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# Compiled Quick Guides SHPA

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## About the SHPA Quick Guides

SHPA Quick Guides are designed to complement the *SHPA Standards of practice for clinical pharmacy services* and align with shpaclinCAT. The full *SHPA Standards of practice for clinical pharmacy services* can be found at [www.shpa.org.au/Practice-Standards](http://www.shpa.org.au/Practice-Standards).

Prepared by the SHPA Clinical Pharmacy Committee of Specialty Practice July 2013.

## Prioritising day-to-day workload

Clinical pharmacists are often required to prioritise tasks to ensure effective and efficient distribution of services with finite resources.

Pharmacists need to prioritise their day-to-day activities according to daily workload and patient needs. Activities must be delivered in a timely manner considering each patient's needs, e.g. are they being discharged? Is the activity needed before a procedure?

This document will assist you to plan your day-to-day clinical activities in the most effective and efficient manner.

### Guide

Pharmacy departments may prioritise particular services or patients in line with the facility's goals. Refer to local policies for service priorities. Adjust daily priorities according to changing circumstances and refer to a supervisor if assistance is required.

### Prioritise patients according to risk for medication-related problems

#### **Patient characteristics:**

- extremes of age (paediatric and geriatric) and body weight/BMI
- high-risk disease states, complex medical or surgical procedures
- renal or liver function impairment
- history of adverse medicine events, difficulty with managing their own medicines or medication misadventure is a known or suspected cause of admission
- deteriorating clinical state or transfer from high care.

#### **Medicines therapy:**

- multiple medicine, multiple prescribers or complex medication regimens
- recent significant changes to the medication regimen
- high-risk medicines including those with a narrow therapeutic index or that requiring specialised monitoring.

### Daily routine for the delivery of pharmacy services

1. Gather information to support decision making on prioritisation. Sources of information include patient/bed handover lists, medication management plans, daily/weekly team planning meetings.
2. Complete medication reconciliation for pending discharge or transfer medication orders (See *Quick guide: Medication reconciliation*).
3. Provide any patients that are being discharged with the medicines that they require along with an accurate and complete list of their medicines with information for ongoing care. Liaise with the patients' community healthcare providers as appropriate (See *Quick guide: Facilitating the continuity of medication management on transition between care settings*).
4. Complete a medication reconciliation for new patients.
5. Complete an assessment of current medication management and clinical review in order of patient priority (See *Quick guide: Assessment of current medication management* and *Quick guide: Clinical review, TDM and ADR*).
6. Participate in interdisciplinary care planning and follow up any outstanding issues.
7. Complete medication reconciliation of discharge and transfer medication orders for patients being discharged the next day.
8. Provide other clinical pharmacy services e.g. providing information to members of the healthcare team, teaching and training, providing education services as required and as time permits. e.g. provision of medicines information to the healthcare team, teaching and training, provision of education services as required and as time permits.

## Clinical review, therapeutic drug monitoring (TDM) and adverse drug reactions (ADR)

Clinical review, TDM and ADR management aim to ensure safe and appropriate treatment with medicines. Review of patient-specific clinical information assists in understanding a patient's clinical progress and treatment options. Ongoing clinical review and TDM is essential to re-evaluate and modify therapeutic goals as the patient's condition and response to therapy change.

This document will help you to assess a patient's current medication management in accordance with Chapter 3: Clinical review, therapeutic drug monitoring and adverse drug reactions in *SHPA Standards of practice for clinical pharmacy services*.

### Guide

#### Clinical review

- Obtain patient-specific information about signs, symptoms and clinical progress: routine observations, e.g. temperature, blood pressure; weight; fluid balance; urine output; biochemistry results, e.g. electrolytes, creatinine; haematology results; microbiology results; radiological investigations; bowel charts; peak flow/spirometry; nutrition; and pain scores.
- Interpret and evaluate the clinical information obtained.
- Identify actual and potential medicines-related problems. Prioritise these according to their risk and urgency. Liaise with the prescriber to resolve any issues and document these in the health record.

#### TDM

TDM may be used to optimise therapy for medicines where there is a known relationship between measured concentration in body fluids and pharmacological effect.

To interpret drug concentrations other details need to be known to relate the measured concentration to therapeutic effect. Data to record when taking samples include time of sampling, time of last dose and duration of current medicines regimen. When interpreting results, consider the following:

- drug, dose, formulation and dosing schedule
- method of administration
- indication for treatment
- reason for TDM
- duration of current medicines regimen
- time of last dose
- time of sampling prior drug monitoring and other relevant laboratory results
- patient-specific factors, e.g. renal and hepatic function, cardiac status, age, weight
- relevant pharmacokinetic and pharmacodynamic properties of the drug
- potential for drug interactions
- other environmental factors, e.g. smoking
- potential for sampling or measurement error
- local laboratory parameters
- pharmacogenomics and genetic markers.

Identify actual and potential medicines-related problems. Prioritise these according to their risk and urgency. Liaise with the prescriber to resolve any issues and document these in the health record.

#### ADR

- Detect ADRs through monitoring at-risk patient groups and encourage nursing and medical staff and patients/carers to report any suspected ADRs.
- Document comprehensive ADR details include: description of the reaction; time of onset and duration of reaction; complications and sequelae; treatment and outcome of treatment; relevant investigation results or autopsy report.
- Assess the likelihood that the medicine has caused the suspected ADR.
- Recommend treatment options for the ADR and, if appropriate, recommend alternative treatments.
- Ensure all suspected ADRs are communicated appropriately by: documenting in the health record, including local electronic prescribing or dispensing system and if appropriate attach relevant alert notices/stickers to medicine administration records and health record.

## Documenting clinical activities

The primary reason for documenting clinical activities is to improve the quality of each patient's care. Documentation demonstrates the accountability of the pharmacist and the evidence of impact of the pharmacist's services.

Documenting clinical activities provides a permanent record of identified actual and potential medicines-related problems, clinical decisions made and suggested changes to medicine therapy for individual patients.

Documenting clinical interventions and incidents can also identify areas for quality improvement by revealing trends in medicines-related problems. The continuous and periodic documenting of workload statistics and KPIs aims to assess efficiency and quality of pharmacy service provision and may assist in strategic planning.

### Guide

#### Medication reconciliation

Document all details relating to medication reconciliation in the patient's MMP or health record including the information obtained from an accurate medication history and assessing patient adherence with the prescribed medicines regimen.

#### **Clinical interventions and medication-related problems identified as part of medication reconciliation, assessment of current medication management and when facilitating the continuity of medication management on transition between care settings.**

Consider documenting the following details or activities relating to medicines-related problems and potential actions in the patient's MMP or health record:

- identified serious clinical problems with discussion of the pharmacist's assessment including: medicine(s) involved; date and patient demographic data; treating unit/provider; pharmacist identifier; category of the medicine-related problem; category of the pharmacist recommendation; category of the action taken in response to the medicine-related problem
- action taken in response to the medicine-related problem: prescriber has accepted pharmacist recommendation; prescriber has not accepted pharmacist recommendation; pharmacist has provided service as recommended; patient has accepted pharmacist recommendation; patient has not accepted pharmacist recommendation; unknown at time of recording
- recommendations for therapeutic drug monitoring and evaluation of therapeutic drug monitoring data
- ADR assessment and management recommendations
- serious concerns about medicine therapy that cannot be verbally communicated to a medical officer (or which has not been addressed by medical staff, or which would potentially imply negligence by the pharmacist if not documented).

#### **Providing information to patients and other health professionals**

- details of patient education and administration and adherence aids provided
- response to patient-specific questions from other staff e.g. recommended doses
- provision of patient-specific medicines information and specific therapeutic information, e.g. potential drug interactions.

#### **Non patient-specific activities**

Other clinical activities should be recorded when the information is useful in determining the efficiency and quality of the clinical service and to assist in strategic planning, for example:

- attendance at interdisciplinary ward rounds and meetings
- contribution to under-graduate and post-graduate teaching
- contribution to workplace training
- participation in research activities
- participation in drug usage evaluation and medication safety projects
- membership of organisation committees.

## Medication reconciliation

Medication reconciliation should be undertaken on presentation or admission to a health service organisation, transfer between wards and care settings within an organisation, discharge or transfer from the health service organisation to the community or other organisations and transfer between community-based providers.

This document will help you to accurately undertake the medication reconciliation process.

### Guide

The purpose of medication reconciliation is to ensure patients receive all intended medicines and to avoid errors of transcription, omission, duplication of therapy, and drug–drug and drug–disease interactions.

The procedure for each organisation should be standardised. Ideally, the medication reconciliation process should commence as soon as possible on presentation or admission and a documented, confirmed medicines list be available before medicines are prescribed.

A medication history is a record of all the medicines actually taken by the patient in the period before admission or presentation for the episode of care and includes information about previous adverse drug reactions (ADRs), adverse medicines events and allergies and recently ceased or changed medicines.

Obtaining a best possible medication history involves: reviewing background information and conducting a patient/carer medication history interview.

Refer to Chapter 8: Medication reconciliation in the *SHPA Standards of practice for clinical pharmacy services*.

### Medication reconciliation on presentation

Obtain and document the best possible medication history. Review background information and conduct an interview with the patient and/or carer using a structured interview technique. Ensure all details of medication history are documented in the patient's health record including confirmed allergies and ADRs, recently ceased or changed medicines and the use of complementary/alternative medicines (CAMs).

Confirm the accuracy of the medication history using secondary sources of information (e.g. patient's-own medicines, carers, community pharmacies, GPs). Obtain patient consent before requesting patient-specific information from other healthcare providers. Update the medication history if new information becomes available.

Compare the medication history with the prescribed medicines and follow-up discrepancies. Compare the medication history with the current medication orders in the context of the patient's current condition, their treatment plan and medication management plan. Identify and address any discrepancies and/or medicine-related problems.

Supply verified information for ongoing care. Document details on the patient's medication management plan, (MMP) or directly in the health record and communicate to the patient/carer and other health professionals as appropriate.

### Medication reconciliation on transfer to a different unit/ward of care, when a new medication order is written, and on discharge from a health facility

Check that the discharge/transfer medication orders match current medication orders, the medicines supplied at discharge and the discharge plan. Check that there is a plan for recommencing medications withheld on admission and any changes noted.

The medication history should be listed in the discharge summary including the reasons for any changes between admission and discharge. Ensure that the details are included in the patient's electronic health record.

Reconcile the patient's own medicines with discharge/ transfer medication orders and discuss changes to medicines during the episode of care and expected changes for discharge/transfer (See *Quick guide: Facilitating discharge and transfer* and *Quick guide: Documenting clinical activities*).

Discuss with the patient what medicines will be required on discharge to ensure continued supply. Obtain permission from the patient to supply required medicines and remove ceased medicines for destruction.

## Assessment of current medication management

An assessment of a patient's current medication management aims to optimise therapy and outcomes by ensuring the safety and appropriateness of prescribed medicines, taking into account patient-specific factors including their medical condition and previous experience with medicines. The goals are for the patient to receive the most appropriate dose and dosage form of their medicine, timing of dosage and duration of therapy and that the risks of medicines-related problems are minimised.

An assessment of a patient's current medication management should not be done in isolation. It requires a systematic, in-depth assessment of current medicines in consultation with the patient taking into account the patient's medication history, the patient's medication management plan (MMP), data from the medication administration record and a clinical review including therapeutic drug monitoring (TDM).

This document will assist you in assessing a patient's current medication management in accordance with Chapter 2: Assessment of current medication management in *SHPA Standards of practice for clinical pharmacy services*.

### Guide

Medication order review involves assessing all current and recent orders and administration records including: national inpatient medication charts, variable dose medicines, intravenous fluid and electrolyte orders, single dose medicines, anaesthetic and operative records, epidural medicines, analgesics, enteral and parenteral nutrition orders, outpatient and/or discharge prescriptions and other relevant medication orders. Medication charts may vary slightly between different hospitals and patient groups. For each medicine order assess:

#### Clarity

- Ensure that the prescriber's intention is clear to enable the safe supply and administration of medicines.
- Ensure that all medicines are prescribed by their active ingredient or as recommended by local policy and ensure prescribing abbreviations meet local and national policy.
- Annotate the order to clarify the administration of modified release products, IV administration method, indication and maximum dose in 24 hours for PRN medications, administration in relation to food and relevant restrictions, e.g. schedule 8.
- Ensure cancelled medicine orders comply with national and local prescribing policies and ensure date and time the medication is to commence and cease is written.
- Ensure that the duration of the medicine is appropriate.
- Ensure that the time the dose should be given is endorsed in the relevant section of the chart.

#### Validity

- Check that patient identifiers are present.
- Ensure that the order is signed and the prescriber can be identified.
- Ensure that the order conforms with legal and funding requirements and any additional requirements are fulfilled, e.g. authority granted.

#### Appropriateness

- Consider local guidelines for patient management when making recommendations on the choice of medicines.
- Check medication orders for interactions including drug–drug, drug–patient, drug–disease and drug–nutrient interactions and: identify mechanism of the interaction; -consider clinical significance; decide on an appropriate course of action.
- Consider interactions with laboratory tests and environmental factors, e.g. smoking, alcohol consumption, motor vehicle driving.
- Consider the cost of the medicine therapy to the patient, hospital and community.
- Check the availability, i.e. government restrictions, marketing approval, hospital formulary limitations, methods of obtaining further supply outside of the facility.
- Check all medication orders for duplication.
- Check the dose with respect to patient's previous experience with medicine, disease state, pregnancy, age, renal function, liver function, interactions, dose form and method of administration.
- Check dose conversions required with any changes to route or formulation.
- Check that the most appropriate route of administration is selected.
- Check that the timing of administration is appropriate with respect to food/feeds, administration rounds, convenience, scheduled procedures/investigations, TDM requirements.
- Check orders for medicines to which the patient may be allergic or have experienced an ADR.
- Ensure infusion solution, concentration and rate of administration are appropriate and clinical targets are appropriate.
- Check the administration record to see that all doses have been given as prescribed.
- Check the availability of the medicine and annotate the supply method of individual medicines, ensure necessary medicines are available



## Facilitating the continuity of medication management on transition between care settings

The pharmacist's role in facilitating transition between care settings is to achieve continuity of medication management for the patient. The care settings may include hospital, residential aged care and community services. The patients may be admitted, ambulatory or residential.

Planning for transition between care settings should commence on admission and be ongoing during the episode of care. All patients should have access to information about their medicines. Medicines information should be supplied to the patient/carer and other relevant health professionals as required during the episode of care.

If all steps of facilitating medication management on transition cannot be completed for every patient, prioritise those who are most likely to benefit from the service.

This document will assist you in facilitating the continuity of medication management in accordance with Chapter 6: Facilitating the continuity of medication management on transition between care settings in the *SHPA Standards of practice for clinical pharmacy*.

### Guide

#### Manage patient's medicines and communicate with patient and/or carer on transition

- Reconcile discharge/transfer medication orders with the patient's current medication, medication history taken on admission and patient's own medicines.
- Discuss with the patient/carer the medicines that need to be supplied or sourced on discharge or transfer.
- Return the patient's own medicines where appropriate. Remove ceased medicines for destruction with the patient's permission. Provide patient with the medicines that they require together with an accurate and complete list of their medicines or discharge medication record.
- Provide the patient/carer with instructions on how to get further supplies of their medicines after discharge or transfer.
- Provide verbal and written medicines information including information on changes to their medicines, CMIs, details regarding the further supply of medicines and other information required for ongoing care.
- Provide information about adherence aids.
- Discuss the need for follow-up either at home, residential care, outpatients or non-admitted settings.

#### Liaise with other health professionals on transition

Obtain patient consent and then communicate all medicines-related information in a timely manner to the patient's GP, community pharmacist, residential care provider or other health professional. The method and extent of communication will vary depending on the needs of individual patients, and the available time and resources.

Provide the following information to all involved in the patient's care:

- the details of medicines prescribed on discharge or transfer, a contact name within the hospital and a telephone number
- a verified list of all the patient's medicines beginning at the episode of care, changes made during the episode of care and a detailed rationale of these changes
- any monitoring requirements for ongoing management of the patient's medicines
- information regarding the patient's need for periodic medicines review. Include recommendations on the need for a Home Medicines Review, Residential Medication Management Review, MedsCheck, Diabetes MedsCheck or other review process to support the patient's medication management plan
- sufficient information about obtaining supplies of ongoing medicines after transition, including special packaging requirements
- reported adverse drug events and adverse drug reactions during the episode of care
- information regarding assistance required
- an interim medication chart (if available) for patients discharged to residential care facilities.

Document the information provided and who it has been transferred to on in the patient's health record.

#### Post-discharge follow-up of patients at high risk of medication misadventure

Identify high-risk patients in consultation with the interdisciplinary team and arrange appropriate follow-up for the immediate post-transfer period, e.g. MedsCheck, Diabetes MedsCheck, outpatient or non-admitted review. Detect ADRs through monitoring at risk patient groups and encourage nursing and medical staff and patients/carers to report any suspected ADRs.