Government of Western Australia
Department of Health

Policy Frameworks
MP 0104/19
Effective from: 29 May 2019

Medication Review Policy

1. Purpose

The purpose of this Policy is to mandate minimum requirements for the review of a patient's medications on presentation to hospital, during hospitalisation and prior to transition back into the community or transfer to other health care facilities.

The objective of this Policy is to reduce the risk of preventable medication-related adverse events and improve patient safety.

This Policy is a mandatory requirement under the *Clinical Governance, Safety and Quality Policy Framework* pursuant to section 26(2)(c) of the *Health Services Act 2016*.

This Policy supersedes Operational Directive 0039/07 – *Pharmaceutical Review Policy*.

2. Applicability

This Policy applies to Health Service Providers that provide inpatient care.

3. Policy requirements

Each Health Service Provider must have its own governance arrangements (for example clear procedures, roles and responsibilities) in place for medication review which are aligned with the Standards of Medication Review set out below. Further guidance on how to meet the Standards is provided in *Best Practice Principles for Medication Review: Guidance Document*.

Standards of Medication Review

Standard 1: Medication Reconciliation on Admission

Medication reconciliation must be completed by the end of next calendar day (ENCD) following the day of admission by an appropriately credentialed health professional.

If admission medication reconciliation is unable to be completed by the ENCD, a risk assessment must be undertaken by an appropriately credentialed health professional to determine priority of medication reconciliation by acuity or clinical risk for admitted patients.

Standard 2: Medication Chart Review

Prior to the ENCD following admission, all inpatients must have a medication chart review (including but not limited to WA Hospital Medication Chart, WA Anticoagulant Chart, and Insulin Chart) by a clinical pharmacist. A chart review must be recorded in the 'Pharmaceutical Review' section on the WA Hospital Medication Chart or in the patient's medical record.

A daily medication chart review must also be completed by both the patient's prescriber and the nurse/midwife administering the medication.

If unable to undertake daily review, a risk assessment must be conducted to determine the frequency of ongoing chart review, based on the acuity or clinical risk of admitted patients.

Standard 3: Provision of Medication Education to the Patient during Hospitalisation and on Discharge

Medication education (written, verbal or both) is to be provided to the patient/carer by an appropriately credentialed health professional when there is a change to ongoing therapy and/or prior to discharge.

At discharge, the patient and/or their carer must receive medication information, including a list of their medications, in a form they can use, understand and that is culturally appropriate, to enable them to safely and effectively use all medications.

Provision of medication information to the patient must be documented on the WA Medication History and Management Form or in the patient's medical record.

Standard 4: Medication Reconciliation (including medication liaison) at Discharge/Transfer of Care

Medication reconciliation must be completed by an appropriately credentialed health professional upon discharge/transfer of care.

Complete, accurate and reconciled medication information must be provided by the prescriber to the patient's subsequent health care provider (community clinician or receiving hospital) in the discharge/transfer summary, with additional verbal communication where appropriate.

The medication information in the discharge/transfer of care summary (discharge medication profile) must include:

- a current allergy/adverse drug reaction status
- a current and complete list of medications at discharge including name of drug, dose, frequency, route and duration of therapy
- the rationale for change in therapy compared to medications on admission
- ongoing monitoring and medication management requirements.

4. Compliance monitoring

Health Service Providers are responsible for complying with this Policy.

The System Manager will monitor Health Service Provider compliance with this policy through assessment of data from the biannual Medication Reconciliation Audit.

The Medication Reconciliation Audit is a biannual audit that is conducted by Health Service Providers as per agreement with the Director General and Health Service Provider Chief Executives. Data is reviewed and collated by the Medicines and Technology Unit, Patient Safety and Clinical Quality Directorate, to provide a six monthly statewide report to Health Service Providers to assist with benchmarking across WA Health.

The System Manager may periodically conduct further compliance audits as required.

5. Related documents

Nil

6. Supporting information

The following information is not mandatory but informs and/or supports the implementation of this Policy:

- Best Practice Principles for Medication Review: Guidance Document
- WA Medication History and Management Form – this form can be used to document medication history, education and medication reconciliation.
- Medication Reconciliation Audit Resources
    - Medication Reconciliation Audit Guidelines
    - WA Medication Reconciliation Audit Tool – this tool is the recommended data collection form for the Medication Reconciliation Audit
    - Medication Review Reporting Form – this form is used to report the summary Medication Reconciliation Audit data to the System Manager. Two new indicators have been added to assist sites in demonstrating compliance with Standard 2 and 3 of this policy.
- Position statement for the use of complementary and alternative medicines (Council of Australian Therapeutic Advisory Groups)

7. Definitions

The following definition(s) are relevant to this Policy.

Term	Definition
Appropriately Credentialed Health Professional	A pharmacist, doctor, nurse or midwife who has the relevant knowledge in medication history taking and medication education. Refer to Credentialing and Defining Scope of Clinical Practice Policy.
Chart Review	A comprehensive review of a patient's current medication chart(s) to affirm appropriateness of therapy, identify potential risks associated with a patient's medications and

	clarify information that is not clear or legitimate.
Community clinician	A clinician that is involved in the patient's health care in a primary health setting. This can include, but is not limited to, a general practitioner (GP), community pharmacist, or specialist nurse/midwife.
Discharge/Transfer of Care Summary	A written detailed overview of the events during a patient's hospitalisation, including current medications and drug allergy status at the time of discharge/transfer of care.
Health care facility	Premises where medical, surgical treatment, mental health and/or nursing care are provided to inpatients. This excludes a day hospital facility and a nursing post.
Medication Education	An interactive consultation between the patient/carer and credentialed health professional, in which the patient is educated about their medications (including what the medication is for, how long it is to be taken, special directions, adverse effects). This may include the provision of written information and can form part of the consumer medication action plan.
Medication History	The recording of all medicines (including over-the-counter medicines and complementary therapies) a patient is taking at the time of hospital admission or presentation by an appropriately credentialed professional. It includes recording previous adverse drug reactions and allergies and any recently ceased or changed medicines. Also known as best possible medication history (BPMH).
Discharge Medication Profile	A complete list of current medicines at discharge. A medication profile should include, but is not limited to: • generic medicine name • suggested trade names • indication for the medicine • dosing schedule • special instructions • allergy status.
Medication Reconciliation on Admission	Medication reconciliation on admission is the formal process undertaken by an appropriately credentialed health professional which includes: ▪ Interviewing the patient and documenting a medication history. ▪ Confirming the medication history with a second source. If clinical judgment determines this is not necessary, this decision should be explicitly documented. ▪ Reconciliation, which involves comparing the clinician's admission orders to the medication history and ensuring that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.
Medication Reconciliation at Discharge/Transfer of Care	Medication reconciliation at discharge or transfer is the formal process undertaken by an appropriately credentialed professional which includes:

	▪ Reconciliation which involves comparing the clinician's discharge or transfer medication orders (includes discharge prescriptions and discharge summary) to the medication history and WA Hospital Medication Chart to ensure that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders. ▪ Medication liaison which involves ensuring that clinical handover of the patient's medications (including rationale for change in therapy and monitoring requirements) occurs between all health care professionals involved in the patient's care and relevant information is also communicated to the patient and/or carer.

8. Policy contact

Enquiries relating to this Policy may be directed to:

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9. Document control

Version	Published date	Effective from	Review date	Amendment(s)
MP 0104/19 v.1.0	26 February 2019	26 February 2019	26 February 2022	Original version
MP 0104/19 v.1.1	17 May 2019	17 May 2019		Update of broken links
MP 0104/19 v.1.2	29 May 2019	29 May 2019		Minor Amendment – Fixed broken links

10. Approval

Approval by	Dr David Russell-Weisz, Director General, Department of Health
Approval date	14 February 2019

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