the safe administration of injectable drugs in anaesthesia www.anzca.edu.au/resources/professional-documents/documents/professional-standards/professional-standards-51.html

Further information on labelling of injectable medicines, fluids and lines, including frequently asked questions, is available from www.safetyandquality.gov.au/our-work/medication-safety/user-applied-labelling/
Documentation of patient information

The clinical workforce accurately records a patient’s medication history and this history is available throughout the episode of care.

21. Does adverse drug reaction (ADR) information need to be documented on all medication charts?

ADR documentation on the NIMC can serve as the source of truth of ADRs for all medication charts. ADR information does not need to be documented in full on ancillary charts e.g. clozapine, heparin or parenteral fluid charts. However the ancillary charts need to include a printed warning to:

- check the NIMC for ADRs e.g.

![Check Medication Chart for Adverse Drug Reactions](image)

or

- apply an ADR sticker if there is an existing ADR that refers the user to the NIMC for details e.g.

![Attach ADR Sticker](image)

(See Medication Chart for details)

Where the ADR is recorded in an electronic health record, there needs to be one source of truth of ADRs maintained in the record with active transfer of information to the e-medication management and pharmacy systems. The record needs to appear on the prescribing screen, and prescribing and dispensing systems need to have functioning, active alerts linking ADRs with medicines prescribed. Monitoring of any overrides of the alerts needs to be in place.

22. To what extent will implementation of each criterion be expected and to what extent will this be assessed? Is 80% sufficient?

There are no targets established for extent of compliance with items in the standards. For example, in the case of Action Item 4.7 requiring patients to have adverse drug reactions (ADRs) documented, the expectation is that health service organisations have systems in place for all patients to have ADRs documented and that this is monitored for compliance. The health service should have:

- a policy and/or procedure for documenting ADRs
- evidence of education provided to staff about the procedure
- evidence that ADR documentation has been audited (this could be done as part of the NIMC audit)
- evidence of quality improvement activities planned or undertaken to improve documentation, if required.

23. Who can document the medication history and reconcile medicines?

Health professionals who have received training in taking a Best Possible Medication History and reconciling medicines and may include pharmacists, nurses, doctors, and pharmacy technicians. The organisation should have a policy on medication reconciliation and staff should be clear about their roles and responsibilities for history taking and reconciling medicines. There are models in which nurses undertake the process and consult with a pharmacist if there are any issues or discrepancies requiring follow up with the prescriber.

Where resources are limited and medication reconciliation cannot be undertaken for every patient health service organisations should prioritise medication reconciliation to those patients at higher risk.
of medicine misadventure. A multidisciplinary approach is recommended with responsibilities assigned to the relevant professional groups, including responsibility at weekends and after hours when there may be no pharmacy service.

Where histories are recorded in the patient’s electronic record and used to facilitate continuity of care through to discharge, the health service organisation should map the work flow that facilitates BPMH availability when the discharge summary and prescription are being prepared. If the NIMC paper version is used, it may be necessary to print a copy of the history to keep with the NIMC if the history is not available electronically when medicines are being prescribed.

### 24. What is the medication management plan and where is it available from?

The national Medication Management Plan (MMP) is a standardised form for documenting medicines taken prior to presentation at the hospital and for reconciling patients’ medicines. It has been designed for use by nursing, medical, pharmacy and allied health staff to improve the accuracy of information recorded on admission and available to the clinician responsible for therapeutic decision making. The form contains checklists to assist staff obtain a comprehensive medication history, identify medication risks for the patient and determine which patients would benefit from a home medicines review after they have been discharged. The MMP is suitable for adult and paediatric patients.

The Commission recommends that the MMP is used to document medication histories and reconcile medicines on admission, during intra-hospital transfer and on discharge from the health service. The MMP should be kept with the active NIMC during the episode of care, so that it is available when medication orders are changed and new medicines are prescribed. The MMP and resources for implementing the MMP are available from the Commission’s website. Design files for use by printers can be supplied by emailing mail@safetyandquality.gov.au

#### Medication management processes

**The clinical workforce is supported for the prescribing, dispensing, administering, storing, manufacturing, compounding and monitoring of medicines**

### 25. Is there a need to document daily min/max temperatures when refrigerators are fitted with alarms?

Where refrigerators are installed with alarms that indicate when the temperature is outside set parameters, there needs to be regular testing and scheduled maintenance of alarms. Health service organisations also need to have a policy for responding to the alarm and staff need to be aware of the policy.

It is still necessary to monitor the temperature of the refrigerators. There are temperature recording devices that can be placed in refrigerators to record and monitor the temperature on an ongoing basis. They replace the need to check and record the minimum and maximum temperature daily.

### 26. Is recording and auditing of all drug items returned to Pharmacy Departments and all disposals required?

Health service organisations are not required to keep a log of items returned to pharmacy departments other than Schedule 8 medicines, but are required to undertake a risk assessment of the management of pharmaceutical waste in terms of work health and safety, environmental safety and security of storage on site. A snapshot audit of the volume, type and cost of returned medicines may be informative in monitoring the effectiveness of the drug distribution system and determining whether there are opportunities for reducing excessive waste.
27. What are high risk medicines?

High risk medicines are medicines that have a high risk of causing serious injury or death to a patient if they are misused or used in error. Errors with these products are not necessarily more common, but the effects can be more devastating. Examples of high-risk medicines include anticoagulants, insulin, opioids, chemotherapy, concentrated electrolytes, IV digoxin, neuromuscular blocking agents.

Health service organisations can use the APINCH medicines to develop a list of high risk medicines kept in their institution and guide their work in identifying potential risks and introducing strategies to reduce errors from these medicines.

A  Anti-infectives, antidepressants and antipsychotics,

P  Potassium and other electrolytes

I  Insulin

N  Narcotics and other sedatives, neuromuscular blocking agents

C  Chemotherapeutic agents

H  Heparin and other anticoagulants

ISMP [www.ismp.org](http://www.ismp.org) is also a useful reference source for developing a list of high risk medicines.


Actions to address risks identified with high risk medicines can be prioritised, and this should be based on an assessment of how high risk medicines are managed within the organisation using audits, incident analysis, risk assessment tools and benchmarking activities. This should be done in consultation with the Drug and Therapeutics Committee. A recommended approach in prioritising work is to use a risk matrix to assess potential risk level and likelihood of occurrence such as the one available from the Commission’s website [www.safetyandquality.gov.au/our-work/accreditation/accreditation-newsroom/](http://www.safetyandquality.gov.au/our-work/accreditation/accreditation-newsroom/)

Systems to address risk related to high risk medicines use should be in place in all areas of the hospital, including those areas where staff may be unfamiliar with the medicine.

**Continuity of medication management**

The clinician provides a complete list of a patient’s medicines to the receiving clinician and patient when handing over care or changing medicines.

28. Do all patients being discharged from hospital require a medication list?

Ideally all patients discharged home should be given a list of the medicines they should continue to take at home. Health service organisations unable to provide a medication list to all patients should identify those groups of patients who would most benefit from a medication list and target activities to those patients. Such patients could include those over 65 years of age, those taking multiple medicines, with changes to their medicines during the admission, suspected of non-adherence, taking high risk medicines or with repeated frequent admission to hospital.

Patients admitted to a health service organisation for an operation such as eye or ear surgery who have no changes made to their medicines apart from additional eye drops and medicines associated with the surgery, should be supplied with a comprehensive list of medicines on discharge.
29. Does the requirement to provide a current, comprehensive list of medicines to the receiving clinician and patient apply to outpatients?

The provision of a current, comprehensive list of medicines to the receiving clinician and patient at clinical handover applies wherever care is completely transferred. In the case of patients attending outpatient clinics e.g. oncology clinics, the clinic would not be expected to generate a comprehensive list of all medicines at every attendance. However there should be systems to inform the referring doctor of any changes made to any medicines or of new medicines commenced and the patient should be informed of changes, including new medicines prescribed, and their medicines list amended or a new list provided.

30. In rural sector facilities, who is responsible for reconciling the patients’ medicines on discharge?

In the rural sector the person responsible for reconciling the patients’ medicines on discharge will differ depending on the situation and resources available. Where the discharging doctor is the GP that admitted the patient and is looking after them throughout the episode of care and into the community, there is no handover of care to another clinician and risk for error is low. In this case, the GP should reconcile the medicines. The medicines the patient is to continue on post-discharge must be recorded in the patient’s hospital medical record. Where there are changes made during the admission this information must be communicated to the GP’s practice to ensure that the GP practice records can be updated with the changes.

Where the person discharging the patient is handing over the patient to another clinician then the reconciliation can be done by staff who are trained to reconcile medicines - nurse, pharmacist or medical officer. Patients can be prioritised according to their risk and health services need to devise a process that is effective for their situation.

31. Who generates the patient’s medicines list when there is no pharmacist at the hospital?

Where there is no pharmacist at the health service to prepare and provide a medicines list for the patient, the list may be provided through a number of different mechanisms. Each health service organisation will need to determine what system best serves their needs, and establish a protocol that clarifies roles and responsibilities, as failure to meet this standard may compromise patient care and increase the risk of readmission. Examples of systems include:

- GP generating the list from their software, either in the health service organisation (if software is available) or in the practice, and the patient collects the list on the way home or the next day.
- Where the patient has an existing medicines list and there are no changes, they can continue to use their current list and be instructed to do so. A staff member will need to check the list is still current.
- Community pharmacy preparing the medicines list from a reconciled list of discharge medicines/discharge summary provided by the hospital that includes changes made during the admission. If the patient has had problems managing their medicines and qualifies for a Home Medicines Review the GP could refer the patient to the community pharmacy or an accredited pharmacist for a review and preparation of a medicines list. There is also the community pharmacy Medscheck Program for “at risk” patients which may be suitable for some patients.
- Nursing staff trained and competent to reconcile medicines generating a medication list using a computerised program, preferably from an existing IT program that contains the medicines prescribed. As an example, in Queensland, nurses receive training to use the Queensland Health Enterprise-wide Liaison Medication System (ELMS) program to generate medication lists. The GP at the health service may check the list is correct.
32. How can medicines be built into clinical handover in hospital, especially high risk medicines e.g. shift to shift handover?

Health service organisations should be building medicines into clinical handover procedures e.g. shift to shift handover. Both Standard 4 Medication Safety and Standard 6 Clinical Handover are clear about medicines being included in handover. The MMP and NIMC can be used as tools to assist in this process. It is not necessary for all medicines to be discussed at shift to shift handover but important medicines information, including information on high risk drugs, instructions about changes and medicines to be ceased must be included. Similarly when patients are transferred temporarily e.g. to medical imaging the NIMC can be used but this must be accompanied by verbal discussion about critical, high risk medicines.

Medicines should be a standard item in handover protocols. It is especially important when transferring between levels of care when the risk of error is high. Health service organisations should do a local risk assessment to determine what to include in their handover protocols.

Communicating with patients and carers

The clinical workforce informs patients about their options, risks and responsibilities for an agreed medication management plan

33. What is an agreed medication management plan. Is this the same as the national Medication Management Plan and should all patients have one?

The medication management plan referred to in Item 4.14 is not the national Medication Management Plan (MMP) that is used by clinicians to record the medicines taken prior to presentation to hospital, reconcile medicines on admission and discharge and document the plan for the use of the patient’s medicines. The MMP is a useful tool for documenting medication issues and identifying actions required to improve medication management for individual patients, however it is designed for use by health professionals and is not in a format that is suitable to share with patients. It can be used to inform the development of an agreed consumer medication management plan and acquit the first key task of item 4.14.1 i.e. the assessment of the patient’s risks for medication misadventure.

The medication management plan referred to in 4.14.1 is a consumer medication management (action) plan that is developed for, and agreed with, the patient / carer and given to the patient or their carer on discharge. The intent is for patients or carers to be involved in decisions about the management of their medicines and have input into and receive a copy of a plan for their medicines management. The plan aligns with the consumer’s Medication Action Plan described in the APAC Guiding Principles to achieve continuity in medication management viii. It should include any treatment goals, the current list of medicines, and any changes made during the episode of care. The consumer medication action plan replaces the medicines list.

This action item (4.14.1) is developmental at this stage and the Commission is developing a template for a consumer medication action plan that will delineate the recommended elements of information required in the plan. This will be available in early 2014.

Not all patients will require a consumer medication action plan. The same criteria for deciding who should have a medication list on discharge could be used to select those who should receive a consumer medication action plan. That is those who are at risk of medication misadventure, such as patients over 65 years of age, those taking multiple medicines, with changes to their medicines during the admission, suspected of non-adherence, taking high risk medicines or with repeated frequent admission to hospital. Health service organisations with limited resources should identify those patients who would most benefit from a consumer medication action plan and target these patients.
References