Government of Western Australia
Department of Health

Medication Safety

Western Australian Medication History and Management Plan (WA MMP)

Patient Safety and Clinical Quality Directorate

The starting point

- Medicine errors result in approximately 140,000 hospital admissions per year (2-3% of all admissions).
- Over half of all hospital medication errors occur at the interfaces of care (admission, transfer and discharge).
- On admission, 1 in 2 patients have one regular medication omitted unintentionally, leading to:
  - Approximately 33% moderate discomfort/clinical deterioration
  - Approximately 6% severe discomfort/clinical deterioration
- The process of medication reconciliation can reduce the risk of these medication errors occurring.

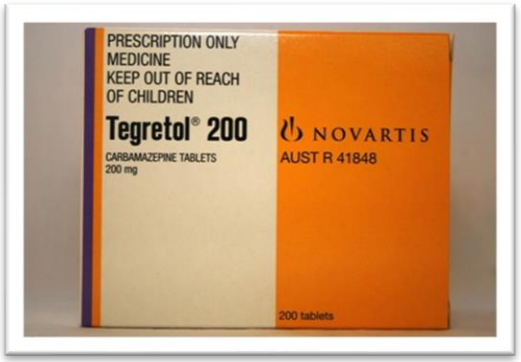
What can go wrong?
(Example 1)

- On admission, a patient was charted for carvedilol (Dilatrend®) 25mg twice daily (hypertensive and heart failure agent).
- The patient was only taking carvedilol 6.25mg twice daily at home.
- Result: The patient received four doses of the higher strength, and developed leg oedema.
- A leg ultrasound test was ordered to rule out deep vein thrombosis before the error was discovered.

What can go wrong?
(Example 2)

- An elderly patient was transferred from another hospital on the public holiday Good Friday after having sustained wounds after a seizure.
- On admission, the patient was prescribed carbamazepine 1250mg bd as per patient.
- The patient received two doses before she became confused and vomited coffee ground vomit and was transferred to Intensive Care Unit.
- The carbamazepine level was 31mg/L

  (normal range : 6-12mg/L).
- The GP was contacted – the patient was actually taking levetiracetam (Keppra®) 1250mg bd.



The High Risk Patient

- Majority of patients aged between 75-85 years (tertiary hospital admissions)

- Factors that make a patient high risk are:
  - > 65 years of age
  - > 5 regular medications
  - > 2 co-morbidities
  - Use of high risk medications
  - Difficulty managing medications (includes vision and cognitive impairment, literacy and language difficulties)

The more medications a patient is taking .....
The higher the risk of adverse drug events

High Risk Medications

High risk medications are defined as “medicines which have a heightened risk of causing significant or catastrophic harm when used in error”.

A list of high risk medications should be determined by each site.

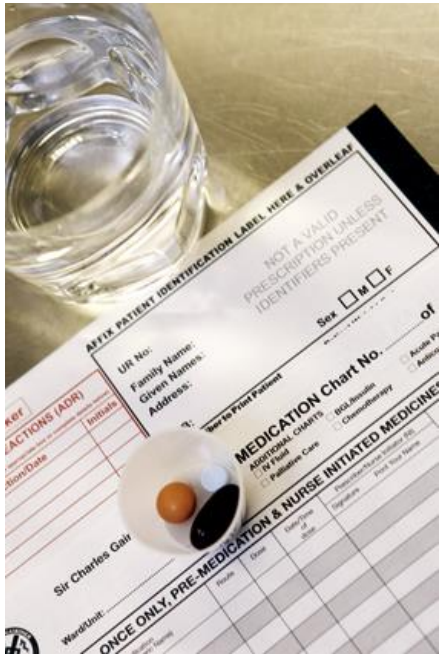
This list may include:

- APINCH medications

  (Anti-infectives, potassium/electrolytes, insulins, narcotic [opioid] analgesics and neuromuscular agents, chemotherapeutic agents, heparin/anticoagulants)
- Medicines with a low therapeutic index
- Medicines that represent a high risk when administered via the wrong formulation or route (e.g. slow release and immediate release oxycodone, phenytoin liquid and capsules)

Medication Reconciliation

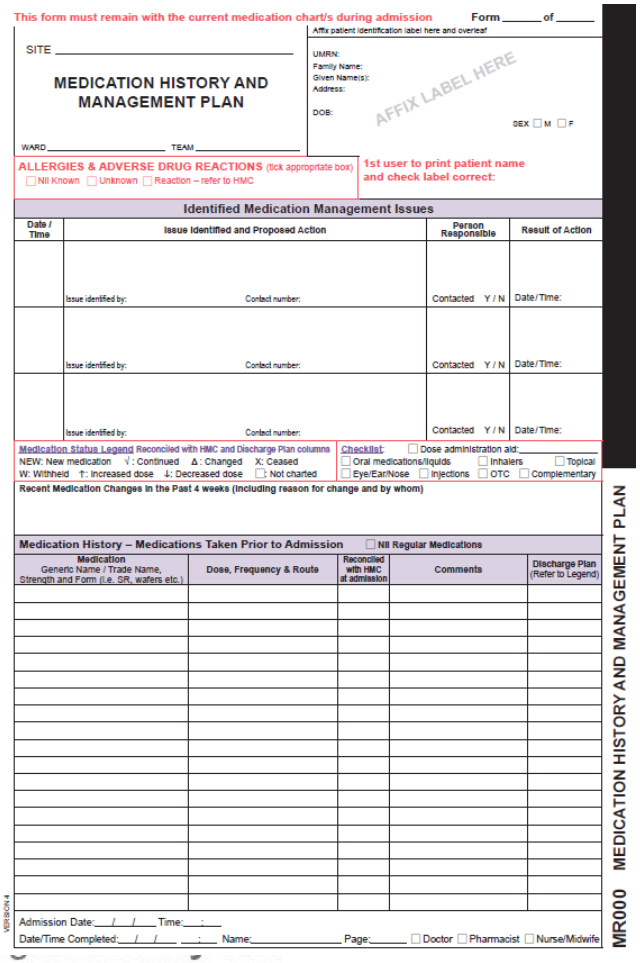
- Medication reconciliation has been shown to reduce errors and adverse events associated with poor quality information at transfer of care and inaccurate documentation of medication histories on patient admission to hospital.
- Points of transition identified as requiring special attention are:
  - admission to hospital
  - transfer from Emergency Department to other care areas (ward, ICU or home)
  - transfer from ICU to ward
  - transfer between wards
  - from the hospital to home, residential aged care facilities or another hospital



- Medication histories and medication risk assessment should be documented and made available to all clinicians at the point of care to ensure medication management is adequately communicated.

WA Medication History and Management Plan (WA MMP)

Front page



This form must remain with the current medication chart/s during admission Form _____ of _____

Affix patient identification label here and overleaf

SITE _____

MEDICATION HISTORY AND MANAGEMENT PLAN

UMRN:
Family Name:
Given Name(s):
Address:
DOB:
AFFIX LABEL HERE
SEX ☐ M ☐ F

WARD _____ TEAM _____

ALLERGIES & ADVERSE DRUG REACTIONS (tick appropriate box)
☐ Nil Known ☐ Unknown ☐ Reaction – refer to HMC

1st user to print patient name and check label correct:

Identified Medication Management Issues

Date / Time	Issue Identified and Proposed Action	Person Responsible	Result of Action
	Issue identified by: Contact number:	Contacted Y / N	Date/Time:
	Issue identified by: Contact number:	Contacted Y / N	Date/Time:
	Issue identified by: Contact number:	Contacted Y / N	Date/Time:

Medication Status Legend Reconciled with HMC and Discharge Plan columns
NEW: New medication √: Continued Δ: Changed X: Ceased
W: Withheld ↑: Increased dose ↓: Decreased dose ☐: Not charted

Checklist: ☐ Dose administration aid:_____
☐ Oral medications/liquids ☐ Inhalers ☐ Topical
☐ Eye/Ear/Nose ☐ Injections ☐ OTC ☐ Complementary

Recent Medication Changes in the Past 4 weeks (including reason for change and by whom)

Medication History – Medications Taken Prior to Admission ☐ Nil Regular Medications

Medication Generic Name / Trade Name, Strength and Form (i.e. SR, wafers etc.)	Dose, Frequency & Route	Reconciled with HMC at admission	Comments	Discharge Plan (Refer to Legend)

Admission Date:__/__/__ Time:__:__
Date/Time Completed:__/__/__ __:__ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife

MR000 MEDICATION HISTORY AND MANAGEMENT PLAN

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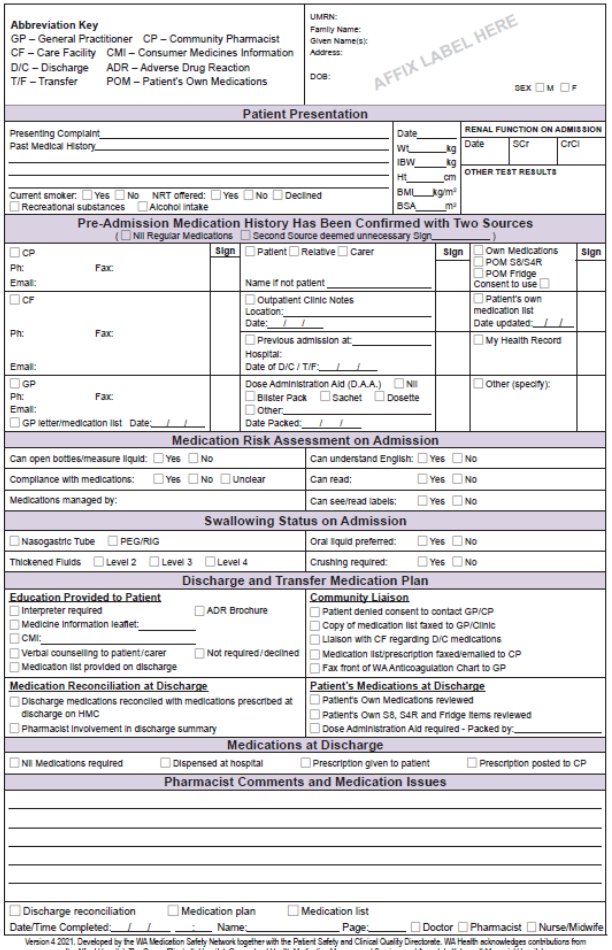
Back page



Abbreviation Key
GP – General Practitioner CP – Community Pharmacist
CF – Care Facility CMI – Consumer Medicines Information
D/C – Discharge ADR – Adverse Drug Reaction
T/F – Transfer POM – Patient's Own Medications

UMRN:
Family Name:
Given Name(s):
Address:
DOB:
AFFIX LABEL HERE
SEX ☐ M ☐ F

Patient Presentation

Presenting Complaint_____
Past Medical History_____

Date_____
Wt_____kg
IBW_____kg
Ht_____cm
BMI_____kg/m²
BSA_____m²

RENAL FUNCTION ON ADMISSION

Date	SCr	CrCl

OTHER TEST RESULTS

Current smoker: ☐ Yes ☐ No NRT offered: ☐ Yes ☐ No ☐ Declined
☐ Recreational substances ☐ Alcohol intake

Pre-Admission Medication History Has Been Confirmed with Two Sources
(☐ Nil Regular Medications ☐ Second Source deemed unnecessary Sign_____)

	Sign		Sign		Sign
☐ CP Ph: Fax: Email:		☐ Patient ☐ Relative ☐ Carer Name if not patient _____		☐ Own Medications ☐ POM S8/S4R ☐ POM Fridge Consent to use ☐	
☐ CF Ph: Fax: Email:		☐ Outpatient Clinic Notes Location: Date:__/__/__ ☐ Previous admission at:_____ Hospital: Date of D/C / T/F:__/__/__		☐ Patient's own medication list Date updated:__/__/__ ☐ My Health Record	
☐ GP Ph: Fax: Email: ☐ GP letter/medication list Date:__/__/__		Dose Administration Aid (D.A.A.) ☐ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other:_____ Date Packed:__/__/__		☐ Other (specify):	

Medication Risk Assessment on Admission

Can open bottles/measure liquid: ☐ Yes ☐ No	Can understand English: ☐ Yes ☐ No
Compliance with medications: ☐ Yes ☐ No ☐ Unclear	Can read: ☐ Yes ☐ No
Medications managed by:	Can see/read labels: ☐ Yes ☐ No

Swallowing Status on Admission

☐ Nasogastric Tube ☐ PEG/RIG	Oral liquid preferred: ☐ Yes ☐ No
Thickened Fluids ☐ Level 2 ☐ Level 3 ☐ Level 4	Crushing required: ☐ Yes ☐ No

Discharge and Transfer Medication Plan

Education Provided to Patient
☐ Interpreter required ☐ ADR Brochure
☐ Medicine information leaflet:_____
☐ CMI:_____
☐ Verbal counselling to patient/carer ☐ Not required/declined
☐ Medication list provided on discharge

Community Liaison
☐ Patient denied consent to contact GP/CP
☐ Copy of medication list faxed to GP/Clinic
☐ Liaison with CF regarding D/C medications
☐ Medication list/prescription faxed/emailed to CP
☐ Fax front of WA Anticoagulation Chart to GP

Medication Reconciliation at Discharge
☐ Discharge medications reconciled with medications prescribed at discharge on HMC
☐ Pharmacist involvement in discharge summary

Patient's Medications at Discharge
☐ Patient's Own Medications reviewed
☐ Patient's Own S8, S4R and Fridge items reviewed
☐ Dose Administration Aid required - Packed by:_____

Medications at Discharge
☐ Nil Medications required ☐ Dispensed at hospital ☐ Prescription given to patient ☐ Prescription posted to CP

Pharmacist Comments and Medication Issues

☐ Discharge reconciliation ☐ Medication plan ☐ Medication list
Date/Time Completed:__/__/__ __:__ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife

Version 4 2021. Developed by the WA Medication Safety Network together with the Patient Safety and Clinical Quality Directorate. WA Health acknowledges contributions from the Alfred Hospital, The Queen Elizabeth Hospital, Queensland Health Medication Management Services and Armadale Kelmscott Memorial Hospital.

Background

- The Western Australian Medication History and Management Plan (WA MMP) was developed by the WA Medication Safety Network to meet WA Health requirements for medication reconciliation.
- The WA MMP is designed to meet the requirements of:
  - The Australian Pharmaceutical Advisory Council's Guiding Principles to achieve continuity in medication management
  - The WA Pharmaceutical Review Policy
  - The National Safety and Quality Health Service Standards (Standard 4 : Medication Safety)
  - The Australian Safety and Quality Goals for Health Care Priority Area 1.1 – Medication Safety

Purpose

- The WA MMP is designed:
  - to record the medicines taken prior to presentation at hospital
  - for reconciling patients' medicines on admission, intra- and inter-hospital transfer, and on discharge.
- To be used by medical, pharmacy and nursing staff to accurately and comprehensively record a best possible medication history (BPMH) on admission, that is available at the point of care.
- It is recommended that it is kept with the current WA Hospital Medication Chart (Adult) or WA Paediatric Hospital Medication Chart (WA PHMC) while the patient is in hospital.

Purpose (continued)

- It can be used as an alternative to the “Medications taken prior to presentation to hospital” section on WA HMC.
- The WA MMP can be used for adult and paediatric patients.
- It is not to be used to record orders for medicines or administration of medicines.
- It is also intended to be used as a record of medication issues and actions taken during the patient’s admission.
  - This information can be referred to during patient’s admission, and used during preparation of discharge summary and prescriptions.

What is medication reconciliation?

The medication reconciliation process has 4 parts:

1. Medication history
   - A formal interview on admission to obtain and document the patient's medication history
2. Confirmation
   - Seeking to confirm with the patient and a second source that information obtained is correct

What is medication reconciliation? (continued)

3. Reconciliation
   - On admission: Checking that medications listed in the medication history match medications ordered by the admitting doctor or that changes are explained
   - On discharge/transfer: Checking that medications on discharge summary and prescriptions match what is written in medication history and WA HMC and explain any changes

Bring any discrepancies identified to the attention of the prescriber.

4. Medication liaison
   - Ensuring that medication information is communicated between all involved in the patient's care – including the patient

Considerations when documenting on WA MMP

- Consider privacy issues when writing on the form (may be kept at end of end where visitors and other persons may have access).
- Facts should be clear, objective, relevant, correct and within context.
- Avoid phrases which imply another practitioner has made an error or missed something significant.

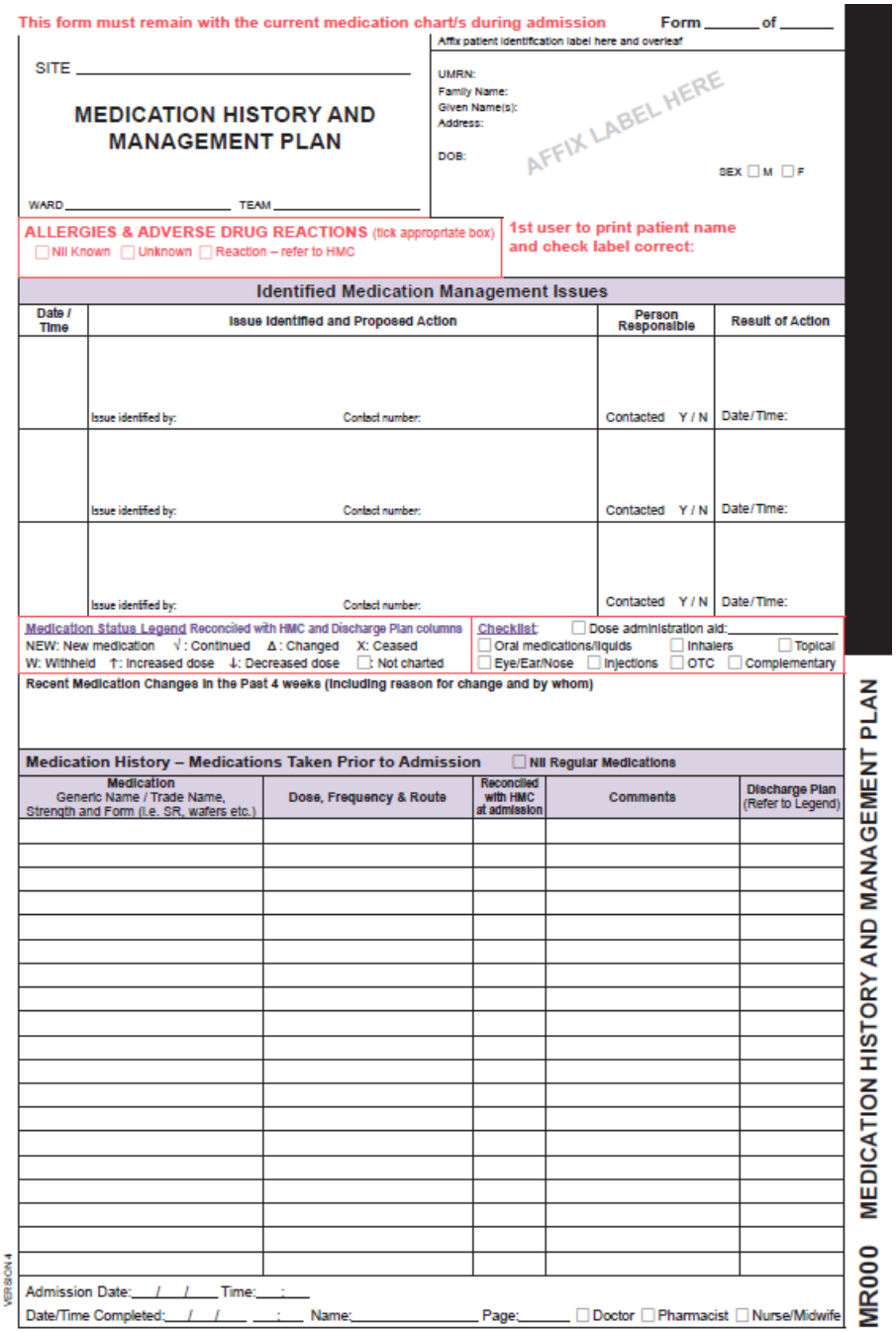
"suggest" or "consider" (preferred)

vs

"do" or "needs"

Considerations when documenting on WA MMP (continued)

- Avoid using unsafe abbreviations. Use only accepted abbreviations. (Refer to Australian Commission on Safety and Quality in Healthcare's Recommendations)
- Write legibly in ink. No matter how accurate or complete the information, it may be misinterpreted if it cannot be read.
- Use ball point pen (black preferred, blue, purple for pharmacists), do not use water soluble ink, erasers, correction tape or fluid.



This form must remain with the current medication chart/s during admission Form _____ of _____

SITE _____

MEDICATION HISTORY AND MANAGEMENT PLAN

WARD _____ TEAM _____

Affix patient identification label here and overleaf

UMRN:
Family Name:
Given Name(s):
Address:

AFFIX LABEL HERE

DOB:

SEX ☐ M ☐ F

ALLERGIES & ADVERSE DRUG REACTIONS (tick appropriate box)
☐ Nil Known ☐ Unknown ☐ Reaction – refer to HMC

1st user to print patient name and check label correct:

Identified Medication Management Issues

Date / Time	Issue Identified and Proposed Action	Person Responsible	Result of Action
	Issue identified by: Contact number:	Contacted Y / N	Date/Time:
	Issue identified by: Contact number:	Contacted Y / N	Date/Time:
	Issue identified by: Contact number:	Contacted Y / N	Date/Time:

Medication Status Legend Reconciled with HMC and Discharge Plan columns
NEW: New medication √: Continued Δ: Changed X: Ceased
W: Withheld ↑: Increased dose ↓: Decreased dose ☐: Not charted

Checklist: ☐ Dose administration aid:_____
☐ Oral medications/liquids ☐ Inhalers ☐ Topical
☐ Eye/Ear/Nose ☐ Injections ☐ OTC ☐ Complementary

Recent Medication Changes in the Past 4 weeks (including reason for change and by whom)

Medication History – Medications Taken Prior to Admission ☐ Nil Regular Medications

Medication Generic Name / Trade Name, Strength and Form (i.e. SR, wafers etc.)	Dose, Frequency & Route	Reconciled with HMC at admission	Comments	Discharge Plan (Refer to Legend)

Admission Date:__/__/__ Time:__:__
Date/Time Completed:__/__/__ __:__ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife

MR000 MEDICATION HISTORY AND MANAGEMENT PLAN

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Delivering a **Healthy WA**

Western Australian Medication History and Management Plan

FRONT PAGE

Identification of patient

Complete the patient identification by EITHER:

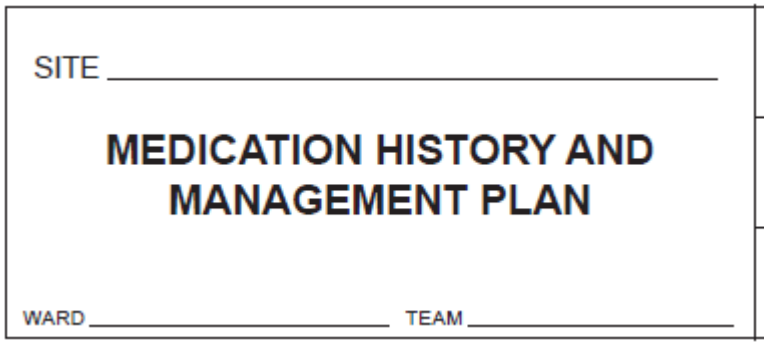
- affixing the current patient identification label

OR

- as a minimum, write the patient name, UR number, date of birth and sex to be written in legible print.

Patient Location

- Clearly indicate the patient's ward location and team on the front page of the WA MMP.
- If the patient is transferred to a different ward or team, update the WA MMP accordingly.


SITE _____

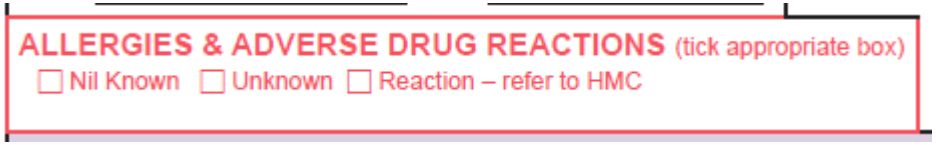
MEDICATION HISTORY AND MANAGEMENT PLAN

WARD _____ TEAM _____

Allergies and Adverse Drug Reactions

- This section is to be cross-referenced to the allergy and adverse drug reaction section on the WA HMC.
- Medical, nursing staff and pharmacists are required to complete "Allergies and Adverse Drug Reactions (ADR)" details for all patients on the WA HMC.

  (Use "allergy" as prompt as patients more familiar with the term)



- "Nil Known": If patient is unaware of previous allergy or ADR
- "Unknown": If allergy and ADR status is unknown
- "Reaction": If allergy or ADR is identified → place ADR sticker in the box, and document medications responsible.
  Document the reaction details and date of reaction on the WA HMC.

Medication Issues and Management Plan

- Any medication management issues and required actions can be documented in the “Identified Medication Management Issues” section of the form.
- This area can be used:
  - to document any issues identified through the process of admission medication reconciliation (e.g. omission, incorrect dose, incorrect drugs, etc.)
  - to document any issues identified through the process of medication review (e.g. dose adjustments required, potential and actual drug interactions, etc.)
  - as a handover document between clinicians
  - on discharge (or transfer) to prompt communication of outstanding issues or actions to the next healthcare provider.

Medication Issues and Management Plan (continued)

- To document a medication issue, complete the following:
  - Date (and time) that the issue was identified
  - A description of the issue
  - Any action that is required
  - Name and contact number of person identifying the issue
  - The person responsible for that action
- Once the action has been completed, document the date of action and a description of the results/outcome of the action. This may be completed at a different time to the identification of the issue.
- Where permitting, direct verbal contact with prescriber is preferred in addition to documenting the detected issue.

Medication Issues and Management Plan (continued)

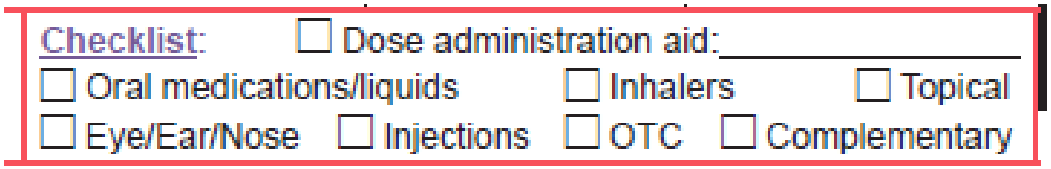
Any URGENT medication issue/s should be brought to the attention of the attending medical officer AS SOON AS POSSIBLE using more direct forms of communication such as telephone or pager.

Medication Issues and Management Plan (continued)

Identified Medication Management Issues			
Date / Time	**Issue Identified and Proposed Action**	**Person Responsible**	**Result of Action**
8/8/22	Patient usually takes telmisartan 40mg mane. Not charted. Please review and chart if appropriate Issue identified by: A.B (pharmacist) Contact number: Pager 650	Dr Smith Contacted (Y) / N	Charted Date/Time: 8/8/22
10/8/22	Patient in acute kidney injury. Consider withholding telmisartan and metformin Issue identified by: A.B (pharmacist) Contact number: Pager 650	Dr Smith Contacted (Y) / N	Withheld, review serum creatinine Date/Time: 10/8/22
14/8/22	Patient's renal function back to baseline. Consider restarting telmisartan and metformin Issue identified by: A.B (pharmacist) Contact number: Pager 650	Dr Smith Contacted (Y) / N	Monitor UECs and consider restarting if stable Date/Time:14/8/22

Medication History Checklist

- The checklist is a tool to assist in determining a patient's complete medication history on presentation to hospital.


Checklist: ☐ Dose administration aid: _____
☐ Oral medications/liquids ☐ Inhalers ☐ Topical
☐ Eye/Ear/Nose ☐ Injections ☐ OTC ☐ Complementary

- It is recommended that the checklist is routinely used as part of the medication history interview with the patient or carer to help structure the interview, and obtain as much information as possible.

Recent Medication Changes in the Past 4 weeks

Recent Medication Changes in the Past 4 weeks (including reason for change and by whom)

- Recently ceased or recent changes to medicines can be recorded in this section of the form along with other relevant information, such as the reason for the change.
- Recent changes to a patient's medicines may highlight the possibility of an adverse drug event which may have been the cause of the patient's admission.

Medication History

Medication History – Medications Taken Prior to Admission ☐ Nil Regular Medications				
Medication Generic Name / Trade Name, Strength and Form (i.e. SR, wafers etc.)	Dose, Frequency & Route	Reconciled with HMC at admission	Comments	Discharge Plan (Refer to Legend)
Admission Date:___/___/___ Time:___:___ Date/Time Completed:___/___/___ ___:___ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife				

- On admission :

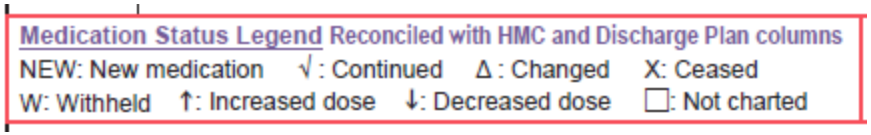
  The admitting medical officer, pharmacist or other credentialed professional trained in taking an accurate medication history should complete this section.

Medication History (continued)

- Record the patient's complete list of medicines normally taken prior to admission (prescription, non-prescription and complementary medicines)
- If a patient is not taking any regular medicines, the "Nil Regular Medications" box can be ticked, and the person confirming this should sign.
- For each medicine, document :
  - medication details (generic/trade name, strength, form, route)
  - dose and frequency

Medication History (continued)

- Each medicine taken prior to admission should be checked against those prescribed on the WA HMC.
  - Use the 'Medication Status Legend' to note the plan for each medicine:



    - If they match (medication, strength, dose and form), place a tick in the "Reconciled with WA HMC" column.
    - Document doctor's plan (if known) in "Reconciled with WA HMC" column – i.e. withhold, cease, change.
    - If the medication is not charted and no reason for withholding has been identified, annotate a box, '☐' in the "reconciled with WA HMC" column to indicate follow up is required

Medication History (continued)

- The “Comments” section may be used to document extra information that might be pertinent.

Medication History – Medications Taken Prior to Admission ☐ Nil Regular Medications				
Medication Generic Name / Trade Name, Strength and Form (i.e. SR, wafers etc.)	**Dose, Frequency & Route**	**Reconciled with HMC at admission**	**Comments**	**Discharge Plan** (Refer to Legend)
Tiotropium 18microg cap	1 cap mane INH	W	Withheld whilst on ipratropium 2.5mg nebs QID	
(Spiriva®)				
Temazepam 10mg tab	1 nocte po	↓	Decreased dose to PRN only	
Aspirin 100mg tab	1 mane po	X	Ceased, no clear indication	
Paracetamol SR 665mg tab	2 TDS po	Δ	Changed to liquid as patient has difficulty swallowing	
Atorvastatin 40mg tab	1 mane po	✓		

Medication History (continued)

- Most hospitals use this section to document medication taken prior to admission (as suggested in the title of the table), however if hospitals choose to include newly-initiated/prescribed medications that are intended to be continued at discharge in this section, the term “NEW” should be clearly documented in either the “Reconciled with WA HMC” or “Discharge Plan” accordingly.
- If doctor’s plan is not known, clarify with attending medical officer.

- Other information :
  - Indicate date and time of admission
  - Document date and time medication history was completed or amended, with initials of person obtaining medication history
  - If multiple forms are required, indicate the number of forms in existence.

Admission Date:__/__/___ Time:__:__

Date/Time Completed:__/__/___ __:__ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse

Medication History (continued)

- On discharge :
  - Medications on discharge/transfer are to be reconciled with the WA HMC, prescriptions and discharge summary.
  - Document the doctor's plan for each medication (refer to legend) in "Discharge Plan" column
    - If Consumer Medicines Information is provided, document "CMI" in "Discharge Plan" column, in addition to actual discharge plan (i.e. continue, increase, decrease, NEW).
  - Further space for documenting medication management at discharge is on the back page of the form.

Abbreviation Key
GP – General Practitioner CP – Community Pharmacist
CF – Care Facility CMI – Consumer Medicines Information
D/C – Discharge ADR – Adverse Drug Reaction
T/F – Transfer POM – Patient's Own Medications

UMRN:
Family Name:
Given Name(s):
Address:
DOB:
AFFIX LABEL HERE
SEX ☐ M ☐ F

Patient Presentation

Presenting Complaint_____
Past Medical History_____

Current smoker: ☐ Yes ☐ No NRT offered: ☐ Yes ☐ No ☐ Declined
☐ Recreational substances ☐ Alcohol intake

Date_____
Wt_____kg
IBW_____kg
Ht_____cm
BMI_____kg/m²
BSA_____m²

RENAL FUNCTION ON ADMISSION

Date	SCr	CrCl

OTHER TEST RESULTS

Pre-Admission Medication History Has Been Confirmed with Two Sources

(☐ Nil Regular Medications ☐ Second Source deemed unnecessary Sign_____)

	Sign		Sign		Sign
☐ CP Ph: Fax: Email:		☐ Patient ☐ Relative ☐ Carer Name if not patient _____		☐ Own Medications ☐ POM S8/S4R ☐ POM Fridge Consent to use ☐	
☐ CF Ph: Fax: Email:		☐ Outpatient Clinic Notes Location:_____ Date:__/__/__ ☐ Previous admission at:_____ Hospital: Date of D/C / T/F:__/__/__		☐ Patient's own medication list Date updated:__/__/__ ☐ My Health Record	
☐ GP Ph: Fax: Email: ☐ GP letter/medication list Date:__/__/__		Dose Administration Aid (D.A.A.) ☐ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other:_____ Date Packed:__/__/__		☐ Other (specify):	

Medication Risk Assessment on Admission

Can open bottles/measure liquid: ☐ Yes ☐ No	Can understand English: ☐ Yes ☐ No
Compliance with medications: ☐ Yes ☐ No ☐ Unclear	Can read: ☐ Yes ☐ No
Medications managed by:	Can see/read labels: ☐ Yes ☐ No

Swallowing Status on Admission

☐ Nasogastric Tube ☐ PEG/RIG	Oral liquid preferred: ☐ Yes ☐ No
Thickened Fluids ☐ Level 2 ☐ Level 3 ☐ Level 4	Crushing required: ☐ Yes ☐ No

Discharge and Transfer Medication Plan

Education Provided to Patient
☐ Interpreter required ☐ ADR Brochure
☐ Medicine information leaflet:_____
☐ CMI:_____
☐ Verbal counselling to patient/carer ☐ Not required/declined
☐ Medication list provided on discharge

Community Liaison
☐ Patient denied consent to contact GP/CP
☐ Copy of medication list faxed to GP/Clinic
☐ Liaison with CF regarding D/C medications
☐ Medication list/prescription faxed/emailed to CP
☐ Fax front of WA Anticoagulation Chart to GP

Medication Reconciliation at Discharge
☐ Discharge medications reconciled with medications prescribed at discharge on HMC
☐ Pharmacist involvement in discharge summary

Patient's Medications at Discharge
☐ Patient's Own Medications reviewed
☐ Patient's Own S8, S4R and Fridge items reviewed
☐ Dose Administration Aid required - Packed by:_____

Medications at Discharge

☐ Nil Medications required ☐ Dispensed at hospital ☐ Prescription given to patient ☐ Prescription posted to CP

Pharmacist Comments and Medication Issues

☐ Discharge reconciliation ☐ Medication plan ☐ Medication list
Date/Time Completed:__/__/____ __:__ Name:_____ Page:_____ ☐ Doctor ☐ Pharmacist ☐ Nurse/Midwife

Version 4 2021. Developed by the WA Medication Safety Network together with the Patient Safety and Clinical Quality Directorate. WA Health acknowledges contributions from the Alfred Hospital, The Queen Elizabeth Hospital, Queensland Health Medication Management Services and Armadale Kelmscott Memorial Hospital.

Western Australian Medication History and Management Plan

BACK PAGE

Patient Identification and Location

- Complete patient ID section as per the front of the form.

Abbreviation Key GP – General Practitioner CP – Community Pharmacist CF – Care Facility CMI – Consumer Medicines Information D/C – Discharge ADR – Adverse Drug Reaction T/F – Transfer POM – Patient's Own Medications	UMRN: Family Name: Given Name(s): Address: DOB: AFFIX LABEL HERE SEX ☐ M ☐ F

Patient Presentation

- This section can be used to document important medical history pertinent to the patient's medication management.
- The patient's weight and height can be documented in this section.
  - Ideal Body Weight (IBW) and Body Surface Area (BSA) may be calculated and noted here (for dose adjustments)
- The patient's renal function on admission can be recorded here to assess whether any dose adjustment is necessary.
- Document whether the patient has a history of smoking

Patient Presentation

Presenting Complaint_____
Past Medical History_____

Current smoker: ☐ Yes ☐ No NRT offered: ☐ Yes ☐ No ☐ Declined
☐ Recreational substances ☐ Alcohol intake

Date_____
Wt_____kg
IBW_____kg
Ht_____cm
BMI____kg/m²
BSA_____m²

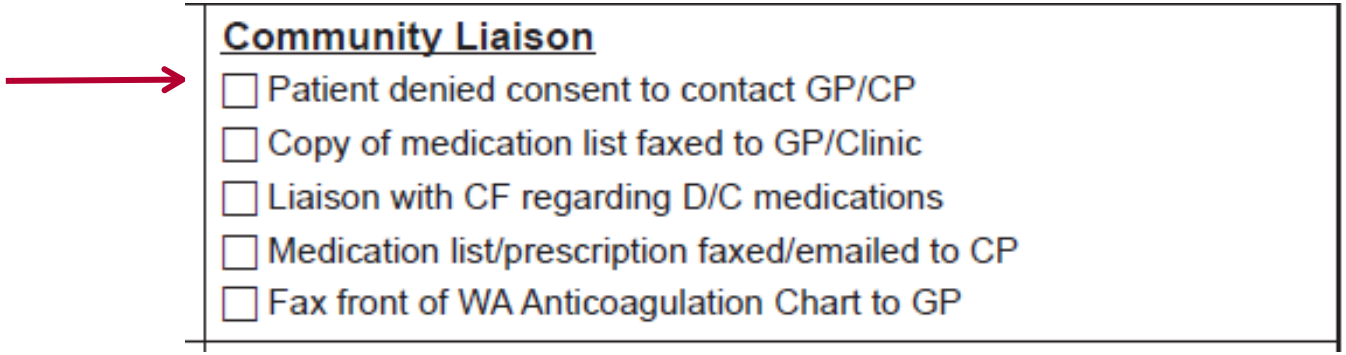
RENAL FUNCTION ON ADMISSION

Date	SCr	CrCl

OTHER TEST RESULTS

Pre-Admission Medication History

- Confirmation of the medicines list with a second information source improves the accuracy and completeness of the list.
- Prior to contacting a patient's community pharmacy or GP, it is important to obtain consent from the patient (or carer/ guardian if the patient is unable to) to contact the primary healthcare provider.
- If consent is not given, document in the Discharge and Transfer Medication Plan section.



Sources of medicines list

- Tick the source(s) used, document who confirmed it, and the date where relevant.
- Document contact details of the patient's GP, community pharmacy or nursing home/hostel for future reference for discharge medication reconciliation.
- If speaking to patient/relative/carer, indicate which person has been interviewed and record their name

Pre-Admission Medication History Has Been Confirmed with Two Sources
(☐ Nil Regular Medications ☐ Second Source deemed unnecessary Sign_____)

	Sign		Sign		Sign
☑ CP SQ Pharmacy Ph: 93456789 Email:	AB	☐ Patient ☑ Relative ☐ Carer Wife = Jane Name if not patient _____	AB	☑ Own Medications ☐ POM S8/S4R ☐ POM Fridge Consent to use ☐	AB
☐ CF Ph: Fax: Email:		☐ Outpatient Clinic Notes Location:_____ Date:__/__/__		☐ Patient's own medication list Date updated:__/__/__	
		☑ Previous admission at: Ward 4 Hospital: Bentley Hospital Date of (D/C) T/F: 13/07/2022	AB	☑ My Health Record	AB
☑ GP Dr A Smith Ph: 9234 5678 Email: ☐ GP letter/medication list Date:__/__/__	AB	Dose Administration Aid (D.A.A.) ☐ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other:_____ Date Packed:__/__/__	AB	☐ Other (specify):	

Sources of medicines list (continued)

- If using previous hospital discharge information, document the specific ward within the relevant hospital, indicate with a circle if the patient was discharged or transferred and include either the admission or discharge date.
  - e.g. If discharged from same hospital:

    Previous admission at: *Bentley*

    Hospital : *Ward X*

    Date of D/C / T/F: *30/08/2021*

- Specify type of Dose Administration Aid (DAA) if used as a source, and date packed (to ensure DAA is current)

Medication Risk Assessment

- The ‘Medication Risk Assessment on Admission’ and ‘Swallowing Status on Admission’ allows documentation of the patient’s:
  - adherence issues
  - level of independence prior to admission and on discharge
  - ability to self-administer medicines (e.g. with or without DAAs)
  - ability to swallow medicines and preference for oral dosage forms.

Medication Risk Assessment(continued)

Medication Risk Assessment on Admission	
Can open bottles/measure liquid: ☐ Yes ☐ No	Can understand English: ☐ Yes ☐ No
Compliance with medications: ☐ Yes ☐ No ☐ Unclear	Can read: ☐ Yes ☐ No
Medications managed by:	Can see/read labels: ☐ Yes ☐ No
Swallowing Status on Admission	
☐ Nasogastric Tube ☐ PEG/RIG	Oral liquid preferred: ☐ Yes ☐ No
Thickened Fluids ☐ Level 2 ☐ Level 3 ☐ Level 4	Crushing required: ☐ Yes ☐ No

- These sections identify issues which may require action by nursing, pharmacy or medical staff regarding supply and supervision of medicine administration on discharge.

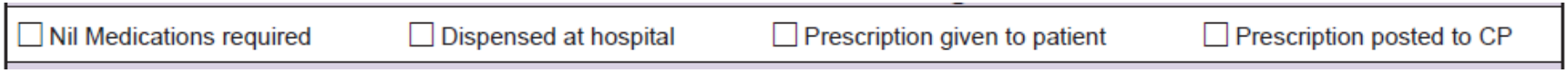
Discharge and Transfer Medication Plan

- A checklist of common tasks which occur on discharge or transfer to a healthcare facility all for each task to be considered, completed if appropriate and documented is listed here.

Discharge and Transfer Medication Plan	
Education Provided to Patient ☐ Interpreter required ☐ ADR Brochure ☐ Medicine information leaflet:_____ ☐ CMI:_____ ☐ Verbal counselling to patient/carer ☐ Not required/declined ☐ Medication list provided on discharge	**Community Liaison** ☐ Patient denied consent to contact GP/CP ☐ Copy of medication list faxed to GP/Clinic ☐ Liaison with CF regarding D/C medications ☐ Medication list/prescription faxed/emailed to CP ☐ Fax front of WA Anticoagulation Chart to GP
Medication Reconciliation at Discharge ☐ Discharge medications reconciled with medications prescribed at discharge on HMC ☐ Pharmacist involvement in discharge summary	**Patient's Medications at Discharge** ☐ Patient's Own Medications reviewed ☐ Patient's Own S8, S4R and Fridge items reviewed ☐ Dose Administration Aid required - Packed by:_____

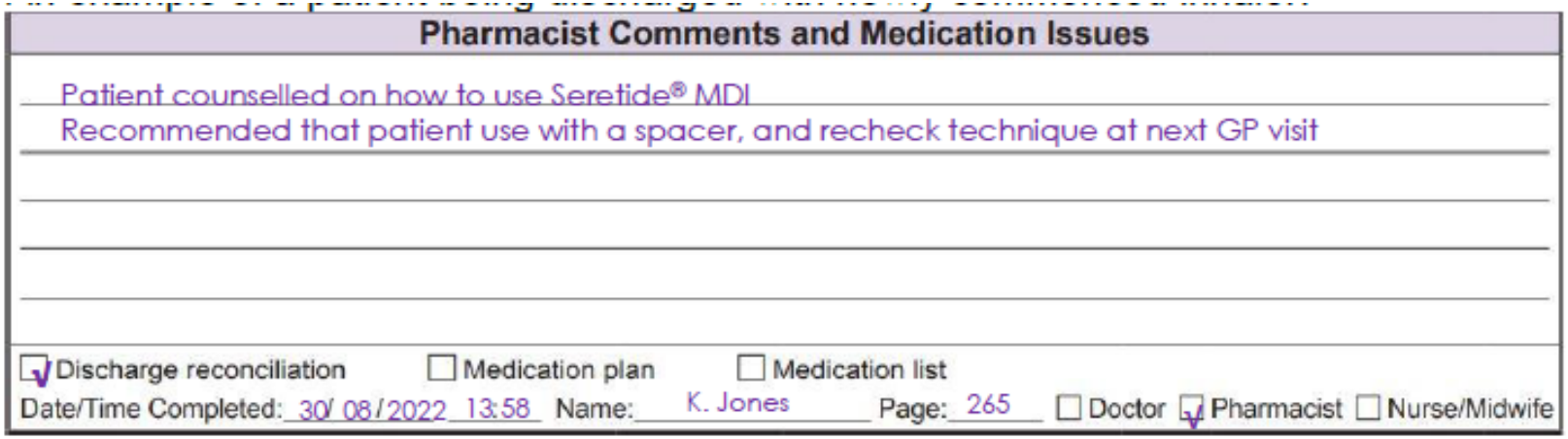
Discharge and Transfer Medication Plan (continued).

- The Medications at Discharge section allows for a record of whether medications were required whether dispensed at the hospital or a reconciled prescription was provided to the patient to be dispensed at a community pharmacy.



- If the discharge prescription is to be faxed to community pharmacist, document this in the pharmacist comments and medication issues section.

Pharmacist Comments and Medication Issues



Pharmacist Comments and Medication Issues

Patient counselled on how to use Seretide® MDI
Recommended that patient use with a spacer, and recheck technique at next GP visit

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Date/Time Completed: 30/ 08 / 2022 13:58 Name: K. Jones Page: 265 ☐ Doctor ☑ Pharmacist ☐ Nurse/Midwife

- This section is available to make further comments regarding the patient's medication management that are not covered by other aspects of the form, finishing with space to document the final discharge activities.

Pharmacists Comments and Medication Issues (continued)

- When the medicines on the WA MMP have been reconciled against the WA HMC, discharge prescriptions and discharge summary, the final discharge reconciliation section of the chart should be ticked and the entry signed and dated.

- Also tick the boxes to indicate if a medication plan or consumer medication list has been provided in addition to medication reconciliation on discharge.

References

- WA Medication Review Policy MP0104/19 Effective from 29 May 2019. Clinical Governance, Safety and Quality Policy Frameworks
- Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards – Medication Safety Standard.[cited 2022 Sept 18].
- Australian Commission on Safety and Quality in Health Care. *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines* (December 2016). [Internet]. [cited 2017 April 10]. Available from : https://www.safetyandquality.gov.au/wp-content/uploads/2017/01/Recommendations-for-terminology-abbreviations-and-symbols-used-in-medicines-December-2016.pdf
- Office of Safety and Quality. *Consumer Adverse Drug Reaction Information.* Clinical Alert Policy webpage [Internet]. [cited 2017 April 11]. Available from :http://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/

Contact Information

- For further information or feedback, contact :

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- The Medicines and Technology Unit kindly acknowledges the time and consultation of the members of the WA Medication Safety Collaborative in the development of the WA MMP, with special thanks to Nam-Anh Nguyen in assisting with the previous version of the PowerPoint presentation.