Discharge information - Medications

Frequently Asked Questions (FAQ)

This FAQ page answers questions about Regulation 34(3)e of the *Health Services (Health Service Establishments) Regulations 2013.* This regulation applies to all procedures undertaken in private hospitals and day procedure centres in Victoria.

What is regulation 34 (3)e?

Regulation 34(3)e of the *Health Services (Health Service Establishments) Regulations 2013* states that the discharge summary of patients must include a list of all medications currently prescribed for the patient, irrespective of whether the medication is in relation to the health service received at the health service establishment.

Why was this change made to the regulations?

Patient safety is the basis for this change. It is a risk if patients are only asked about a select number of medications deemed relevant to the procedure they are undertaking during the pre-admission clinical assessment. The pre-admission process must capture the full list of medications that a patient is currently prescribed.

How do registered facilities comply with this regulation?

Any changes to medication must be in written form so that the patient does not have to rely on memory and so that the patient can pass on the information to carers and health care professionals if needed. Patients may not remember oral instructions about medications, particularly if they have been given instructions as they recover from an anaesthetic, or they have declining cognitive capacity or disabilities.

If the procedure has caused a change in medication either through the addition of new medications or the discontinuation of previous medications, this change must be captured very clearly for the patient.

What happens if there are no changes to the patient's medication list following the procedure?

A full list of medications should be captured during a pre-admission clinical assessment. If the patient develops complications from the procedure and requires treatment in an emergency department or by another health practitioner, patients must have a full list of their currently prescribed medications.

If there are no changes to a patient's medications, the facility may simply reproduce the list (for example by photo-copying a hardcopy of the pre-admission clinical assessment or printing a copy of the medications provided by the referring doctor or pharmacist) and write "nil changes" on it. This can then be included in the discharge summary.

We are a small Day Procedure Unit – Does this regulation apply to us?

Any procedure (even minor) that requires anaesthetics, increases clinical risk. Interactions between anaesthetics and other medications is not limited to a subcategory of medications, and patients must be asked about all medications. A full list of medications gives clinical staff complete knowledge of a patient's potential risk factors.

There may be discrepancies between the medications information a patient provides and that provided by a general practitioner. Any differences should be resolved before treatment.

Further questions regarding the implementation of this regulation, please contact Victor Di Paola at the Private Hospitals Unit on 9096 9990.

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