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PRACTICE STANDARDS

Standards of practice for clinical pharmacy services – Chapter 16: My Health Record

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OVERVIEW: STANDARDS OF PRACTICE FOR CLINICAL PHARMACY SERVICES

The practice of clinical pharmacy continues to evolve with the changing needs and demands of contemporary health care. These standards are applicable to the delivery of clinical pharmacy services across all care settings: inpatients, outpatients and patients in the community.[1,2]

They describe the activities delivered by pharmacists for patients to minimise the risks associated with the use of medicines and to optimise the use of medicines. Comprehensive and accountable clinical pharmacy services are an essential component of contemporary health care. Ideally, every health service organisation will have resources to provide all clinical pharmacy activities to every patient based on their needs.

Australian and overseas practice-based evidence confirms that the pharmacist activities described in these standards support an individual patient's medication management plan (MMP) and reduce morbidity, mortality and the cost of care.[3-5]

Clinical pharmacy services for individual patients support the objectives of:

- Guiding Principles to Achieve Continuity in Medication Management[6]
- National Safety and Quality Health Service Standards[7]
- Australian Safety and Quality Goals for Health Care[8]
- National Safety and Quality Health Service Standards: Accreditation Workbook[9]
- National Strategy for Quality Use of Medicines[10]
- Medication Safety Self-Assessment: for Australian Hospitals[11]
- Antimicrobial Stewardship in Australian Hospitals.[12]

In addition, clinical pharmacy services for individual patients enable the objectives of national strategies to improve patient safety and quality of care to be met, such as:

- Patient-Centred Care: Improving Quality and Safety through Partnerships with Patients and Consumers[13]
- Match Up Medicines: A Guide to Medication Reconciliation[14]
- National Inpatient Medication Chart (NIMC), Pharmaceutical Benefits Scheme hospital medication chart (PBS HMC), Paediatric Medication Chart, Private Hospital NIMC and Private Hospital Day Surgery NIMC[15]
- National Residential Medication Chart[16]
- National Medication Management Plan[17]
- Australian Charter of Healthcare Rights[18]
- OSSIE Guide to Clinical Handover Improvement.[19]

Other Society of Hospital Pharmacists of Australia (SHPA) standards of practice and guidelines in specialty areas should be read in conjunction with these standards including:

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This article publishes a new chapter in SHPA's Standards of Practice for Clinical Pharmacy Services: 'Chapter 16: My Health Record'. This chapter was approved by the SHPA Board of Directors in July 2021; it will be incorporated into the Standard the next time it is fully updated. The chapter is published here along with the Standard's 'Overview' section, to provide context on the purpose and scope of such chapters; further, references in the 'Overview' here have been updated to reflect current practice. Information about all of SHPA's Standards of Practice can be found at the SHPA website.

This Standard is for professional practice and is not prepared or endorsed by Standards Australia. It is not legally binding.

- Standards of Practice for Medication Safety[20]
- Medicines Use Evaluation Guideline[21]
- Standard of Practice in Oncology and Haematology for Pharmacy Services[22]
- Standards of Practice for Mental Health Pharmacy[23]
- Standards of Practice for the Community Liaison Pharmacist[24]
- Guidelines for Self-Administration of Medication in Hospitals and Residential Care Facilities[25]
- Standard of Practice in Emergency Medicine for Pharmacy Services[26]
- Standards of Practice for the Provision of Consumer Medicines Information by Pharmacists in Hospitals[27]
- Standard of Practice in Intensive Care for Pharmacy Services[28]
- Standards of Practice for the Provision of Palliative Care Pharmacy Services[29]
- Standard of Practice in Clinical Trials for Pharmacy Services [30]
- Standards of Practice for Medicines Information Services.[31]

The professional conduct of pharmacists providing clinical services in all aspects of practice should be guided by the:

- Pharmacy Board of Australia and Australian Health Practitioner Regulation Agency codes and guidelines[32-40]
- SHPA Code of Ethics[41]
- National Competency Standards Framework for Pharmacists in Australia.[42]

Familiarity with the medicines management pathway and how other non-clinical hospital pharmacy services support each step of the pathway is useful to understand the context of clinical pharmacy services (Figures 1, 2).

Objective and definition

Objective

The objectives of a clinical pharmacy service and clinical pharmacy activities are to minimise the inherent risks associated with the use of medicines, increase patient safety at all steps in the medicines management pathway and optimise health outcomes.

Definition

Pharmacists undertake clinical pharmacy activities for individual patients to minimise the inherent risk associated with the use of medicines. Clinical pharmacy activities support a collaborative approach (with patients, carers, prescribers and other health professionals) to medicines management.

Clinical pharmacy activities described in these standards include:

- medication reconciliation
- assessment of current medication management
- clinical review, therapeutic drug monitoring and adverse drug reaction management
- contributing to the MMP
- providing medicines information
- facilitating continuity of medication management on discharge or transfer
- participating in interdisciplinary ward rounds and meetings
- training and education
- participating in research
- quality improvement activities and peer review.

A clinical pharmacy service describes a team of pharmacists (with support from pharmacy technicians and assistants) who are involved in the delivery of a combination of these activities to individual patients or groups of patients.

Extent and operation

These standards are comprised of 16 chapters that detail the clinical pharmacy activities listed above. They provide guidance on maximising clinical pharmacy services and activities, managing workloads, using pharmacy support staff and improving the quality of clinical pharmacy services. These chapters are:

- Chapter 1: Medication reconciliation
- Chapter 2: Assessment of current medication management
- Chapter 3: Clinical review, therapeutic drug monitoring and adverse drug reaction management
- Chapter 4: Medication management plan
- Chapter 5: Providing medicines information
- Chapter 6: Facilitating continuity of medication management on transition between care settings
- Chapter 7: Participating in interdisciplinary care planning
- Chapter 8: Prioritising clinical pharmacy services
- Chapter 9: Staffing levels and structure for the provision of clinical pharmacy services
- Chapter 10: Training and education
- Chapter 11: Participating in research
- Chapter 12: Standard of practice for pharmacy technicians to support clinical pharmacy services[43]
- Chapter 13: Documenting clinical activities

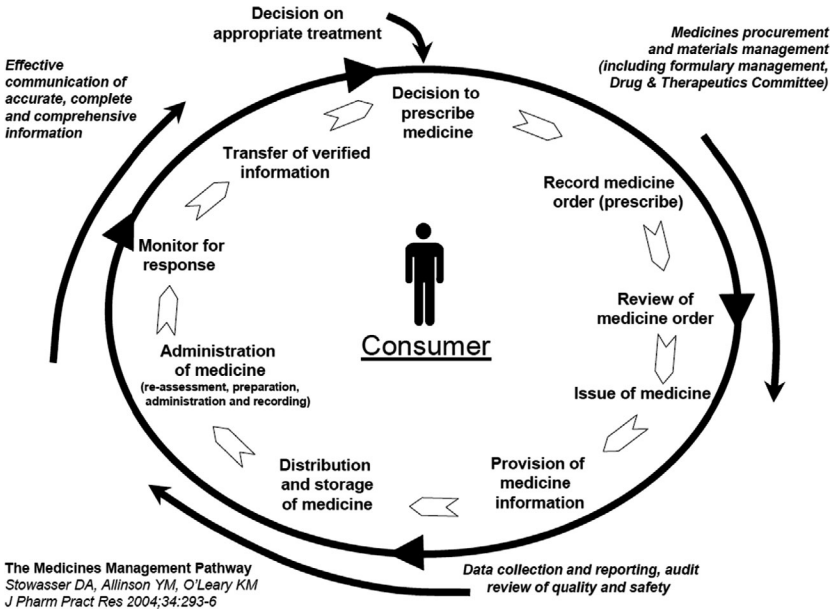

Figure 1 Overview of the medicines management pathway cycle.

- Chapter 14: Improving the quality of clinical pharmacy services
- Chapter 15: Clinical competency assessment tool
- Chapter 16: My Health Record

Each chapter is also linked to relevant competencies and accreditation frameworks.

Clinical pharmacy activities are not restricted to hospital practice; pharmacists in many settings deliver the activities described in these standards. However, the notion of a designated clinical pharmacy service is generally associated with hospital practice.

There should always be a separation of the functions of prescribing, dispensing and administering medicines in all practice settings, wherever possible. In some settings, for example, theatres, rural and remote areas, or in emergencies this may not always be possible, but the principle is supported as it provides the checks and balances necessary for safer prescribing and delivery of medicines.[44]

Separating these functions ensures that another health professional takes an independent review of the next step in the medicines management pathway. Pharmacists proactively collaborate with prescribers, retrospectively review medicines ordered and intervene when errors or omissions have occurred or improvements can be made. The clinical pharmacy activities described in these standards focus on the optimum use of medicines for an individual patient, and are required irrespective of the number of prescribers or the profession of the prescriber. Medicines ordered by pharmacists authorised to prescribe should be reviewed by the dispensing pharmacist or the clinical pharmacist responsible for the patient's care.

Decision support and therapeutic information offered through electronic prescribing systems can support prescribing within designated parameters, but they do not replace review of prescribed medicines by a pharmacist.

Communication and cooperation between acute, subacute, non-acute and primary care sectors is important for patients to receive uninterrupted care. For this reason, facilitating continuity of medication management on discharge or transfer is a core clinical pharmacy activity.

Where appropriate, pharmacists should contribute to a patient's electronic health record to facilitate the continuity of medication management. Pharmacy services should be available when patients require them, seven days per week and for extended hours. Limiting services to business hours and five days per week reduces the timeliness of service delivery and may impact on patient care.

Ideally, every health service organisation will have resources to provide a clinical pharmacy service to every patient based on their needs. However, limited funding and insufficient staffing levels to meet patient numbers and inpatient throughput mean that pharmacy services may not be provided to all patients. Pharmacy managers, in conjunction with the organisation's managers, need to plan for these circumstances by determining the groups of patients that will benefit the most from a clinical pharmacy service and which clinical pharmacy activities are prioritised in their organisation.

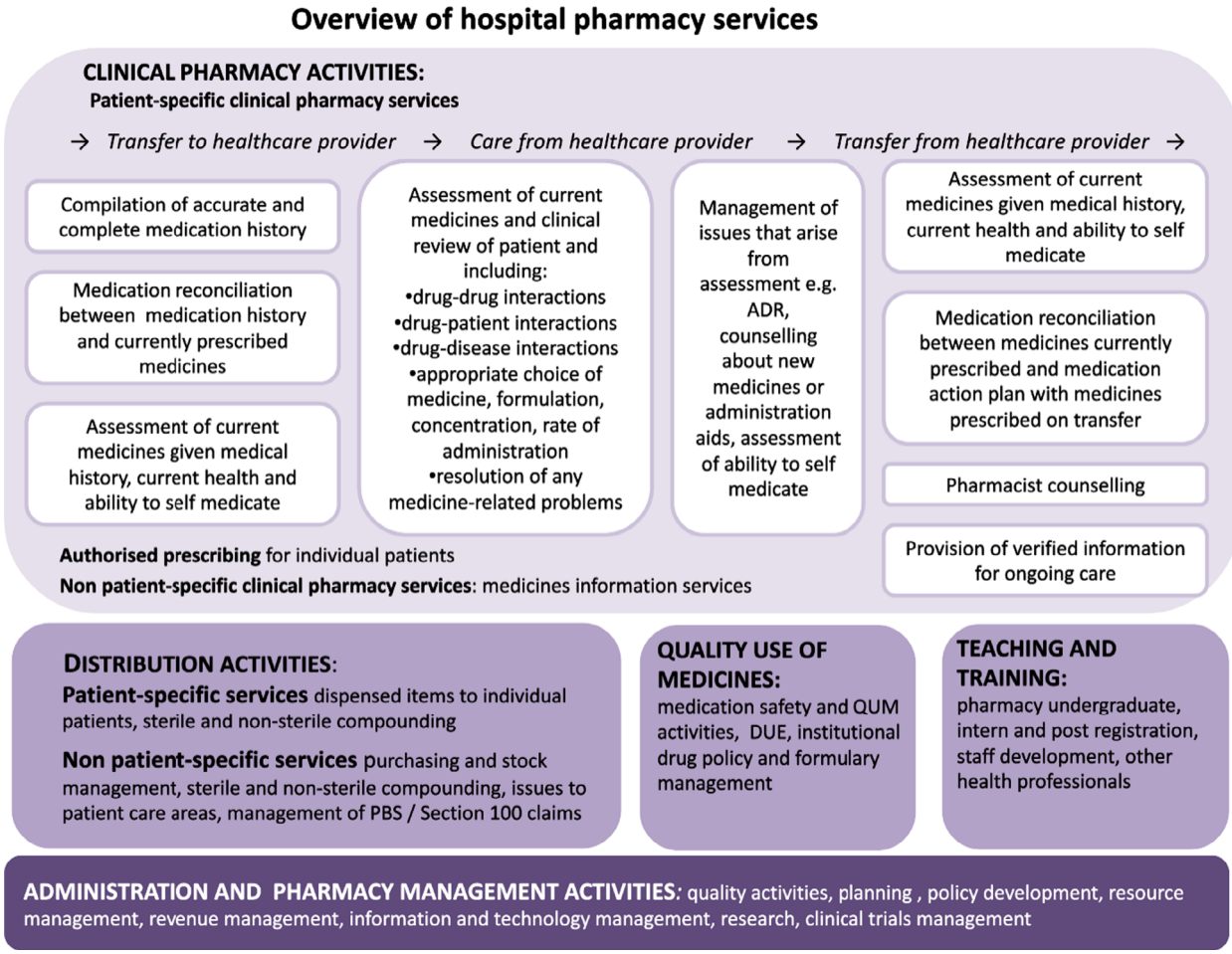

Figure 2 Hospital pharmacy services that support the medicines management pathway.

These decisions should be in line with the organisation's policies and need to be described in service agreements that detail the patients/service areas that will have access to clinical pharmacy services and which clinical pharmacy activities are priorities for each group of patients/service area. These decisions should also align with the National Safety and Quality Health Service Standards and their goals.[7,8]

Pharmacists also need to prioritise the patients who will receive which clinical pharmacy activities on a day-to-day basis. Patients most at risk of medicine-related problems are likely to obtain the maximum benefit from clinical pharmacy activities. Patients most at risk of medicine-related problems include those who:[1,15,17,45,46]

- 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 five or more medicines
- take more than 12 doses of medicines per day
- take a medicine that requires therapeutic monitoring or is 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 sight, confusion/dementia or other cognitive difficulties
- have impaired renal or hepatic function
- have problems using medication delivery devices or require an adherence aid
- 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.

In addition to meeting their continuing professional development requirements, pharmacists have a responsibility to contribute to the training and education of other pharmacists, pharmacy students and health professionals. This may involve experiential training of undergraduate and post-graduate students, or orientation and training of inexperienced pharmacists or those recently returning to the workplace. The shpaclinCAT competency framework for pharmacists provides a tool to support pharmacist development as part of an ongoing program of review and enhancement.[47]

Pharmacists should be involved in presentations and education programs for colleagues and patient groups, for example, cardiac rehabilitation, participate in medication management-related nursing education and in public health education programs, for example, smoking cessation. Pharmacists should support, initiate and participate in research projects, whenever possible. Pharmacists involved in research activities must adhere to the principles and procedures outlined by key authoritative bodies and the organisation's research and ethics committees.[29,48,49]

Participation in quality use of medicines activities within hospitals and research into optimal use of medicines and the practice of clinical pharmacy are essential components of a clinical pharmacy service. Quality use of medicines activities are inclusive of medication safety, medicines use evaluation and antimicrobial stewardship.[12,20,21] Pharmacists can be involved in medicines use evaluation activities by identifying clinical areas requiring evaluation, data collection and the design and provision of education programs.

Each pharmacy service should have a clearly defined quality improvement governance system which outlines the goals for the quality of service delivery. This governance system should be in accordance with the larger framework of the organisation.[7,8] A quality improvement governance system for a clinical pharmacy service should consider the range and day-to-day prioritisation of clinical pharmacy activities delivered and any service agreements.

CHAPTER 16: MY HEALTH RECORD

Introduction

My Health Record is a patient-controlled electronic health record that facilitates the sharing of an individual's health information with healthcare providers.[50] A patient's health information may sit in a range of locations, for example, a hospital, imaging centre or general practice.[51] My Health Record is designed to be integrated into local clinical software, to connect the various points of care so that health information can be shared securely, in real-time.[52] My Health Record can be updated by the patient and/or their authorised representatives or healthcare providers.[53]

The benefits of having consolidated health information that can be viewed and shared include:

- less time spent explaining and re-sending patient information to enquiring healthcare providers external to the health service
- facilitation of continuity of care by providing health information that can be accessed by healthcare providers external to the health service
- improvement of patient understanding and management of their health, especially those with chronic and complex conditions.[54]

My Health Record provides authorised healthcare providers access to various components of health information, including but not limited to:

- medical history;
- current medicines, allergy and adverse drug reaction information;
- pathology and DI reports;
- advance care planning information & patient-entered information.[52]

My Health Record is not a complete record, as the upload of clinical information is dependent on the healthcare provider, health service use and patient control. It does not replace the existing clinical records held in the local clinical information system or the direct sharing of health information between healthcare providers and patients, neither does it affect the delivery of core services by the health service. It should act to strengthen and support the healthcare system by providing an additional source of health information.

A glossary is provided in Appendix 1.

The role of My Health Record in hospital pharmacy services

As a patient moves between the community and hospital health services, discrepancies in clinical records, including medicines information, are common and can lead to poor patient outcomes.[46,55] My Health Record is a tool that can be used as an additional source of information for medicines, allergies and adverse drug reactions.[51] It can facilitate continuity of care by providing timely access to key health information.

Medicine discrepancies are more prevalent in the hospital setting, at transitions of care and for patients with chronic conditions, or those who are taking multiple medicines.[56] My Health Record is an important resource

for pharmacists, for example, when undertaking a medication reconciliation, as it provides timely access to the patient's clinical information.[57] This, in turn, enables the charting and prescribing of medicines in an accurate and timely manner, reducing the risk of medicine discrepancies and omissions.

By providing access to an additional source of clinical information, My Health Record can enhance medicines management and continuity of care, promote the safe and quality use of medicines and reduce the risk of serious medication errors.[56] This is in line with the National Medicines Policy[58] and National Quality Use of Medicines Strategy.[59]

Objective and Definition

Objective

The purpose of My Health Record is to provide a relevant, up-to-date digital health record that supports the clinical care of an individual by consolidating the patient's health information from various points of care. The objective of this chapter is to provide guidance on the appropriate use, and integration of, My Health Record in clinical pharmacy practice.

Definition

My Health Record is an electronic management system for a patient's health information.[50] It provides online access to health information including medicines, allergies and adverse reactions, medical conditions, health summaries, immunisation history and pathology results from different points of care.[51]

Pharmacists, where authorised by their healthcare provider organisation, can access and view a patient's My Health Record, in addition to uploading dispensing records and a Pharmacist Shared Medicines List (PSML) if utilising conformant clinical software.[50] The clinical information contained in a patient's My Health Record can be utilised to support clinical decision-making, optimise patient care and reduce medication discrepancies.[60] For example, a recent dispensing history uploaded into My Health Record can be used as an additional source of information to reconcile medicines (names, doses and frequency), reducing the dependence on a patient's memory, or the PSML can be utilised upon discharge from hospital (see 'Medicines Management'), or can be utilised by the healthcare provider at the next point of care, to accurately prescribe current medicines.

Extent and Operation

Medication discrepancies and miscommunication in clinical records may occur at any point of care but are more significant when patients transition between care settings.[56,61] The 2017 World Health Organization (WHO) report emphasised that improving communication at transition points is vital in avoiding medicine-related harm.[62] My Health Record is an important source of clinical information that can be accessed in a timely manner and therefore enhance the clinical decision-making process, reduce the risk of medication discrepancies and improve efficiency in the delivery of a health service.[60]

The clinical information available in My Health Record can be utilised in various clinical pharmacy activities including, but not limited to:

- medication reconciliation (Chapter 1)
- therapeutic drug monitoring and adverse drug reaction management (Chapter 3)
- documenting clinical activities (Chapter 13)
- facilitating continuity of medicines management during transition between care settings (Chapter 6).

The following documents and views can be found in a patient's My Health Record:

- Medicines Information View
- prescription and dispense records
- PSML
- discharge summaries
- Medicare overview, for example, Pharmaceutical Benefit Scheme records and Australian Immunisation Register
- shared health summaries
- specialist letters
- event summaries
- pathology and diagnostic imaging reports
- personal health summary, for example, over-the-counter (OTC) medicines and allergies.

Where My Health Record is integrated with hospital clinical information systems, discharge summaries, dispensing records of discharge medicines and the PSML may assist with maintaining continuity of care as the patient transitions out of the hospital to another health service and/or community care. Organisational policies must incorporate provisions relating to the use of My Health Record. This may include dispensing guidelines and clinical service guidelines.

Table 1 provides examples of the various documents and records in My Health Record and their use in clinical pharmacy activities. This table is not exhaustive and there may be other areas of application not covered within this table, for example, clinical activities performed by the pharmacist outside of the hospital setting.

Table 1 Examples of documents and records in My Health Record that are of use in clinical pharmacy activities

My Health Record documents and information	Clinical pharmacy activities		
	Medication reconciliation	Therapeutic drug monitoring and adverse drug reaction management	Transition of care and discharge
Prescribing and dispense records	✓	✓	✓
Pharmacist Shared Medicines List	✓	✓ (from community)	✓ (from hospital)
Discharge summaries	✓ (from previous admissions)	✓ (from previous admissions)	✓ (from current admission)
Medicare information	✓		✓
Event summaries	✓	✓	✓
Specialist letters	✓		
Shared health summaries	✓		
Pathology and diagnostic imaging reports		✓	✓
Patient-entered information, for example, over-the-counter medicines, allergies	✓	✓	✓
Medicines Information View	✓	✓	✓

Policies and Procedures

Medicines Management

Medicines management comprises multiple activities to manage the safe and effective use of medicines for a patient at each episode of care.[63] By undertaking clinical pharmacy activities, pharmacists can minimise risks associated with the use of medicines, increase patient safety at all steps of the medicines management pathway and optimise health outcomes for the patient.

The medication reconciliation process (Chapter 1) is an essential element of medicines management and should be performed at all points of transition of care. As part of the medication reconciliation process, for example, the pharmacist must obtain a patient's best possible medication history. Pharmacists can utilise My Health Record as one source of health information to aid in obtaining the best possible medication history. My Health Record does not replace the patient or carer interview in this process.

Prescription and dispensing records can provide medicines information including dose, strength and dispensing history. This may be particularly important after-hours or on weekends when access to usual sources of information is not available, for example, when the community pharmacy or GP practice is closed. Other sources of clinical information or contact details (e.g. general practitioner (GP) or community pharmacy) can be used to ascertain and verify current medicines, immunisation records or allergies and details of recent health events.

By providing the clinical information in a consolidated platform, My Health Record facilitates the accurate and timely prescribing of a patient's regular medicines so that doses are not missed. This enables treatment to be quickly and efficiently tailored to achieve the optimal outcome for the patient. Further, as many hospital admissions are related to medication discrepancies or misadventures, My Health Record is an important tool that can be used to quickly identify medicine-related issues, for example, duplication of therapy or drug–drug interactions.

My Health Record may be of value as a patient transitions to another point of care, for example, from the hospital to the home or a residential care facility, as health information can be shared with other healthcare providers external to the health service. Where integrated with conformant clinical software, discharge summaries, dispensing records of discharge medicines and a PSML (yet to be enabled for hospital pharmacies) can be uploaded by the health service, to the patient's My Health Record, providing an accurate summary of medicines and clinical information upon discharge from hospital. This can subsequently be viewed by a healthcare provider external to the health service and used to accurately review and/or prescribe medicines (see Chapter 6).

Whilst My Health Record provides key health information, it is not complete and may not contain all of the patient's clinical information or provide an up-to-date status of their health. When reviewing clinical information, pharmacists must exercise professional judgement in determining the currency and relevance of any clinical document in My Health Record.[64] As part of best practice, a pharmacist should always verify the information in the patient's My Health Record using additional sources of health information (Chapter 1).

Prescription and dispense records

Prescription and dispense records provide key medicines information including:

- name (generic and brand), strength and dose of each medicine
- form, route and frequency of administration
- maximum number of prescription repeats
- date of prescribing
- date of dispensing
- quantity dispensed
- directions included on each label.

They are a useful tool for medication reconciliation, assessing compliance with prescribed therapy or upon discharge from hospital, by way of a record of discharge medicines. The information is viewed in either the 'Prescription and Dispense View' or the 'Medicines Information View' of the My Health Record.

There are certain limitations to consider with this functionality. For example, whilst some medicine changes may be visible via the medicines information view (see 'Access and View Format' below), medicines that have been ceased or doses that have been changed may not be reflected in My Health Record, unless an updated recorded is uploaded. Further, the accuracy of these records is dependent on all items dispensed being uploaded and the patient not deleting any dispense or prescription record.[56] A second information source must therefore be obtained when using these records for determining a medication history (see Chapter 1 for further information on medication reconciliation).

Where the hospital dispensing software is conformant, the dispensing information will automatically be uploaded via the prescription exchange service. Where a dispensing error has occurred, the error may be superseded by a new record.[65] There is no requirement to obtain the patient's consent prior to uploading, as this is authorised by the *My Health Records Act 2012*.

Pharmacist Shared Medicines List

The PSML is a list of all medicines the patient is known to be taking at the time the list is created and uploaded to the patient's My Health Record. This includes prescribed medicines, OTC and complementary medicines. The PSML reduces medication discrepancies and improves medication safety. A PSML may only be created and uploaded by a pharmacist, which may include information from:

- hospital discharge medicines list
- dose administration aid medicines list
- pharmacist professional services, for example, home medicines review.[66]

The PSML is an important resource that can be utilised by the pharmacist as part of the medication reconciliation process. It may also play a role in other medicines management activities, for example, the pharmacist may identify an interaction between a complementary medicine and a prescribed medicine based on the information in the PSML.

When integrated into hospital health systems, the PSML will facilitate continuity of medicines management and reduce the risk of medication discrepancies for patients transferring between care settings, by providing timely access to an accurate medicines list which can be accessed and viewed by healthcare providers external to the hospital.

The PSML can be found in the 'Documents' section of the My Health Record or via a link in the 'Medicines Information View' (see below). Professional guidelines relating to generating and uploading the PSML have been developed and issued by the Pharmaceutical Society of Australia (PSA).[51]

Adverse drug reactions and allergies

Both adverse drug reactions and allergies can be documented in a patient's My Health Record and viewed in the Medicines Information View. Pharmacists should check on admission, as part of medication reconciliation, any documented allergies or previous adverse drug reactions. Allergies may be entered by the patient in their health summary or may be documented in event summaries, shared health summaries, discharge summaries and/or specialist letters.

If an adverse drug reaction occurs during the patient's admission, it must be recorded in the individual patient clinical notes, as per local policy (refer to Chapters 3 and 13) and reported to the Therapeutic Goods Administration (TGA), where required. Discharge summaries uploaded to My Health Record should include details of the new adverse drug reaction. Where clinical software is conformant, it may additionally be recorded in My Health Record as an event summary.[i] This must be in an appropriate format, including details of the date (etc), medicine, and presentation of the reaction, the assessment made and the action taken.[67]

Other Clinical Information

There are various other clinical documents uploaded into My Health Record which can be useful when undertaking clinical activities, for example:

- discharge summaries
- Medicare information
- shared health summaries
- event summaries.

These documents may contain various health information including medical conditions, medicines, allergies, diagnostic investigations and immunisation records, in addition to Medicare (to see PBS information when a dispense record is missing to possibly fill gaps in information) and GP details. Pharmacists may utilise these documents to obtain a patient's medical history and medication history. Pathology and diagnostic imaging reports can also be utilised to review and monitor recent and/or relevant results. This may be important for a patient who has regular therapeutic drug monitoring, for example, warfarin, or to ascertain when the last medicine level was determined.

Pharmacists should exercise professional judgment and review only the relevant health information to provide health care to the patient, while additionally taking into account that My Health Record is not authoritative. Clinical information can be removed by the patient, access to view certain information may be restricted and any changes in clinical information, for example, cessation of medicines, may not be reflected until an updated record is uploaded to supersede the prior record.

Medicines information view

The medicines information view is a dynamic view, which sorts and displays medicines information and allergies or adverse reactions held in a patient's My Health Record documents in date or alphabetical order.[74]

The information is gathered from the patient's most recent (within the last two years):

- prescription and dispense records
- Pharmaceutical Benefits Scheme claims
- shared health summaries, discharge summaries, event summaries, specialist letters
- Personal Health Summary
- PSML.

The medicines information view can be used by pharmacists to facilitate the medication reconciliation process. It may additionally be of benefit for other healthcare providers during transitions of care.

Access, Privacy and Security

General access

Within hospitals, My Health Record may be integrated into local clinical software, including electronic medical records and dispensing software.[57] Integration is site- and/or health service-dependent.[68] Access by a health service or individual provider is subject to the patient's access controls, authorisations under the *My Health Records Act* and the organisation authorising an individual to access My Health Record. Speak to your Health Information Manager about accessing My Health Record in your hospital.[69]

Pharmacists can access My Health Record through conformant clinical software, including dispensing software,[ii] or via the National Provider Portal (NPP). The NPP is a read-only system, which does not support the upload of clinical information. By default, pharmacists and other healthcare providers are able to view documents in My Health Record under a 'General access' setting. Patients can control access to their My Health Record by enabling access controls. This allows patients to either restrict access to their entire My Health Record or to specific documents.[70] Under restricted settings, a pharmacist may gain access by obtaining the record access code or limited document access code, respectively, or through the emergency access function (see 'Emergency access' below).

Non-pharmacist staff, for example, dispensary technicians, working within the hospital pharmacy service will only be able to access My Health Record where they are appropriately authorised and supervised by the delegating pharmacist. The Digital Health Guidelines for Pharmacists provide information on how to integrate the My Health Record into a dispensary workflow.[71]

Emergency access

In an emergency, for example, an unconscious patient admitted to hospital via the emergency department, a pharmacist will be able to access and view the patient's My Health Record using an emergency access function.[72] The emergency access function bypasses the My Health Record access codes, is recorded in the My Health Record access history and may send a notification to the patient, where this function is enabled.

The emergency access function only needs to be invoked where the patient has restricted access to My Health Record, namely, changed the default 'General setting', and in circumstances where:

- there is a serious threat to the individual's life, health or safety and their consent cannot be obtained; or
- there are reasonable grounds to believe that access to the My Health Record of that person is necessary to lessen or prevent a serious threat to public health or safety.[73]

Emergency access is granted for five days, with any access controls set by the patient temporarily overridden. This allows the pharmacist or healthcare provider full access to vital clinical information, such as allergies and medicines. Unlawful use of the emergency access function can lead to civil or criminal penalties. Refer to Emergency Access Factsheet, Digital Health Guidelines for

Pharmacists, and the Office of Australian Information Commissioner for further information.[73]

Privacy

Pharmacists have professional and legal obligations to protect their patients' health information.[75] When using My Health Record, pharmacists must adhere to relevant state, territory and Commonwealth privacy legislation, regulations and guidelines under the Code of Conduct for Pharmacists[40] and Professional Practice Standards.[76] Health information must be kept confidential, secure and must not be disclosed without the patient's consent. My Health Record is only to be accessed and viewed by a pharmacist in the course of providing health care to that patient.[77] As part of best practice, pharmacists should discuss with the patient how My Health Record will be used to view and upload clinical information. Where a patient requests that clinical information is not uploaded (this includes dispensing records or sensitive information), the pharmacist must comply.[51]

In the Australian Capital Territory, Queensland and New South Wales, express consent from the patient is required before the disclosure of sensitive information, for example, notifiable diseases. Uploading of health information to My Health Record is considered to be such a disclosure. Pharmacists in these jurisdictions must refer to relevant legislation before uploading medicines information or dispensing records concerning the sensitive information.[51] Further information is available in the Digital Health Guidelines for Pharmacists.

Further information relating to confidentiality, privacy laws and disclosure of sensitive information can be found in legislation and policy below:

- My Health Records Act[72]
- My Health Records Regulations[78]
- My Health Records Rule[79]
- My Health Records (National Application) Rules[80]
- Privacy Act[81]
- My Health Record Privacy Policy[82]
- Office of the Australian Information Commissioner (OAIC) – Handling information in a My Health Record[83]

Security

Participating health services, including hospital pharmacy services, must comply with the security requirements stipulated in *My Health Records Rule 2016* to register for My Health Record and to remain registered. Policies and procedures that govern access to and use of My Health Record and the protection of a patient's individual health information must be developed and maintained and be accessible to all staff. A My Health Record security and access policy, for example, should detail:

- how pharmacists and non-pharmacist staff access the system
- training to be delivered to staff before they can access My Health Record along with ongoing training obligations as required
- physical and information security measures used by the pharmacy and/or health service, for example, screen saver modes, password protections on software
- processes for managing clinical incidents related to the use of My Health Record, for example, a data breach.[51,75]

Additional information on data breach and mandatory notification requirements can be found in the Office of the Australian Information Commissioner (OAIC) guidelines or on the My Health Record website.[84,85]

Training and Education

Pharmacists and other pharmacy staff must be provided with training on My Health Record prior to accessing and using My Health Record. Introductory training should be broad and general, covering the benefits of My Health Record, the features and clinical documents available, privacy and security policies, and the applications of My Health Record to clinical pharmacy activities. Ideally, this training should be part of orientation and coordinated with clinical information system training and provided on an ongoing basis as required. Ongoing training should be provided regardless of new functions being enabled.

Recommended My Health Record training includes, but is not limited to:

- understanding when you can view and upload information (responsible access to a patient's My Health Record, namely, maintaining privacy), and appropriate and lawful use of the Emergency Access ('break glass') function
- the process to follow if there is a clinical incident, for example, a data breach
- how to upload an event summary and PSML, where functionality is enabled
- how to adjust the dispense record in conformant dispensing software, for example, where the patient withdraws consent or a dispensing error occurs
- the preferred documentation standards when entering clinical information to a patient's My Health Record
- how to encourage patients to engage meaningfully with their My Health Record and the language to

use that supports patient use of My Health Record[51]
- understand participation obligations and penalties for misuse of the My Health Record system.

There are various education and training resources currently available for My Health Record. These include, but are not limited to:

- Australian Digital Health Agency resources
  - My Health Record Training and Support[86]
  - My Health Record in the hospital setting[87]
  - My Health Record in community pharmacy[88]
  - Pharmacist Shared Medicines List[66]
- Digital Health Guidelines for Pharmacists[51] and online modules via their Digital Health Hub
- Pharmacy Guild of Australia Digital Health Hub and GuildED (member access only)
- SHPA Frequently Asked Questions: Hospital Pharmacy and My Health Record.[89]

Training and education focusing on the use of My Health Record within site-specific clinical information systems and application to clinical pharmacy activities should be developed in line with this Chapter, other applicable Chapters in SHPA Standards of Practice for Clinical Pharmacy Services, the Australian Digital Health Agency and relevant legislation and regulations.

Quality Improvement

Ongoing evaluation of My Health Record is important to provide the evidence for its application, to evaluate the contributing effects and to further promote the integration and use of My Health Record.[90] To meet the requirements of the *My Health Records Rule 2016*, organisations must have established policies and procedures to govern the use of My Health Record. These policies and procedures should be reviewed, in addition to auditing staff use of My Health Record and clinical incidents involving My Health Record, as part of a quality improvement system. For further information, refer to the current edition of Australian Commission on Safety and Quality in Health Care National Safety and Quality Health Service Standards.

CONFLICTS OF INTEREST STATEMENT

The author has no conflicts of interest.

ENDNOTES

[i]At this stage, the uploading of event summaries is yet to be broadly enabled across hospitals and associated clinical software.

[ii]A full list of conformant dispensing software is available at https://www.myhealthrecord.gov.au/for-healthcare-professionals/conformant-clinical-software-products.

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APPENDIX 1

GLOSSARY

access history	An audit trail of all activity related to a patient's My Health Record, detailing when it was accessed and when a document was changed or removed[51]
clinical information system	A system used by a healthcare provider to manage patient and practice records. It may include a software component connected to My Health Record (e.g. pharmacy dispensing software)[51]
conformant clinical software	Dispensing or other clinical software capable of interacting with My Health Record[51]
discharge summary	A summary of the hospital admission that supports the transfer of a patient from a hospital back to the care of their nominated primary healthcare provider[52]
data breach	Means instances of unauthorised collection, use or disclosure of health information included in a healthcare recipient's My Health Record[51,52]
emergency access	Referred to as a 'break glass' function, this function allows the healthcare provider to bypass the access code (s), via the conformant clinical software, in certain urgent situations
eReferral	An electronic referral report communicated directly between healthcare providers, currently operational between GPs to specialists[52]
eHealth	The use of information and communication technologies for health
event summary	A summary which captures key information about a healthcare event relevant to ongoing care[52]
healthcare provider	A practitioner who provides services to individuals or communities to promote, maintain, monitor or restore health (such as a pharmacist, GP, dentist, nurse, physiotherapist or caseworker)[51]
limited document access code	An access code provided by the patient to a healthcare provider or representative to allow viewing of documents in the My Health Record, where the patient has limited the access
medicines management	Comprised of multiple activities and three system processes to manage the safe and effective use of medicines for patients at each episode of care. It involves the prescribing, dispensing, administering and monitoring of medicines.[63]
pharmacist shared medicines list	A list of reconciled medicines that the patient was known to be taking at the time the list was created by a pharmacist[51]
prescription exchange service	An eHealth service that supports defined interfaces and services to facilitate the transfer of electronic prescriptions and related information between participating systems
point of care	The location where care is provided to the patient
record access code (RAC)	An access code provided by the patient to a healthcare provider or representative to allow viewing of My Health Record, where the patient has limited the access
shared health summary	A clinical summary of a patient's medical history, medical conditions and treatments prepared and reviewed by an individual's key healthcare provider[91]
specialist letter	A document which captures key information about specialist visits[52]

APPENDIX 2

COMPARATIVE TABLE OF MEDICINES INFORMATION VIEW FORMAT AND PHARMACIST SHARED MEDICINES LIST (PSML)

	PSML	Medicines information view
What is it?	A list of medicines that the patient was known to be taking at the time it was created by a pharmacist	Sorts and displays medicines information held in a patient's My Health Record documents in date or alphabetical order
Who can create and upload?	Pharmacist	N/A: dynamic view
When to create?	Upon preparing a: -hospital discharge medicines list -dose administration aid medicines list	A dynamic view that is generated at the point in time when a My Health Record is viewed

Appendix (*continued*)

	PSML	Medicines information view
	-report of pharmacist professional services, for example, Meds Check, Home Medicines Review or Residential Medication Management Review	
How to create?	From a pharmacists' clinical software, for example, professional services software or local clinical software	N/A: dynamic view

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