ADVANCED PHARMACY AUSTRALIA

In partnership with

RACGP Royal Australian College of General Practitioners

Safe Medication Management at Transitions of Care

This resource has been developed to support healthcare professionals in ensuring safe and effective medication management during patient transitions between care settings.

The patient is a member of the health care team and is engaged in care and communication across the continuum

Transitioning from primary to acute care

General practitioner (GP)	General practice pharmacist (GPP)	Hospital pharmacist
☐ Refer planned hospital admissions to the GPP, where possible, for medication management review. ☐ Ensure the patient's health record at the practice has a current health summary that includes, where relevant: adverse drug reactions, allergy details, current medication list, current health problems, past health history, recent pathology results, immunisations, family history, health risk factors (e.g., smoking, nutrition, alcohol, physical activity), social history, including cultural background. ☐ Communicate relevant up-to-date patient health information in a timely, authorised, and secure manner in response to valid requests, or prior to a planned admission.	☐ Establish and provide a point of contact in the general practice for pre-admission clinics ☐ Undertake medication reconciliation and review prior to a planned hospital admission. ☐ Prepare and provide a current medication list to the patient and the hospital in case of a planned admission, and respond to queries from the admitting hospital in a timely manner. ☐ If patient has opted into My Health Record, ensure the clinical documents (e.g. patient health summary, pharmacist shared medicines list (PSML)) on that platform are current.	☐ Obtain a best possible medication history (BPMH) on admission in a timely manner and collaboratively prescribe medications on the inpatient medication chart. ☐ Assess current medication management to identify medication-related problems. ☐ Commence clinical review, therapeutic drug monitoring and adverse drug reaction management. ☐ Participate in interdisciplinary care planning during team meetings, ward rounds, and clinical handovers. ☐ Establish a medication management plan. (MMP). ☐ Facilitate the timely and accurate supply of medications. ☐ Document clinical activities and interventions in the patient's hospital health record. ☐ Inform the patient that their medication management is being coordinated by the relevant team of hospital clinicians and will be communicated to their primary care providers upon discharge. ☐ Advocate the benefits of a general practitioner to a patient who does not already have one.

Transitioning from acute to primary care

Hospital pharmacist	General practice pharmacist (GPP)	General practitioner
☐ Develop a plan for medication management after discharge/care transition in consultation with the healthcare team and the patient. ☐ Collaboratively prepare/review and reconcile discharge medication orders according to patient's medication management plan. ☐ Provide patient with sufficient supplies of appropriately labelled medications or facilitate the supply of a Dose Administration Aid through the community pharmacy. ☐ Provide instructions on how to get further supplies especially of non-PBS medications if PBS alternatives are not possible. ☐ Provide patient with medication information and a new medication list outlining changes in therapy, specifying new and/or ceased medications. ☐ Identify patients who would benefit from a Hospital-Initiated Medication Review or an outreach appointment and recommend a doctor's referral. ☐ Assess patient's ability to self-administer medications and arrange support services where required e.g., dose administration aid (DAA), medication prompts. ☐ Collaboratively complete the medication management and ongoing monitoring sections of the patient's medical discharge summary. ☐ Provide the patient with a copy of their discharge summary, if available at discharge, and inform them that it will be sent along with their medication management plan, to their primary care providers upon discharge. ☐ Prepare and communicate medication information for clinical handover including provision of Interim Medication Administration Charts where appropriate, to the relevant primary care providers in a timely manner. ☐ Identify patients at risk of readmission, or who require support post-discharge and communicate to the GP the need to prioritise an appointment within 48-72hrs of discharge. ☐ Encourage all other patients to book an appointment with their GP within 7 days of discharge or earlier if required.	☐ Review inpatient information. ☐ Identify high-risk patients and arrange appropriate follow-up for the immediate post-discharge period. ☐ Undertake medication reconciliation post discharge. ☐ Work collaboratively and in partnership with the patient and interdisciplinary team to develop a plan for medication management in line with recommendations made in the patient's discharge summary, and refer for Home Medicines Review where appropriate. ☐ Communicate with the patient's community pharmacist, hospital pharmacist/s and prescriber/s, to clarify medication-related issues, discrepancies, and medication changes. ☐ Update the patient's practice record and ensure their My Health Record (MHR) is current and includes an up-to-date pharmacist shared medicines list (PSML). ☐ In consultation with the patient post-discharge, provide them with: ☐ an up-to-date medication list ☐ emergency action plans where relevant (e.g., asthma, COPD and heart failure) ☐ education and information on current medication plan	☐ Review inpatient admission information and ensure: ☐ they are electronically notated, or, if on paper, signed or initialled ☐ follow-up any arrangements and investigations are actioned ☐ Identify high-risk patients and arrange appropriate follow-up for the immediate post-discharge period. ☐ Work collaboratively and in partnership with the patient and relevant health professionals to develop a plan for medication management in line with recommendations made in the patient's discharge summary. ☐ Refer patients to the General Practice Pharmacist, where one is present, for review of medication management plan, updating of medication information, and provision of patient education and information relevant on medication changes in recent hospital admission. ☐ Identify patients at need of a Home Medication Review (HMR) and refer to a credentialed pharmacist. ☐ Support the patient to engage with follow up arrangements / appointments.

** Reference to 'patients' include the patients' carers, families and/or other support people.*

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