Medication Reconciliation – Completing the Medication History and Management Plan Procedure

1. Purpose

The purpose of this Procedure is to detail the minimum requirements for the completion of the Western Australian (WA) Medication History and Management Plan (MHMP) at WA Country Health Service (WACHS) – South West (SW) sites. The WA Medication History and Management Plan (WA MHMP) User Guide serves as the reference document by which the process of medication reconciliation is completed.

2. Procedure

2.1 Guiding principles

Medication reconciliation is a core action of the National Safety and Quality Health Service (NSQHS) Standard 4 – Medication Safety. The WA MHMP has been developed by the WA Medication Safety Network to meet WA Health requirements for medication reconciliation. Together with the WA Hospital Medication Chart (WA HMC), the MHMP is the accurate repository for pharmaceutical information in the medical record to enable therapeutic decision making.

Medication history taking and medication reconciliation is a key component of Medication Safety practices for patients admitted to WACHS-SW facilities. It is a clinical process that can be undertaken by pharmacy, medical or nursing staff and therefore this procedure is applicable to medical, pharmacy and nursing staff.

2.2 Completing the WA MHMP

General

A Best Possible Medication History (BPMH) is to be taken by an appropriately credentialed health professional as early as possible in the patient's episode of care. Whenever practical, this should be performed before the end of the next calendar day after admission.

Where a clinical pharmacist is available, ideally this pharmacist takes and records the BPMH, and reconciles this with the WA HMC. At regional sites or where no clinical pharmacist is available (including weekends and public holidays), this BPMH should be performed and reconciled with the medication chart by either a nurse or the admitting doctor.

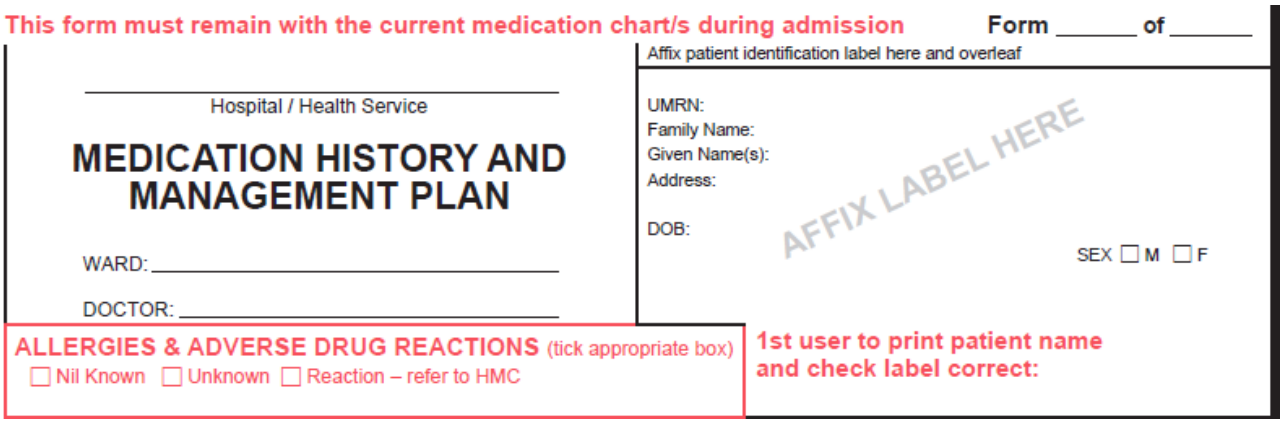
Within WACHS-SW the BPMH is to be recorded on the MR 170.1 Medication History and Management Plan.

It is called the "Best Possible Medication History" because it is a medication list based on the best available source(s) at the time of review. As such, a BPMH can be amended or improved as more accurate and comprehensive information becomes available.

If the MHMP needs updating if an error is made, put a single line through the error and initial and date it. Rewrite and use the comments section on back page to explain.

Do not use water soluble ink, erasers, correction tape or fluid. Only acceptable abbreviations can be used, and a list of acceptable abbreviations has been published by the Australian Commission on Safety and Quality in Health Care and should be adhered to. (see Appendix A for WA Therapeutic Advisory Group (WATAG) list)

A. Patient identification section

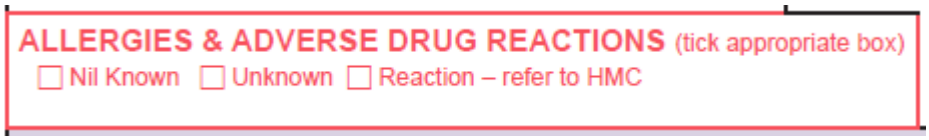


A three-point patient identification check must be completed for all patients when completing the WA MHMP. Attach an addressograph sticker to both the front and back of the WA MHMP. If there are no stickers available, all fields must be completed in writing.

B. Ward and doctor section

It is recommended that this be filled in.

C. Allergies and adverse drug reactions (ADR) section



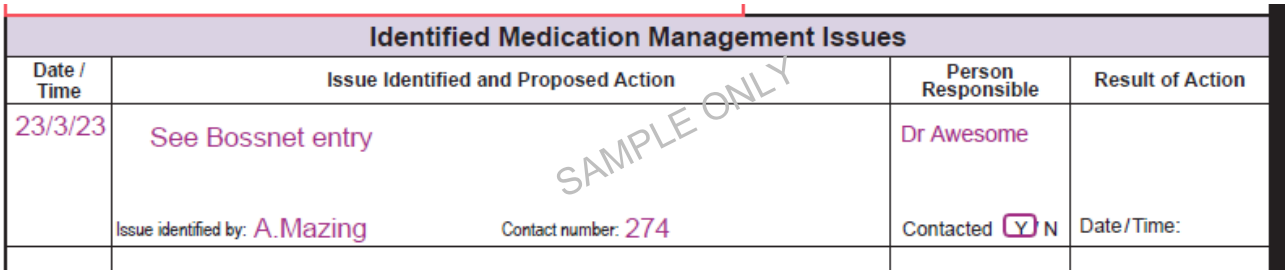
This section is to be completed. The appropriate tick box must be completed and if there is an ADR, the ADR details are to be completed on the WA HMC. If unable to obtain ADR history, the 'unknown' box should be ticked at the very minimum and communicated to relevant staff to be followed up (e.g. medical, nursing or pharmacist). The "unknown" box can only be ticked if:

- no one is available that can answer the question at the time of completion, and this must be handed over it be chased up at another time when the appropriate resource is available e.g. GP clinic open.
- in an emergency situation.
- patient is unable to communicate (e.g. patient is intubated, delirious) and nil other sources are available.

D. Identified medication management issues section

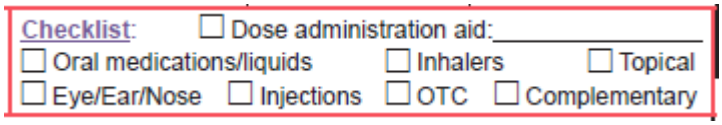
Any medication management issues and required actions are to be documented in the patient's digital medical record (BOSSnet) and communicated to key staff for resolution.

"See BOSSnet entry" can be written in this section, to direct clinical staff to where documentation of issues can be found.



Identified Medication Management Issues			
Date / Time	Issue Identified and Proposed Action	Person Responsible	Result of Action
23/3/23	See Bossnet entry SAMPLE ONLY Issue identified by: A.Mazing Contact number: 274	Dr Awesome Contacted Y N	Date/Time:

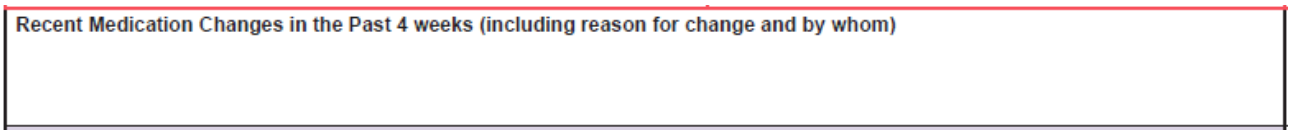
Medication history checklist:



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 and it is recommended to be routinely used as part of the medication history interview to ensure all forms of medications have been considered.
- This is because patients often forget to mention formulations other than tablets or capsules and may not consider non-prescribed medications important as they were not prescribed by a doctor.

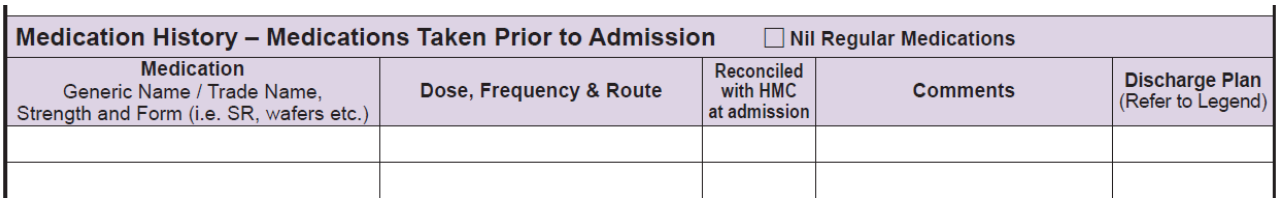
Recent medication changes:



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

- It is strongly recommended that details of recent changes to medications (in the past month or as clinically relevant) are to be included in the section above.

E. Medication history – medications taken prior to admission section



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)

- A complete list of all medications taken prior to admission including prescription, non-prescription, over the counter and complementary medicines should be recorded (use the "Medication History Checklist" to help guide this).
- If it is confirmed that the patient is not taking any regular medications the "**Nil Regular Medications**" box can be ticked.

Medication column:

- Document medications using generic names
- Include medication brand when appropriate (e.g. warfarin, insulins, biosimilars, Parkinson's medications, thyroid medications and multi-ingredient products with 4 or more ingredients)
- Include formulation for high risk medications e.g. methotrexate tab vs injection, modified release (MR) medications that have significant difference in formulation, or where changing the formulation may impact therapy. For example:
  - Madopar ® (Levodopa/benserazide) capsules, tablets, dispersible tablets
  - Inhaler types: turbuhaler, MDI (metered-dose inhaler), Accuhaler etc.

Dose, frequency & route column:

- Dose:
  - Document medication strength and form in the first column, and the dose, frequency and route in the second column.
  - It should be clearly identifiable what form and strength of medication a patient uses at home.
  - This information facilitates the correct transcription onto the discharge summary, to avoid confusion and subsequent harm to the patient.
- Frequency:
  - Document how frequently the patient takes the medication and annotate at what time e.g. "morning" or "night", not "daily".
  - Where there is dose ambiguity, document in the comments column "dose as per patient".
  - Where the medication is regular but periodic, indicate when the last dose was taken and/or when next dose is due. Note if this information is unavailable state "due date to be confirmed". For example:
    - Where the medication is for a specific duration or cycle, document which day the patient is on or the date the cycle is due to commence.
    - Amoxicillin and clavulanic acid 875/125 mg BD, 5 day course commenced 2/10/22 due to cease 7/10/22.
    - Denosumab 60 mg subcut every 6 months. Last dosed 5/1/23. Next dose due 5/7/23.
- Route:
  - Any medications that are not oral should have their route documented.
  - For topical preparations include the area where it is to be used (if known) for example "apply to back".
  - For ophthalmic preparations include which eye(s) the preparation is for (if known).

Transfers from another Hospital:

If a patient is transferred from another hospital, it is inadequate to simply document the medications from the transferring hospital's medication charts or list. The medications taken by the patient prior to hospitalisation need to be ascertained and documented to allow reconciliation on discharge to be performed.

Any medication changes during the admission should be documented as per Appendix B.

If an MHMP was completed at the transferring hospital and a copy of this MHMP is transferred with the patient, this can be used as a source for the BPMH however it is not

appropriate to use this as the MHMP for use at WACHS -SW sites. A new MHMP form is to be used for each patient per admission.

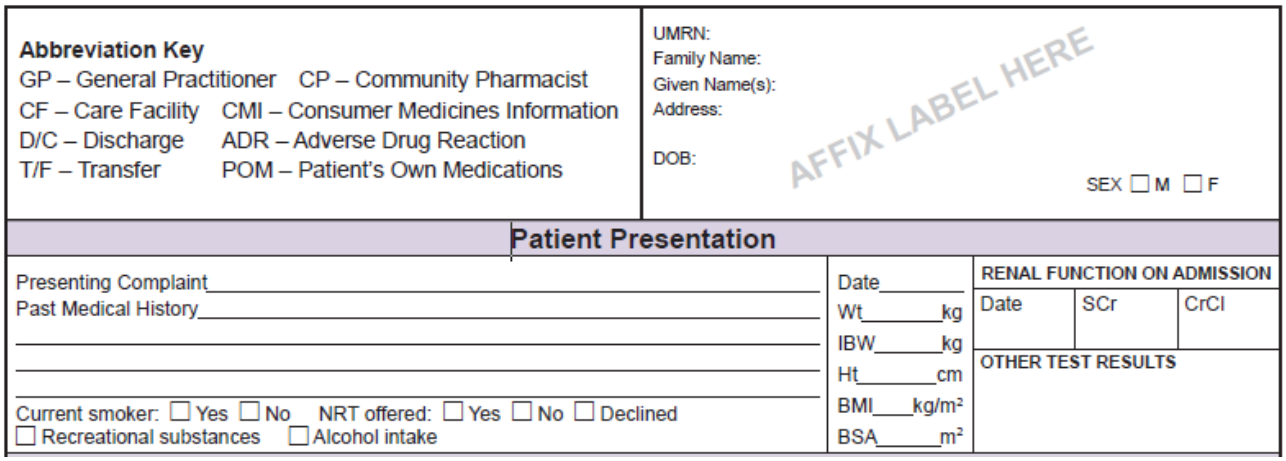
Patients with Dose Administration Aids (DAA):

In the event a patient utilises a pharmacy-packed dose administration aid or dosette box and also has non-packed medicines, the medicines which are packed and non-packed should be clearly documented/differentiated on the MHMP.

- This may prevent the situation whereby non-packed medications are added to the DAA without the patient's knowledge on discharge.
- It is also useful to know which medicines are unpacked as this may give information about how a patient may manage their medicines.

It is also recommended that the pharmacy name and contact details be recorded. This allows these details to be used to liaise with them, and sort out new packs if any changes were made during the admission.

F. Presenting complaint section



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

The completion of this section is optional however, completion is recommended as it assists in reconciling medicines based on the patient's presenting complaint and past medical history and improves the usefulness and comprehensiveness of the MHMP as a management plan document.

Past medical history:

This section is relevant and aids the history taking process but is not mandatory.

Renal function on admission, weight and height:

It is not mandatory to complete this section. Where clinically appropriate, this section can be completed.

G. Pre-admission medication history has been confirmed with two sources section

This section must be completed.
It is expected that all medication histories are performed using a minimum of TWO reliable sources of information. If clinical judgment determines this is not necessary, this decision

should be documented by ticking and signing the second source deemed unnecessary section of the MHMP.

Tick and sign the source if used.

E.g. a patient may use a DAA, however it was not sighted during the admission. In this scenario, the Blister Pack box is ticked but not signed. Similarly, if a community pharmacy is recorded but not contacted on admission, the box is ticked but not signed.

Where available, community pharmacy details should be completed including phone numbers. This is useful should there be enquiries regarding the history taken and if needed to liaise with on discharge. It is also helpful for future admissions.

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: 9345 6789 Fax: 9345 6790	AB	☐ Patient ☑ Relative ☐ Carer Name if not patient Wife - Jan	AB	☑ Own Medications ☐ POM S8/S4R ☐ POM Fridge	AB
☐ CF Ph:		☑ Previous admission at: XCH Hospital: Date of D/C T/F: 13/07/16		☐ Patient List	
☑ GP Dr A Smith Ph: 9234 5678 Fax: 9234 5670 ☐ GP letter Date: / /	AB	Dose Administration Aid (D.A.A.) ☑ Nil ☐ Blister Pack ☐ Sachet ☐ Dosette ☐ Other: Date Packed: / /		☐ Other:	

Considerations when utilising various sources include:

Patient/relative/carer:

In most circumstances, the patient is usually interviewed as the primary source of information. However, if they are not the person responsible for managing the medications at home, this may not be the best option.

Similarly, it may not be appropriate or practical to interview the patient in some circumstances. The person interviewed (including name and relationship) should be documented to allow for follow up if further information is required.

Patient's own medicines (POMs):

POMs are a very useful source of information when used in conjunction with an interview of the person responsible for managing the medications at home.

If POMs are used as a source and the name and contact details of the pharmacy are available, it is helpful if these are documented. These details often become useful for readmitted patients.

If POMs are used as a source but are not actually viewed by the staff member completing the MHMP (e.g. family/carer reading the details of the POM over the phone to the staff member or viewing photos of the POM on a patient's mobile phone) document these details on the MHMP.

This may help with reconciling medicines on discharge, e.g. to determine whether it is possible to review and reconcile POM on discharge.

Identify the dispensing date on POMs if possible as this may:
- aid in assessing compliance
- identify how current the medication is.

Double check the patient name on medications brought in. It is not uncommon for other family members' medications to be brought in by mistake.

Medications brought in by the patient may be incomplete. Refrigerated items, for example, are often left at home.

POMs should not be routinely sent home even after the BPMH has been taken as they are important when counselling/reconciling on discharge and may need to be referred to during the admission.

GP/Community pharmacy (CP):

It is good practice to document the name(s) and phone number(s) of community pharmacies and/or GPs if they are known. This may help with any further follow up if required, discharge planning and readmissions.

If documenting the community pharmacy name, document the phone number, location (e.g. suburb) and fax number if applicable (e.g. DAA).

If a patient is readmitted and a previous MHMP is used as a source of information, it is good practice document the community pharmacy details (if they are still relevant). This may assist with discharge planning or if follow-up is required.

Note:
- The patient may visit more than one doctor and/or pharmacy.
- GP letters often contain historical medications which are no longer current.

Care facility (CF):

The name and contact details (phone number and, where known, the fax number) of the community pharmacy which provides DAAs for the care facility should be documented in the community pharmacy part of the" sources section" of the MHMP.

These details should be documented regardless of whether the community pharmacy was contacted or not. These details are required for reconciling medicines on discharge or discharge planning.

Care facility medication lists provided on admission may be out of date and/or incomplete. Check the date. If the date on the medication list is more than 2 weeks old, it is recommended to contact the community pharmacy for an up-to-date list.

Be aware that patients in respite care may have medications packed by a different pharmacy to the one that normally services that facility, and some patients in low level residential care/independent living units may be self-managing medications.

Previous hospital admissions:

If using a previous discharge summary as a source for the BPMH (i.e. recent admission), other important information should be reviewed and documented.

Refer to the MHMP of that admission (if available) to document any current/relevant information about DAA use (particularly pharmacy-packed DAA), community pharmacy details, adherence issues, who manages the patient's medicines, etc.

Ensure that these details are still current/relevant.

The older a discharge summary is, the more likely there have been changes since the time it was written.

Dose administration aids:

If such a system is in use, the 'Blister Pack' or 'Sachet' box must also be ticked even if the DAA itself wasn't sighted by the staff member.

Similarly, the packing pharmacy details (name, phone number and fax number where known) needs to be documented in these situations irrespective of whether the pharmacy was contacted in the history taking process.

If unable to ascertain whether a patient utilises a pharmacy-packed DAA at the time of review, documentation of this should occur and be followed-up.

Patient list:

When utilising patients' own lists, consider when the list was created and identify the author to assist with assessing how reliable the list may be.

My Health Record (MHR):

My Health Record is a secure online summary of a patient's health information, including dispensing records from community pharmacies, GP medication summaries and discharge summaries from other hospitals.

The MHR can be accessed through multiple clinical applications, such as Notifications and Clinical Summaries (NaCS), BOSSnet and iSoft Clinical Manager (iCM).

There are known limitations with the information as displayed in the MHR.

The Department of Human Services (DHS) uploads PBS data post processing; this may have a 3-6 week lag time.

It is important to note that any non-PBS data is not uploaded through this mechanism, and if the pharmacy dispensing doesn't actively upload the information then it will not be available.

Note:

- Given the MHR is patient controlled, the information available is to be considered like all other sources; it is important to correlate it with at least another source.

- GP letters often contain historical medications which are no longer current.
- Community pharmacy dispensing records will not include over the counter items and may not include Non-PBS items.

H. Medication risk assessment on admission section

It is important to document who usually manages the patient's medications at home, whether it is the patient themselves, or a family member/carer. This enables the discharging clinical staff member to target discharge activities e.g. counselling, to the most appropriate person(s). Similarly, adherence/compliance issues can assist with discharge planning. The remainder of the risk assessment is to be completed as clinically appropriate.

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: Daughter	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

I. Swallowing status on admission section

This section only needs to be documented if the swallowing status will affect the administration of medicines during the admission e.g. PEG, crushing required etc.

J. Discharge and transfer medication plan section

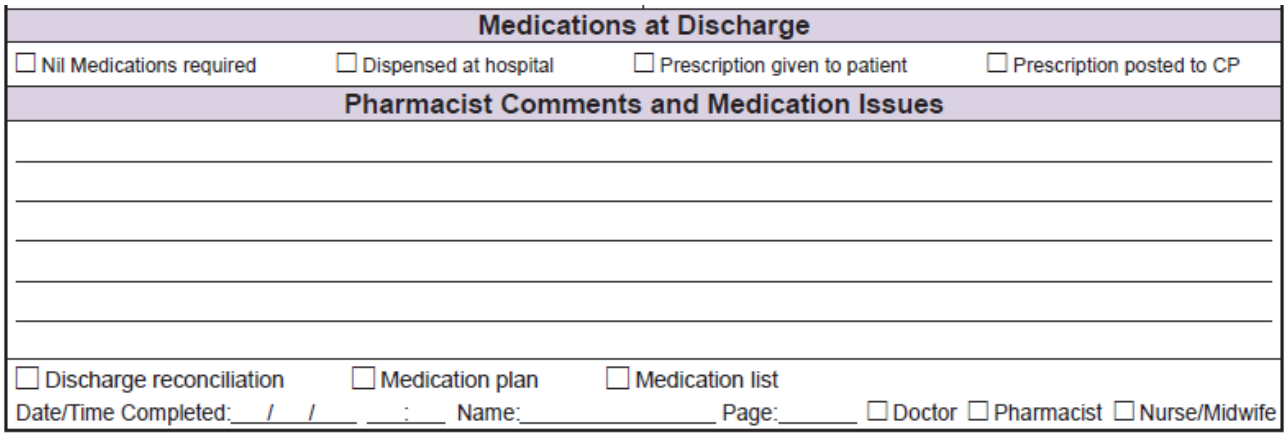
Discharge and Transfer Medication Plan	
Education Provided to Patient ☐ Interpreter required ☐ ADR Brochure ☐ Medicine information leaflet:_____ ☐ CMI:_____ ☐ Verbal counselling to patient/carer ☐ Not required/declined ☐ Medication list provided on discharge	**Community Liaison** ☐ Patient denied consent 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:_____

Medication related activities performed on discharge can be documented in this section with the bottom of the form signed off.

K. Medications at Discharge

This section may be used to document whether medications were supplied by the hospital on discharge, or if the prescription was given to the patient to obtain from their community pharmacy.
Alternatively, the 'Nil Medications required' box can be ticked if there were nil changes to medication or if a dose change resulted in the patient being able to use existing medication at home.

The nil medications required section may also be applicable if a patient is being transferred to another hospital.



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			

L. Pharmacist comment and medication issues section

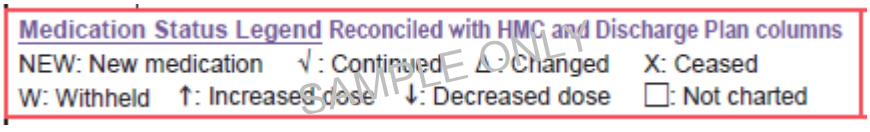
This section may also be useful to document date of administration of new medicines given during the admission such as denosumab, zoledronic acid, iron infusions, B12 injections, vaccines and depot injections. Judicious use of this section is recommended to avoid confusion.

2.3 Reconciliation with the WA HMC

Over half of all hospital medication errors occur at admission, transfer or discharge. One in two patients have at least 1 regular medication unintentionally omitted, which can lead to discomfort and medical deterioration.

The process of medication reconciliation can reduce the risk of these medication errors occurring.

When complete, the list of medications taken prior to admission is reconciled with the medications charted in the WA HMC. A medication status legend is available for reference on page 1 of the WA MHMP form.



It is recommended that clinicians should review the medications charted, along with the patient's BOSSnet notes. Any discrepancies between the medications taken prior to admission and the medications charted may be due to:

- unintentional omission
- being withheld
- ceased on admission
- change of dose as per doctor
- incorrectly charted due to no medication history available.

Where there are omissions of the patient's usual medicines or unintentional changes, identify this and contact the prescriber and/or document in the patient's electronic record

(BOSSnet), (depending on urgency of attention required). When documenting these interactions include the name of the member of staff that was spoken to.

Only document intentional changes – consult the medical team to clarify and resolve any discrepancies prior to documenting the change. Where there remains uncertainty about the status of the change, document 'For R/V' in the reconciliation column. (See Appendix B).

Once the WA MHMP form has been completed, this is to be reflected on each of the WA HMC(s). The tick box "See WA MHMP" should be completed on the "Medicines taken prior to presentation to hospital" section of the WA HMC to indicate that an MHMP has been completed.

The completed WA MHMP form is to be filed with the WA HMC for the duration of the admission.

Medicines taken prior to presentation to hospital

(Prescribed, over the counter, complementary)

✓ See WA MMP Own medicines brought in? Y ☐ N ☐ Administration aid (specify) .....

Medicine	Dose and frequency	Duration	Medicine	Dose and frequency	Duration

Not for administration

GP: Community pharmacy:

Sign: ..... Print: ..... Date: ..... Medicines usually administered by: .....

3. Roles and Responsibilities

All staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

Staff development nurses, medical education team and senior leads are responsible for incorporating training for this procedure into the orientation process for relevant disciplines

Authorised prescribers (including nurse practitioners and endorsed midwives), nurses and midwifes are responsible for undertaking a best possible medication history and medication reconciliation, relative to the urgency of the situation, before prescribing or administering medications.

Pharmacists are responsible for undertaking a best possible medication history and medication reconciliation to support safe medication prescribing and administration.

4. Monitoring and Evaluation

4.1 Monitoring

Managers of clinical areas, health sites and services are responsible for monitoring compliance with this procedure. This procedure is to be monitored via the review of audit and local CIMS data. WA Medication Reconciliation Audit should be completed every 6 months.

Recommended audit numbers are as below:

- Regional resource centres – 30 patients

- District hospitals (if participating) – 10 patients

Individual ward areas are to evaluate clinical incidents related to medication history and reconciliation and trends should be reported to the WACHS-SW Medication Safety Sub Committee.

4.2 Evaluation

The evaluation of this document will be managed via the WACHS-SW Medication Safety Sub Committee, utilising WA Medication Reconciliation Audit results for the SW region for trends in completion rates, in line with review timelines for this document.

5. Compliance

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

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

6. References

- Medication Safety: Western Australian Medication History and Management Plan (WA MMP) – Patient Safety and Clinical Quality Directorate. Department of Health.
- 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.
- Western Australian Medication History and Management Plan (WA MMP) User Guide. Feb 2022. V3. Developed by the Western Australian Medication Safety Collaborative in association with the Medicines and Technology Unit. Department of Health.
- WACHS - Great Southern: Medication Reconciliation on Admission and Discharge Guideline.

7. Definitions

Term	Definition
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. 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.
Medication reconciliation	Medication reconciliation involves comparing the clinician's orders (either admission, discharge or transfer medication orders) to the medication history and relevant medication charts ensuring that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.
WA Medication History and Management Plan MR170.1	The WA Medication History and Management Plan (WA MHMP) 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.

8. Document Summary

Coverage	WACHS – South West
Audience	Nursing, midwifery, medical and pharmacy staff
Records Management	Clinical: Health Record Management Policy
Related Legislation	• Medicines and Poisons Act 2014 (WA) • Medicines and Poisons Regulations 2016 (WA)
Related Mandatory Policies / Frameworks	• Medication Review Policy – MP 0104/1 • Clinical Governance, Safety and Quality
Related WACHS Policy Documents	• Medication Handling and Accountability Policy • Medication Prescribing and Administration Policy
Other Related Documents	• WA Medication History and Management Plan (WA MHMP) User Guide • ACSQHC Recommendations for terminology, abbreviations and symbols used in medicines documentation
Related Forms	• MR 170.1 Medication History and Management Plan
Related Training Packages	• MHMP Take 5 PowerPoint presentation • Completing the MHMP Poster
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 2361
National Safety and Quality Health Service (NSQHS) Standards	4.01, 4.03, 4.05, 4.06, 4.08
Aged Care Quality Standards	N/A
National Standards for Mental Health Services	N/A

9. Document Control

Version	Published date	Current from	Summary of changes
1.00	13 July 2023	13 July 2023	New procedure

10. Approval

Policy Owner	Regional Director South West
Co-approver	Executive Director Clinical Excellence Executive Director Nursing and Midwifery
Contact	WACHS-SW Regional Chief Pharmacist
Business Unit	Clinical Services
EDRMS #	ED-CO-23-243925

This document can be made available in alternative formats on request.

Appendix A: Acceptable Prescribing Terms and Abbreviations

Acceptable Prescribing Terms and Abbreviations

Intended meaning	Acceptable term or abbreviation
Dose frequency or timing	
(in the) morning	morning, mane
(at) midday	midday
(at) night	night, nocte
twice a day	bd
three times a day	tds
four times a day	qid
every 4 hours	every 4 hrs, 4 hourly, 4 hrly
every 6 hours	every 6 hrs, 6 hourly, 6 hrly
every 8 hours	every 8 hrs, 8 hourly, 8 hrly
once a week	once a week and specify the day in full
three times a week	three times a week and specify the days in full
when required	prn
immediately	stat
before food	before food
after food	after food
with food	with food
Dose forms	
capsule	cap
cream	cream
drops	drops
injection	inj
metered dose inhaler	metered dose inhaler, inhaler, MDI
mixture	mixture
ointment	ointment, oint
patient controlled analgesia	PCA
pessary	pess
powder	powder
suppository	supp
tablet	tablet, tab

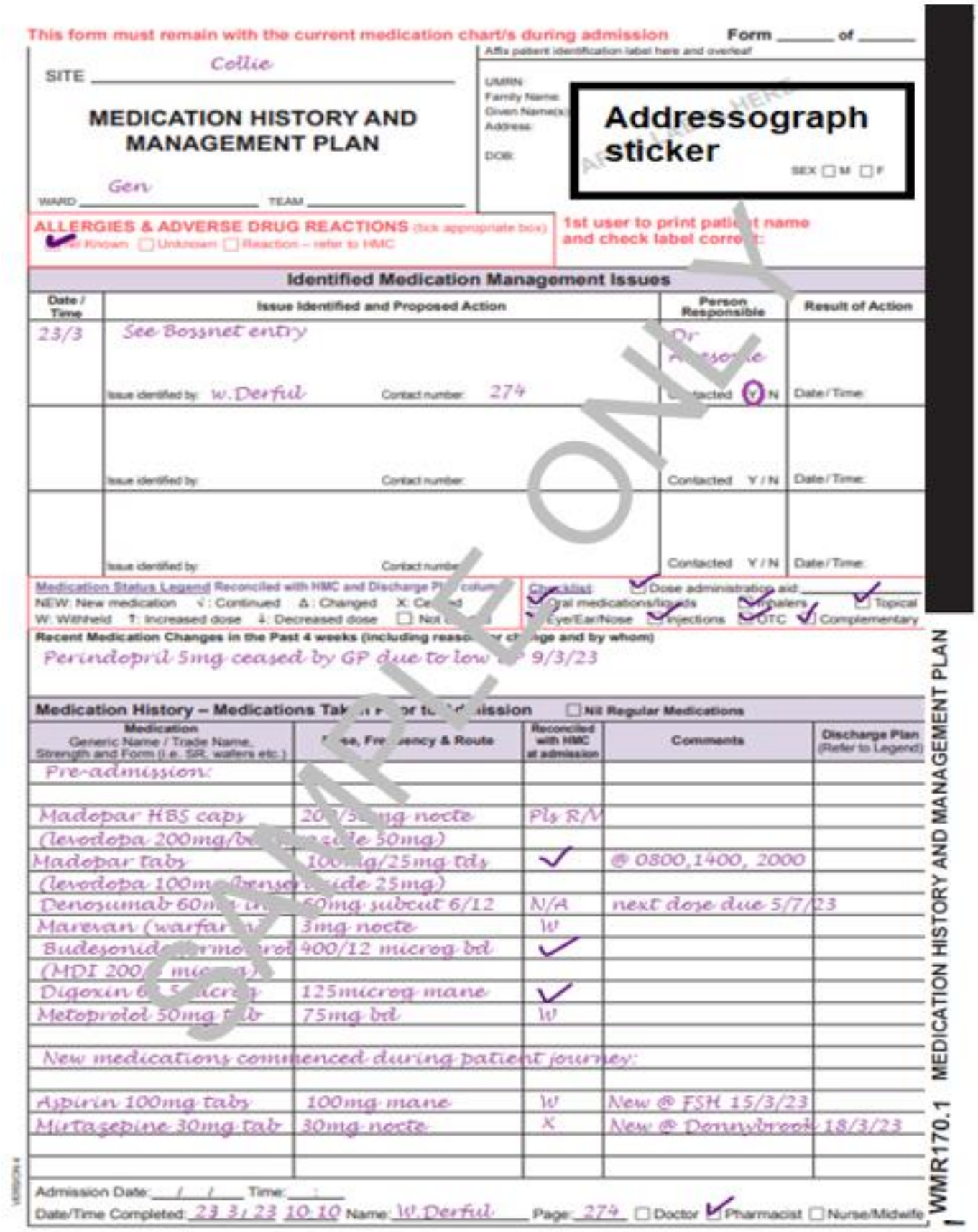
Intended meaning	Acceptable term or abbreviation
Route of administration	
ear	ear(s) specify left, right or both
epidural	epidural
eye	eye(s) specify left, right or both
inhale, inhalation	Inhale, inhalation
intraarticular	intraarticular
intramuscular	IM
intranasal	intranasal
intrathecal	intrathecal
intravenous	IV
irrigation	irrigation
left	left
naso-gastric	NG
nebulised	NEB
oral	PO
percutanous enteral gastrostomy	PEG
per rectum	PR
per vagina	PV
peripherally inserted central catheter	PICC
right	right
subcutaneous	subcut
sublingual	subling
topical	topical
Units of measure and concentration	
gram(s)	g
litre(s)	L
milligram(s)	mg
millilitre(s)	mL
microgram(s)	microgram, microg
millimole	mmol
international unit(s)	international unit(s)
unit(s)	unit(s)
percentage	%

Government of Western Australia Department of Health

WA.TAG

better health • better care • better value

Appendix B: MHMP Example



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

SITE Collie

Affix patient identification label here and overleaf

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

Addressograph sticker

SEX ☐ M ☐ F

MEDICATION HISTORY AND MANAGEMENT PLAN

WARD Gen 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
23/3	See Bossnet entry Issue identified by: W.Derful Contact number: 274	Dr [illegible] 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 [illegible]

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)
Perindopril 5mg ceased by GP due to low [illegible] 9/3/23

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)
Pre-admission:				
Madopar HBS caps	200/5[illegible]mg nocte	Pts R/V		
(levodopa 200mg/be[illegible]zide 50mg)				
Madopar tabs	100mg/25mg tds	✔	@ 0800,1400, 2000	
(levodopa 100m[illegible]ranse[illegible]ide 25mg)				
Denosumab 60m[illegible] in[illegible]60mg subcut 6/12		N/A	next dose due 5/7/23	
Marevan (warfar[illegible])	3mg nocte	W		
Budesonid[illegible]rmo[illegible]rol	400/12 microg bd	✔		
(MDI 200[illegible] mic[illegible]a)				
Digoxin 6[illegible]5[illegible]icrog	125microg mane	✔		
Metoprolol 50mg t[illegible]b	75mg bd	W		
New medications commenced during patient journey:				
Aspirin 100mg tabs	100mg mane	W	New @ FSH 15/3/23	
Mirtagepine 30mg tab	30mg nocte	X	New @ Donnybrook 18/3/23	

Admission Date: / / Time:
Date/Time Completed: 23/3/23 10.10 Name: W.Derful Page: 274 ☐ Doctor ✔ Pharmacist ☐ Nurse/Midwife

WMR170.1 MEDICATION HISTORY AND MANAGEMENT PLAN

SAMPLE ONLY

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:
Addressograph sticker
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: Jan (wife)	GP	☐ Own medications ☐ PCS/S4R ☐ POM Faxed Consent to use ☐	
☑ CF TerryWhite Australind Ph: 9797 1303 Fax: 9463 1442 Email:	GP	☐ 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
☐ GP Ph: Fax: Email: ☐ GP letter/medication list Date: / /		Dose Administration Aid (DAA) ☐ Nil ☐ Blister Pack ☐ Sachet ☐ Dose ☐ 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: wife	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 at 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 iMC
☐ Pharmacist involved 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

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