Western Australian Medication History and Management Plan (WA MMP)

User Guide

February 2022

Version 3

Developed by the
Western Australian Medication Safety Collaborative
in association with the
Medicines and Technology Unit

CONTENTS

1. BACKGROUND

Communication problems between settings of care or between health professionals are a frequent cause of medication errors and adverse drug events. Unintentional changes to patients' medicine regimens often happen during hospital admissions. These unintended changes can cause serious problems during a hospital stay or when patients are discharged.

The process of 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. It is important that this information is documented and made available to all clinicians to ensure medication management is adequately communicated.

The Western Australian Medication History and Management Plan has been developed by the Western Australian Medication Safety Collaborative to meet WA Health requirements for medication reconciliation.

The WA Medication History and Management Plan is designed to meet the requirements of the Australian Commission for Safety and Quality in Health Care, National Safety and Quality Health Service Standards – Medication Safety Standard and the WA Medication Review Policy 0104/19 – Standards 1, 3 and 4.

2. PURPOSE OF THE WA MEDICATION HISTORY AND MANAGEMENT PLAN

The WA Medication History and Management Plan (WA MMP) is a standardised form designed for health services to record the medicines taken prior to presentation at the hospital to use for reconciling patients' medicines on admission, intra- and inter-hospital transfer and on discharge, as this is considered essential for the medication reconciliation process.

The WA MMP provides health service providers with a form that can be used by medical, pharmacy and nursing staff to obtain and accurately record medicines information about patients when they are being admitted to hospital. Use of the form helps to ensure that treating clinicians have the best possible medication history available to them when making therapeutic decisions for patients.

A medication history and management plan should be available at the point of care. It is recommended that it is kept with the current WA Hospital Medication Chart (WA HMC) and WA Paediatric Hospital Medication Chart (WA PHMC) so that it can be kept up to date throughout the patient's hospital admission and is available to reconcile the patient's medications at discharge. The medical record number assigned to the plan should be as close as possible to the hospital's medical record number for the WA HMC/WA PHMC (ideally the preceding number) so that once the patient is discharged the plan is filed with the WA HMC/WA PHMC for that admission.

It can be used as an alternative to the "**Medications taken prior to Presentation to Hospital**" section on the WA HMC/WA PHMC. The WA MMP can be used for adult and paediatric patients.

It is not to be used to record orders for medications or administration of medicines.

The WA MMP is also intended to be used as a record of medication issues and actions taken during the patient's episode of care. This information can also be used during the preparation of the patient's discharge summary and prescription of medication(s) at time of discharge.

3. WHAT IS MEDICATION RECONCILIATION?

Medication reconciliation **on admission** is the formal process of:

- **Interviewing the patient and documenting a best possible medication history**

This involves obtaining and recording a complete and accurate medication history of each patient's current home/pre-admission medications (details must include generic medication name, strength, dose, frequency, form, and route). Information about 'over-the-counter' medications and complementary therapies should also be documented, as well as recording previous adverse drug reactions and allergies and any recently ceased or changed medications.

- **Confirmation**

It is important to confirm the pre-admission medication history with two sources. It is ideal to always interview the patient or whoever manages the medications at home (as one of the sources for the medication history), where practicable. If clinical judgment determines that a second source to confirm the pre-admission medication history is not necessary, this decision should be explicitly documented.

- **Reconciliation**

This involves comparing the clinician's admission orders to the medication history and ensuring that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.

Medication reconciliation **on discharge or transfer** is the formal process of:

- **Reconciliation**

The process of comparing the clinician's discharge or transfer medication orders (including discharge prescriptions and the discharge summary) to the medication history and WA HMC/WA PHMC to ensure that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.

- **Medication liaison**

This involves ensuring that frequent and accurate communication regarding the patient's medications occurs between all clinicians involved in the patient's care and that relevant information is also communicated to the patient and/or carer.

When care is transferred (e.g. between wards, hospitals, or community), a current and accurate list of medicines, including reasons for change, is provided to the person taking over the patient's care as part of clinical handover.

Points of transition identified requiring special attention are:

- admission to hospital
- transfer from the Emergency Department to other care areas (wards, Intensive Care Unit or home)
- from the Intensive Care Unit to the ward
- transfer between wards

- from the hospital to home, residential aged care facilities, transitional care facilities, or to another hospital.

4. CONSIDERATIONS WHEN DOCUMENTING ON THE WA MEDICATION HISTORY AND MANAGEMENT PLAN

Consider privacy issues when writing on the form as it may be kept at the end of the bed where visitors and other persons may have access to the information.

- Use appropriate wording. Facts should be clear, objective, relevant, correct and within context.
- Ensure wording in the "**Identified Medication Management Issues**" section is objective, discreet, respectful, and not critical of the patient and members of the healthcare team.
- Avoid phrases which imply another practitioner has made an error or missed something significant. Choose words such as "suggest" or "consider" rather than "do" or "needs".

Avoid using unsafe abbreviations. Use only accepted abbreviations.[3]

Write legibly in ink. No matter how accurate or complete the documentation of the medication history is, it may be misinterpreted if it cannot be read.

- Use ball point pen - black ink is preferable although blue or purple pen (purple for pharmacists only) is acceptable.
- Do not use water soluble ink (e.g. fountain pen).
- Do not use erasers, correction tape or fluid. Errors must be crossed out and corrections rewritten.

The WA MMP is to be kept with the active medication chart(s), preferably filed in front of the WA HMC/WA PHMC, throughout the patient's admission.

Should there be more than one WA MMP form used, the forms should be stapled together, and numbered accordingly in the top right-hand corner of the front page.

5. FRONT PAGE OF THE WA MEDICATION HISTORY AND MANAGEMENT PLAN

5.1 Identification of the patient

Complete the patient identification by EITHER:

• affixing the current patient identification label

OR

• as a minimum, the patient's name, UR number, date of birth and sex written in **legible print**.

First user to print patient name and check label correct to ensure correct addressograph is chosen and aligns with WA HMC/WA PHMC/medication chart process for patient identification.

An example of when a patient identification label is used, the first user is to print the patient's name:

5.2 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.

5.3 Allergies and adverse drug reactions

This section is to be cross-referenced to the allergy and adverse drug reaction section on the WA HMC/WA PHMC.

Medical officers, nursing staff and pharmacists are required to complete "**Allergies and Adverse Drug Reactions (ADR)**" details for all patients on the WA HMC/WA PHMC *(Patients may be more familiar with the term allergy, than ADR, so this may be a better prompt.)*

- If the patient is not aware of any previous allergy or ADRs, tick the "**Nil Known"** box.
- If allergy and ADR status is unknown, tick the "**Unknown"** box.
- If an allergy or ADR is identified, then an "Adverse Drug Reaction" sticker can be placed in this box and the medication(s) responsible can be documented. The **"Reaction"** box should be ticked. Ensure all known details of the reaction, including the date of reaction, is recorded on the WA HMC/WA PHMC

5.4 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. Where possible, direct verbal communication with the doctor(s) involved is preferred.

This area can be used:

- to document any issues identified through the process of admission reconciliation (e.g. omissions, incorrect doses, incorrect medications, etc.)
- to document any issues identified through the process of medication review (e.g. dose adjustments required, potential and/or actual drug interactions, etc.)
- as a handover document between clinicians
- on discharge (or on transfer to another health facility) to ensure that any outstanding medication issues or actions are transferred or communicated to the next healthcare provider.

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:

To document a medication issue, complete the following:

- date and time that the issue was identified
- a description of the issue
- name and contact number of the person identifying the issue
- any action that is proposed
- the person responsible for that action
- that the person responsible has been contacted

Once an action has been completed, document the date of the 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.

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.

An example on how to document a medication issue is shown below.

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

5.5 Medication history checklist

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

The Medication History Checklist is a tool to assist in determining a patient's complete medication history on presentation to hospital.

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.

5.6 Recently ceased or recent changes to medicines

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/contributed to the patient's admission.

5.7 Medication history – medications taken prior to admission

On admission, the admitting medical officer, pharmacist, nurse, midwife or other credentialed professional trained should complete an accurate medication history.[1]

A complete list of all medicines normally taken or used prior to hospital admission including prescription, non-prescription, over the counter, and complementary medicines should be recorded.

If it has been confirmed that the patient is not taking any regular medications the **"Nil Regular Medications"** box can be ticked.

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)

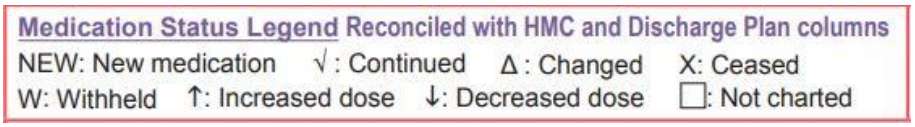
For each medication, document:

- medication details
  - generic name
  - brand name (when appropriate; for example, combination tablets, inhalers, insulins etc)
  - strength
  - form (for example, slow release (SR), wafers, tablets etc)
- dose, frequency, and route
- any additional comments

An example on how to document each medication:

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)
Telmisartan 40mg tab	1 mane po			
Metformin MR 500mg tab	2 mane po			
Metoprolol 50mg tab	25mg BD po			
Aspirin 100mg tab	1 mane po with food			
Rosuvastatin 20mg tab	1 mane po			
Fluticasone/salmeterol	2 puffs BD INH			
250/25microg MDI(Seretide®)				
Glyceryl trinitrate 400microg/spray	1 PRN sublingual			
Salbutamol 100microg/dose MDI	2 puffs every 4 hrs prn INH		Pt states increased use last 2 weeks	
Probiotic capsule	1 daily po			

When complete, the list of medications taken prior to admission is reconciled with the medications charted in the WA HMC/WA PHMC. A **Medication Status Legend** is available for reference on the WA MMP form.



Clinicians should review the medications charted in the WA HMC/WA PHMC, alongside with the patient integrated notes. Any discrepancies between the medications taken prior to admission and medications charted in the WA HMC/WA PHMC may be due to the following reasons:

- Omission
- Withheld
- Ceased on admission
- Change of dose as per doctor
- Incorrectly charted due to no medication history available

The above is not an exhaustive list. Using the legend, complete the **Reconciled with** WA HMC/WA PHMC **at admission** section of the WA MMP.

- Medicines which are prescribed as per medication history (that is, same as pre-admission medication strength, dose, frequency, form, route), should have a ‘tick’ placed in the “Reconciled with HMC at admission” column.

- The doctor’s plan to continue (at current dose/frequency), withhold, cease or change (increase or decrease dose) the medicines on admission should be recorded for each medicine listed.

- If the medication is not charted and no reason for withholding has been identified, annotate a box ‘□” in the “Reconciled with HMC at admission” column to indicate follow-up is required.

- The **Comments** section may be used to document extra information that may be pertinent.

An example of how to reconcile medications on admission with medications charted in the WA HMC/WA PHMC:

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 (Spiriva®)	1 cap mane INH	W	Withheld whilst on ipratropium 2.5mg nebs QID	
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	✓		

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 to communicate this.

Indicate the date and time of admission. Document the date and time medication history was completed or amended with initials of the health professional obtaining the medication history.

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

If multiple medication history and management forms are required for the patient, staple the forms together and indicate the number of forms in existence on the front of each form i.e. 1 of 2, 2 of 2.

Form _____ of _____

On discharge, document the doctor’s plan for each medication on discharge. Medications on discharge/transfer are to be reconciled with the WA HMC/WA PHMC, prescription, the discharge summary, and the patient medication list if prepared. Use the Medication Status Legend to complete this column.

An example of how to reconcile medications on discharge with medications charted in the WA HMC/WA PHMC:

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 (Spiriva®)	1 cap mane INH	W	Withheld whilst on ipratropium 2.5mg nebs QID	√
Temazepam 10mg tab	1 nocte po	↓	Decreased dose to PRN only	↓
Aspirin 100mg tab	1 mane po	X	Ceased, no clear indication	X
Paracetamol SR 665mg tab	2 TDS po	Δ	Changed to liquid as patient has difficulty swallowing	Δ
Atorvastatin 40mg tab	1 mane po	√		√

6. BACK PAGE OF WA MEDICATION HISTORY AND MANAGEMENT PLAN

6.1 Patient identification

Complete this section as per the front of the form.

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

DOB:

AFFIX LABEL HERE

SEX ☐ M ☐ F

6.2 Patient presentation

This section can be used to determine the indication of medications that the patient is taking (from documentation of past medical history and presenting complaint).

The patient's weight and height can be documented in this section. Ideal Body Weight (IBW) and Body Surface Area (BSA) may be then calculated and recorded to aid dose adjustment (if necessary).

The patient's renal function on admission may be recorded here to determine whether the patient's dosage of medications will need to be adjusted in accordance with the patient's renal function status.

Patient details including their smoking status, use of recreational substances and alcohol intake can also be recorded in this section.

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

6.3. Pre-Admission medication history sources

Confirmation of the medicines list with a second information source improves the accuracy and completeness of the medicines list on admission. The community healthcare provider(s) may be contacted if appropriate. Use the **Abbreviation Key** while completing the remainder 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

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 below.

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

If consent provided, tick the source(s) used, and document who has confirmed the information and the date of confirmation. If a second source of information is determined as not necessary to confirm the medication details, tick the **"Second Source deemed unnecessary"** box, and sign it.

Pre-Admission Medication History Has Been Confirmed with Two Sources

(☐ Nil Regular Medications ☑ Second Source deemed unnecessary Sign A.B)

	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):	

It is ideal to always interview the patient or whoever manages the medications at home (as one of the sources for the medication history), where practicable. This may be done at a later time, for example when the patient or carer is unavailable, or the patient is unable to be interviewed on admission (e.g. intensive care unit patient or sedated/delirious patients). Often, it is the patient or whoever manages the medicines that can provide important

information about the pre-admission medicines (including adherence, dosage administration aids, recent changes, etc.) If the medication history is confirmed with a relative or carer, document the name of this person for future reference.

Where possible, document contact details of the patient's General Practitioner, Community Pharmacy or Nursing Home/Hostel for future reference for medication reconciliation at discharge, even if not used as a source.

Where the Care Facility (CF) is not directly contacted as a source, but Webster pack list or CF notes or records are sent in with the patient or faxed in, these may be documented under the CF section as a source (i.e. phone number may be included here but does not indicate that the CF was necessarily contacted by phone as a source for the medication history).

Specify type of Dose Administration Aid (D.A.A.) used as information source, and date packed (to ensure that D.A.A. is current). D.A.A. use should be documented regardless of whether the D.A.A. is used as a source. Similarly, if the patient/carer does NOT use a D.A.A., this should be documented by ticking the "Nil" box. This is extremely helpful on discharge when organising medicines (e.g. faxing versus dispensing prescriptions).

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. Using previous hospital discharge information:

> Previous admission at: Ward 4
> Hospital: Bentley Hospital
> Date of D/C: 30/08/2022

An example of how to fill in this section is shown below.

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: 9555 5555 Fax: 9555 5555 Email:	A.B	☐ Patient ☑ Relative ☐ Carer Name if not patient Wife (Jane)	A.B	☑ Own Medications ☐ POM S8/S4R ☐ POM Fridge Consent to use ☐	A.B
☐ 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: 30 / 08 / 2022		☐ My Health Record	
☑ GP Dr A Smith Ph: 9555 5555 Fax: 9555 5555 Email: ☐ GP letter/medication list Date: / /	A.B	Dose Administration Aid (D.A.A.) ☑ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other: Date Packed: / /		☐ Other (specify):	

6.4 Medication risk assessment on admission

The medication risk assessment on admission allows documentation of the patient's level of medication independence. Information including who manages the patient's medications, their ability to read/see labels and compliance assists clinicians with discharge planning. For example, if a patient's carer manages their medications, it would be best to speak with the carer regarding any medication changes during their admission when discharging the patient.

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

6.5 Swallowing status on admission

The swallowing status on admission sections assists clinicians when charting inpatient medications. It assists with decisions to commence new medications. For example, if a clinician would like to prescribe a slow-release tablet formulation, but the patient requires their medicines to the be crushed, they may consider an immediate tablet formulation as an alternative.

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

6.6 Discharge and transfer medication plan

This checklist outlines common tasks which occur on discharge. Each task should be considered, completed if appropriate and documented.

An example of a discharge and transfer medication plan for a patient who brought in their patient own medications into hospital and on discharge, is commencing on a new Webster pack (D.A.A) to aid with medication compliance:

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: Pharmacy 101

Patient information leaflets include:

- How to manage your medicines after going home from hospital
- Adverse Drug Reaction Information

6.7 Medications at discharge

There are occasions when medications are not required to be dispensed at the discharging hospital. Following discharge reconciliation and related medicine education, document how/if medicines are to be supplied.

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

6.8 Pharmacist comments and medication issues

This section of the form is available to make any further comments regarding the patient's medication management that are not covered by other sections and to document the time and date discharge reconciliation was completed.

When the medicines on the WA MMP have been reconciled against the HMC, discharge prescription, discharge summary and consumer medication list if prepared, the final discharge reconciliation section of the chart should be ticked, and the entry signed and dated. The discharge plan for each medicine is documented adjacent to the medication list on admission on the first page of the form.

If a medication plan or a consumer medication list was provided following discharge reconciliation this can be recorded by ticking the relevant boxes.

An example of a patient being discharged with newly commenced inhaler:

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

☑ Discharge reconciliation ☐ Medication plan ☐ Medication list

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

7. REFERENCES

1. WA Medication Review Policy MP0104/19 Effective from 29 May 2019. Clinical Governance, Safety and Quality Policy Frameworks

2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards – Medication Safety Standard.[cited 2022 Sept 18].

3. 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

4. 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/safety/PDF/Clinical%20alerts/Adverse%20Drug%20Reaction%20Information.ashx