ADVANCED PHARMACY AUSTRALIA

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RACGP
Royal Australian College of General Practitioners

Medication Management at Transitions of Care

PRACTICE UPDATE

This Practice Update, a collaboration between Advanced Pharmacy Australia (AdPha) and the Royal Australian College of General Practitioners (RACGP), provides health practitioners with guidance on medication management services at key transitions of care.

Purpose

The purpose of this document is to clearly define the role of the hospital pharmacist, general practice pharmacist (GPP), and the general practitioner (GP) in delivering safe and quality medication management services to their patients transitioning between acute and primary care.

In cases where a GPP is not part of the team, the roles and responsibilities detailed in this document should be assumed by the GP.

Background

Transitions of care are a high-risk part of the healthcare journey for patients. The Australian Commission on Safety and Quality in Health Care (the Commission) recognises this issue in their report on Safety Issues at Transitions of Care.[1] Transitions of care episodes typically involve complex care arrangements, involve multiple care providers and interdisciplinary teams at various stages of care. Safely transitioning from primary to acute care, and back to primary care following a significant health event, relies on clear, accurate and timely communication between healthcare providers in both sectors, and with the patient and/or carer. Often, it is the lack of clear, accurate and timely communication, and defined, agreed responsibilities at transitions of care that lead to medication-related errors and adverse events.

Transitioning into acute care

In Australia, there are 250,000 medicine-related hospital admissions each year and another 400,000 presentations to emergency departments (ED).[2] To facilitate continuity of care and a safe transition into an acute care setting, a complete and accurate medical and medication record is essential. This will ensure timely and appropriate identification and management of medication-related issues. Without a timely clinical handover across care settings, several issues that impact patient care and safety can occur. These include;

- Medication errors
- Adverse drug events (ADEs)
- Delayed treatment
- Inappropriate treatment decisions
- Medication duplication
- Medication omission
- Incomplete medical history
- Inadequate consideration of the needs of priority populations[3]
- Inappropriate, unnecessary or duplicated laboratory or diagnostic testing.

Hospital admissions, planned or unplanned, can be stressful for patients and their family/carers. Patients may not always have their medications or current medication list with them. Health practitioners must therefore ensure processes are in place to facilitate the timely and accurate transfer of medication data from the primary to the acute care setting.

Roles and responsibilities of general practitioner

The RACGP *Standards for general practices* (5th edition) (the Standards) require general practice staff and GPs to maintain patient records and manage clinical handover to external care providers. The following indicators are intended to help optimise the quality of patient records (including information about patient medication and allergies) in general practice and transfer information to both patients and other health providers, thereby allowing a safe transition into acute care:

- C5.3▶A: Our practice manages the handover of patient care both within the practice to other members of the clinical team and to external care providers.
- C6.2▶A: Our practice has a system to manage our patient health information.
- C6.3▶B: Our patients are informed of how they can gain access to their health information we hold.
- C6.3▶C: In response to valid requests, our practice transfers relevant patient health information in a timely, authorised and secure manner.
- C7.1▶A: Our practice has an individual patient health record for each patient, which contains all health information held by our practice about that patient.
- C7.1▶B: Our active patient health records contain, for each active patient, their identification details, contact details, demographic, next of kin, and emergency contact information.

- C7.1▶C: Our patient health records include records of consultations and clinical related communications.
- C7.1▶D: Our patient health records show that matters raised in previous consultations are followed up.
- C7.1▶E: Our practice routinely records the Aboriginal or Torres Strait Islander status of our patients in their patient health record.
- C7.1F: Our practice routinely records the cultural backgrounds of our patients in their patient health record, where relevant.
- C7.1▶G: Our patient health records contain, for each active patient, lifestyle risk factors.
- QI1.3▶A: Our practice team uses a nationally recognised medical vocabulary for coding.
- QI2.1▶A: Our active health records contain a record of each patient's known allergies.
- QI2.1▶B: Each active patient health record has the patient's current health summary that includes, where relevant: adverse drug reactions, current medicines list, current health problems, past health history, immunisations, family history, health risk factors (eg smoking, nutrition, alcohol, physical activity), social history, including cultural background.
- QI2.1C: Our active patient health records contain, where relevant, a record of each patient's: assigned sex at birth, variations of sex characteristics, gender.
- GP2.1▶B: Our health service provides continuity of care.
- GP2.3▶A: Our practice collaborates with other health services to deliver comprehensive care.

Role and responsibilities of general practice pharmacist

AdPha Standards of Practice for Clinical Pharmacy Services[4] describe GPP requirements for patients transitioning into acute care settings:

- ClinP1, ClinP4: Ensure patients have an up-to-date medication list to facilitate best possible medication history (BPMH) and medication reconciliation on admission to acute care.
  - For planned admissions, provide the hospital with an up-to-date medication list prior to admission.
  - Establish and provide a point of contact for pre-admission clinics.
  - Ensure patients have up-to-date emergency action plans when required e.g., asthma, chronic obstructive pulmonary disease (COPD), heart failure, 'sick-day' management).
- ClinP16: Determine the currency and relevance of any clinical documents in My Health Record where available and ensure the pharmacist shared medicines list (PSML) is up-to-date.

Role and responsibilities of hospital pharmacist

AdPha *Standards of Practice for Clinical Pharmacy Services*[4], the *Standard of practice in general medicine for pharmacy services*[5], and the *Standard of practice in dispensing and distribution for pharmacy services*[6] describe hospital pharmacist requirements for patients transitioning into acute care settings:

- ClinP1: Conduct a patient/carer medication history interview to establish best possible

medication history (BPMH) from at least three appropriate sources.

- ClinP16: Access key health information available on the patient's My Health Record, where available, as an additional source of information for medicines, allergies and adverse drug reactions.
- ClinP2: Assess current medication management to identify medication-related problems.
- ClinP3: Commence clinical review, therapeutic drug monitoring and adverse drug reaction management.
- ClinP7: Participate in interdisciplinary care planning.
- ClinP4: Establish a medication management plan.
- GenM: Participate in partnered pharmacist medication charting (PPMC).
- ClinP6: Facilitate continuity of medication management.
- DispD: Facilitate the timely and accurate supply of medicines that comply with regulatory and legal requirements.
- ClinP13: Document clinical activities and interventions in the patient's health record (e.g. patient record/history, medication record, medication management plan).

Transitioning back to primary care

Medicines are the most common health intervention; up to 90% of people may experience medication changes during their hospital stay.[7,8] As highlighted in Chapter 6 of AdPha's *Standards of Practice for Clinical Pharmacy Services*, 50% of medication errors and up to 20% of adverse drug events result from poor communication of medical information at transitions of care.[9] Omitting one or more medications from the discharge summary exposes patients to twice the risk of re-admission to hospital.[10] Without a timely clinical handover across care settings, the following medication-related problems can also occur:

- Disruption of care
- Delayed follow-up care
- Medication duplication or omission
- Unintentional continuation or discontinuation of medications
- Inability to address hospital identified care issues that may result in readmissions.

Changes made to a patient's medications during their hospital stay and communicated to the patient and/or their carer at the point of discharge, can be overwhelming, especially when the patient is vulnerable and recovering from their hospitalisation. The patient and/or their carer may struggle to recall and accurately communicate medication changes and the treatment plan to their primary care providers post-discharge. The onus is on health care practitioners caring for these patients to embed processes in their practice that ensure the timely transfer of clear, comprehensive, and accurate discharge summaries between the acute and primary care setting.

Role and responsibilities of hospital pharmacist

AdPha *Standards of Practice for Clinical Pharmacy Services*[4], the *Standard or practice in general medicine for pharmacy services*[5], the *Standard of practice in dispensing and distribution for pharmacy services*[6], and *Standard of practice in geriatric medicine for pharmacy services*[12] describe hospital pharmacist requirements for patients transitioning back to primary care:

- ClinP7: Participate in interdisciplinary discharge planning or planning for ongoing care.
- ClinP6: Collaboratively prepare/review and reconcile discharge medication orders according to patient's medication management plan.
- ClinP6, DispD: Ensure patient receives sufficient supplies of appropriately labelled medicines and that medication lists and discharge medication records are complete and accurate.
- ClinP6, DispD: Provide patient with instructions on how to get further supplies of their medicines especially non-PBS medicines.
- ClinP5, ClinP6: Provide verbal and written medicines information, including information on changes to their medicines.
- ClinP6, GeriMed: Discuss the need for follow up either at home, residential care, outpatients or general practitioner.
- ClinP6: Collaboratively complete the medication management and ongoing monitoring sections of the patient's medical discharge summary.
- ClinP6, GeriMed: Liaise with community pharmacies to facilitate continuity of medication

management and supply, including changes to dose administration aids.

- ClinP6, GenM, DispD: Provide the following information to all involved in the patient's care, including the patient and/or carer where relevant:
  - ClinP6: a copy of the discharge summary and the updated medication list at discharge.
  - ClinP6, GeriMed: details of medicines prescribed on discharge or transfer, a contact name within the hospital and a telephone number.
  - ClinP6, GeriMed: verified list of the patient's current medicines, any changes to the patient's admission medicines and detailed rationale for medication changes.
    - ClinP6, GeriMed: monitoring requirements for ongoing management of the patient's medicines.
    - ClinP6, GeriMed: information regarding the patient's need for periodic medication reviews. Include recommendations on the need for a Hospital-Initiated Medication Review (HIMR)[11], Residential Medication Management Review (RMMR), MedsCheck, Diabetes MedsCheck or other review process to support the patient's Medication Management Plan including:
      - post-acute care follow-up
      - outpatient or non-admitted medication review
      - hospital-in-the-home
      - post-discharge outreach or liaison services for those at high risk of medication misadventure
    - ClinP6, DispD: sufficient information about obtaining supplies of ongoing medicines after transition, including special packaging requirements.
    - ClinP6, GeriMed: reported adverse drug events and adverse drug reactions during the episode of care.
    - ClinP6: patients at risk of medication misadventure are followed up, monitored and receive adherence aids, if required.
    - GeriMed: provide an interim medication chart (if available) for patients discharged to residential care facilities.

Role and responsibilities of general practice pharmacist

AdPha Standards of Practice for Clinical Pharmacy Services[4] and the *Standard of practice in geriatric medicine for pharmacy services*[12], describe GPP requirements for patients transitioning back to primary care:

- ClinP6, GeriMed, ToCare: Identify high-risk patients in consultation with the interdisciplinary team and arrange appropriate follow-up for the immediate post-transfer period e.g., GP appointment Home Medicines Review (HMR), outpatient or non-admitted review.
- ClinP1, ClinP4, ToCare: Undertake medication reconciliation after care transition.
- ClinP4: Develop a plan for medication management after care transition in line with recommendations made in patient's hospital discharge summary.
- ClinP7, ToCare: Undertake a comprehensive interdisciplinary medicine review.
- ClinP5, ClinP6m, ToCare: Ensure patients have an up-to-date medication list post-hospital discharge.

- ClinP5, ToCare: Provide patient education and medicines information, reiterating medication changes.
- ClinP4, ClinP6, ToCare: Ensure patients have up-to-date emergency action plans e.g., asthma, angina, COPD, heart failure.
- ClinP6, GeriMed, ToCare: Ensure discharge medicines are reconciled with practice records.
- ClinP6, ToCare: Follow-up communication with patients, community pharmacist, hospital pharmacists and prescribers to clarify medication-related problems or discrepancies or communicate medication changes post care transition.

Role and responsibilities of general practitioner

The Standards supports accredited general practices and GPs to record clinical encounters with other health providers (including acute care) in a patient's health record and maintain consistency and continuity of care. The Standards also require accredited practices and GPs to have systems to recall and review patient results and other clinical correspondence.

- C6.2▶A: Our practice has a system to manage our patient health information.
- C5.1▶B: Our clinical team supports consistent diagnosis and management of our patients.
- C7.1▶C: Our patient health records include records of consultations and clinical related communications.
- QI2.1▶B: Each active patient health record has the patient's current health summary that includes, where relevant: adverse drug reactions, current medicines list, current health problems, past health history, immunisations, family history, health risk factors (eg smoking, nutrition, alcohol, physical activity), social history, including cultural background.
- GP2.1▶B: Our health service provides continuity of care.
- GP2.2▶A: Pathology results, imaging reports, investigation reports, and clinical correspondence that our practice receives are: reviewed; electronically notated, or, if on paper, signed or initialled; acted on where required; incorporated into the patient health record.

Communication and information sharing across care settings

Role and responsibilities of general practitioner

In addition to the above-mentioned indicators that relate to maintenance of patient records, the Standards requires accredited practices and their GPs to communicate with other health providers in ways that maintain continuity of care.

- C5.3▶A: Our practice manages the handover of patient care both within the practice to other members of the clinical team and to external care providers.
- C6.3▶B: Our patients are informed of how they can gain access to their health information we hold.
- C6.3▶C: In response to valid requests, our practice transfers relevant patient health information in a timely, authorised and secure manner.
- GP2.1▶B: Our health service provides continuity of care.
- GP2.2▶A: Pathology results, imaging reports, investigation reports, and clinical correspondence that our practice receives are: reviewed; electronically notated, or, if on paper, signed or initialled; acted on where required; incorporated into the patient health record.
- GP2.3▶A: Our practice collaborates with other health services to deliver comprehensive care.
- GP2.3▶B: Our practice's referral letters are legible and contain all required information.
- GP2.4▶A: Our practice team transfers care to another practitioner (in our practice or in another practice) when a patient requests the transfer.
- GP2.4▶B: Our practice facilitates the transfer of care of a patient when the practitioner requests transfer of care.

Role and responsibilities of hospital and general practice pharmacists

In addition to the above mentioned Standards that relate to the roles and responsibilities of pharmacists at transitions of care, AdPha *Standards of Practice for Clinical Pharmacy Services*[4] describes the importance of effective communication and information sharing to facilitate the timely transfer of medication information to support continuity of care.

- ClinP4: On discharge or transfer hospital pharmacists should ensure a copy of the medication management plan remains with the patient's permanent health record and details of ongoing management are communicated to the patient/carer and other health practitioners.
- ClinP6: Communication and liaison with the patient/carer and other health practitioners (e.g. GP, community pharmacists, other primary health practitioners) facilitates the continuity of a patient's medication management. This communication may be via the patient's discharge summary, medication management plan (MMP), electronic health

record or equivalent, and for high-risk patients, ideally a conversation with the primary care practitioner e.g., GP or GP Pharmacist.

- ClinP6: Hospital pharmacists should be contactable after discharge or transfer, as patients/carers or primary healthcare practitioners may require further information despite comprehensive counselling. The name and contact number of the hospital pharmacist or the organisation's pharmacy service should be made available to the patient/carer and primary healthcare practitioners at the time of discharge.

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- RACGP Expert Committee Quality Care
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