Australian Government

Department of Health and Aged Care

Achieving continuity in medication management

GUIDING PRINCIPLES

National quality use of medicines

About these Guiding Principles

These Guiding Principles are intended only as a guiding document. They are not prescriptive.

The document sets out recommended parameters and procedures for medication management during transitions of care, to ensure continuity.

This document does not provide clinical practice guidelines for specific health conditions or procedures, nor is it intended to be used as accreditation standards or a comprehensive policy and procedure manual for healthcare service providers.

The Guiding Principles are based on current best practice and available evidence and are intended to be applicable to all healthcare settings. Their application must consider relevant national, state and territory legislative requirements, profession-specific licensing or registration, codes of practice, guidelines and standards, quality and accreditation standards and requirements.

Title: Guiding Principles to Achieve Continuity in Medication Management
ISBN: 978-1-76007-471-5
Publications Number: DT0003019

Contents

Acknowledgements

The Australian Government Department of Health and Aged Care would like to thank the many people who contributed to the development of this document. This includes consumers and carers and the following organisations – including those that participated on the Project Advisory Group and those that provided comments during the consultation period.

- Aged Care Quality and Safety Commission
- Anglicare Southern Queensland
- Austin Health Pharmacy Department
- Australian College of Nursing
- Australian Commission on Safety and Quality in Health Care
- Australian Digital Health Agency
- Australian Medical Association
- Australian Nursing and Midwifery Federation
- Australian Primary Health Care Nurses Association
- College of Emergency Nurses Australasia
- Council of Australian Therapeutic Advisory Groups
- Department of Health, Tasmania
- Department of Health, Western Australia
- Dubbo Health Service
- Gowan and Associates
- Home Instead
- Hunter New England Local Health District
- Life Care
- Mater Health
- Mederev
- Medication Services Queensland, Queensland Health
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Prescribing Service (NPS MedicineWise)
- NSW Clinical Excellence Commission
- NSW Nurses and Midwives' Association
- Pharmacy Board of Australia
- Pharmacy Guild of Australia
- Pharmaceutical Society of Australia
- Quality Aged Care Action Group Incorporated
- Queensland Health
- Queensland Nurses' and Midwives Union
- Ramsay Health
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- Royal Australian College of General Practitioners
- Royal North Shore Hospital
- Royal Victorian Eye and Ear Hospital
- School of Nursing and Midwifery, Faculty of Health, Deakin University
- Services for Australian Rural and Remote Allied Health
- Society of Hospital Pharmacists of Australia
- South Australia Health
- South Australian Medicines Advisory Committee
- Southern Cross Care (SA, NT and Vic.)
- South West Healthcare
- Sydney Adventist Hospital
- University of Sydney
- University of South Australia
- Western Australia Centre for Health and Ageing, University of Western Australia
- WA Country Health Service, Department of Health, Western Australia
- Western Australian Therapeutic Advisory Group
- Western Health.

Introduction

Guiding Principles

These *Guiding Principles to Achieve Continuity in Medication Management* promote practice that keeps the individual receiving care at the centre of an integrated health system. They set a framework for providing comprehensive continuity of medication management for all individuals receiving care, and include actions to support vulnerable groups that use the healthcare system.

Related publications

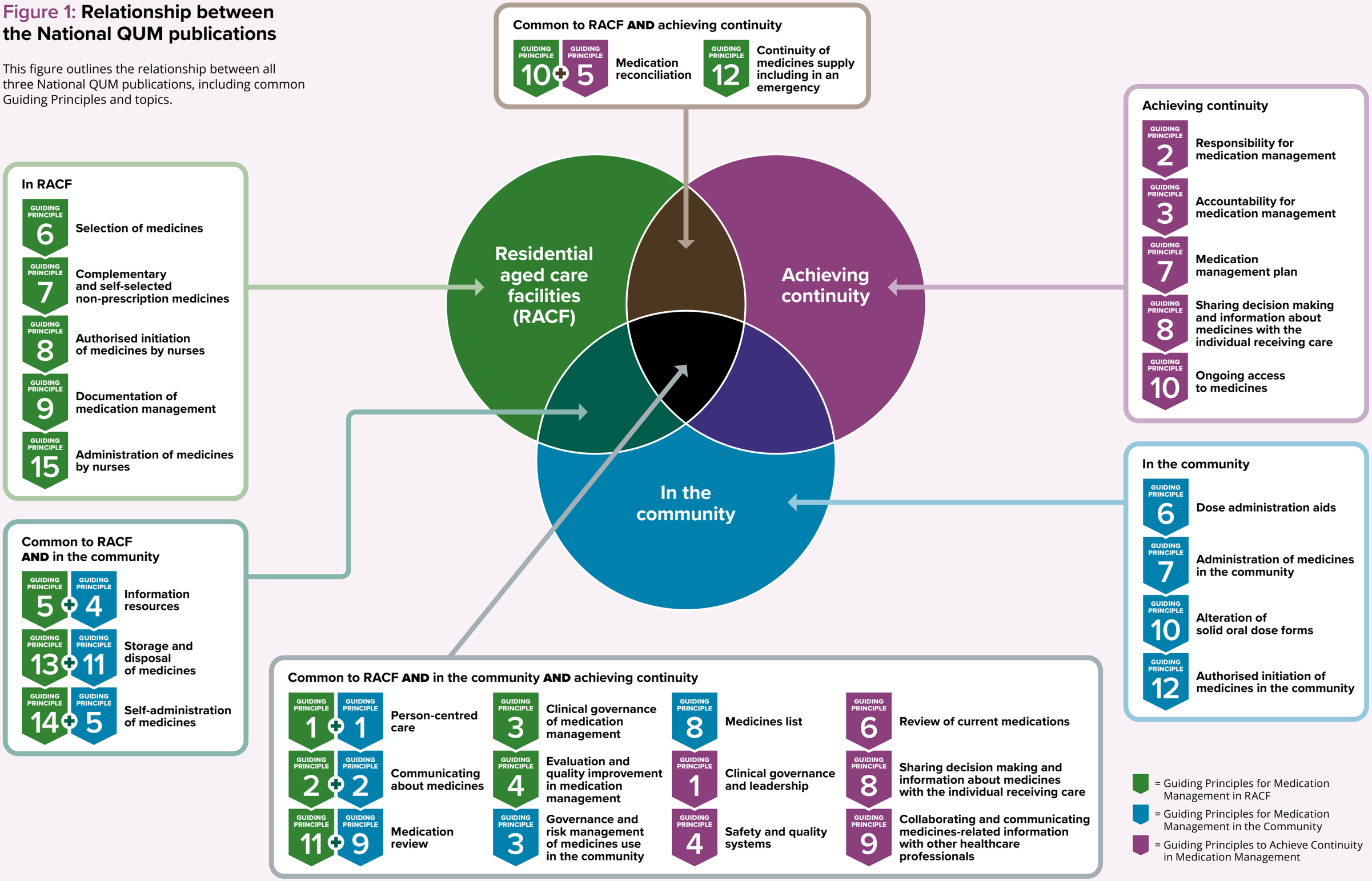
Users of *Guiding Principles to Achieve Continuity in Medication Management* should be aware of these other closely related publications, and refer to them as needed:

- ***Guiding Principles for Medication Management in the Community***
- ***Guiding Principles for Medication Management in Residential Aged Care Facilities*** and its 'supplement' ***User Guide: Role of a Medication Advisory Committee***
- ***Glossary for the Guiding Principles and User Guide***.

Figure 1 outlines the relationship between all three National QUM publications.

Figure 1: **Relationship between the National QUM publications**

This figure outlines the relationship between all three National QUM publications, including common Guiding Principles and topics.



Purpose and scope of the Guiding Principles

Evidence from research into medication safety indicates that significant harm occurs when medicines are unintentionally ceased when individual's move between different healthcare settings.[1] There is also good evidence that continuity in medication management can improve with a systems approach. As an individual transitions throughout the health system, every point of contact in the system presents an opportunity for medication reconciliation and for multidisciplinary collaboration and coordination on medication management.

Transitions of care occur when all or part of an individual's care is transferred between healthcare locations, providers, or levels of care within the same organisation (such as ward to the intensive care unit) or the individual's condition and care needs change. From an individual's perspective, gaps in the transitions across the settings of care are experienced in several ways. Individuals report them as 'falling through gaps' or 'being forgotten about'. Many transitions are associated with poor communication and information sharing between healthcare professionals and organisations, which is a recurring theme in studies describing the reasons for breaks in care across services.[1]

There is a continued need for developing and implementing initiatives that embed and create a systematic approach to best practice for continuity of medication management across the patient journey. Keeping the individual at the centre of these initiatives and employing shared decision-making as routine practice, increases the awareness and confidence of the individual receiving care and will help create the shift necessary to reduce medication errors and adverse drug events, and achieve positive patient outcomes.

These *Guiding Principles to Achieve Continuity in Medication Management* (the Guiding Principles) build on the 2005 edition of the guiding principles and are underpinned by Australia's National Medicines Policy (NMP).[2] The NMP aims to create the environment in which 'appropriate structures, processes and accountabilities enable medicines and medicines-related services to be accessible in an equitable, safe, timely, and affordable way'. One of the four objectives of the NMP is the 'Quality use of medicines (QUM) and medicines safety'. In 2019, 'QUM and Medicines Safety' was declared Australia's 10th National Health Priority. The policy also advocates a partnership approach to QUM and recognises that governments, healthcare professionals and providers, the individual receiving care, their carer and/or family have a shared responsibility in this endeavour.

The key to safe and appropriate management of medicines, is a coordinated approach that supports and encourages continuity in all areas of the community and healthcare sector, while observing relevant state and territory legislation.

These Guiding Principles are to be applied by:

- All providers of healthcare services and healthcare professionals involved in medication management
- The individual (and/or their carer) receiving care.

The Guiding Principles are intended to guide healthcare professionals and the individual, their carer and/or family in the quality use of medicines in the continuity of medication management. They offer a systems approach to the medication management pathway – that is, they advocate consistent and standard practice across all providers of healthcare services. The Guiding Principles are intended for use by all QUM partners, including government, healthcare professionals and providers, the individual, their carer and/or family.

The Guiding Principles will:

- Provide healthcare services with guidance for developing consistent standards of practice
- Provide a practical framework for approaching the medication management pathway across the continuum of care
- Assist healthcare service providers, healthcare professionals and the individual, their carer and/or family, to understand their responsibilities in the continuum of health care.

The Guiding Principles apply to transitions of care within a facility as well as transfers between healthcare services. Examples of transitions of care that the Guiding Principles cover are shown in **Table 1**.

Table 1: **Transitions of care**

Type of transitions	Example
Between care types	An individual's general practitioner (GP) refers them to an allied health professional for a telehealth consultation
Between healthcare providers	Responsibility of an individual's health care is handed over from one nurse to another during clinical handover in a hospital
Between levels of care in the same location	An individual is transferred from an emergency department (ED) to an intensive care unit in a hospital
Between healthcare locations or settings	In an emergency, an individual is attended to by an ambulance service and is transferred to an acute care service
When care needs change	An individual is transferred from an acute care service to an aged care home
When an individual's preferences change	An individual is transferred from an oncology ward in an acute care service to a palliative care service due to end-of-life care preferences
When access to services change	An individual's ongoing care is transitioned from pediatric and youth services to adult services
Between levels of healthcare	An individual is discharged from a mental health inpatient facility back to their GP

Overarching principles

The overarching principles, outlined in **Table 2**, should be evident in the planning, design, evaluation and implementation of all policies, strategies, programs, and initiatives related to the Guiding Principles.

Table 2: **Overarching principles related to the Guiding Principles**

Principle	Description
Person centred	▸ A person-centred approach necessitates a greater focus on people with special and specific needs ▸ It includes older people in residential aged care; Aboriginal and Torres Strait Islander peoples; people from culturally and linguistically diverse (CALD) backgrounds (including migrants and refugees); people with mental illness, disability or chronic conditions; those living in rural and remote areas and other vulnerable groups
Equity	▸ A focus on delivering positive health outcomes that matter most to people and their communities ▸ All communities are supported to access safe, effective, high-quality, and affordable medicines and medicines information when needed, irrespective of diversity, background, age, location, or personal circumstance ▸ The strive to eliminate health inequities that are disproportionately experienced by groups within the community ▸ These groups include, but are not limited to, Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds, those living in rural and remote areas, and other vulnerable groups
Coordination and collaboration	▸ A focus placed on the multidisciplinary collaboration and coordination required for effective medication management at transitions of care ▸ Optimal care is provided when providers of healthcare services do not act in isolation but in conjunction with each other ▸ Multidisciplinary collaboration and coordination may be facilitated by the existence of digital solutions with interoperable digital solutions between sections and different health professions

Development of the Guiding Principles

This document is the updated edition of the *Guiding Principles to Achieve Continuity in Medication Management*.[3] It builds on the previous edition, which was released by the (former) Australian Pharmaceutical Advisory Council in 2005.

In 2021, the (former) Australian Government Department of Health engaged the Australian Commission on Safety and Quality in Health Care (the Commission) to review and update the 2005 edition in consultation with stakeholders.

The University of Sydney was engaged by the Commission in 2021 to undertake a literature review and environmental scan[1] to identify current best-practice evidence to inform the revision. Areas of importance were identified in the quality use of medicines and medication safety landscape for the continuity of medication management.

The review process involved:

- Public consultation with over 80 peak organisations, and experts, involved in medication management across transitions of care
- Analysis of relevant documents and published literature
- Targeted consultations with consumers and those working within providers of healthcare services, including prescribers, registered nurses and pharmacists.

The Commission was supported by a project advisory group which provided strategic and practical advice to inform the revision.

The importance of improving medication management

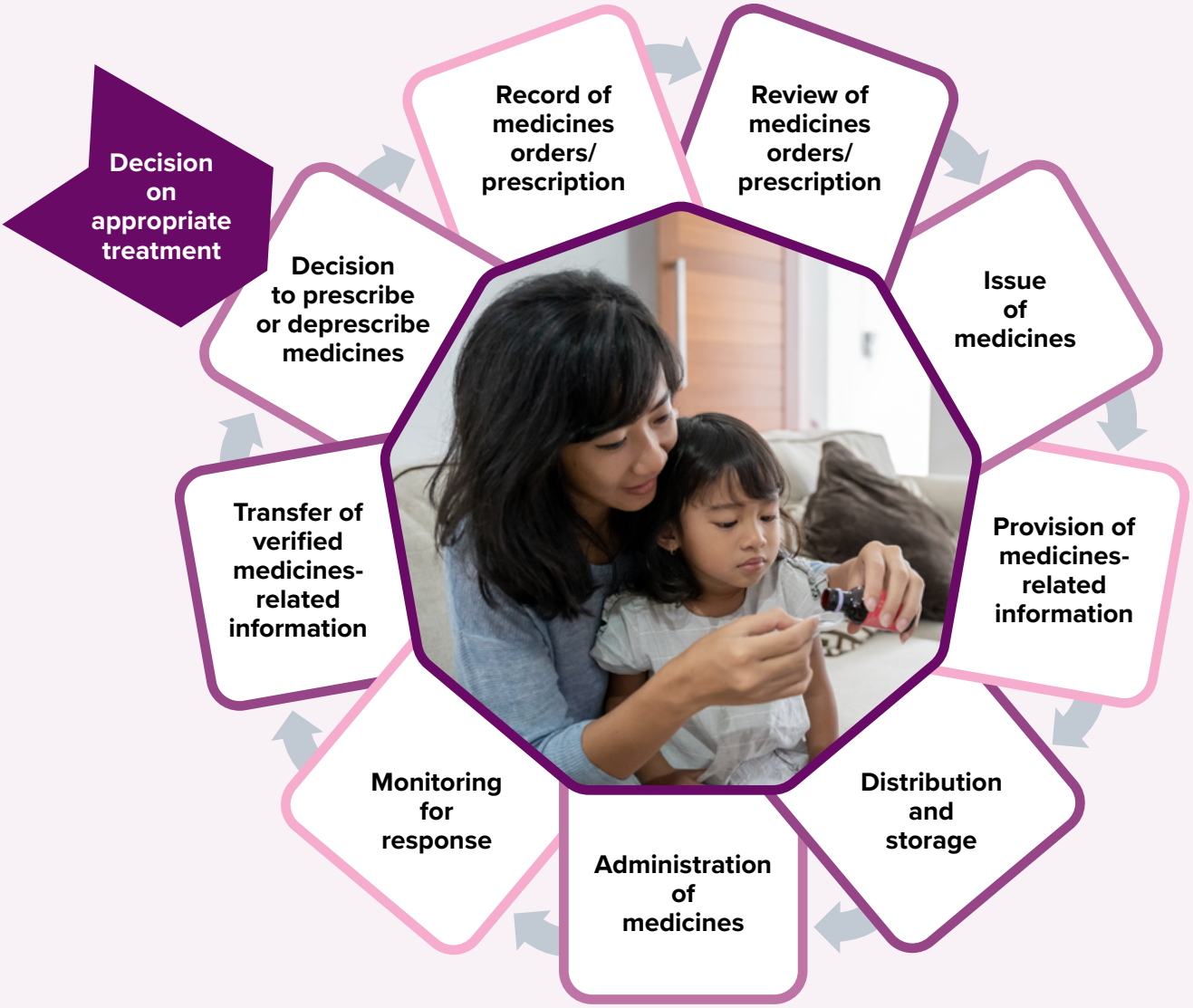
The World Health Organization's ***Medication without harm – WHO Global Patient Safety Challenge – Australia's response***[4], identified that improving medication safety at transitions of care was a key priority area. The medication management pathway includes multiple steps, as outlined in **Figure 2**, and the movement of individuals across or within care settings presents challenges for the continuity of medication management. Additional challenges can arise when managing individual's with complex care needs. The potential for mistakes, oversights, and miscommunications increases during transitions of care. The transfer of incomplete or incorrect information has been reported. For instance, it is reported that:

- Between 10% and 67% of medication histories have at least one error, and up to 33% of these errors have the potential to cause patient harm[5]
- More than 50% of medication errors occur at transitions of care[5]
- Less than 40% of medication changes are explained in electronic discharge summaries[4], and 42% of patients are prescribed at least one potentially inappropriate medicine at discharge, as defined by the Beers Criteria[6]
- Individuals with one or more medicines missing from their discharge information are 2.3 times more likely to be readmitted to hospital than those with correct information at discharge[5]
- The complete absence of a discharge summary was associated with a 79% increase in the risk of readmission within seven days and a 37% increased risk of readmission within 28 days[7]
- Poor communication is an underlying cause of healthcare complaints across all states and territories according to the complaints received by the Complaints Commissioners in 2017–18[8]
- The transition from paediatric to adult healthcare services is often associated with deterioration in the health of adolescents with chronic conditions[9]
- Involving the individual, their carer and/or family in decision making, resulted in the detection of 1,100 (9.5%) medication errors out of a total of 11,540 medication errors reported.[10]

Refer to the **Appendix: Background information**, for details of:

- Findings of the University of Sydney report: *Review and update the guiding principles to achieve continuity in medication management*[1], regarding 'Emerging challenges during transitions of care'
- Further information on the application and mapping of these Guiding Principles.

Figure 2: **Medication management pathway**

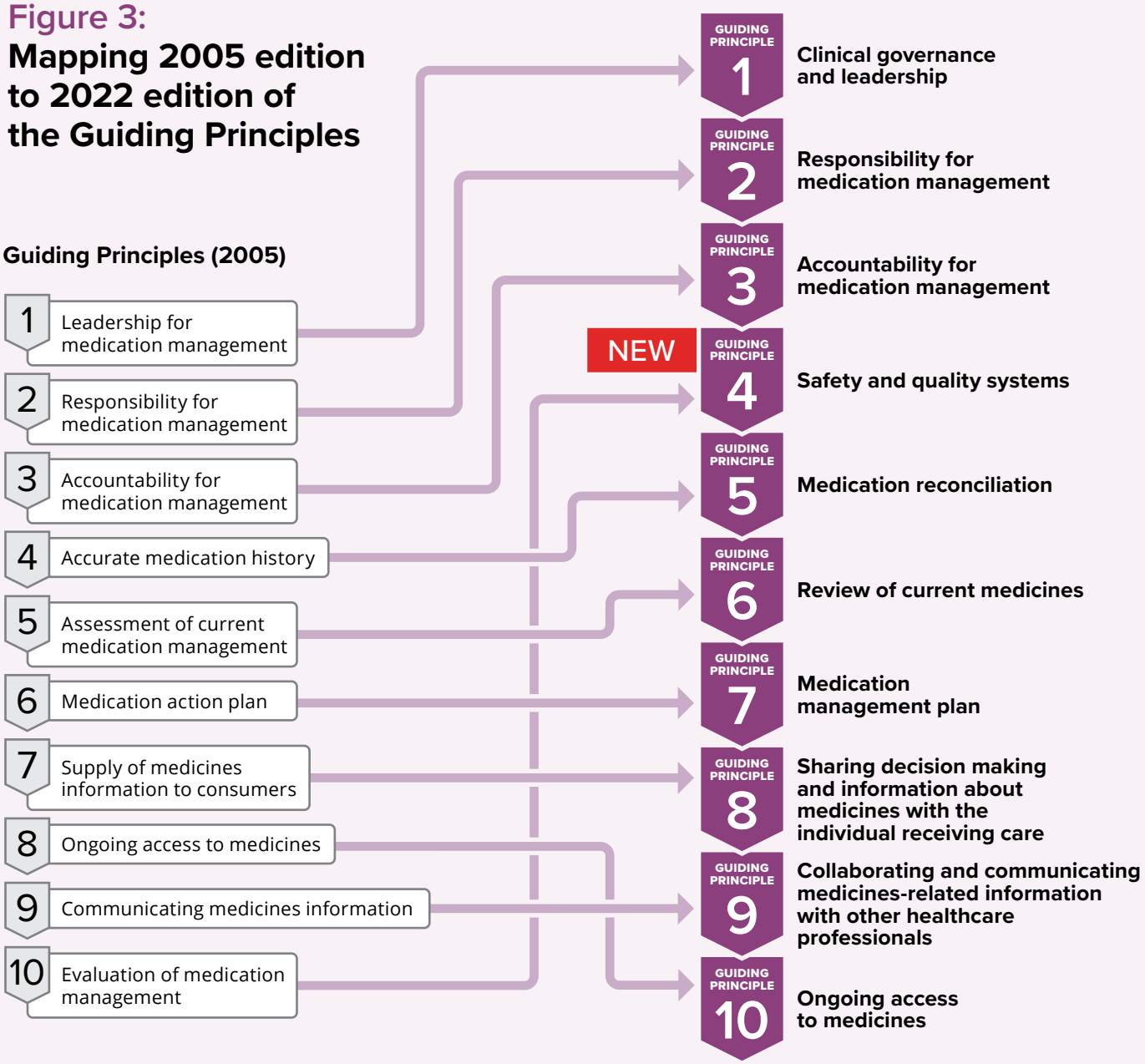


Adapted from the Australian Commission on Safety and Quality in Health Care ***National Safety and Quality Health Service Standards Guide for Hospitals***[102] 'Medication Safety Standard'.

Summary of changes

Content for these Guiding Principles (2022) was informed by **The importance of improving medication management** and the **Appendix: Background information** as well as stakeholder feedback and review of the National Medicines Policy (NMP). The result is a new numbering, naming and configuration to a total of 10 Guiding Principles. The mapping of the 2005 edition to the 2022 edition of the Guiding Principles is illustrated in **Figure 3**.

Figure 3:
Mapping 2005 edition to 2022 edition of the Guiding Principles



How to use the Guiding Principles

Each of the 10 Guiding Principles has:

- A heading
- A statement of each Guiding Principle
- An explanatory note – summary and intent
- Key terms – with background, context and additional information
- Action items for the providers of healthcare services, the healthcare professional(s) and the individual, their carer and/or family.

A consolidated list of suggested **Resources** are included for each of the Guiding Principles.

Guiding Principles 1–4 set the overarching system requirements for the effective implementation of the remaining six principles. Guiding Principles 5–10 outline the specific activities needed.

Each Guiding Principle should be read in conjunction with the supporting information, which includes further explanation of each principle and information to support its implementation – such as examples and references to practice settings. Where relevant, key terms have been provided under each of the Guiding Principles which provides the background, contextual and additional information on the use of key terms in the specific context of the Guiding Principle.

Throughout these Guiding Principles, the responsibility for the action items refers to:

- **The providers of healthcare services** – A separately constituted service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of a governing body. A service unit involves a group of healthcare professionals and others working in a systematic way to deliver health care to individuals. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, residential aged care facilities (RACF) and healthcare professionals' rooms.
- **Healthcare professionals** – A trained healthcare professional who provides direct clinical care to individuals. Healthcare professionals may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, pharmacists, allied health professionals and other healthcare professionals who provide health care, and students who provide health care under supervision.
- **The individual, their carer and/or family** – An individual who has used, or may potentially use, healthcare services, or is a carer and/or family member for an individual using healthcare services. Depending upon the individual's circumstances this will also include substitute decision-makers.

The Guiding Principles

GUIDING PRINCIPLE 1

Clinical governance and leadership

Leaders of healthcare services have responsibilities in ensuring the safe and quality use of medicines and in ensuring the ongoing continuity of medication management.

GUIDING PRINCIPLE 2

Responsibility for medication management

Providers of healthcare services, managers and healthcare professionals have a responsibility to participate in all aspects of medication management in partnership with the individual receiving care, their carer and/or family.

GUIDING PRINCIPLE 3

Accountability for medication management

Providers of healthcare services, managers and healthcare professionals are jointly and individually accountable for making sure that activities to support the continuity of medication management are implemented.

GUIDING PRINCIPLE 4

Safety and quality systems

Safety and quality systems are integrated within governance processes to enable providers of healthcare services and healthcare professionals to actively manage and improve the safety and quality of health care for and with individuals receiving care.

GUIDING PRINCIPLE 5

Medication reconciliation

Accurate and complete medication reconciliation should be performed at the time of presentation or admission, or as early as possible in the episode of care. Medication reconciliation needs to be performed at all transitions of care.

GUIDING PRINCIPLE 6

Review of current medicines

Throughout each episode of care, the safe and quality use of current medicines needs to be assessed and reviewed in partnership with the individual receiving care.

GUIDING PRINCIPLE 7

Medication management plan

A medication management plan needs to:

- Be developed by healthcare professionals, in collaboration with the individual receiving care, to develop strategies to manage the individual's medications medicines
- Form an integral part of care planning for the individual receiving care
- Be reviewed during the episode of care and before transition of care.

GUIDING PRINCIPLE 8

Sharing decision making and information about medicines with the individual receiving care

As early as possible in the episode of care, the individual receiving care, their carers and/or family should receive sufficient information, in a form they can use and understand, to enable them to safely and effectively use all medicines in accordance with the agreed medication management plan.

GUIDING PRINCIPLE 9

Collaborating and communicating medicines-related information with other healthcare professionals

When an individual is transitioned to another episode of care, the transferring healthcare professional needs to supply comprehensive, complete and accurate information to the healthcare professional responsible for continuing the individual's medication management in accordance with their medication management plan.

GUIDING PRINCIPLE 10

Ongoing access to medicines

The individual receiving care, their carer and/or family needs to receive sufficient supplies of medicines and information about how to obtain further supply of medicines, to enable them to fulfil or comply with their medication management plan. This should consider person-specific circumstances and equity of access.

GUIDING PRINCIPLE 1

Clinical governance and leadership

Leaders of healthcare services have responsibilities in ensuring the safe and quality use of medicines and in ensuring the ongoing continuity of medication management.

Summary and intent

Providers of healthcare services leaders and senior healthcare professionals need to ensure that there are overarching clinical governance policies and procedures in place to ensure the continuity of medication management. Leaders need to ensure that systems and resources are in place to enable medication management across the continuum of care. The clinical governance strategies should consider its local circumstances.

If not already in place, in settings such as in hospitals and residential aged care facilities (RACFs), medicines governance groups should be established (such as drug and therapeutics committees or medication advisory committees). Alternatively, the principles of clinical governance for the different services should be recognised, and processes should be implemented within the organisation's committee structure.

Policies and governance structures also need to address responsibilities of individual healthcare professionals with sufficient information to complete their role in the medication management pathway. Each provider of healthcare services needs to take responsibility for identifying, developing and utilising appropriate resources.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Clinical governance

The set of relationships and responsibilities established by providers of healthcare services, between regulators and funders, managers, owners and governing bodies (where relevant), healthcare providers, the workforce, the individual receiving carer and/or their carer and other stakeholders to ensure optimal clinical outcomes.

Clinical governance framework

A provider of healthcare service's clinical governance framework describes the safety and quality systems and processes that need to be in place to ensure the delivery of safe, high-quality health care. A robust clinical governance framework provides assurances to the individual and the community of safe health care, as well as driving improvements in services.

Providers of healthcare services implementing safety and quality standards – such as the National Safety and Quality Health Service (NSQHS) Standards, or the National Safety and Quality Primary and Community Healthcare Standards (Primary and Community Healthcare Standards) – will establish their own clinical governance frameworks.
A number of resources are available to support the implementation of these standards, including the **National Model Clinical Governance Framework**.[11]

Medicines governance must align within the overall governance structure of the healthcare service. This includes having a formalised structure that includes a medicines governance group articulated within the organisation's governance framework and/or organisational chart.

Coordinated governance in medication management

Coordinated governance in medication management occurs when public, private, acute and primary sectors implement, in accordance with local policies, agreed processes that address the transitional problems encountered during continuity of medication management. For example, this might require including primary care or allied health representation on hospital clinical governance structures and vice versa, to ensure there is consistency and alignment of strategies.

Medicines governance group

Medicines governance groups provide expert advice and overarching governance of medication management to ensure the judicious, appropriate, safe, and quality use of medicines.[12]

They play a key role in the governance of medication management and bring significant benefits through improved multidisciplinary communication, collaboration and understanding of medication management processes. For RACFs, refer to ***Guiding Principles for Medication Management in Residential Aged Care Facilities***.

Medicines governance groups have authority to establish processes to implement and monitor quality improvement initiatives through appropriate organisational and management pathways.

Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services need to have clinical governance processes in place to support the safe transitions of care. This includes the need for the providers of healthcare services to implement their respective standards with a focus on the continuity of medication management:

Acute care standards

- **National Safety and Quality Health Service (NSQHS) Standards**[13]
- Implementation of strategies that support the **National Model Clinical Governance Framework**.[11]

Primary and community care

- **National Safety and Quality Primary and Community Healthcare Standards**[14]
- Pharmaceutical Society of Australia ***Clinical Governance Principles for Pharmacy Services***[15]
- ***Aboriginal Community Controlled Health Organisations Medicines Management Guidelines***, Principle 1: Medicines management group.[16]

Aged care

- **Aged Care Quality Standards**.[17]

Practical implementation of the clinical governance standard could involve:

- Establishing and maintaining a clinical governance framework or processes
- Setting priorities and strategic directions for safe and high-quality clinical care for the continuity of medication management and ensuring that these are communicated effectively to the workforce

- Developing and implementing policies and procedures for continuity of medication management and minimising patient harm by
  - developing and endorsing policies and procedures and providing advice on interpretation and application of the standards and national, state and territory legislative requirements
  - ensuring that current versions of all relevant policies and procedures are readily available and accessible to healthcare professionals
  - outlining the roles, responsibilities and accountabilities of multidisciplinary team members in the continuity of medication management (refer to **Guiding Principle 2: Responsibility for medication management** and **Guiding Principle 3: Accountability for medication management**)
- Designing systems that enable the individual, their carer and/or family to be partners in healthcare planning, design, measurement and evaluation
- Promoting a culture of safety and quality improvement – safety and quality systems are integrated with governance processes to actively manage and improve the safety and quality of healthcare for individuals (refer to **Guiding Principle 4: Safety and quality systems**)
- Establishing and maintaining systems for coordinated care with other providers of healthcare services – for example, maintaining and updating the individual's My Health Record or implementing interoperable Electronic Medical Records
- Using multidisciplinary collaborative practice agreements with shared responsibility and accountability
- Ensuring clinical governance aligns with governance of digital health strategies to ensure mechanisms are in place for the systematic review of digital health or hybrid solutions to ensure ongoing system optimisation and safety, and where necessary, implementation across multiple sites.

For healthcare professionals

Healthcare professionals need to work within, and be supported by, well-designed clinical systems and processes to deliver safe, high-quality clinical care. Healthcare providers are responsible for the safety and quality of their own professional practice and codes of conduct.

For the individual, their carer and/or family

The medicines governance committee needs to include a representative of an individual receiving care. Involving individuals provides the opportunity for their views to be considered on the committee's standing agenda items and for them to participate in the development and review of medicines-related policies, procedures and guidelines. They should participate as partners to the extent that they choose. This can be in relation to their own health care, and in service design and governance.

Those receiving care, their carer and/or family should be encouraged to provide feedback on the management of their medicines and advised about how to lodge a complaint or incident report.

GUIDING PRINCIPLE

2

Responsibility for medication management

Providers of healthcare services, managers and healthcare professionals have a responsibility to participate in all aspects of medication management in partnership with the individual receiving care, their carer and/or family

Summary and intent

Providers of healthcare services or organisations, and healthcare professionals employed within, are responsible for ensuring that activities are implemented to support the continuity of medication management.

All stakeholders have a shared responsibility in working towards implementation of the Guiding Principles in an equitable, efficient and sustainable manner.

Clearly defining roles and responsibilities for each of the steps, will ensure that all essential elements of the continuity of medication management pathway are completed for each individual.

Every healthcare professional involved in the medication management pathway needs to be aware of their own role, and the roles of others in the pathway to ensure there is effective communication between different healthcare professionals.

The provider of healthcare services or organisation needs to have policies and procedures in place that enable all staff members to have a clear understanding of their responsibilities. The provider of healthcare services or organisation also has a responsibility to ensure adequate resources are in place, and the accurate and timely continuity of medication management across the pathway.

It is particularly important to state how responsibilities are assigned for those steps that are not clearly aligned with one healthcare profession. Examples of these steps include:

- Collection and transfer of complete and accurate medicines-related information, such as medication history, discharge/transfer medication record
- Medication reconciliation and review
- Managing medicines during specific circumstances such as staff shortages
- When the individual receiving care has been physically transferred, such as from hospital to RACF
- Ensuring clear communication about medicines with the individual, their carer and/or family.

Responsibilities can be delegated. Delegation can be at the discretion of the allocated manager, who is usually responsible for the delivery and oversight of their specific provider's services. Alternatively, it can depend on when and where services are provided.

Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services have a responsibility to:

- Identify and allocate resources and responsibilities for performing the elements of these Guiding Principles, considering
  - if responsibility is being allocated, it can only be to an individual who is safely able to perform the role within their scope of practice
  - decisions and details about roles and responsibilities need to be communicated to all healthcare professionals involved in the medication management pathway
  - the healthcare professional responsible for a particular role may differ depending on the time of day or week; consider who is responsible after hours, on weekends and on public holidays
- Support implementation of interoperable digital health technology to facilitate continuity of medication management
- Conduct audits to identify problems and develop solutions related to continuity of medication management
- Plan, adapt, support and monitor quality improvement programs
- Develop mechanisms for education and training of healthcare professionals to implement the Guiding Principles; this should ensure that the workforce delivers healthcare within their scope of practice, and have the skills required to perform tasks effectively
- Provide strategies for enabling effective interactions between different healthcare professionals
- Work together with the Primary Health Networks and the providers of healthcare to collaboratively discuss and confirm arrangements for responsibility once the individual receiving care has been physically transferred out of their care.

As an example of how responsibility can be delegated during particular elements of the medication management pathway, the NSW Clinical Excellence Commission has developed a **user guide**[18] to help health service organisations allocate responsibilities. This guide assists team members to recognise who is accountable for each step of medication reconciliation (refer to **Guiding Principle 5: Medication reconciliation**).

For healthcare professionals

Healthcare professionals need to:

- Work within, and be supported by, well-designed clinical systems to deliver safe, high-quality clinical care
- Take responsibility for the safety and quality of their own professional practice, and professional codes of conduct and only work within their scope of practice
- Support safe transitions of care by maintaining accurate and up-to-date records of the individuals they are caring for
- Provide information to the individual, their carer and/or family, advising them of their responsibilities, and the key role they play in the continuity of medication management; this should include providing strategies to support the individual, their carer and/or family in taking on these responsibilities (refer to **Guiding Principle 8: Sharing decision-making and information about medicines with the individual receiving care**)
- Actively take part in in the development of the organisational culture to enable, and give priority to, patient safety and quality
- Model professional conduct that is consistent with a commitment to safety and quality at all times.

Responsibilities may look different depending on the setting. **Examples of transition responsibilities** outlines how this could look practically.

Examples of transition responsibilities

Example 1: Following transition to an acute hospital from home

- On admission, medication reconciliation is undertaken by the doctors and/or pharmacists with the individual receiving care and their carer
- The prescriber is responsible for ensuring the medicine is prescribed correctly in order for the pharmacist to supply the required medicine
- The pharmacist is responsible for supplying the medicines
- The nurse verifies the medicine before administration
- The individual receiving care, their carer and/or family are involved in decision making regarding medicines and are provided with information throughout the episode of care.

Example 2: Following transition from hospital to home

- On transition out, responsibility for discharge reconciliation of medicines is undertaken by doctors and/or pharmacists in discussion with the individual and their carer
- The responsible healthcare professional in hospital is responsible for sending an accurate discharge summary to the individual's regular general practitioner (GP) as soon as possible after discharge and for discussing the next steps with the individual
- The individual has a responsibility to see their GP as soon as possible after discharge from hospital
- The GP is responsible for reconciling and reviewing the medicines on discharge with the individual following discharge from hospital, and supplying the individual with prescriptions if required
- The community pharmacist is responsible for verifying, supplying and counselling the individual on the medicines.

For the individual, their carer and/or family

Healthcare professionals have a responsibility to support the individual, their carer and/or family in:

- Maintaining a **Pharmacist Shared Medication List**[19], held within the person's My Health Record, or **medicines list**[20] of all their medicines (prescription, [self-selected] complementary and non-prescription medicines), and advising them to bring the list with them to all their healthcare appointments (including if they need to go into hospital), and requesting that it is updated and reviewed as necessary
- Their critical role of reporting any side effects that their medicines could be causing, which may reduce the individual's willingness to follow the medicines dose schedule or regimen.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

GUIDING PRINCIPLE

3

Accountability for medication management

Providers of healthcare services, managers and healthcare professionals are jointly and individually accountable for making sure that activities to support the continuity of medication management are implemented.

Summary and intent

Providers of healthcare services are jointly accountable, with other team members, for ensuring that all aspects of medication management in the continuum are overseen, undertaken and evaluated. Each healthcare professional is individually accountable for their assigned responsibilities.

This accountability includes ensuring the safe transition of individuals to the next episode of care.

Where the designated healthcare professional, is not on staff or on duty in a healthcare service, an alternate healthcare professional needs to be assigned, and their acceptance of responsibilities established. This needs to be outlined in the organisation's policies and procedures.

Demonstrating responsibility and accountability

Example: During a transition of care from home to a residential aged care facility

- On admission to a residential aged care facility (RACF), the responsible GP should provide the RACF with comprehensive information containing up-to-date summaries, current care plans or health check summaries, a current medicines list, the relevant investigation results and other relevant information
- Where possible, the individual receiving care, their carer and/or family are responsible for sharing with the treating team details about their medicine(s) list to establish the medication history
- The responsible GP will prescribe the individual's regular medicines in discussion with the individual, their carer and/or family, following medication reconciliation and review
- The registered nurse is responsible for sending the individual's medication administration chart either electronically or physically to the contracted (or preferred) pharmacy
- The contracted (or preferred) pharmacy is responsible and accountable for the timely supply of medicines.

GUIDING PRINCIPLE 4

Safety and quality systems

Safety and quality systems are integrated within governance processes to enable providers of healthcare services and healthcare professionals to actively manage and improve the safety and quality of health care for and with individuals receiving care.

Summary and intent

Incidents should be recognised, reported and analysed, to improve the quality of care provided. This involves using the safety and quality systems from **Guiding Principle 1: Clinical governance and leadership**, when:

- Implementing policies and procedures for continuity of medication management
- Managing risks associated with continuity of medication management
- Identifying training requirements to deliver the safe continuity of medication management
- Measuring and implementing quality improvement processes.

Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services have a responsibility to:

- Establish and implement governance processes to support patient safety and quality systems (refer to **Guiding Principle 1: Clinical governance and leadership**)
- Use organisation-wide risk management systems which are overseen by a medicines governance group to
  - identify, monitor, manage and review risks and near-misses associated with continuity of medication management and minimising harm to the individual receiving care
  - advise on risk management systems associated with medication management
  - develop processes to manage clinical risks for different populations served by the organisation, clinical and workplace risks for the workforce, and organisational risks

  - use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system
  - ensure that a healthcare professional with expertise in medication management is included in incident analysis.
- Deliver or provide access to training on continuity of medication management and minimising individual harm, including
  - assess the competency and training needs of the workforce in line with the requirements
  - perform a risk assessment to inform the training schedule and to set priorities for those who require training
  - develop or provide access to training and education resources to meet the needs of the workforce in relation to comprehensive care
  - consider what training the workforce may need to effectively use the clinical incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate risks
- Measure, implement and evaluate quality improvement processes, including
  - monitoring effectiveness and performance (refer to **Resources**) and linking quality improvement strategies
  - implementing strategies to improve the outcomes from continuity of medication management and associated processes
  - reporting on delivery of continuity of medication management.

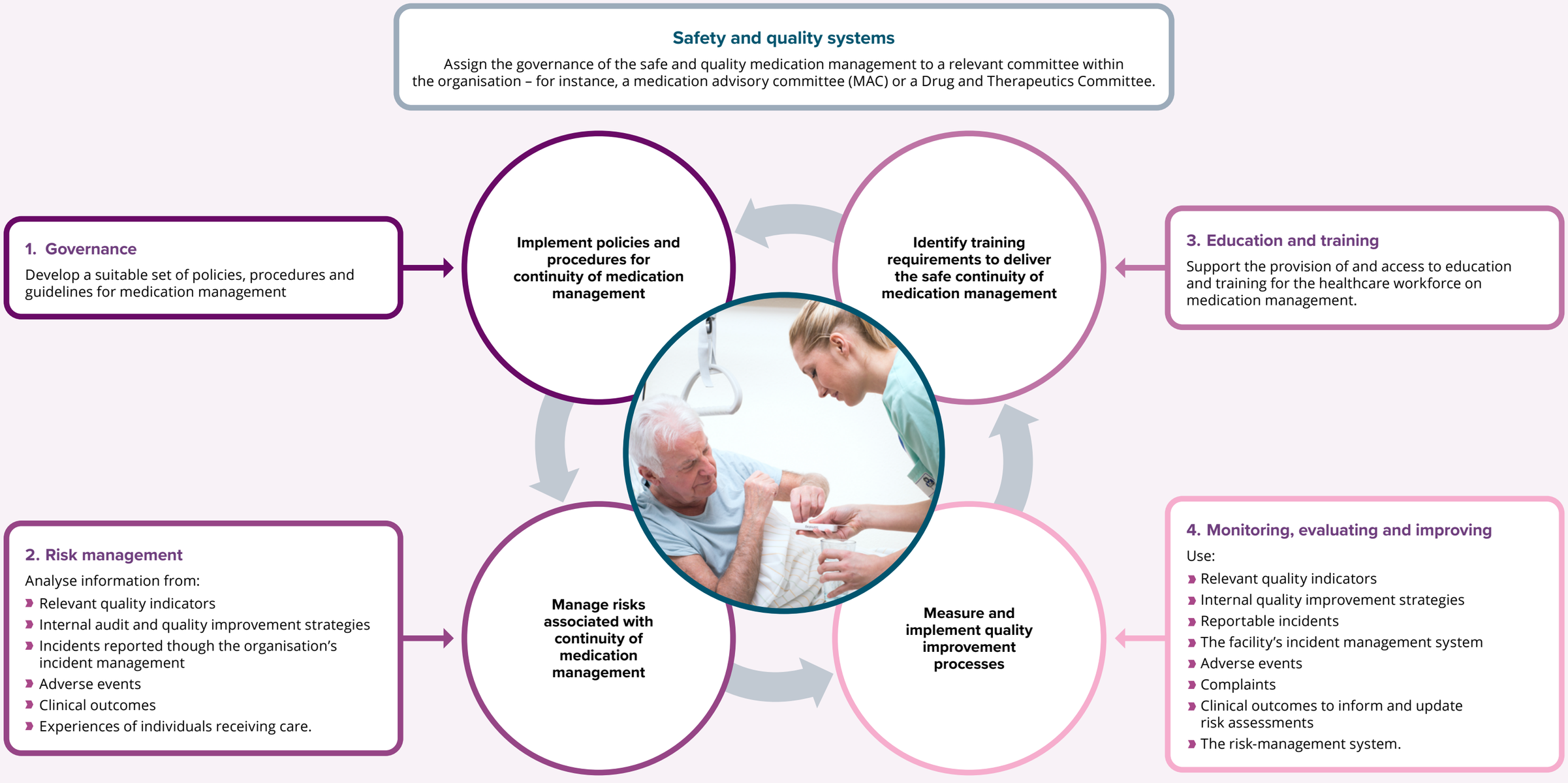
In the respective organisation, the full implementation of the **National Standards**[21] provides in greater detail, those actions relating to the patient safety and quality systems.

Figure 4 provides an illustration of how safety and quality systems are person-centred and integrated within clinical governance and leadership of medication management.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

Figure 4: **Priority areas for actions**



GUIDING PRINCIPLE

5

Medication reconciliation

Accurate and complete medication reconciliation needs to be performed at the time of presentation or admission, or as early as possible in the episode of care and where necessary on transition out of care. Medication reconciliation needs to be performed at all transitions of care.

Summary and intent

Medication reconciliation processes have been shown to reduce errors and adverse events associated with poor information quality at transitions of care and inaccurate documentation of a medication history when an individual receiving care is transferred to another care setting. Medication reconciliation ensures that those receiving care receive all the medicines intended by the individual's prescriber.

The following are examples of circumstances that need to elicit medication reconciliation processes:

- Transfer to or from a new care setting – for example, an individual's transfer to a RACF from the community or hospital or hospice (refer to ***Guiding Principles for Medication Management in Residential Aged Care Facilities***), home to hospital, hospital to home; transfer between wards and care settings within an organisation, hospital to hospital
- When existing medicines orders are changed or a new medicine is ordered
- When there are significant changes to a medicines regimen in the past three months
- When there are changes in the individual's medical condition or abilities
- When paper-based medication charts are rewritten or electronic medicines orders are updated in a RACF or hospital
- Where there is a transfer between community-based providers
- For individuals who attend an acute care service as a day patient or for ambulatory care (such as chemotherapy, renal replacement therapy); this needs to be completed at the first episode of care and then every 6–12 months, following a recent admission or when there is a change in their treatment plan
- For an individual newly commenced on a dose administration aid (DAA), or following changes to an individual's medicines using a DAA (for additional information on DAAs, refer to ***Guiding Principles for Medication Management in Residential Aged Care Facilities*** – **Guiding Principle 15: Administration of medicines by nurses**)
- Transition of young people from paediatric to adult health care.

Medication reconciliation should be performed in collaboration between the individual's healthcare professionals and the individual, their carer and/or family. It requires a multidisciplinary approach that includes doctors, nurses, pharmacists and other allied health professionals across the continuum of care with the individual, their carer and/or family.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Medication reconciliation

This is a four-step process and involves the stages summarised in **Figure 5**.

Medication reconciliation needs to be performed and documented at the time of presentation or admission, or as early as possible in the episode of care following the individual's consent. Each healthcare professional has a responsibility to ensure that they have the most accurate list of medicines taken by the individual.

Once the best possible medication history (BPMH) is documented and verified, it needs to be reconciled against the individual's existing medicines orders on record and documented to:

- Ensure continuity of medication management
- Identify medicines-related problems
- Identify potential medicines-related discrepancies
- Inform the decision-making process
- Optimise the safe and quality use of medicines.

Best possible medication history (BPMH)

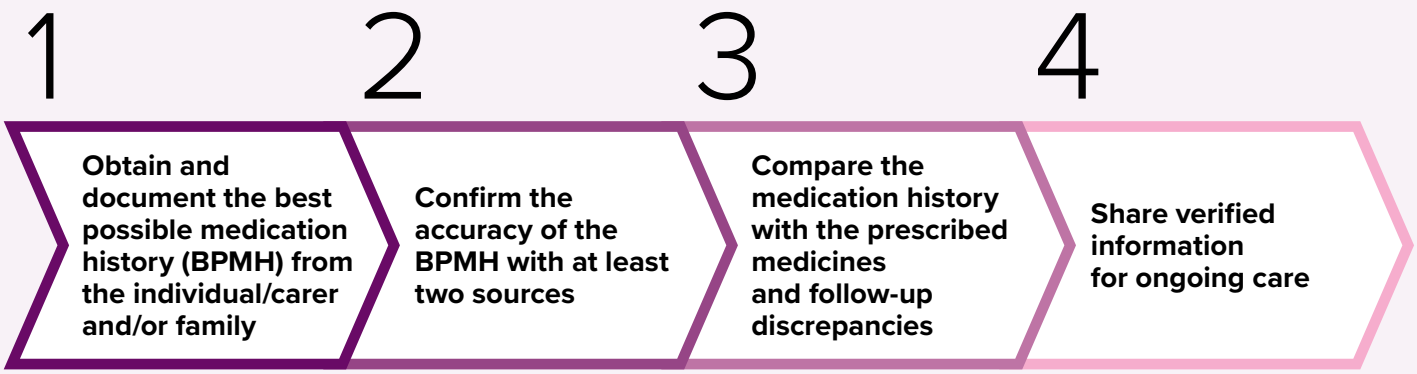
The BPMH is obtained by following a systematic process of interviewing the individual receiving care, their carer and/or family about their actual medicines list (prescription, complementary and non-prescription medicines) at the time of transition. It also includes information about previous adverse drug reactions (ADRs), adverse medicines events and allergies, and recently ceased or changed medicines. The history is then verified with at least one other reliable source of information to determine the complete and accurate list. This list can be used as a baseline or point of reference throughout the episode of care to avoid duplication of recording and potential discrepancies between information sources.

Reconciliation of the BPMH

The BPMH is compared with the medicines the individual is taking, any discrepancies identified and resolved (with or by the prescriber), and changes documented, thus updating the individual's baseline medicines list. Medication reconciliation needs to include:

- Review of previous medicines orders alongside new orders and the medication management plan
- Review and resolution of discrepancies as they arise, as well as available information to determine if discrepancies are intentional or not
- Documentation of the discrepancy in the patient's medical record and communication with the prescriber to resolve medicines-related problems.

Figure 5: **Key steps in medication reconciliation**



Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services need to ensure they have policies and procedures in place for medication reconciliation which include guidelines on:

- The structured interview process for obtaining the BPMH
- Steps involved in the medication reconciliation process
- Who is responsible for each step and at what stage they should occur in the episode of care
- Documentation requirements including where and what should be documented – such as use of a standardised form, paper-based, electronic or hybrid arrangement
- A systematic process for handing over or follow up, if the verification step of medication reconciliation is unable to be completed in the one event (that is, in the event it is performed on a Sunday or after hours and the individual's regular pharmacy or GP cannot be reached)
- Education and training requirements for healthcare professionals to perform medication reconciliation
- Procedures to support the early transfer of information, such as ambulance transfer procedures should include bringing the individual's medicines to hospital with the individual
- The ongoing need for shared decision-making and involvement of the individual, their carer and/or family in the process.

The provider of healthcare services needs to:

- Ensure that those responsible for performing medication reconciliation have access to a standardised paper-based or electronic form for documenting all the relevant information
- The implementation of tools and workflows that support medication reconciliation such as
  - a standardised form for the documentation of medication histories which is easy to recognise, access, reconcile and update when new information becomes available – an example of this is the **National Medication Management Plan** (NMMP).[22] This template can be used to inform a similar document type in an electronic format
  - electronic tools such as electronic medical records including My Health Record and **electronic medication management** (eMM)[23] systems such as the **Electronic National Residential Medication Charts** (eNRMCs).[24] Implementation and use of digital health strategies require clinical oversight and need to be user-friendly, interoperable, align with workflows and meet quality standards
  - the **Partnered Pharmacist Medication Charting** (PPMC)[25] model in the acute hospital setting, which involves collaborative prescribing between the doctor and the pharmacist, and allows for better integration of the skills and expertise of pharmacists and other healthcare professionals
- Provide access to effective education strategies for performing medication reconciliation, with a key focus on person-centred care and health literacy; as well as adequate training in the use of digital health strategies that support medication reconciliation
- Ensure there are sufficient resources allocated for performing medication reconciliation – such as funding a medication history service in the pre-admission clinic and emergency department, an aged care pharmacist, or a GP-based pharmacist
- If necessary, have strategies for prioritising high-risk vulnerable populations if medication reconciliation cannot be completed for all individuals – such as targeting individuals most likely to obtain maximum benefit, as outlined in the SHPA **Standards of Practice for Clinical Pharmacy Services**.[26]

For healthcare professionals

Healthcare professionals trained in performing medication reconciliation including medical and nurse practitioners, pharmacists and registered nurses can take a BPMH and reconcile the medicines. Depending on the work environment, healthcare professionals need to be aware of their responsibilities in the process as outlined by the organisation's policies and procedures.

Prior to conducting the medication history interview with the individual and/or their carer, the healthcare professional needs to review the patient's background information. Refer to the SHPA **Standards of Practice for Pharmacy Services**[26] for the type of background information that can be used to inform the interview.

The key steps in medication reconciliation summarised in **Figure 5** are outlined in further detail in **Table 3.**

Table 3: New episode of care – key steps in medication reconciliation

Key steps	Description
1 **Obtain and document the best possible medication history (BPMH) from the individual, their carer and/or family**	Healthcare professionals must be sensitive to the different perspectives, expectations and needs of the individual (for example, the inclusion of Aboriginal Health Workers or qualified interpreters). › Review background information › Conduct a structured interview with the individual, their carer and/or family (in person or via telehealth) as soon as possible **Guidance for doctors** › ***RACGP aged care clinical guide (Silver Book)***[27]; this includes applying general **principles of medication management**[28] that consider 'all medicines taken' by the individual **Guidance for pharmacists** › Pharmaceutical Society of Australia ***Guidelines for comprehensive medication management reviews***[29] › The Society of Hospital Pharmacists of Australia **Standards of Practice for Clinical Pharmacy Services**[26]
2 **Confirm the accuracy of the BPMH with at least two sources**	› Following the individual's consent, confirm the medication history using two sources such as – discharge summary from the most recent hospital admission – their My Health Record including the Pharmacist Shared Medicines List – their nominated GP or primary healthcare practitioner records – medical specialist or community nurse communication – community pharmacy dispensing history – patient's own medicines (including dose administration aids) and prescriptions (community pharmacy, discharge or outpatient) – their personal medicines list, for instance, on the MedicineWise smartphone app – real time prescription monitoring services – their Aged Care Transfer Summary or the medication chart from their RACF – their community medicines administration records (community care workers) › Discrepancies between the medicines list and other sources of information need to be discussed with the individual as well as the treating doctor › Document the BPMH in a purpose-designed paper-based or electronic form › Update the medication history if new information becomes available

Key steps	Description
3 **Compare the medication history with the prescribed medicines and follow-up discrepancies**	›› Reconcile the individual's medication history with the prescribed medicines including prescription, [self-selected] complementary and non-prescription medicines; ideally a BPMH is obtained before any medicines orders are written ›› Identify any discrepancies and/or medicines-related problems ›› Address any discrepancies and/or medicines-related problems; resolving the problem is appropriate or making recommendations for the prescriber and/or other healthcare professionals ›› Document information about any medicines-related problems and steps taken to resolve the problems The prescriber needs to action these discrepancies as soon as possible to minimise any ongoing errors
4 **Share verified information for ongoing care**	›› Verified medication history information is communicated to the next care provider, and an individual's own medication records are updated – for instance, My Health Record and/or **medicines list**[20] ›› Healthcare professionals ensure that the current list of medicines is accurately communicated each time care is transferred or medicines are reordered on an individual's medication chart (paper-based or electronic)

At any step in the process, if contacted, and with the individual's consent, the healthcare professionals need to provide the required information about an individual's current regular medicines.

There may be situations when the healthcare professional is unable to complete the full medication reconciliation process – for example, where an individual's acute condition changes suddenly or if the medication reconciliation process occurs outside of regular operating hours when sources for verifying cannot be accessed. Information may need to be gathered over several interviews as the individual and/or their carer recall their medicines and/or the prompts become available. If medication reconciliation is being performed by multiple people, it should be handed over in a readily accessible form and amended or updated as necessary when new information becomes available.

If medication reconciliation cannot be completed for all individuals, the healthcare professional needs to prioritise individuals most likely to obtain maximum benefit. Guidance to support individuals who might be at risk of medicines-related problems can be found in the SHPA **Standards of Practice for Clinical Pharmacy Services**[26] – Chapter 1: Medication reconciliation.

Throughout each step, healthcare professionals should adopt a person-centred and coordinated approach that involves the individual, their carer and/or family, and consult them on:

- How they feel about their current medicines regimen
- The appropriateness and effectiveness of their current medicines and rationalising them if indicated
- Problems associated with current medicines, including any possible adverse medication events associated with the episode of care
- This could involve getting a sense of an individual's
  - medication-taking behaviours (including adherence to the dosage regimen, or whether they have any difficulty taking their medicines)
  - understanding of why they are taking certain medicines
  - perception of the effectiveness of their medicines.

Case study 1: Transfer from hospital to the community

Scenario

An individual is discharged from a mental health ward in hospital. The individual's regular medicines prior to admission included a monthly depot injection. The individual was due to have their depot injection whilst in hospital and it was administered during their hospital admission two days later than normal. On discharge the individual was to continue on the same depot injection and dose; however, some of their other medicines had been changed.

What needs to happen following discharge?

At the individual's first visit to their community centre, the healthcare professional needs to perform a complete medication reconciliation with the individual and update their records accordingly. This should include:

- Checking the last time the individual received their depot injection with them and the previous administering healthcare professional to ensure it is due
- Verifying that the strength or dose and frequency of the depot injection has not changed
- Liaising with the individual's GP and pharmacist about any other changes that have been made to the individual's regular medicines
- Updating the individual's medical record (paper based or electronic) to reflect the changes.

For the individual, their carer and/or family

With each new episode of care, the individual receiving care will need to actively assist their healthcare professionals in collating a complete and accurate medication history.

The individual should provide consent for healthcare services and healthcare professionals to access and share, where necessary, any relevant medicines-related information about themself. They must also be given the opportunity to ask questions throughout the process.

The details of the medication history and reconciliation process will be documented, including any changes to an individual's medicines (and the reasons for these changes) within the individual's health record (paper or electronic) and reported to their general practitioner.

The individual, their carer and/or family should maintain a list of all their current medicines, noting those recently ceased or not being taken. If they encounter difficulties with this process, healthcare professionals need to provide strategies to support them in maintaining a list. Keeping an individual's medicines list up to date will ensure that everyone involved in their health care knows which medicines are required and should be being used. Their healthcare professional will ensure that the individual's own medication records such as the My Health Record and/or **medicines list**[20] are also updated.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

GUIDING PRINCIPLE

6

Review of current medicines

Throughout each episode of care, the safe and quality use of current medicines needs to be assessed and reviewed in partnership with the individual receiving care.

Summary and intent

From the early stages and throughout each episode of care, current medicines and other therapies need to be reviewed to ensure the quality use of medicines. This involves selecting management options wisely and carrying out regular reviews of medicines to confirm if they are still necessary and to identify, resolve and prevent medicines-related problems. Medication review is particularly important where there has been a significant change in an individual's health status or medicines use.

Assessment of all current medicines and how they are managed must involve the individual, their carer and/or family as well as healthcare professionals. Medication review can involve the individual's GP, pharmacist, nursing staff and other relevant healthcare professionals. Pharmacists are ideally placed to undertake medication reviews, but medicines should also be reviewed by other healthcare professionals whenever decisions are being made about prescribing/deprescribing, dispensing and administering medicines.

Each healthcare professional involved in an individual's care has the responsibility to work within their scope of practice and use their specific knowledge and skills to ensure the safe and quality use of medicines for individuals in their care. This may also mean referring individuals to other healthcare professionals.

If risks with medicines use are identified early, it may prevent a potentially avoidable hospitalisation or an avoidable hospital readmission. During the episode of care, the medication review should be an ongoing process of:

- Being documented
- Continually being re-evaluated
- Contributing to the overall care plan
- Informing the medication management plan
- Being shared with healthcare professionals involved in the individual's care and the individual receiving care, their carer and/or family.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Medication review

This is usually considered to be a systematic and comprehensive assessment of an individual's medicines use and the management of those medicines. The focus of a medication review is the individual's health, independence, care and comfort and **Figure 6** illustrates its association with other aspects of medication management.

Polypharmacy

This is the use of multiple medicines to prevent or treat medical conditions. It is commonly defined as the concurrent use of five or more medicines by the same individual. Medicines include prescription, complementary and non-prescription medicines.

Australian Government-funded medication review services

These include:

Home Medicines Review (HMR)

An **HMR**[30] is an Australian Government-funded service in which the medical practitioner and the accredited pharmacist both participate in the medication review process, consistent with the business rules for Item 900 of the Medicare Benefits Schedule.

Residential Medication Management Review (RMMR)

An **RMMR**[31] is a collaborative medication review provided by an accredited pharmacist in accordance with a program funded by the Australian Government for eligible people receiving care within a government-funded RACF, consistent with the business rules for Item 903 of the Medicare Benefits Schedule.

Medication use review (MedsCheck)

A **MedsCheck**[32] service is provided within a community pharmacy and consists of a review of a patient's medicines to improve the patient's understanding of their medicines and ultimately, patient outcomes. The service aims to support self-management by evaluating a patient's knowledge about their medicines, addressing any problems the patient has identified with their medicines, and advising the patient about the best way to utilise and store their medicines.

Implementation – key tasks and strategies

For the providers of healthcare

The providers of healthcare services need to ensure that existing processes for medication review reflect and support a QUM approach. They also need to:

- Determine locally the most appropriate healthcare professional responsible for conducting the various types of medication reviews, which may depend on the healthcare professional's scope of practice, their practice area or training
- Ensure that the workforce has the knowledge, skills, competence and delegated regulatory and legal authority to conduct medication reviews, including comprehensive medication reviews
- Ensure the workforce is resourced to perform medication reviews and where necessary, have systems in place for prioritising medication reviews for individuals who are most at risk of, or have suffered, a medicines-related problem. Risk assessments and stratification should be based on evidence and local organisational priorities
- Promote partnership, communication and shared responsibility between all involved in a medication review to achieve optimum health benefits and outcomes
- Monitor trends in medicines-related problems identified from the medication review, including those that have been prevented
- Where possible, facilitate the availability of digital health technology to support medication reviews – such as electronic medical records, optimised Clinical Decision Support, **Real Time Prescription Monitoring** (RTPM)[33] programs, and access to an individual's **My Health Record**.[34]

The providers of healthcare services have a responsibility to have policies, procedures and guidelines in place that outline the process for performing and following up a medication review. These need to:

- Comply with relevant state and territory legislation
- Recommend that during an episode of care, the individual receives a comprehensive medication review as soon as possible and if necessary, is referred for a comprehensive medication review – such as HMR or RMMR
- Identify those responsible for follow-up, implementing agreed strategies and monitoring the individual's ongoing health status and medicines-related risk profile
- Advise on how and where to document actions and recommendations as a result of a medication review
- Require the results of a medication review to be communicated to the individual's relevant medical practitioner(s) in paper-based or electronic form

For healthcare professionals

In conducting a medication review, an individual's medicines use needs to be assessed in order to identify, resolve and prevent medicines-related problems, including inappropriate polypharmacy. If there is no clear benefit, or if the continued use of a medicine may cause harm, this may result in a recommendation to cease (or deprescribe) one or more medicines.

Where assessed as necessary, and following the individual's consent, healthcare professionals should initiate a comprehensive HMR or RMMR to be completed by an accredited pharmacist. This can be initiated in both the primary and acute sector. In the event that a comprehensive medication review is recommended while in hospital but cannot be undertaken, referral for a community-based medication review should occur. Medication reviews can occur in person or via telehealth, depending on the needs of the individual. There are two typical pathways:

1. **Primary-care initiated pathway** – An **HMR**[30] or **RMMR**[31] can be initiated by the following types of medical practitioners – GPs, specialists in pain medicine and palliative medicine, and other specialist physicians and psychiatrists. Accredited pharmacists can conduct two follow-up consultations within one to nine months after the initial HMR or RMMR.
2. **Hospital-initiated pathway** – An Australian Government-funded medication review for all individuals at risk of medicines-related harm. This referral model aims to allow the discharging hospital to initiate a referral for an HMR, recognising that there may be issues with an individual's timely access to a GP (or, where an individual may not access a GP post-discharge from hospital). This model should be adapted according to the local context and needs within various hospital settings.

Following an HMR or RMMR, the findings report needs to be shared with the referring doctor as well as the individual's regular GP. The regular GP is central to the coordination of care.

Guidance for pharmacists and medical practitioners on medication management reviews can be found in the **Resources**.

When an individual, their carer and/or family are from culturally and linguistically diverse (CALD) backgrounds, the need for an interpreter must be assessed immediately. All people from all communities or groups should be supported to have their medicines reviewed, irrespective of diversity, background, age, location, or personal circumstance. These groups include, but are not limited to, Aboriginal and Torres Strait Islander peoples, people from CALD backgrounds, those living in rural and remote areas, and other vulnerable groups.

Review of medication management

A medication review needs to occur following medication reconciliation. In all settings, assessment of an individual's current medication management involves the following two elements:

1. Reviewing all medicines orders and administration records (where relevant) to optimise therapy and to ensure that medicines are administered safely and appropriately
2. Comparing the individual's current medicines to their medication management plan, BPMH and data from the medication administration record, laboratory results and therapeutic drug monitoring.

The responsible healthcare professional needs to review each medicine in consultation with the individual, their carer and/or family and where appropriate, with their doctor and/or nurse. They need to determine whether:

- There is a clear indication for continuing therapy with each medicine
- All medicines are prescribed by their active ingredient or as recommended by local policy
- The dose or frequency or form and route are appropriate for the indication and the individual
- The intended duration of use is documented
- There are any contraindications (due to previous allergies, adverse medicine events or clinical conditions, drug–drug, drug–patient, drug–disease and drug–nutrient interactions) and consider clinical significance
- The individual has been taking the medicine as prescribed or directed
- The medicine has been achieving the goals of therapy
- There is duplication of medicines and if polypharmacy is an issue resulting in a need for **deprescribing**[35] and medication optimisation (see **Resources** for tools)
- An individual's **drug burden index (DBI)**[36] has been reviewed
- Any medicines have been inadvertently omitted
- There has been appropriate monitoring of the medicine such as serum levels, biochemistry or side effects
- The cost or benefit of therapy to the patient, hospital and community is sustainable
- The medicines are available – for instance, checking for any government restrictions, marketing approval, hospital formulary limitations, methods of obtaining further supply outside of the facility, a medicines shortage.

In addition to reviewing the patient's medicines orders, in collaboration with the individual, their carer and/or family, the healthcare professional needs to:

- Assess their ability to adhere to their medication management plan (MMP) before and during the episode of care.
- Assess if polypharmacy is an issue impacting on adherence and if it can be avoided
- Ensure all medicines are ordered according to the individual's therapeutic goals and the MMP
- Consider their beliefs, attitudes and preferences with the outcomes of using the medicine, especially if it has been newly prescribed
- Determine expected treatment outcomes – for instance, its effectiveness for the medical condition and for symptom management
- Establish if the medicine is safe to use in the context of comorbidities and other medicines being taken, including whether inappropriate polypharmacy is an issue.

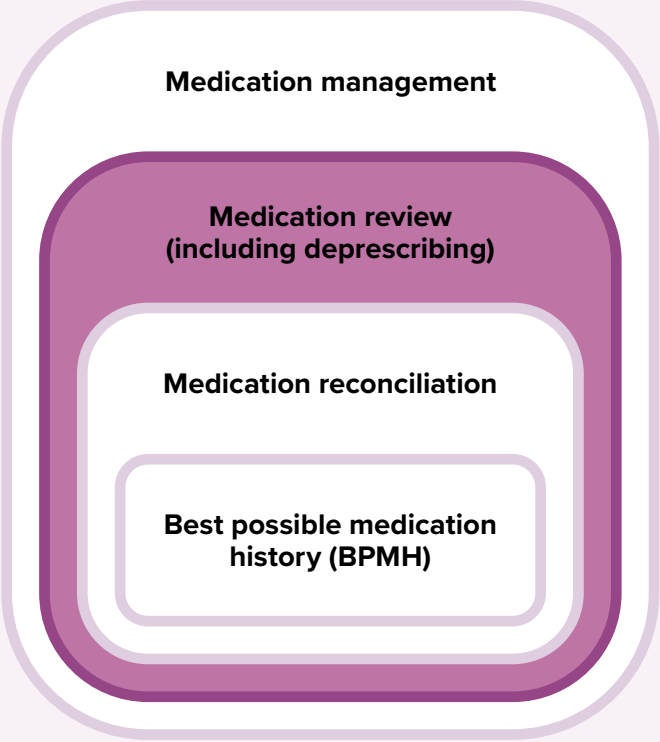
Following the review, the healthcare professional needs to decide on an appropriate course of action with the individual receiving care, their carer and/or family. If the review is being conducted by a healthcare professional other than the individual's regular GP (such as in hospital), major changes should be discussed with the regular GP prior to the changes being made. The individual's regular GP is the coordinator of their care and should be involved in decision making, along with the individual receiving care.

The assessment of medicines and medication management should be fully documented, as the information will provide a basis for the medication management plan, which will outline how to address any identified issues (refer to **Guiding Principle 7: Medication management plan**).

Figure 6 demonstrates the relationship between each of the stages of medication management.

The healthcare professional needs to ensure that if the medication review results in any changes to an individual's medicines, there are processes in place for updating the individual's medication chart (paper-based or electronic) and their own medication records – for instance, the individual's My Health Record or medicines list.

Figure 6: Overview of medication management



For the individual, their carer and/or family

- The individual and/or their carer can request for their medicines to be reviewed at any time by their medical practitioner or pharmacist. This includes requesting a comprehensive medication review – such as **MedsCheck**[32], **HMR**[30] or **RMMR**[31]
- The need for a medication review can also be identified for the individual by their medical practitioner, pharmacist, RACF nursing staff or other healthcare professionals and requires the individual's consent
- Following consent, the individual should share with the healthcare professionals, details of their medicine-taking habits as outlined above, including information on adherence, concerns with their medicines and whether they are meeting their therapeutic goals
- The details of the medication review will be documented, including any actions or recommendations in an individual's medication management plan – or the individual's health record or electronic equivalent – and needs to be communicated to their referring medical practitioner.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

GUIDING PRINCIPLE

7

Medication management plan

A medication management plan needs to:

- **Be developed by healthcare professionals, in collaboration with the individual receiving care, to develop strategies to manage the individual's medicines**
- **Form an integral part of care planning for the individual receiving care**
- **Be reviewed during the episode of care and before transition of care.**

Summary and intent

A medication management plan (MMP) is a continuing plan developed and used by healthcare professionals, in collaboration with the individual, their carer and/or family, to develop strategies to manage the use of medicines. The MMP or equivalent may be used in inpatient, outpatient or non-admitted areas, emergency departments, subacute facilities or in primary care.

The MMP lists issues identified during the assessment of the individual's current medication management and goals of medication management. It should combine information, such as medication reconciliation, assessment of current medication management, clinical review, and therapeutic drug monitoring.

An MMP should be:

- Developed with the individual as early as possible in the episode of care
- Documented and include a multidisciplinary approach with doctors, nurses, pharmacists and the individual, their carer and/or family, across the continuum of care
- An integral part of care planning for the individual
- Reviewed during the episode of care and before a transition.

The MMP is intended for use by, and sharing amongst, all healthcare providers and the individual receiving care, their carer and/or family. The plan needs to be considered in the context of the overall goals of medication management developed for each individual.

Although an MMP is a 'living document' which travels with the individual and is reviewed and updated during each episode of care, providers of healthcare services need to retain a copy in the medical record which is current at the time of a transition of care.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Medication management plan

An MMP is a continuing plan for the use and management of medicines developed in collaboration with the patient. The MMP records medicines taken before admission and aids medication reconciliation throughout the individual's episode of care. It is a record of patient-specific medicines-related issues, actions taken to resolve issues and medication management goals developed during the episode of care. All health professionals are responsible for documenting on the MMP in all settings.

National Medication Management Plan

Designed for use in Australian healthcare services, the **National Medication Management Plan (NMMP)**[22] is a standardised form to improve the accuracy and completeness of documented information to support continuity of medication management and medication reconciliation during transitions of care.

Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services need to ensure there are existing policies and procedures in place for completing an MMP. They need to:

- Determine locally the most appropriate healthcare professional to complete an individual's MMP, including information about who is authorised to modify the plan and at what stage or frequency the plan is formally reviewed; these may be dependent on the healthcare professional's scope of practice, the healthcare professional's practice area and training or accreditation
- Promote partnership, communication and shared responsibility by all involved in the individual's care
  - advise on how and where to document actions and recommendations formed in an MMP
  - ensure the healthcare professionals have the knowledge, skills, competence and delegated regulatory and legal authority to prepare an MMP
  - consider what training the workforce may need to effectively prepare an MMP
  - develop locally or use the **NMMP**[22] standardised template to document the MMP in either paper-based or electronic form
  - require the findings in an MMP to be communicated to the individual's relevant healthcare professional(s) in paper-based or electronic form.

For healthcare professionals

Prior to development of the MMP

The healthcare professional needs to:

1. Explore and respect the individual's values, beliefs, expectations, opinions and decisions about their medicines and the treatment plan
2. Discuss therapeutic goals that enhance self-management and facilitate interactive negotiations about the goals of each medicine as part of the medication management plan.
3. Discuss the possible medicines options with the individual and allow them time to make an informed decision
4. Review the individual's understanding of the treatment options
5. Explore and respond appropriately to the individual's concerns and expectations about their health and the use of medicines to maintain their health.

Developing the plan in partnership with the individual

Following medication reconciliation, relevant healthcare professionals need to develop the MMP in partnership with the individual, with consideration for:

- Person-specific factors relevant to the choice of medicine, dose, frequency, route of administration, formulation and/or duration of therapy – for example, lifestyle, preferences, beliefs, cultural influences, health literacy, pregnancy, breast feeding, co-existing conditions, current medicines, allergies, intolerances, genomic information, the ability to swallow
- The likely cost associated with the treatment options which are discussed with the individual. Consider the individual's eligibility to access subsidised medicines such as the Pharmaceutical Benefits Scheme (PBS), or those listed on Repatriation Pharmaceutical Benefits Scheme (RPBS)
- Supplementing verbal information with written information about the condition and treatment options (refer to **Guiding Principle 8: Sharing decision-making and information about medicines with the individual receiving care**)
- Referring clinical issues that are outside the health professional's scope of practice to other health professionals.

The key elements of an MMP can be seen in **Figure 7**.

Figure 7: The key elements of an MMP

Key elements of an MMP

These include:

- ☐ An individual's identification and general information
- ☐ Details of the BMPH and medication review
- ☐ Incorporating findings from the medication review that will help inform the MMP (refer to **Guiding Principle 6: Review of current medicines**); for example, if an accredited pharmacist has conducted an HMR, the findings of the HMR – such as the individual has had an adverse medicine event or cannot self-administer their own medicines – should be shared with the GP and incorporated into the MMP
- ☐ Risk assessment, such as adverse medicines dose events, allergies, visual impairment and administration aids
- ☐ Action plan – such as description of the problem, goals of therapy, action to be taken to achieve goals, person responsible for action
- ☐ Medication changes during episode of care
- ☐ Medication list on transition out of a facility
- ☐ Who usually administers the individual's medicines
- ☐ Preferred administration methods and formulations
- ☐ Immunisation status
- ☐ Details of individual's GP and community pharmacy
- ☐ Recommendations for an HMR or other follow-up if necessary
- ☐ Communication details, such as to whom and where the MMP was sent and whether referral was recommended.

The individual receiving care should remain at the centre of the development of the MMP and, where possible, should be involved in shared decision-making. The MMP must be accessible and should be kept with the current medication chart or with the patient's healthcare record throughout an episode of care.

For the individual, their carer and/or family

The individual receiving care needs to be involved in determining treatment goals and in the development of an MMP.

Information needs to be person-centred and tailored, in a form that can be used and understood, and that is sensitive to the individual's needs – for example, culturally sensitive, considers the level of health literacy, available in the individual's preferred language.

A copy of the MMP should be provided to the individual in paper or electronic format, depending on the provider of healthcare services and the individual's preferred method, For further information, refer to **Guiding Principle 8: Sharing decision-making and information about medicines with the individual receiving care**.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

GUIDING PRINCIPLE

8

Sharing decision-making and information about medicines with the individual receiving care

As early as possible in the episode of care, the individual receiving care, their carers and/or family need to receive sufficient information, in a form they can use and understand, to enable them to safely and effectively use all medicines in accordance with the agreed medication management plan.

Summary and intent

The individual, their carer and/or family; healthcare professionals; and visiting healthcare professionals need to have access to medicines-related information to support optimal medication management.

Providing medicines-related information to an individual receiving care or their carer and/or family is a core element of patient-centred care. It:

- Improves the individual's capacity for involvement
- Engages them in their health care
- Encourages the safe and appropriate use of medicines, enhancing therapeutic outcomes.

The individual, their carer and/or family need information to support decision-making about their medicines to support informed consent, and to assist the individual in managing their own medicines. The provision of appropriate medicines-related information is even more important at transitions of care, particularly where medicines are being changed. The medicines-related information needs to be person-centred, respectful and tailored to their health literacy and in a form they can use and understand. Culturally safe care includes personable two-way communication and trusting relationships.

This should take place in a well-timed way during an episode of care so that by the end of the episode of care, the individual, their carer and/or family will have received both (verbal) counselling and written information to support them in making an informed decision about their medicines.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Health literacy

Individual health literacy is the skills, knowledge, motivation and capacity of an individual to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which each individual assesses, understands, appraises and applies health-related information and services.

Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services need to ensure that information resources are available for sharing with the individual, their carer and/or family. This is integral to the providers' quality assurance, education and information technology policies, procedures and guidelines.

To ensure effective use of information resources, health service organisations need to consider how to make the medicines-related resources readily accessible to different users, including after hours and in remote locations. Provision of information should consider the health literacy, level of understanding of medicines information, language skills and cultural background of the individuals to whom the information is being provided.

The provider of healthcare services has a responsibility to:

- Establish and regularly review policies and processes on providing and maintaining a range of medicines-related information
- Ensure the responsibility for providing medicines-related information is outlined in the policy and procedures and that there are adequate staffing resources to facilitate this
- Provide communication mechanisms that are tailored to the diversity of the individuals who use its services
- Ensure that up-to-date resources (refer to **Resources**) are available in clinical practice areas to healthcare professionals, non-clinical staff, the individual, their carer and/or family, and visiting healthcare providers when needed
- Support healthcare professionals to provide and discuss medicines-related information with the individual, their carer and/or family when treatment options are being considered and when treatment decisions have been made
- Support healthcare professionals on how to access and use medicines-related information, health literacy and interpersonal communication training for healthcare professionals
- Ensure strategies are in place for developing and sharing an individual's medicines list that is seamless and requires little transcription to minimise the risk of errors
- Ensure there are systems and processes to support the use of communication tools or services – for instance, interpreters, visual aids or hearing services.

The providers of healthcare services must ensure that organisational policies, procedures, and guidelines include the requirement to:

- Align practice with existing **National Standards**[21]
- Provide medicines-related information to the individual, their carer and/or family as part of any clinical consultation, using written information, if relevant, to help inform the individual about any newly prescribed medicines
- Obtain informed consent for treatment with specialised or unregistered medicines – for example, Special Access Scheme medicines or off-label use of medicines
- Encourage and support professional development opportunities and education programs for healthcare providers in communication, health literacy and patient-centred practice
- Collaborate across the healthcare sector on health literacy, including sharing strategies and lessons learnt across and between professions and sectors
- Facilitate electronic infrastructure to support digital health strategies such as telehealth, electronic prescriptions, **Electronic National Residential Medication Chart**[37] and access to the My Health Record – to support the sharing of medicines-related information with the individual, their carer and/or family. The implemented strategies need to align with existing standards.

For healthcare professionals

Prior to supplying and/or prescribing an individual a new medicine, the healthcare professional should provide the individual, their carer and/or family with sufficient medicines information, in a form they can use and understand. It is essential that information describing changes to the medicines regimen is shared with the individual:

- Prior to, and on commencement of, a new medicine
- Prior to transition.

Where the individual is under the care of more than one healthcare professional, the responsibility for provision of medicines-related information needs to be coordinated amongst the multidisciplinary team.

An individual's understanding of their medicines and retention of information will be optimised if education occurs on an ongoing basis during their episode of care and at the time of discharge or transition. It may be necessary to schedule education interviews at different times, such as during an ambulatory clinic visit, on admission, during the medication history interview, throughout an inpatient stay, and/or immediately before or at discharge or transfer. At each stage in the medication management pathway, the healthcare professional needs to establish the individual's level of understanding of their medicines.

Prior to, and on commencement of, a new medicine

As a baseline, the following medicines-related information needs to be provided to the individual by the responsible healthcare professional:

- Verbal and written information (paper-based or electronic) that is person-centred; details included in the medicines-related information leaflet should be discussed verbally as well as the relevant contact details for healthcare professionals and healthcare services for any follow-up information
- Cost of medicines – information leaflets outlining the cost of subsidised or non-subsidised medicines should be available to the individual where appropriate
- Monitoring of the medicine, for example
  - tests or follow-up appointments
  - when an individual will require tests or follow up to monitor a particular medicine, such as a blood test or the need for monitoring by another healthcare professional such as a podiatrist
  - information about the reason for the test(s) and instructions on how to organise
- How to identify and report medicines-related patient safety incidents
- Types of monitoring aids if required – such as diabetes blood sugar chart
- Where relevant, the need for a follow up medication review – for example, **Home Medicines Review**[30] or **MedsCheck**[32])
- Self-administration of any new medicines
- How and where to access medicines in the future.

During the interview the individual's understanding of the medicines-related information they have been provided should be assessed – for example, by asking them to describe how they are going to take their medicines. When sharing information with the individual, their carer and/or family, individual factors should be considered. Modifying the strategies used in counselling should be considered for individuals:

- With cognitive or perceptual problems
- Taking medicines that may impair their ability to recall information
- With language difficulties that require an interpreter – where appropriate use counselling aids such as pictorial aids or multilingual resources
- According to levels of health literacy
- According to their preferred methods for receiving information.

Following the provision of information, the individual should be in a position to give informed consent to commencing treatment with a medicine prior to it being prescribed.

Prior to transition

Before transition, an individual should be provided with a package of relevant information about their medicines. The contents of the package should be discussed with the individual. The providing healthcare professional should ensure the individual, their carer and/or family understands the contents of the package and should provide them with the opportunity to ask further questions. The information should be provided to the individual in either paper-based or electronic form, depending on their preference. As a minimum, an individual and/or their carer needs to be provided with:

- A medication management plan (which includes a list of all medicines expected to be taken by the individual at discharge or transfer)
- A complete, patient friendly or application based (such as **NPS MedicineWise smartphone app**)[38] medicines list, including the active ingredient names of the medicines, which also reflects what is in the discharge summary, if relevant
- Verbal and written information about medicines that have been stopped during the episode of care and how these relate to current medicines and any new medicines commenced during the episode of care

- Information about the intended duration of medicines and instructions on reducing or ceasing medicines where appropriate
- Important person-specific information – such as documentation about adverse medicines events, allergies and medicines that have been ceased, and why they were ceased
- Prescriptions (including repeat prescriptions) supplied in a format that suits the need of the individual. That is where prescribing relies on electronic methods (such as telehealth) or telephone services (such as verbal prescription or medicines orders), the competency of the individual to be able to use that technology is assessed prior to its use.

Before an individual transitions from an episode of care, the responsible healthcare professional should ensure that the individual clearly understands the rationale and consequences of any change in their medicines as a result of the episode of care. At the end of the episode of care, the healthcare professional should:

- Summarise the vital information
- Assess the individual's understanding
- Ensure the individual has all the relevant information
- Supply adherence aids as necessary
- Ask the individual if they have any questions or if there is any information they did not understand.

The healthcare professional should document in the healthcare record that the individual, their carer and/or family have been informed and/or provided information about their medicines.

For the individual, their carer and/or family

The individual, their carer and/or family should have access to information about treatment options so they are able to make informed choices about their medicines.

The information should be person-centred and tailored, in a form that can be used and understood, and is sensitive to the individual's needs, such as culturally sensitive; considers the level of health literacy; and is available in the individual's preferred language. Technology should be used wherever possible, acknowledging that some individuals will prefer paper-based materials and may require large print versions.

Medicines-related information should be available to support all stages of the medication management pathway. Access to good quality medicines-related information:

- Supports conversations between individuals, their carers and healthcare providers about medicines
- Promotes informed decision-making about the benefits and risks of different treatment options
- Is essential to support informed consent
- Should be combined with good communication about medicines and health information by healthcare providers.

Individuals should continue to be supported in maintaining an up-to-date list of all their medicines. Whilst it is important to encourage individuals to maintain an up-to-date record of their medicines, it is also important that healthcare professionals should also verify the information in a medicines list.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

GUIDING PRINCIPLE

9

Collaborating and communicating medicines-related information with other healthcare professionals

When an individual is transitioned to another episode of care, the transferring healthcare professional should supply comprehensive, complete and accurate information to the healthcare professional responsible for continuing the individual's medication management in accordance with their medication management plan.

Summary and intent

When an individual transitions from an episode of care, the transferring healthcare professional should supply an accurate, comprehensive and up-to-date medicines list with the individual on transfer of care.

This involves the teams of healthcare professionals working together and communicating effectively to plan, manage and coordinate medication management with the individual, their carer and/or family. An individual may have multiple prescribers and it requires providers of healthcare services to have systems and processes in place to support this, and to foster a collaborative and person-centred care culture.

An individual's confidentiality and wishes must always be respected. An individual's consent must be obtained before sharing their information with other healthcare professionals.

Digital health systems aimed at improving medicines documentation and system-wide integration in healthcare have been implemented in Australia and should be utilised. Those relating to medicines documentation are commonly referred to as **electronic medication management**[23] (eMM) systems, which include decision-support functionality and medicines administration records.

Implementation – key tasks and strategies

For the providers of healthcare services

The providers of healthcare services have a responsibility to implement policies and procedures which:

- Educate, train and support the workforce about the use of these tools and their responsibilities to safely and effectively communicate medicines-related information
- Outline expectations about the time frame in which communication of information should occur (emphasising timely communication that is relevant to the criticality of the information) and how to escalate communication problems in the event of no response from the receiving healthcare professional
- Include processes to support closed-loop communication; this is when the person who is communicating the information knows that the message has been received and there is a response that lets them know that action has been accepted, implemented, and completed
- Include the need for regular updates to paper-based and/or electronic medication management systems to ensure that the medicine orders are correct – for instance, at handover and/or transition of care
- Outline the organisation's expectations and requirements for non-healthcare professionals when they are communicating an individual's medicines-related information (including maintaining patient confidentiality).

The providers of healthcare services should implement their respective national safety and quality standards, and best-practice medication management systems to support continued medicines supply at transition of care such as:

Hospitals

- **National Residential Medication Chart** (NRMC)[39]
- **Electronic medication management**[23] systems
- ***National guidelines for on-screen presentation of discharge summaries***[40]
- Interim Residential Care Medication Administration Charts. **The MedGap Project**.[41]

Residential aged care facilities

- **National Residential Medication Chart**[39]
- **Electronic National Residential Medication Chart (eNRMC)**.[37]

Across all sectors

- ***National guidelines for on-screen display of medicines information***[42]
- ***Recommendations for terminology, abbreviations and symbols used in medicines documentation***[43]
- Electronic health records (such as **My Health Record**[44] – pharmacist shared medicines list, event summary, discharge summary)
- **Electronic prescriptions**[45]
- **Active ingredient prescribing**.[46]

The implemented systems should be user-friendly, align with workflows and processes and support medication safety. The electronic system should facilitate little transcription, to reduce the risk of medication errors. Ideally, the health service organisation should aim to implement an eMM system that is interoperable with other electronic information systems.

For healthcare professionals

At all transitions of care, the responsible healthcare professional needs to:

- Liaise with local healthcare services to which the individual is being transitioned, in support of gathering relevant medicines-related
- Ensure complete, accurate and timely medicines-related information is shared with relevant healthcare services
- Ensure information provided to community healthcare providers is verified and suggestions about specific processes for monitoring one or more medicines are highlighted
- Identify individuals at high risk of hospital admission or readmission, in consultation with the interdisciplinary team
- Arrange appropriate follow-up for the immediate post-transfer period and implement other strategies to minimise risk.

With the individual's consent, the information should be transferred via various secure routes such as paper-based, electronic transfer (uploaded to the My Health Record) and secure messaging. The transfer of information method must take into account privacy and confidentiality issues and be in accordance with any privacy guidelines and legislation. The responsible healthcare professional should document the information provided and to whom it has been transferred in the patient's healthcare record.

In primary care

When a GP initiates a referral to hospital, they have a responsibility to provide a comprehensive referral containing up-to-date and timely information. If the individual is being transferred from a RACF, these may be sent via the registered nurse at the RACF.

Information to be shared between primary and acute care

- Demographic and contact information
- Reason for referral to the healthcare service
- Relevant findings, investigations; medical summary, medicines (in the form of a list, or a NRMC) and allergies
- Knowledge of any treatment being provided by other healthcare practitioners
- An Advance Care Directive (when appropriate)
- The individual's need for an interpreter and cultural support
- Any disability support needs, including advocates and/or substitute decision-makers
- A copy of their medication management plan
- Where relevant, a comprehensive medical assessment and mental health treatment plan.

Providers operating in community settings should also consult the ***Guiding Principles for Medication Management in the Community***.

In acute care

Information to be shared between acute and primary care

Information sent to primary healthcare providers (the GP and community pharmacists, RACFs or other services such as specialists), should include a detailed rationale explaining any changes in medication management during an episode of care.

Every healthcare professional responsible for a stage in the continuum of care must ensure they have shared any necessary information, and that the individual, their carer and/or family is given information during and upon completion of the episode of care. The healthcare professional should ensure the individual has had their discharge medicines reconciled against their admission medicines prior to transfer, to ensure no medicines were unintentionally ceased during admission.

They should provide the following verified information:

- A verified list of all the individual's medicines at the beginning of the episode of care and changes made during the episode of care
- Explanation of the changes to therapy during the episode of care
- A discharge or transfer medicines list (complete and accurate list of all current medicines)
- The medication management plan
- Any medicines issued at discharge and/or transfer and the source for further supply
- Sufficient information about obtaining supplies of ongoing medicines after transition, including special packaging requirements
- Details of medication management during the episode of care, including any reported adverse medicines events, any specific needs regarding medication management, and information about assistance required, including any risk of medicines-related problems
- Information regarding the individual's need for a periodic medication review, including recommendations on the need for a Home Medicines Review, Residential Medication Management Review, MedsCheck, or other review process to support their medication management plan
- An Interim Residential Medication Administration Chart (IRMAC), if available, for individuals transferred to RACFs (refer to ***Guiding Principles for Medication Management in Residential Aged Care Facilities*** for further information).

Non-healthcare professionals

Non-healthcare professionals play a role in communicating complete medicines-related information with individuals and other healthcare professionals about an individual's care or transfer. Non-healthcare professionals (such as a ward clerk, a general practitioner's or specialist's receptionist, a pharmacy assistant or administrative workforce) may also communicate with other healthcare professionals about follow up, referrals and transfers. Within the scope of their training, they have a responsibility in the communication of patient-related information.

Case study 2: Organising a dose administration aid

Scenario

An individual is being transferred from hospital back to their home. Prior to admission the individual was using a dose administration aid (DAA) organised through their regular community pharmacy.

What should happen

The hospital treating doctor should coordinate with the hospital pharmacist and the individual being transferred to ensure a DAA is updated and ready for collection on transfer. The hospital doctor, pharmacist and individual being transferred should begin planning the coordination of the DAA at least 48 hours prior to discharge. The community pharmacy should be provided with sufficient time to receive the updated prescriptions and medicines list or discharge summary (via various secure routes such as paper-based or electronic transfer [uploaded to the My Health Record], secure messaging or email) to prepare the DAA. The pharmacist should verify the medicines list against the medicines the individual was taking when admitted to ensure no medicines were unintentionally ceased during admission. It would be worthwhile to also share the MMP with the community pharmacist. This information should also be made available to the individual's regular GP to ensure they are aware of the updated medicines list and the supply source for ongoing medicines.

Case study 3: An adolescent transferring to adult services

Scenario

An adolescent is managed in the community by both a paediatrician for a specialised paediatric condition requiring a restricted substance and their general practitioner for common childhood illnesses, and is transferring to adult services.

What should happen

As the adolescent is on a restricted substance, early coordination and communication should take place between the paediatrician, general practitioner and the individual to organise a doctor who can prescribe their restricted substance or medicine. Steps needing to be taken include:

- The GP should be the central coordinator of care and early planning should support the individual through adolescent transition to adult healthcare services
- The healthcare professionals across the different organisations should communicate and coordinate in the early planning and transition to adult healthcare services
- Transition meetings with different service providers, the individual and family should take place early to ensure the adolescent is clear about the process and their options
- The adolescent should be involved in the discussions and decision-making
- A pharmacist should provide an updated medicines list which should be discussed with the individual and support the individual in ongoing access to medicines
- The adolescent should be familiar with where to obtain their medicines, how to order them and where to access equipment they might need to support the continuity of medication management
- The young person should be encouraged to build a relationship with a community pharmacy that can support them with their medicine needs
- The individual should be supported in having their own Medicare and/or healthcare cards set up prior to transition.

For the individual, their carer and/or family

An individual's heath information should be shared with other healthcare professionals for the purpose of continuity in medication management. An individual should be supported in providing consent to provide or share information with healthcare professionals, with an understanding of why this needs to occur, and to whom the information will be sent. The individual should be assured of continuity and consistency in their care and treatment, and have a shared understanding and clarity about ongoing responsibilities.

If the individual is unable to consent to the disclosure of their information, the healthcare professional may disclose information to another healthcare professional treating the individual, or another responsible individual, provided that the healthcare professional is satisfied that the disclosure:

- Is reasonable and necessary to provide appropriate care or treatment or is made for compassionate reasons
- Is not contrary to any wishes the individual has about disclosing health information.

Resources

A list of suggested **Resources**, relevant to this Guiding Principle, are included at the end of this document.

GUIDING PRINCIPLE

10

Ongoing access to medicines

The individual receiving care, their carer and/or family should receive sufficient supplies of medicines and information about how to obtain further supply of medicines to enable them to fulfil or comply with their medication management plan. This should consider person-specific circumstances and equity of access.

Summary and intent

A key aspect of facilitating the continuity of medication management is to ensure the individual has affordable, continued and uninterrupted access to the medicines they require to support their medication management plan. Any disruption to medicines supply may lead to adverse outcomes, including poor symptom control and unplanned hospital readmissions.

Healthcare professionals should ensure that an individual receives a sufficient supply of medicines in a planned and timely way. Extra consideration should be given to individuals with complex care needs such as palliative care and end-of-life care patients. Shared decision-making and communication between the individual, their carer and/or family should take place regarding access to medicines early in the episode of care. The individual should be given the opportunity to ask questions and express any concerns regarding access. To avoid specific supply difficulties, it might be necessary for healthcare providers to coordinate among themselves before an individual is transferred.

National and local medicines shortages can have immediate and long-term impacts on medication management across the healthcare continuum. In addition, factors such a pandemic (for example, COVID-19) or natural disasters (such as bushfires or floods) may lead to changes relating to continuity of supply of medicines. Many of these changes, which could be temporary, are state or territory specific and legislated.

Pre-emptive measures should be in place to prevent impacts on continuity of medicines supply. Policies, procedures and guidelines should outline how the healthcare facility manages and responds, where safe and quality use of medicines is potentially undermined by disruption to the continuity of medicines supply.

Key terms

All technical terms in these Guiding Principles are defined in the ***Glossary for the Guiding Principles and User Guide***. This section provides background, contextual and additional information on the use of key terms in the specific context of this Guiding Principle.

Medicines shortage

A medicines shortage occurs when the supply of a medicine in Australia is not likely to meet normal or projected user demand. Local supply disruptions are not medicines shortages but can still impact safe and quality use of medicines.

Maintaining fair and equitable access to medicines is integral to safe and quality care. Medicines supplies may be impacted for several reasons, including manufacture, financial viability, and problems within the global supply chain. Any resulting medicines shortage may directly or indirectly impact on the safe and quality use of medicines.

The Therapeutic Goods Administration (TGA) publishes the **Medicines Watch List**[47] setting out all shortages that have a critical patient impact. The **medicine shortage reports database**[48] includes information about shortages of reportable medicines in Australia, including those arising from the discontinuation of products. The TGA has information on **accessing medicines during a shortage**.[49] This includes access through **Schedule 19A**[50] whereby consumers can access products not listed on the Australian Register of Therapeutic Goods ('off label' use) during medicines shortages.

Implementation – key tasks and strategies

For the providers of healthcare services

The provider of healthcare services should have policies, procedures and guidelines in place that address ongoing access to medicines. These need to:

- Comply with relevant state and territory legislation
- Aim to reduce omissions of critical medicines and the subsequent potential for readmission to hospital by
  - providing medicines supply at transition of care
  - assigning responsibility and accountability relating to ongoing access to medicines
- Cover a range of circumstances, including when
  - a new medicine is prescribed or there is an urgent change to the dose or formulation of an existing medicine
  - an individual is transferred between care settings
  - orders change for medicines packed in DAAs or a DAA is required urgently, outside of the scheduled delivery period
  - an unexpected medicines shortage occurs.

Providers of healthcare services should facilitate the use of digital health strategies to facilitate ongoing access to medicines such as **telehealth**[51], **electronic prescriptions**[45] and **eNRMCs**.[37] While digital-only models of care provide convenience in some circumstances, they do not always provide the same quality and safety of care. Such models should be provided when it is safe and clinically appropriate to do so.

For healthcare professionals

Healthcare professionals should ensure that the individual receiving care receives a sufficient supply of medicines in a planned and timely way. This means, the prescriber should prescribe enough medicine to carry the individual through to the next appointment or visit (for example, doctor, outpatient clinic), or to complete the course of treatment or according to the therapeutic goals in the medication management plan.

Factors to consider to minimise the risk of interrupted supply

- The availability of the medicine being prescribed and in the required strength
- The brand(s) of medicine
- The cost to the individual, both for a specific medicine and collectively with the remainder of their medicines
- The ability of the individual to access their medicines, due to limited mobility
- The individual's understanding of the processes involved for obtaining their medicines – for example, explained in a language they understand, factoring in any visual impairment, cognitive impairment and health literacy
- Environmental factors such as the COVID-19 pandemic, bushfires and flooding.

Steps to minimise the risk of interrupted supply

Provide the individual, their carer and/or family with sufficient advice and information about ongoing access to medicines. Shared decision-making with the individual and their carer should include a discussion on:

- Having a regular GP as the coordinator of care and a designated pharmacy to facilitate ongoing access and communication
- The availability of multiple brand names for medicines; to minimise the potential for errors caused by confusion about brand names, healthcare professionals should confirm that the individual understands and recognises the active ingredient name of each of their medicines
- The cost, and strategies to minimise the cost – for example, a combination product or PBS-subsidised medicine
- Alternative options if supply is interrupted or unaffordable – that is, due to cost or access
- The need for, and importance of, periodic medication review by a doctor and/or pharmacist
- Where available, measures to promote equality in access to medicine, for example, consideration of alternate supply schemes such as **Special Access Scheme**[52], **Medicines Access Programs in hospitals**[12], **Closing the Gap (CTG) – PBS Co-payment Program**[53], the **S100 Remote Area Aboriginal Health Services (RAAHS) Program**.[54]

Supporting ongoing access in specific scenarios

Where there is an immediate need for the medicine but where it is not practicable to obtain a valid PBS prescription, **continued dispensing arrangements**[55] can be utilised in accordance with professional guidelines.

Individuals under palliative care

Situations may arise where medication management might be more difficult, such as for individuals under palliative care. There is often a need to switch from solid oral dose formulations to subcutaneous medicines, which may not be held as usual stock in community pharmacies. The **Palliative Care schedule**[56] should be utilised when prescribing for palliative care and end-of-life care patients to ensure effective ongoing supplies of medicines are available for patients who choose to die at home. Coordinated communication between the treating doctor, the individual, their carer and/or family, community nursing and the community pharmacy should occur to ensure continuity of medication management.

If an individual's usual medicine has been declared as in 'serious scarcity'[57] by the TGA

Following discussion between the individual and the GP, the community pharmacist should dispense what is outlined in the serious scarcity notice which may result in a different dose form of the same medicine (for example, two 20 mg tablets in place of a 40 mg tablet) or a different dose form of the same medicine (such as a capsule instead of a tablet) to ensure there is no interruption of supply. This change should be clearly documented and communicated with the individual, their carer and/or family and with the individual's usual prescriber.

Clinical trial, patient familiarisation, or compassionate use of medicines

These should only be commenced once the individual is informed and provides consent on the understanding that the continuing subsidy and/or supply of such medicines cannot be guaranteed once they leave that episode of care.

Case study 4: Transfer from hospital to home

Scenario

An individual is being discharged on new and changed medicine from hospital to home.

What should happen?

Depending on the hospital, on discharge, supply of medicines could come from the hospital or community pharmacy. The treating doctor should provide the hospital pharmacist with advanced notice that an individual is being discharged. Before the transfer occurs, discharge medication reconciliation should occur and be verified by the pharmacist.

Prescriptions for discharge medicines should be written with sufficient time to ensure that a pharmacist has an opportunity to review and dispense the required medicines, prepare written support material (for example, consumer medicine information, discharge medication record, or patient-friendly medicines list) and provide appropriate verbal counselling without significantly delaying the individual's departure from the healthcare service. In each circumstance, the individual should be provided with appropriate information on how and when to obtain further supply of their medicines.

Healthcare professionals should pay special attention to the ongoing supply options for those individuals, their carers and/or families who come from rural and remote areas.

With the individual's consent, the responsible healthcare professional should remove ceased medicines for destruction in accordance with the organisation policies and procedures. Details of medicines returned, re-labelled or removed should be documented.

Case study 5: Individual started on a new medicine

Scenario

An individual is started on a high-cost Pharmaceutical Benefits Scheme (PBS) subsidised medicine in the community.

What should happen?

The prescribing doctor should advise the individual that they are being commenced on a high-cost PBS medicine. The prescribing doctor should ensure that the individual is aware of potential complexities associated with ordering the medicine which could interrupt ongoing access. The individual's regular pharmacy should be involved in discussions about their ongoing medicines requirements. Factors to consider include:

- Not all pharmacies might keep the medicine on hand and may need to order it in advance
- The length of time required for the medicine to arrive at the pharmacy
- The process the pharmacy has in place for advising the individual of the arrival of the medicine.

Case study 6: An individual being transferred to a RACF

Refer to ***Guiding Principles for Medication Management in Residential Aged Care Facilities*** – **Guiding Principle 9: Documentation of medication management** and **Guiding Principle 12: Continuity of medicines supply including in an emergency**.

For the individual, their carer and/or family

In some situations, local-level supply disruptions can occur where a medicine is unavailable in a particular pharmacy or area. In many cases, this temporary disruption will be resolved quickly, and the individual should be able to obtain the medicine once the pharmacy receives new stock.

Shortages of prescription medicines and some over-the-counter medicines are reported by the TGA in the **medicine shortage reports database**.[48] For medicines in short supply, the database will provide an estimate of how long the medicines shortage will last and may advise if there is an alternative medicine available.

In collaboration with the individual, healthcare professionals are experienced in determining suitable alternatives for an individual when a medicine is in short supply or unavailable. Even if there is a shortage, a medicine may still be available. If the medicine is unavailable, the doctor or pharmacist may:

- Supply the individual with a different brand that contains the same active ingredient (which may not be the same dose form or strength)
- Prescribe a similar medicine to treat their condition
- Recommend a new treatment option for them to consider
- Assist them in **accessing their medicine through another pathway**.[49]

In some situations, the individual may also be prescribed a medicine that either:

- They obtain supply from the hospital under the Special Access Scheme or the S100 scheme
- Is not covered under the Pharmaceutical Benefits Scheme
- Is not available in all pharmacies.

This should be discussed with the individual prior to the medicine being prescribed, to ensure continued access is sustainable.

On transfer from hospital, the hospital teams need to ensure that the individual can access supplies after discharge in a timely manner for uninterrupted continuity of medication management.

Resources

Guiding Principle	Relevant resources
GUIDING PRINCIPLE 2	›› Australian Commission on Safety and Quality in Health Care (ACSQHC) ***Communicating for Safety: Improving clinical communication, collaboration and teamwork in Australian health services – Scoping paper June 2020***[8] ›› NSW Clinical Excellence Commission (CEC) ***Guide for determining roles, responsibilities and documentation requirements – Medication Reconciliation toolkit***[18]
GUIDING PRINCIPLE 4	A number of quality assurance frameworks, indicators and standards are available and are recommended for use in conjunction with this document. These include the following. **For the providers of healthcare services** Indicators: ›› ***Medication without harm – WHO Global Patient Safety Challenge. Australia's response***[4] ›› ***Practice-level indicators of safety and quality for primary health care***.[58] The practice-level indicators are designed for voluntary inclusion in quality improvement strategies at the local practice or service level and are intended for local use by organisations and individuals providing primary healthcare services ›› NSW Therapeutic Advisory Group (TAG) **National QUM indicators for Australian Hospitals**[59] ›› Australian Medical Association (AMA) position statement on ***General Practice/ Hospitals Transfer of Care Arrangements – 2018***[7] Key performance indicators related to transfer of care arrangements Standards: ›› **National Safety and Quality Health Service Standards** (NSQHS)[13] ›› **National Safety and Quality Primary and Community Healthcare Standards**[14] ›› The Society of Hospital Pharmacists of Australia (SHPA) **Standards of Practice for Clinical Pharmacy Services**[26] Tools for improving the safety of health service delivery: ›› **QIDS and QARS**[60] ›› **Model for Improvement and PDSA cycles**[61] **For the individual, their carer and/or family** ›› NSW Clinical Excellence Commission (CEC) **NSW CEC safety culture measurement**[62] ›› **Australian Hospital Patient Experience Question Set (AHPEQS)**[63] is a tool with 12 questions that patients answer ›› ***National Safety and Quality Health Service Standards user guide for measuring and evaluating partnering with consumer***[64]

Guiding Principle	Relevant resources
GUIDING PRINCIPLE 5	**For the providers of healthcare services** › Australian Commission on Safety and Quality in Health Care (ACSQHC) **Medical reconciliation – resources for obtaining a best possible medication history**[65] › **Patient safety solution: assuring medication accuracy at transitions in care**[66] **Guidance for doctors** › Royal Australian College of General Practitioners (RACGP) ***RACGP aged care clinical guide (Silver Book)***[27]; this includes applying general **principles of medication management**[28] that consider 'all medicines taken' by the individual **Guidance for pharmacists on medication reconciliation** › Pharmaceutical Society of Australia (PSA) ***Guidelines for comprehensive medication management reviews***[29] › The Society of Hospital Pharmacists of Australia (SHPA) **Standards of Practice for Clinical Pharmacy Services**[26]
GUIDING PRINCIPLE 6	**Quality use of medicines (QUM) services** › QUM services are provided to RACFs by pharmacists under the **7th Community Pharmacy Agreement**[67] (7CPA) by the Australian Government Department of Health and Aged Care. The QUM program supports the delivery of services and activities by pharmacists aimed at supporting the quality use of medicines, including the safe use of medicines, within Australian Government-funded aged care facilities › Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) **Medication Safety Standard**[68] › Pharmaceutical Society of Australia (PSA) – ***Guidelines for comprehensive medication management reviews***[29] – **Professional Practice Standards** version 5[69] › The Society of Hospital Pharmacists of Australia (SHPA) – **Standards of Practice for Clinical Pharmacy Services**[26] – **SHPA Fact sheet: Risk Factors for Medication-related problems**[70] – **Hospital-initiated medication reviews**[71] › Royal Australian College of General Practitioners (RACGP) ***RACGP aged care clinical guide (Silver Book)***[27], Part A and B **Deprescribing resources** › NSW Therapeutic Advisory Group (TAG) **Deprescribing tools**[72] › Primary Health Tasmania **Deprescribing resources**[73]
GUIDING PRINCIPLE 7	**For healthcare professionals** › NPS MedicineWise ***Prescribing Competencies Framework – Embedding quality use of medicines into practice***[74] › The Society of Hospital Pharmacists of Australia (SHPA) **Standards of Practice for Clinical Pharmacy Services**[26], Chapter 4: Medication management plan

Guiding Principle	Relevant resources

GUIDING PRINCIPLE 8

For healthcare professionals

- Australian Commission on Safety and Quality in Health Care (ACSQHC) **Communicating for Safety resource portal**[75]
- Deakin University resource **to support communication during transitions of care** for older people[76]
- ***Talking with your patients about Complementary Medicine – a Resource for Clinicians***[77]

Medicine references — A minimum standard set of medicines-related reference materials could include current versions of:

- ***Australian Medicines Handbook*** (AMH)[78]
- Australian ***Therapeutic Guidelines***[79]
- ***Australian Immunisation Handbook***[80]
- Australian product information and CMI, such as **MIMS**[81]
- References on complementary and alternative medicines, such as **MedlinePlus**[82]

For the individual, their carer and/or family

Consumer medicines information:

- **Consumer medicines information**[83] – an index of CMI searchable by medicine, trade name or active ingredient
- Healthdirect **How to read CMIs**[84]
- NPS MedicineWise
  - **Medicine Finder**[85]
  - **Consumer medicine information explained**[86]
- Health Translations **Translated health information**[87]

Fact sheets and other resources on managing medicines

- **Pill Reminder & Medication Reminder: MedicineWise**[88]
- NPS MedicineWise
  - **Managing your medicines**[89]
  - **Keeping a medicines list**[20]
  - **Medicines list for Aboriginal and Torres Strait Islander people**[90]
- Australian Government Department of Health and Aged Care
  - **Information for consumers**[91]
  - **Health topics – Medicines**[92]
- Veterans' MATES
  - **Health and medicine topics** for veterans and health professions[93]
  - **Tips for remembering your medicines**[94]

Examples of medicines lists:

- NPS MedicineWise
  - **MedicineWise app**[38] for smartphones
  - **Medicines lists in community languages**[95] to print off in English and 10 other languages

Advocacy information:

- **Charter of Aged Care Rights**[96]
- ***Medication: It's Your Choice***[97]
- **Choosing Wisely Australia** Consumers and carers[98]

Guiding Principle	Relevant resources

GUIDING PRINCIPLE 9

For healthcare professionals

- Aboriginal Community Controlled Health Organisations ***Medicines Management Guidelines***[16], Principle 4 – Information sharing
- Australian Medical Association (AMA) **AMA position statement on General Practice/Hospitals Transfer of Care Arrangements 2018**[7]
- Australian Commission on Safety and Quality in Health Care (ACSQHC)
  - National Safety and Quality Health Service (NSQHS) **Communicating for Safety Standard**[99]
  - NSQHS **Communicating for Safety resource portal**[75]
- The Society of Hospital Pharmacists of Australia (SHPA)
  - **Standards of Practice for Clinical Pharmacy Services**[100], Chapter 6: Facilitating Continuity of Medication Management on Transition Between Care Settings
  - **Standards of Practice for Clinical Pharmacy Services**[101], Chapter 16: My Health Record

Appendix: Background information

The Appendix contains background information relating to the Guiding Principles. It includes details of:

- Findings of the University of Sydney report: *Review and update the guiding principles to achieve continuity in medication management*[1], regarding 'Emerging challenges during transitions of care'
- Further information on the application and mapping of these Guiding Principles.

Emerging challenges during transitions of care

The commissioned literature review and environmental scan[1] carried out by the University of Sydney identified areas of importance in the quality use of medicines (QUM) and medication safety landscape, in the context of continuity in medication management. It identified novel strategies for the emerging challenges encountered across the healthcare continuum during transitions of care, which includes:

- Employing a partnership approach to QUM, with a shared responsibility between governments, healthcare professionals, providers of healthcare services, the individual, their carer and/or family
- Clinical governance at transitions of care that involves a culture of safety and quality improvement, both between and within sectors, and ongoing monitoring
- Governance and operating procedures that define the positions, scope and responsibilities of healthcare professionals at each step of the process
- Interprofessional and intraprofessional communications to ensure continuity of effective, safe and accurate medication management
- Multidisciplinary collaborative practice agreements with shared responsibility and accountability
- Pharmacists being integral to the medication reconciliation process
- A General Practice pharmacist model of care to help optimise medication management and reduce medication misadventures resulting in hospitalisations
- Timely and accurate medicines information for general practitioners to undertake medication reconciliation for transitioned patients
- A person-centred approach and shared decision-making for individuals to regain independence and effective self-management
- Carers being provided with appropriate information and actively encouraged to take part in communications about safe and effective medication management
- The interoperability of digital health solutions which are critical to effective medication management at care transitions
- Interim residential care medication administration charts for residential aged care residents discharged from hospital
- Timely electronic discharge summaries that include relevant information
- Training healthcare professionals in the use of My Health Record to facilitate transitions of care.

Acronyms and abbreviations

ACTS	Aged Care Transfer Summary
ACSQHC	Australian Commission on Safety and Quality in Health Care
AMA	Australian Medical Association
AMH	*Australian Medicines Handbook*
BPMH	best possible medication history
CALD	culturally and linguistically diverse
CEC	Clinical Excellence Commission
CMI	consumer medicine information
CTG	Closing the Gap
DAA	dose administration aid
eMM	electronic medication management
EMR	electronic medical record
eNRMC	electronic National Residential Medication Chart
GP	general practitioner
HMR	Home Medicines Review
MAC	medication advisory committee
MBS	Medicare Benefits Schedule
MMP	medication management plan
NMP	National Medicines Policy
NMMP	National Medication Management Plan
NPS	National Prescribing Service
NRMC	National Residential Medication Chart
NSQHS	National Safety and Quality Health Services
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
PSA	Pharmaceutical Society of Australia
QUM	quality use of medicines
RACF	residential aged care facility
RACGP	Royal Australian College of General Practice
RPBS	Repatriation Pharmaceutical Benefits Scheme
RMMR	Residential Medication Management Review
SHPA	The Society of Hospital Pharmacists of Australia
TAG	Therapeutic Advisory Group
TGA	Therapeutic Goods Administration
WHO	World Health Organization

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All information in this publication is correct as at June 2022

DT0003019 June 2022