Medication Recording in Patient Records Procedure

Effective: 24 October 2018

1. Guiding Principles

Keeping an up to date summary of patient medications is important in monitoring for side effects, compliance and drug interactions.

Patients are known to have various prescribers and the pharmacy may be the holder of this information, especially if in Webster pack. In addition, patients sometimes change their own medications, dosages and use over the counter medications.

All of the above need to be checked and an accurate medication record attained. The medication record is only accurate at the time and may change as soon as the patient sees their General Practitioner (GP) or service provider.

It is important to document patient history of medicine allergies and adverse drug reactions. The service must minimise the occurrence of adverse medication events within all settings.

Accurate records of psychotropic medications prescribed by the Wheatbelt Mental Health Service must be kept, as well as any adjustments made due to side effects, ineffectiveness, or patient choice . The best way to do this is to keep an up-to-date medication record in PSOLIS under **Interventions: Medication**.

Changes to medication and the reasons for changes will be easily accessible and can be added to the discharge/transfer summary. This will save searching through progress notes / GP letters / PSOLIS service events.

2. Procedure

New Referrals:

1. Check medication information in the referral from GP. (This should list all medication- not just psychotropic medications prescribed.)
2. Confirm with patient for accuracy.(i.e. is the list current and are they taking as prescribed?)
3. Request consent for pharmacy record. (Check nominated local pharmacy and add to consent form.)
4. Enter up-to-date list on PSOLIS record. (Indicate source of information e.g. GP letter/ Webster pack/ pharmacy printout/ patient report, and date confirmed with patient/carer.)
5. Print and file in Medication division of medical record.
6. Depot medication can be added on PSOLIS under Prescriptions by nurse or psychiatrist and added to your diary as a prompt to check compliance where needed.

Psychiatrist Review:

1. New medication started / Change of Dose / Medication Change / Allergies / Adverse Drug Reactions / Side effects noted (after discussion with psychiatrist as to what needs recording).
2. Enter details on PSOLIS Medication /Interventions record.
3. Print and ask Psychiatrist or nurse to check accuracy and co-sign.

Three Monthly Review:

1. Call GP prior to review to discuss any changes and confirm accuracy. (Also good time to discuss any plans to discharge for GP input.)
2. Check with patient prior to review.
3. Update PSOLIS record and PRINT for patient file.

3. Roles and Responsibilities

The Clinical Director has overall responsibility for ensuring that services are delivered in accordance with this procedure.

Stream Coordinators are to provide orientation and education to relevant WACHS clinicians and staff on the use of this procedure.

All staff are required to work within this procedure.

Case Managers are to ensure PSOLIS records are kept up to date at referral and following any psychiatric review, and at all three (3) monthly Clinical Reviews. Any changes can be checked with psychiatrist for accuracy and to ensure relevant clinical information is noted (e.g. reason for discontinuation or change of medication).

4. Compliance

Failure to comply with this procedure may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

5. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System. See: Records Management Policy

6. Evaluation

This procedure is to be reviewed by Clinical Director every two (2) years or sooner if required.

7. Standards

National Safety and Quality Health Service Standards (First edition 2012) - Standard 4 Medication Safety - 4.1, 4.6, 4.7, 4.8

National Safety and Quality Health Service Standards (Second edition 2017) - Standard 4 Medication Safety - 4.5, 4.6, 4.7, 4.8

8. Related WA Health System Policies

MP 0069/17 Mental Health Consumer Medication Information Policy

9. Policy Framework

Mental Health Policy Framework

This document can be made available in alternative formats on request for a person with a disability

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