Optimising Medication Management for People Transferring Between Hospital and Aged Residental Care

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WAITAHA PRIMARY HEALTH

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EXECUTIVE SUMMARY

In 2025 the Primary Care Taskforce reviewed the management of medications for patients transferring from hospital to an Aged Residential Care (ARC) facility with the aim of:

- mapping current workflows,
- clarifying clinical requirements and responsibilities, and
- identifying opportunities to improve the management of medications during this transfer.

This document reports on the work undertaken, findings and recommended actions to improve medication management to reduce the risk of medication errors and provide operational efficiencies.

Process

A collaborative stakeholder group was established to provide leadership for this project. It comprised of clinicians and leaders from secondary and primary care, community pharmacy, ARC and Health NZ Commissioning.

Eight interviews with 14 subject matter experts were undertaken to gather data on current processes, issues, and actions for improvement. These informed the development of draft workflow maps of patient journeys, and the documentation of issues and recommended actions, which were then analysed into key themes.

Findings

The subject matter experts identified a total of:

- **61 issues** primarily relating to policy constraints, workflow inefficiencies, lack of system integration, and variation across ARC settings.
- **44 recommended actions** relating to process, workflow, communication, policy, and system-improvement themes.

Analysis

The stakeholder group prioritised **16 recommended actions** which were achievable and would improve medication management during the transfer of patients from hospital to ARC facilities. These included improving HealthOne access and usability within ARC, digitising yellow envelope medications lists, improving discharge summary content, standardising medication discharge policies, and clarifying clinical responsibility during transfers.

Of the 16 prioritised recommended actions, it is proposed that the following occur:

- 13 are managed and progressed under business-as-usual activities.
- Further work is undertaken on three ‘transition of care’ actions to:
  - review/redesign the clinical responsibility,
  - define the clinical delegation of responsibility on discharge from hospital to ARC, and
  - define the transfer of responsibility for the treatment plan, dispensing of medicines, and recording.

Summary

Transfers of care between hospitals and ARC facilities across Te Waipounamu continue to present significant risks, particularly in medication management. These risks arise largely from the manual transcription of prescribed medications, variable workflows, and the absence of a shared, interoperable electronic medication platform or single source of truth for prescribed medications.

The current environment of multiple non-interoperable systems requires prescribers, pharmacists, and nurses to transcribe a patient’s medications between various systems (e.g., MedChart to Soprano Medical Templates to create the discharge prescription into MediMap and 1-Chart by prescriber or pharmacist, pharmacist into pharmacy

software RxOne or Toniq for medication dispensing). This level of manual transcribing creates a high risk of transcription errors, delayed charting and approvals, and inconsistent medicine records across care settings.

Outpatient prescribing is also manual, relying on Soprano Medical Templates (SMT) and paper prescriptions, which increases the likelihood of errors and dispensing delays. Furthermore, time-critical medicines (e.g., antivirals, some pre-procedure medicines, and chemotherapy) introduce additional complexity for both ARC facilities and community pharmacies.

Overall, the lack of interoperability between medication systems used in hospitals, general practice, ARC facilities and community pharmacies leads to:

- Patient safety risks from the increased likelihood of medication omissions and errors, and disrupted continuity of care.
- Operational inefficiencies from manual processes and discharge delays, especially on Fridays and at weekends. This places pressure on hospitals, general practice, community pharmacies, and ARC facility capacity.
- Systemic-level risks. Without integrated digital solutions, the sector remains vulnerable to avoidable medication errors and inefficiencies, which could be resolved through coordinated digital transformation.

This work highlights that clinical teams across hospitals, ARC facilities, general practice and community pharmacies are working in an environment characterised by:

- fragmented medication processes during discharge and transfer,
- underutilised digital tools particularly HealthOne access within ARC facilities,
- unclear delegation of clinical responsibility following discharge, and
- non-standardised policies for medication supply and charting.

The long-term goal of a Health NZ supported medication programme must be to establish a coordinated, system-wide approach that enhances patient safety, reduces medication-related risks, supports patient continuity of care and reduces avoidable hospital re-admissions.

While the regional and national digital applications currently available provide the backbone of an interoperable system, meaningful progress requires support and investment from Health NZ and Te Waipounamu executive leaders.

Recommendations

It is strongly recommended that Health NZ place a high priority on continuing work to improve the management of medications during the transfer of patients between hospital and ARC facilities, given its contribution to ensuring patient safety, regulatory compliance, and long-term cost efficiencies**.** Discontinuing or delaying progress could result in gaps in medication management, increasing the risk of adverse events and compromising the quality of care.

Reasons to support this decision include:

- Improvements to the management of medications directly align with Health NZ goals around clinical excellence and national standards for medication safety.
- Investment in this initial project has created a solid foundation to achieve an interoperable environment. Halting now would result in sunk costs that do not deliver the intended benefits.
- Maintaining momentum safeguards patient outcomes, strengthens the transfer of care between hospital and ARC facilities, while building on the clinical collaboration that's already been achieved.

It is recommended that while this work is owned as a programme of work within Health NZ, it is progressed as a collaboration between secondary, primary care, community pharmacy, ARC facilities, with consumers and IT vendors also engaged

To progress this work, it is recommended that:

1. Health NZ Te Waipounamu leadership advocate regionally and nationally for a shared medication record to support improvements in patient care, safety and outcomes enabled through interoperability between systems.
2. Health NZ Te Waipounamu leadership expedite the planned medication programme of work to facilitate greater integration of medicines data across systems within the region,(e.g., with MedChart V12 including integrations with NZePS and the national medication data repository); and the three transition of care recommended actions between hospitals and ARC facilities.
3. Health NZ Te Waipounamu resource the completion of the regional transition of care projects.
   The cost of the Project Management, Business Analyst, and Change Manager roles to undertake the Transfer of Care project is estimated at $300,000. Additional costs, e.g., clinical time and system workflow changes, also need to be considered.
4. Actions that can be undertaken locally are progressed.

TABLE OF CONTENTS

REPORT

1. Background

The transition of care from hospitals to Aged Residential Care (ARC) facilities remains problematic, with a risk of medication errors, miscommunication, and potential patient harm. These risks arise largely from manual transcription and reconciliation of prescribed medicines. The absence of a shared interoperable electronic system across Te Waipounamu and nationally, limits providers access to a single, reliable medication record.

The Primary Care Taskforce[1] was requested to undertake a project to:

- Map the current workflow process on discharge.
- Gather the following clinical information:
    - Clinical requirements: confirm the right clinical information is communicated.
    - Clinical workflows: confirm who is involved, the tasks they undertake in the current process and changes required for future processes.
    - Clinical responsibilities: confirm who has clinical responsibility through the process.
- Identify any local activity which could be undertaken to improve current workflow.

2. Method

A stakeholder group was established to provide leadership for the project. It included people with the following perspectives:

- Clinical Lead PHO
- General Practitioner Rural ARC provider
- General Practitioner Urban ARC provider
- Pharmacology Secondary Care Clinical Lead
- Rural ARC Clinical Manager
- Community Pharmacist
- Corporate ARC Manager
- Corporate ARC Clinical Manager
- Ageing Well Service Development Manager - HNZ Commissioning
- Primary Care Taskforce Chair

Data gathering and analysis

Eight semi-structured interviews with 14 subject matter experts (SME) explored:

- Current workflow process
- Roles and responsibilities
- Systems used
- Issues and challenges
- Improvements and future state

Thematic analysis identified key challenges and recommendations for improvement. Interview data also informed the development of draft workflow maps describing medication management and clinical responsibilities during patient journeys.

[1] The Canterbury Primary Care Taskforce is a collaborative of system and community leaders group formed to improve access by addressing the capacity pressures in primary care.

The stakeholder group reviewed the comprehensive list of issues and recommendations and prioritised the recommended actions that were achievable. Initial refinements to the draft workflow maps were undertaken by key stakeholders, including the hospital pharmacology team and the community pharmacist.

It is noted that the gathering of data focused on clinical workflows and processes. The patient / whānau experience and associated issues and recommended changes were not explored during this project.

3. Findings

Current workflow

Interview findings informed the drafting of workflows for the pathways listed below. These are based on the information available at the time, with further work required to refine and finalise them.

- ARC facility admission.
- Discharge from hospital to an ARC.
- Pharmacy dispensing
- Outpatient appointment for person in an ARC facility
- Medication issue process.

The draft pathways are included in Appendix One.

Improvement of current workflow

SMEs identified a total of 61 issues and challenges. These were grouped into seven themes. A summary of the themes and examples of each are provided in Table 1 below.

Theme	No.	Examples of issues or challenges raised
Policy	33	Hospital clinicians' access and use of Medimap for charting medication changes. Some discharge medications are not held by the ARC facility.
Workflow	21	The prescribed hospital medications are not electronically sent to MediMap, these need to be manually entered between the discharge summary, MediMap and 1-Chart.
Access	2	Delay in the information being uploaded to HealthOne when a patient is registered with a practice that supports the ARC facility.
Process/ workflow	2	Timeframe for sending scripts to pharmacies on a Friday may result in patients not being discharged until Monday, incurring an additional three days in hospital.
Authentications	1	HealthOne is not used to the extent it could be within the ARC facilities with some staff reluctance to install the MS Authentication application on personal devices.
Funding	1	General practitioner time and remuneration required to action the additional work to manage patients coming from hospital to an ARC facility.
Policy/Process	1	Variation between ARC facilities: Some ARC facilities have limited afterhours / weekend medication dispensing, so a different pathway is required to obtain medications e.g., different pharmacy or from the hospital on discharge.

Table 1: Key themes from thematic analysis of issues and challenges

Recommended Actions

SMEs identified a total of 44 recommended actions. These were grouped into six themes: process (total of 14 recommended actions), workflow (11), communication (7), policy (6), HealthOne (4), and process/workflow (2).

Prioritised Recommended Actions

The stakeholder group agreed on 16 achievable actions to improve the management of medications for people transferring between the hospital and ARC facilities. For each, the owner, complexity and level of change (local/regional/national) were identified. These are detailed in Table 2 below.

No	Recommended Actions to Improve Medication Management	Owner	Complexity	Change
1	**Clinical leads engage with HNZ** - Executive Regional Director and Regional Director Data & Digital to raise the risks and patient impact that the current medication environment creates.	Clinical Leads	Low	Local / Regional
2	**Support the future state medication landscape**	PCTF Chair	Low	Local / regional
3	**Promote greater use of HealthOne within the ARC facilities,** to support access to discharge summaries, discharge medications, discharge planning and monitoring of residents who have been transferred into hospital care	HNZ Ageing Well/ HealthOne	Low	Local / Regional
4	**Review HealthOne access requirements** relating to new and respite patients being transferred to an ARC facility, and the timing of ARC being able to view this data.	HNZ Ageing Well/ HealthOne	Low	Local
5	**Resource ARC nurses with practice level access to HealthOne**.	HealthOne	Low	Local / Regional
6	**Review additional HealthOne authentication options** for improved access to support patient care within ARC facilities.	HealthOne	Low	Local
7	**Investigate what clinical information in HCS / HealthOne would be useful for ARC facilities.** *This has been identified as end user education regarding where to find the required clinical information.*	HNZ Gerontology Ageing Well	Medium	Local
8	As part of the hospital discharge summary review, **ensure that the Clinical Care Team name and contact number are included in all discharge summaries**	HNZ National eMeds	Medium	Local/ Regional
9	**Review the discharge transfer of care process with ARC facility leads to improving the transfer of care handover process for patients leaving hospital.** Extend this to include new incoming or respite patients from within Te Waipounamu and northern regions. I.e., what does the facility need to know about the patient and what level of care the patient has received or requires.	HNZ Ageing Well	Medium	Local/ Regional
10	**Make the information within the yellow envelope available in digital form in HCS.**	HNZ Ageing Well	Medium	Local/ Regional/ National
11	**Create a standardised medication discharge policy,** including the supply of medications, medication charting responsibilities, and medication approval responsibilities for the following situations: • Patients discharged from hospital back to the care facility. • New patients referred and transferred from hospital to ARC for respite care. • New patients referred and transferred from hospital to facility long term care. • New patients referred and transferred from home to care for respite. • New patients referred and transferred from home to care for long term care. • New patients referred and transferred from outside Te Waipounamu.	HNZ Ageing Well	Medium	Local
12	**Review practice policies for onboarding locums and providing system access to MediMap, 1-Chart, HealthOne.**	PHO	Low	Local
13	**Provide a single digital contact list for ARCs and community pharmacies** – this work is in progress with the HNZ Gerontology nursing team	HNZ Gerontology	Low	Local / Regional
14	**Hospital Transition of Care - Clinical Responsibility**	HNZ	Medium	Local

	Clinical responsibility currently travels with the patient, but it is proposed that on discharge the responsibility for medical treatment stays with the hospital teams until accepted by community teams/GP (or one week)			
15	**Hospital Transition of Care – Clinical Delegation of Responsibility** Define the delegation of responsibility on transfer from hospital to ARC. This may be patient, facility, GP dependent. Capture and document the hospital clinical change requirements.	HNZ / PHOs	Medium	Local
16	**Hospital Transition of Care – Transfer of Responsibility** Consider the transfer of responsibility for the treatment plan, dispensing of medicines, and recording of administration. Create a standardised transfer of care policy for the safe use of medicines, including the supply of medicines and medication charting responsibilities, for the following types of transfer. • Patients discharged from hospital back to the care facility. • New patients referred & transferred from hospital to care facility for respite. • New patients referred and transferred from hospital to care facility for long term care. • New patients referred and transferred from home to care facility for respite. • New patients referred and transferred from home to a care facility for long term care. • New patients referred and transferred from outside Te Waipounamu to care facility for long term care.	HNZ / PHOs	Medium	Local/

Table 2: 16 prioritised actions including Owner, Complexity and Level of change

4. Proposed approach to delivery of recommended actions

Recommended Actions 1 – 13

Of the 16 recommended actions tabled above, it is proposed that the first 13 can be managed and actioned as part of business-as-usual activities.

Recommended Actions 14-16

The following three recommended actions related to Hospital Transition of Care require further detailed discovery work:

- **Clinical Responsibility:** While this currently travels with the patient, it has been proposed that work be undertaken to explore responsibility for medicine treatment, with consideration given to this staying with the hospital teams until accepted by community teams/GPs, or at an agreed period, e.g., one week.
- **Clinical Delegation:** It is proposed that further work be undertaken to define the clinical delegation of responsibility on discharge from hospital to ARC, noting this can depend on the patient, facility or GP.
- **Transfer of Responsibilities:** It is proposed that further work define the treatment plan, dispensing of medicines, and recording of the administration.

It is recommended that the Transition of Care discovery work be incorporated into the Health NZ medication programme of work, as it requires regional engagement and collaboration across all care providers involved in the ARC patient's journey.

Furthermore, it should include the creation of a standardised medication discharge policy, including the supply of medications, medication charting responsibilities, and medication approval responsibilities for the following situations.

- Patients discharged from hospital back to the care facility
- New patients referred and transferred from hospital to care facility for respite care
- New patients referred and transferred from hospital to care facility for long term care
- New patients referred and transferred from home to care for respite
- New patients referred and transferred from home to care for long term care
- New patients referred and transferred from outside Te Waipounamu

Costs

It is recommended that a Project Manager, Business Analyst and Change Manager be engaged to coordinate and support the delivery of the Hospital Transition of Care discovery work. Initial estimates of time frames, costs, and resource requirements are provided in Table 3.

Note:

- The estimated costs are for the System Analyst, Project Manager and Change Manager only. They do not include costs associated with clinical and governance time and system workflow changes if required. The discovery work would include the identification of the project deliverables and any additional resources required.
- Staff costs are based on data and digital hourly rates

Work Required	Resources Reqd.	Est. Time	Estimated costs
Transition of Care: Project One Detailed discovery of clinical & system requirements (regional), confirmation of draft workflows (local), project deliverables, estimated timeframes and detailed project and deployment plan and business case	• Senior Business Systems Analyst • Senior Project Manager • Stakeholder Group (regional) for three months	3 months	• Senior Business Systems Analyst ($99/hour) based on six hours per day for 12 weeks = $35,640 • Senior Project Manager ($151/hour) based on six hours per day for 12 weeks = $54,360 **Total estimated cost for Project One = $90,000**
Transition of Care: Project Two Implement the Transition of Care, change management plan, governance, detailed discovery of clinical & system requirements (regional), workflow mapping (local), project deliverables, estimated timeframes and a detailed project plan	• Senior Project • Stakeholder Group (regional) • Change Manager	9 months	Senior Project Manager based on six hours per day for 39 weeks (nine months) = $176,670 Change Manager ($151 / hour) based on six hours per day for eight weeks over the duration of the project = $36,240 **Total estimated cost for Project Two = $212,910**

Table 3: estimated costs for Project and Change manager and Business Analyst for Transition of Care work

See Appendix Two for detail on a proposed approach for undertaking the Transition of Care recommended actions.

5. Benefits

This work has highlighted the complexities and risks involved in the discharge process and prescribing of patients' medications when transferring between hospital and ARC facilities. It has also identified opportunities to make improvements to the management of medications through these transitions. The following benefits could be achieved through the continuation and delivery of the recommended actions.

- A medication environment that is coordinated with a whole system approach that enhances patient safety, reduces medication risks, reduces hospital readmissions, and supports patient continuity of care.
- Health NZ has evidence-based insights into the systemic risks and complexities within the current medication management environment across hospitals, ARC, primary care, and community pharmacies. These risks are caused by manual transcriptions and reconciliation of discharge medications, which contribute to medication errors, miscommunication, and patient harm, ultimately impacting the quality of care and patient outcomes.
- Evidence shows the underlying issues relate to the current medication landscape not being interoperable.
- The future systems landscape for internal hospital prescribing and dispensing has been identified and supports connectivity to the National Medications Repository.
- Existing medication software forms the backbone of an interoperable environment.
- Improved discharge and prescribing processes are likely to reduce ARC patient bed days in hospital.
- Improved communication between secondary, primary, ARC and community pharmacy clinical resources.
- Improved access to ARC patient information following discharge through wider use of HealthOne.
- Improved continuity of care for ARC patients.
- Improved transition of care between secondary, primary and ARC facilities.

- A reduction in the medication applications currently in use within Te Waipounamu through regional instances of MedChart and ePharmacy.
- Digitising paper documentation enabling clinical information to be available at the point of care.

6. Risks

Medication issues have been long-standing, problematic and a cause of frustration for clinicians as well as risking patient harm. The work undertaken to date provides the starting point for Health NZ to progress a medication programme of work. The risks of not progressing this in a timely manner are summarised in Table 4 below.

Risk	Impact	Mitigation / Reduction or Elimination
1. Lack of clinician and stakeholder interest and engagement in current and future projects due to delaying the work	• Loss of momentum • Loss of access to clinical subject matter experts to support the medication programme across the health system.	Mitigation: • Assign ownership of the recommendations to Health NZ Te Waipounamu Ageing Well lead. • Commence the discovery phase in a timely manner. Identify the SMEs to be engaged in the Health NZ Te Waipounamu medication programme.
2. Loss of progress arising from Health NZ prioritisation of funds to resource the medication programme nationally and for Te Waipounamu	Future work is not progressed and opportunities for improvement in medication management are not realised	Mitigation: Commence detailed discovery projects to identify the programme requirements, deliverables and potential delivery dates. This phase should identify a high-level programme cost.
3. Lack of vendor engagement and commitment to implementing required system changes covering primary and secondary care.	Reduced time of response by vendors to undertake any required changes	Mitigation: Engage and communicate with all appropriate vendors to raise awareness of the programme and provide estimated timeframes, vendor product development may be required.
4. Limited clinical engagement and leadership from across the health system due to wider capacity pressures.	Insufficient clinical leadership in the project impacting the quality and acceptability of the changes identified.	Mitigation: • Commence delivery of recommended actions and identify stakeholders and clinicians required to support the regional implementation. • Consider options to enable clinician involvement, e.g., payment of time for primary care clinicians

Table 4: Risks of delay in progressing the medications programme or work.

7. Next steps

The scope of this project extended to initiate work on the 16 recommended actions. An update on progress in December 2025 is provided in Appendix Three.

Of note are:

- The tabling of the executive summary of the report with Health NZ – Te Waipounamu Leaders to raise the impact that the medication issues have on patient safety and health outcomes, and to consider

ownership to continue the work to improve management of medicines on transfer from hospital and progress the recommendations.

- Undertaking discussions about the owners responsible for the delivery of the 16 recommended actions.

Suggested next steps are as follows:

- Confirm the owners of the 16 recommendations
- Health NZ to complete a medication management programme business case, benefits, resourcing, high-level planning.
- Progress the Transition of Care projects.
- Review ARC's access and use of HealthOne access.
- Meet with the Gerontology Team, Ageing Well Managers and HealthOne to review HealthOne access and use by ARCs.
- Formalise the work required within Health NZ Data & Digital.
- Include outpatient prescribing proposed for Southern Hospital build within the future Health NZ medication management programme and medication environment for Te Waipounamu.
- Operational management (MedChart and ePharmacy)
  - Clinical Governance
  - Operational Governance
  - Upgrade management
  - Product ownership, clinical and application

8. Recommendations

It is **strongly recommended** that Health NZ place a high priority on continuing work to improve the management of medications during the transition of patients between hospital and ARC facilities, given its contribution to ensuring patient safety, regulatory compliance, and long-term cost efficiencies**.** Discontinuing or delaying progress could result in gaps in medication management, which increase the risk of adverse events and compromise the quality of care. Reasons to support this decision include:

- Improvements to the management of medications directly support Health NZ goals around clinical excellence and align with national standards for medication safety.
- Investment in this initial project has created a solid foundation for achieving an inter-operable environment. Halting now would result in sunk costs, which do not deliver the intended benefits.
- Maintaining momentum safeguards patient outcomes, strengthens the transition of care between hospital and ARC facilities, while building on the clinical collaboration that has already been achieved.

It is recommended that while this work is owned and progressed as a programme of work within Health NZ, it is undertaken as a collaboration between secondary, primary care, community pharmacy, ARC facilities, and consumers. IT vendors should also be engaged as part of the stakeholder group, where required.

To achieve this, it is recommended that:

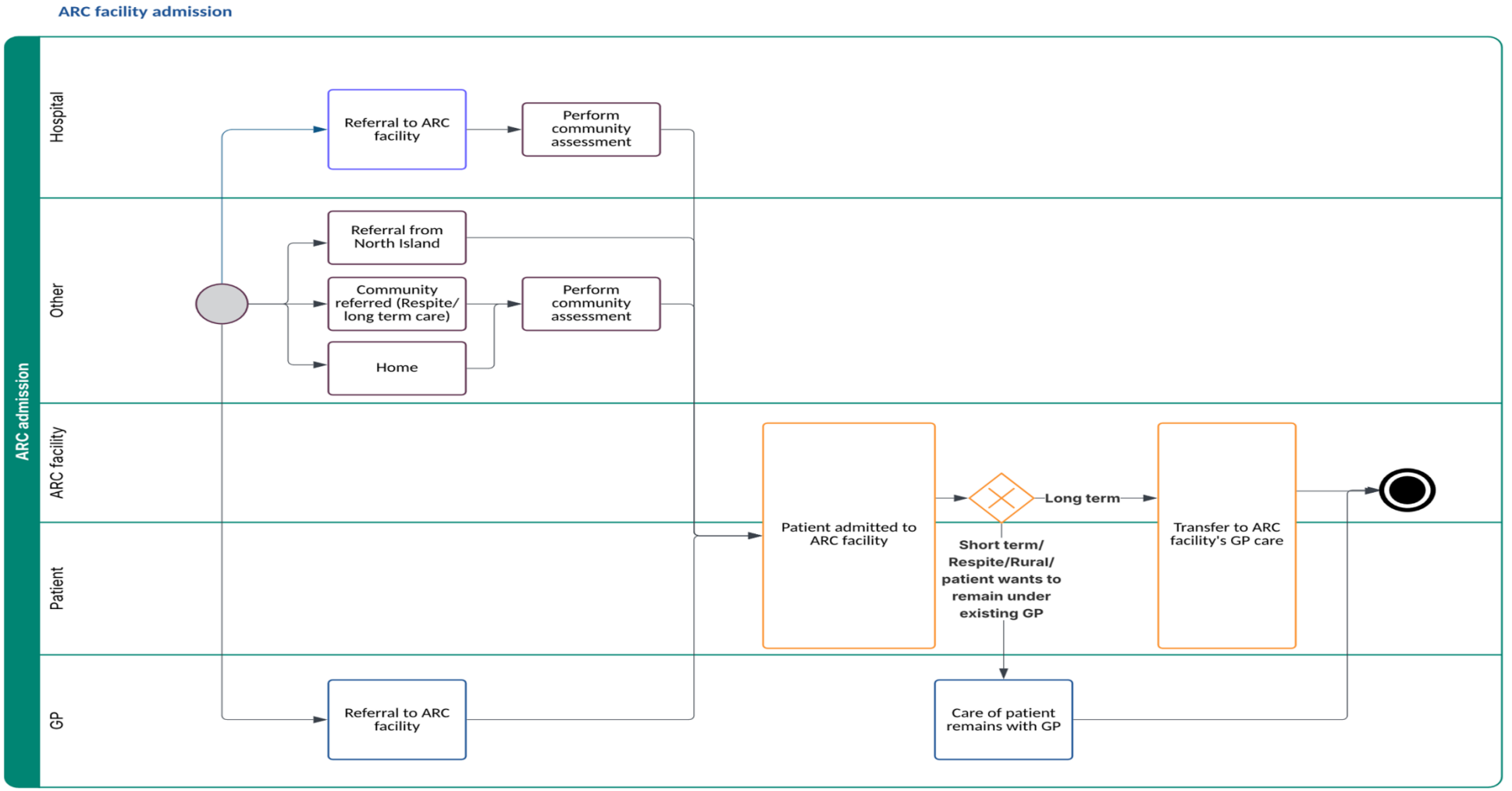
1. Health NZ Te Waipounamu leadership advocate regionally and nationally for a shared medication record to support improvements in patient care, safety and outcomes enabled by interoperability between systems.

2. Health NZ Te Waipounamu leadership expedite the planned medication programme of work to facilitate greater integration of medicines data across systems within the region, for example with MedChart V12 including integrations with NZePS and the national medication data repository and the Transition of Care between hospitals and ARC facilities.

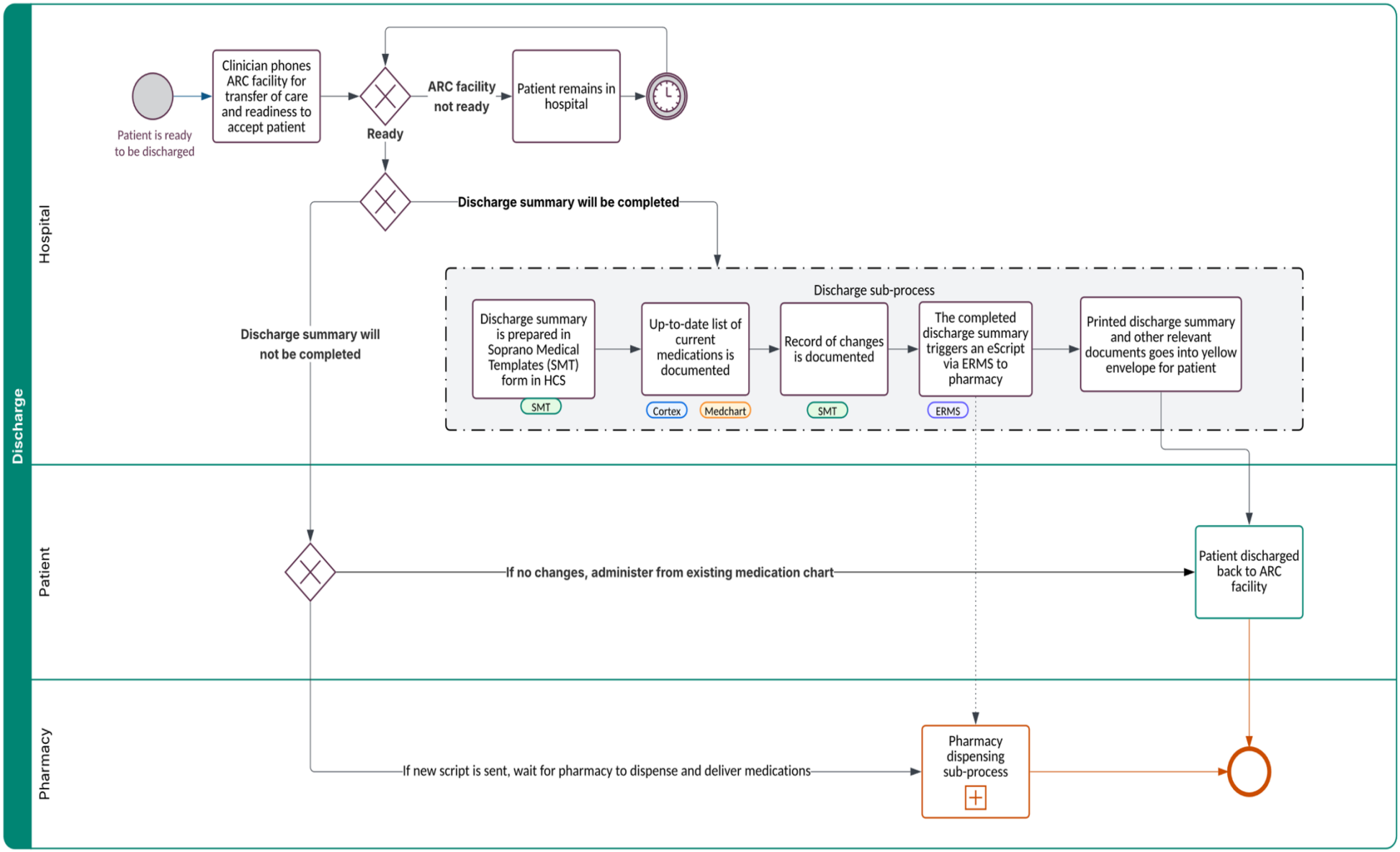
3. Health NZ Te Waipounamu should resource the completion of regional **Transfer of Care** projects to identify the deliverables and activities required to address the challenges experienced.
4. Continue work on recommended actions that can be progressed locally.

APPENDICES

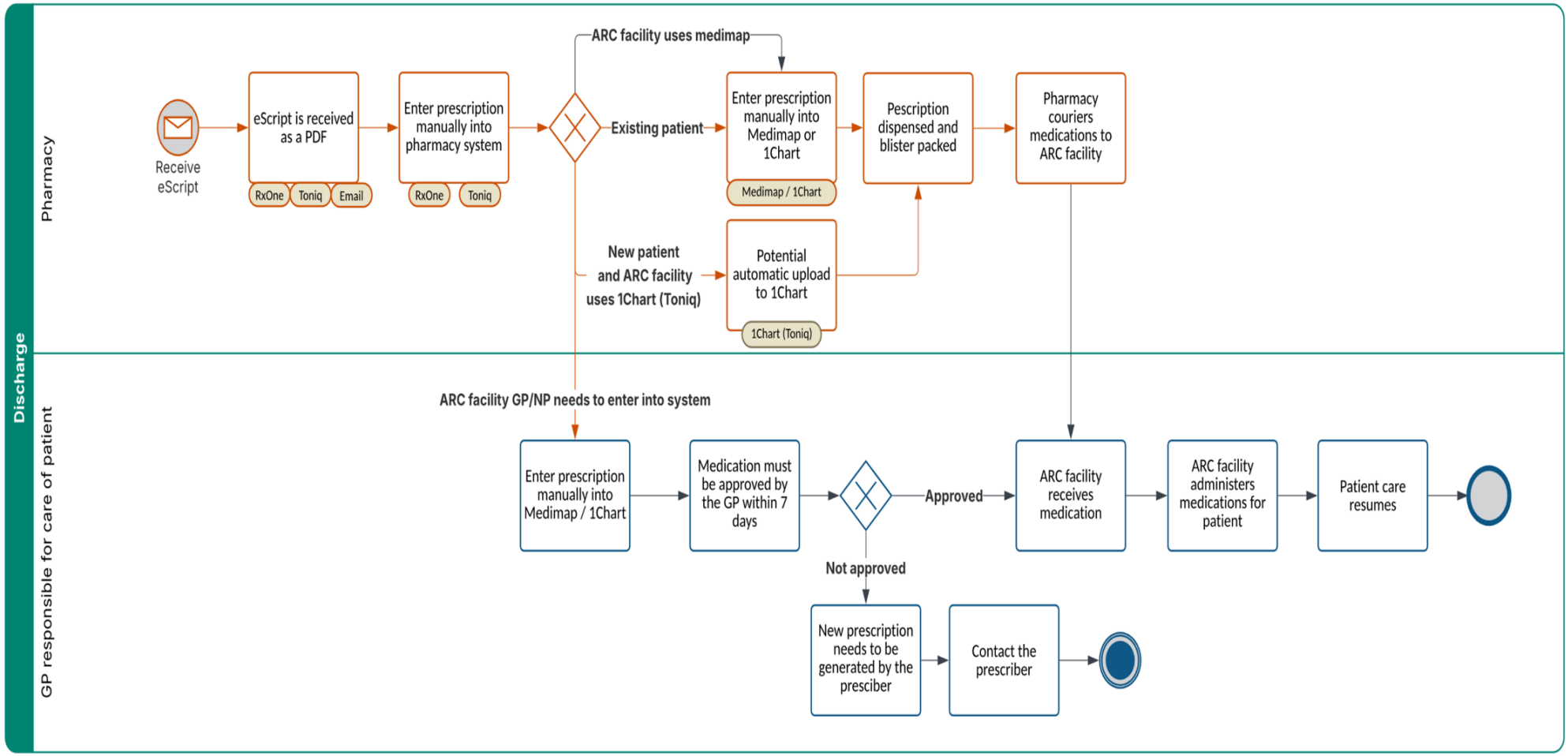
Appendix One: Draft Workflows for patient transfer based on information available: ARC admission, Hospital admission from an ARC, Hospital discharge to ARC, Pharmacy dispensing, Outpatient appointments, Medication issues. Further work is required to review and finalise these draft workflows.



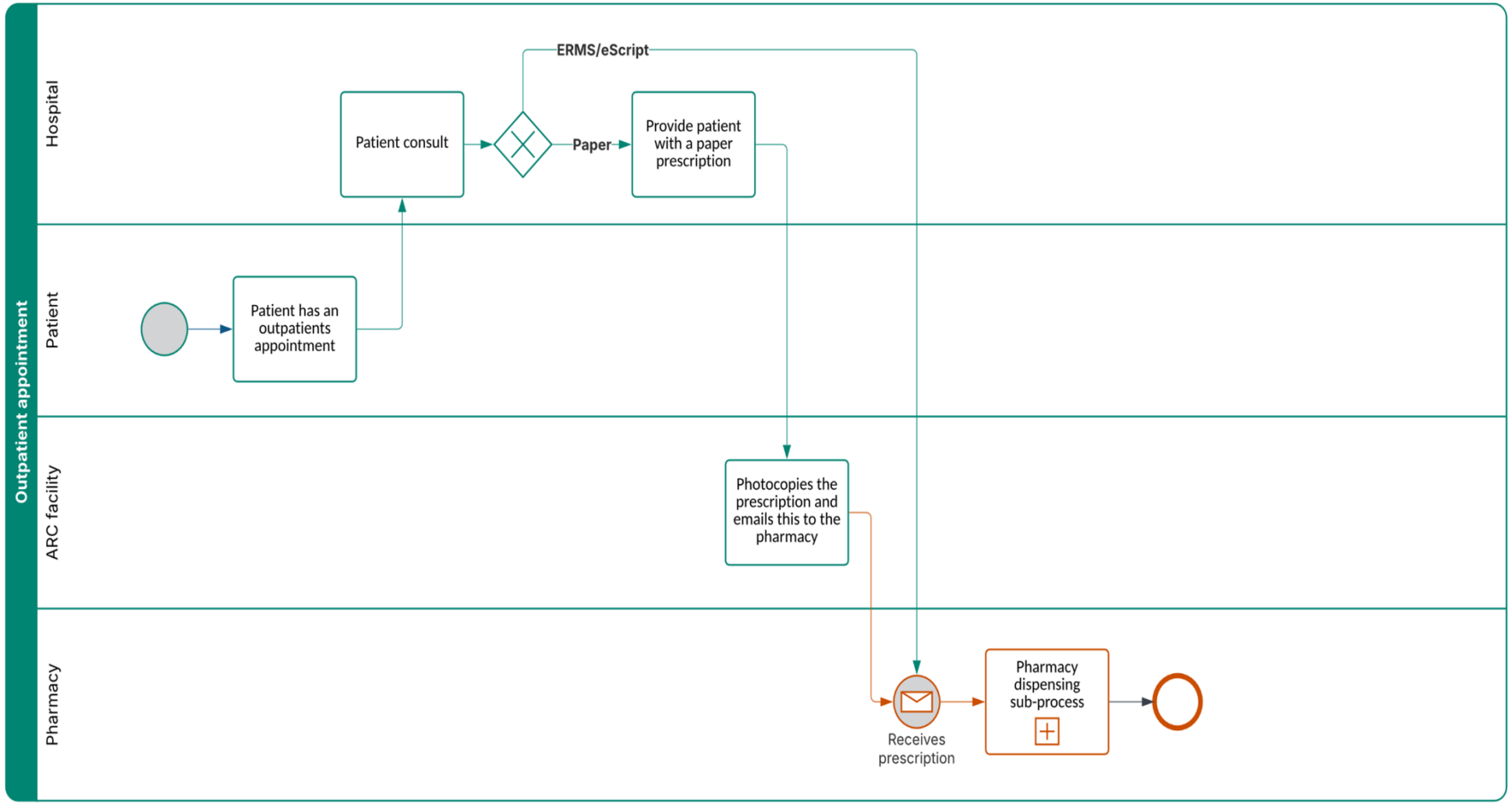
Discharge from hospital



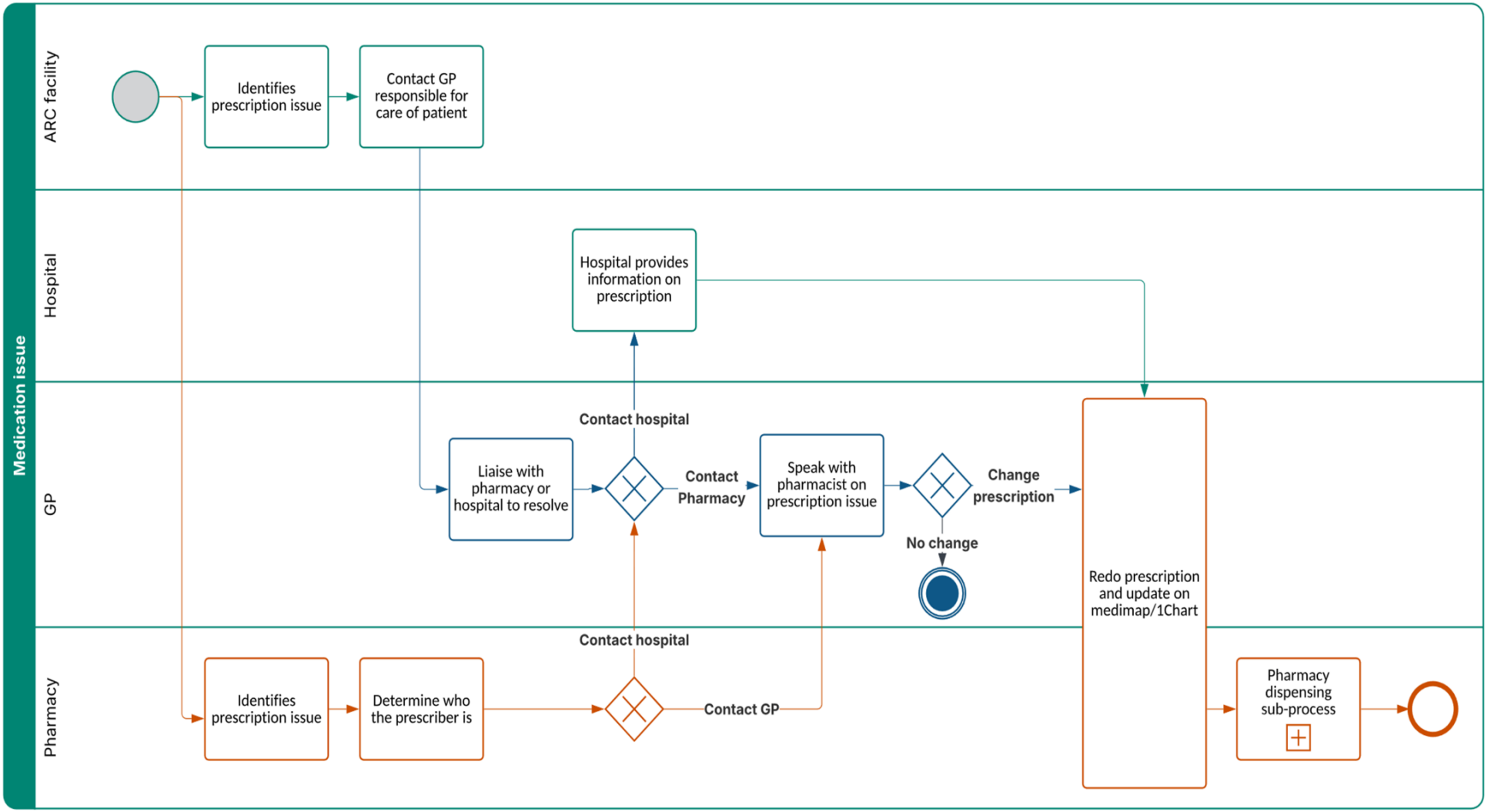
Pharmacy dispensing workflow



Outpatients appointment



Medication issues



Appendix Two: Proposed Approach to Transition of Care

- Allocate a Business Analyst resource to document the clinical and system requirements for the transfer of care recommendations 14-16.
- Work with the PCTF consumer representative and Ageing Well team for Te Waipounamu to raise awareness of the mahi undertaken to date.
    - Understand the issues experienced by families and whānau managing someone in the care of an ARC facility. Incorporate outcomes into the future programme planning as appropriate.
- Meet with Gerontology Team, Ageing Well Managers and HealthOne to review HealthOne access and use by ARCs.
- Formalise the required mahi within Health New Zealand Data & Digital.
- Position the programme as **clinical change** rather than technology, with technology as the enabler.
- Include a representative from secondary care general medicine in the stakeholder group.
- **HNZ to establish and expedite the programme of work for Te Waipounamu**. This programme will include several sub-projects covering the following programme deliverables. The core programme structure should be considered as national with regional delivery teams and SMEs supporting the projects. This model can then be replicated in other regions. Detailed discovery should be commenced to support the programme initiation.
    - Allocation of the Senior Responsible Officer (SRO), allocation of programme lead, establishment of governance, identification of stakeholders, reporting requirements and escalation process.
    - Discovery phase - This work could be the initial continuation of the mahi undertaken to date and will provide a high-level foundation and detail for the overall programme requirements, deliverables and funding.
    - Medication management programme business case, benefits, resourcing, high-level planning.
    - Contractual and maintenance and support vendor review and modifications.
    - Programme change management.
    - Hosting architecture design for MedChart and ePharmacy (infrastructure, hardware, security, user access).
    - Infrastructure build and commissioning.
    - Business and system configuration, workflow, formulary and regimen alignment.
    - Workflow optimisation and alignment.
    - Data migration for MedChart and ePharmacy
    - NZePS Integration with MedChart and ePharmacy
    - Operational support framework, resourcing, service level agreements, upgrade cycles.
    - Implementation (programme kick-off, detailed planning, transition planning, user acceptance testing, go live)
    - Communication.

Appendix Three: Progress Update December 2025

No	Recommendation	Owner	Change	Status	Target	Updates
1	**Clinical leads engage with HNZ** - Executive Regional Director and Regional Director Data & Digital to raise risks and patient impact that the current medication environment creates.	Clinical Leads	Local regional	**Closed**	Dec-25	• Meeting held 19/12/25with Health New Zealand and PHO CE's.
2	**Support the future state medication landscape**	PCTF Chair	Local Regional	**Closed**	Dec-25	• PCTF supported the medication recommendations.
3	**Promote greater use of HealthOne within the ARC facilities,** to support access to discharge summaries, discharge medications, discharge planning and monitoring of residents who have been transferred into hospital care	Health NZ Ageing Well	Local Regional	Open	Feb-26	• Aging Well to own this activity and action under BAU. • Ambulance summary availability within HealthOne to be investigated.
4	**Review HealthOne access requirements** relating to new and respite patients being transferred to an ARC facility and timing of ARC facilities being able to view this data.	HealthOne	Local	Open	Apr-26	• Issue has been raised and passed to HealthOne team to progress.
5	**Resource ARC nurse with practice level access to HealthOne**.	HealthOne	Local Regional	**Closed**	Jan-26	• HealthOne has confirmed that all ARC nursing staff have clinical level access.
6	**Review additional HealthOne authentication options** for improved access to support patient care within ARC facilities	PHO CTO	Local	**Closed**	Dec-25	• The approved and secure access for ARC facilities is via Citrix connectivity. The connectivity process requires 2 factor authentication, 1) the Citrix log in, and 2) through MS Authenticator or Google Authenticator.
7	**Investigate what clinical information in HCS / HealthOne would be useful for ARCs.** *This has been identified as end user education regarding where to find the required clinical information.*	Ageing Well	Local	Open	Feb-26	• Aging Well will progress end user education as to where to find the clinical information within the CDV tree, simple user guide to be created.
8	As part of the hospital discharge summary review, **ensure that the Clinical Care Team name and contact number are included in all discharge summaries**	National eMeds Lead for Forms	Local Regional	Open	Mar-26	• HNZ D&D are looking at Care Pathways replacing SMT. Medication reconciliation to be configured and implemented to support the new discharge summary.
9	**Review the discharge transfer of care process with ARC facility leads to improve the transfer of care handover process for patients leaving hospital.** Extend this to include new incoming or respite patients from within Te Waipounamu and northern regions, I.e., what does the facility need to know about the patient and what level of care the patient has received or requires.	Ageing Well	Local Regional	Open	May-26	• Ageing Well are reviewing the discharge transfer of care process.
10	**Make the information within the yellow envelope available in digital form in HCS.**	National Ageing Well	Local Regional National	**Closed**	Jun-26	• The alignment and digitising of the information within the Yellow Envelope is a deliverable within the National Older Persons Health workplan. Health New Zealand is leading this work. This is a national activity, recommendation closed.
11	**Create a standardised medication discharge policy,** including supply of medications, medication charting responsibilities, medication approval responsibilities for the following situations. • Patients discharged from hospital back to the care facility.	Health New Zealand	Local Regional	**Closed**	Jun-26	• Issue has been reviewed by clinical leads. This will now be a deliverable within the Transition of Care recommendations (14-16). This item is closed, and revised activities incorporated into recommendations 14-16.

	• New patients referred and transferred from hospital to ARC for respite care. • New patients referred and transferred from hospital to facility long term care. • New patients referred and transferred from home to care for respite. • New patients referred and transferred from home to care for long term care. New patients referred and transferred from outside Te Waipounamu.					
12	**Review practice policies for onboarding locums and system access, MediMap, 1-Chart, HealthOne**	PHO	Local	Open	Dec-25	• Project update has been provided and documentation shared with PHO practice relationship manager to progress.
13	**Provide a single digital contact list for ARCs and community pharmacies** – this work is in progress with the HNZ Gerontology nursing team	Health New Zealand Gerontology Team	Local Regional	**Closed**	Jan-26	• Contact spreadsheet has been created, the Information has been shared between ARC, Christchurch and Burwood hospitals. An internal Teams group has been set up to share the information. ARCs have received the contact list. The teams group includes the transitional care team at Christchurch hospital and the Charge Nurses at Burwood. The list will be reviewed every 6 months.

14	**Hospital Transition of Care** - **Clinical Responsibility** Clinical responsibility currently travels with the patient, but it is proposed that on discharge the responsibility for medical treatment stays with the hospital teams until accepted by community teams/GP (or one week)	Health NZ	Local	Not yet started	Dec-26	• Recommendation 14-16 are all deliverables under the Transition of Care Project • Clinical requirements need to be captured and documented • Stakeholder working group required - Secondary care, PHO clinical leads, ARC clinical leads and pharmacy • **Clinical requirements to be captured and documented.**
15	**Hospital Transition of Care – Clinical Delegation of Responsibility** Define the delegation of responsibility on transfer from hospital to ARC. This may be patient, facility, GP dependent. Capture and document the hospital clinical change requirements.	Health NZ /PHOs	Local	Not yet started	Dec-26	• Recommendation 14-16 are all deliverables under the Transition of Care Project. • Clinical requirements need to be captured and documented • Stakeholder working group required - Secondary care, PHO clinical leads, ARC clinical leads and Pharmacy • **Clinical requirements to be captured and documented.**
16	**Hospital Transition of Care – Transfer of Responsibility** Consider the transfer of responsibility for the treatment plan, dispensing of medicines, and recording of administration. Create a standardised transfer of care policy for the safe use of medicines, including the supply of medicines and medication charting responsibilities, for the following types of transfer. • Patients discharged from hospital back to the care facility. • New patients referred & transferred from hospital to care facility for respite. • New patients referred and transferred from hospital to care facility for long term care. • New patients referred and transferred from home to care facility for respite. • New patients referred and transferred from home to care facility for long term care. • New patients referred and transferred from outside Te Waipounamu to care facility for long term care.	Health NZ/PHOs	Local	Not yet started	Dec-26	• Recommendation 14-16 are all deliverables under the Transition of Care Project. • Clinical requirements need to be captured and documented • Stakeholder working group required - Secondary care, PHO clinical leads, ARC clinical leads and pharmacy • Recommendation 11 has been reviewed by Matt Doogue and Ben Hudson, the activity will be a deliverable under the Transition of Care recommendations (14-16). Matt has reviewed the deliverable and updated the wording to reflect that it is a Transfer of Care process and not discharge. ▪ **Clinical requirements to be captured and documented.**

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