Medication Safety

Western Australian Medication History and Management Plan (WA MMP)

Office of Safety and Quality in Healthcare
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.
Medication Incidents in 2012

During 2015/16 there were 30,356 clinical incidents reported in WA Health. Medication incidents were the most frequently reported clinical incident, accounting for 6,744 incidents or 22.4% of all clinical incidents reported in 2015/16.

<table>
<thead>
<tr>
<th>Eight National Standards</th>
<th>(n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 3: Preventing and Controlling Healthcare Associated Infections</td>
<td>548</td>
<td>2.0</td>
</tr>
<tr>
<td>Standard 4: Medication Safety</td>
<td>6,146</td>
<td>22.4</td>
</tr>
<tr>
<td>Standard 5: Patient Identification and Procedure Matching</td>
<td>3,265</td>
<td>11.9</td>
</tr>
<tr>
<td>Standard 6: Clinical Handover</td>
<td>2,489</td>
<td>9.1</td>
</tr>
<tr>
<td>Standard 7: Blood and Blood Products</td>
<td>140</td>
<td>0.5</td>
</tr>
<tr>
<td>Standard 8: Preventing and Managing Pressure Injuries</td>
<td>1,147</td>
<td>4.2</td>
</tr>
<tr>
<td>Standard 9: Recognising/Responding to Clinical Deterioration</td>
<td>526</td>
<td>1.9</td>
</tr>
<tr>
<td>Standard 10: Preventing Falls and Harm from Falls</td>
<td>5,250</td>
<td>19.1</td>
</tr>
<tr>
<td>Total</td>
<td>19,511</td>
<td>71.1</td>
</tr>
</tbody>
</table>
Medication Incidents in 2015/16 (continued)

The most frequent type of medication incident involved medication omissions (14.9%), followed by incorrect medication dose (9.4%). The top five medication incident types, as shown below, accounted for 45.3% of all medication incidents reported in 2015/16.

Table 10: Frequency and Percentage of Top Five Tier Three Confirmed Medication Clinical Incidents Categories for 2015/16

<table>
<thead>
<tr>
<th>Tier Three Medication Categories</th>
<th>(n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omitted medication</td>
<td>915</td>
<td>14.9</td>
</tr>
<tr>
<td>Incorrect medication dose</td>
<td>579</td>
<td>9.4</td>
</tr>
<tr>
<td>Incorrect medication</td>
<td>495</td>
<td>8.1</td>
</tr>
<tr>
<td>Extra medication dose given</td>
<td>397</td>
<td>6.5</td>
</tr>
<tr>
<td>Incorrect dose (formulation/preparation)</td>
<td>339</td>
<td>6.5</td>
</tr>
<tr>
<td>Total</td>
<td>2,725</td>
<td>45.3</td>
</tr>
</tbody>
</table>
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

Delivering a Healthy WA
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 Dept 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

Back page
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 National Inpatient Medication Chart (NIMC) 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 NIMC.

- 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 NIMC 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.

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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.
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.
Allergies and Adverse Drug Reactions

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

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

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

- “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 NIMC.
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)

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Issue Identified and Proposed Action</th>
<th>Person Responsible</th>
<th>Result of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/7/16 10.15</td>
<td>Patient states he takes aspirin 100mg mane Please review if required for this admission</td>
<td>Dr Heart</td>
<td>Charted 2/7/16</td>
</tr>
<tr>
<td></td>
<td>Issue identified by: Pharmacist</td>
<td>Contact number: 1234</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date / Time</th>
<th>Issue Identified and Proposed Action</th>
<th>Person Responsible</th>
<th>Result of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Issue identified by:</td>
<td>Contact number:</td>
<td>Contacted Y / N Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Issue Identified and Proposed Action</th>
<th>Person Responsible</th>
<th>Result of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Issue identified by:</td>
<td>Contact number:</td>
<td>Contacted Y / N Date:</td>
</tr>
</tbody>
</table>
Medication History Checklist

- The 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.
Recent Medication Changes in the Past 4 weeks

<table>
<thead>
<tr>
<th>Recent Medication Changes in the Past 4 weeks</th>
<th>Reason for change</th>
<th>By Whom</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- 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

On admission:

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

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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 NIMC.
  - Use the ‘Medication Status Legend’ to note the plan for each medicine:

<table>
<thead>
<tr>
<th>Medication Status Legend Reconciled with NIMC and Discharge Plan columns</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEW: New medication  √: Continued  Δ: Changed  X: Ceased</td>
</tr>
<tr>
<td>W: Withheld  †: Increased dose  ‡: Decreased dose  CMI: CMI provided</td>
</tr>
<tr>
<td>□: Not charted</td>
</tr>
</tbody>
</table>

- If they match (medication, strength, dose and form), place a tick in the “Reconciled with NIMC” column.
- Document doctor’s plan (if known) in “Reconciled with NIMC” 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 NIMC” column to indicate follow up is required.
Medication History (continued)

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

### EXAMPLES ONLY (Not full medication history)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose, Frequency &amp; Route</th>
<th>Reconciled with NIMC at admission</th>
<th>Comments</th>
<th>Discharge Plan (Refer to Legend)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiotropium Cap 18microg</td>
<td>18microg mane (inhale)</td>
<td>W</td>
<td>Withheld whilst on Ipratropium 2.5mg (neb) qid</td>
<td></td>
</tr>
<tr>
<td>Temazepam Tab 10mg</td>
<td>10mg nocte (po)</td>
<td>△</td>
<td>Decreased to PRN only</td>
<td></td>
</tr>
</tbody>
</table>
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 NIMC” 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.
Medication History (continued)

- **On discharge:**
  - Medications on discharge/transfer are to be reconciled with the NIMC, 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.
Western Australian Medication History and Management Plan

<table>
<thead>
<tr>
<th>Abbreviation Key</th>
<th>GP – General Practitioner</th>
<th>CP – Community Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>CF – Care Facility</td>
<td>CMI – Consumer Medicines Information</td>
<td></td>
</tr>
<tr>
<td>D/C – Discharge</td>
<td>ADR – Adverse Drug Reaction</td>
<td></td>
</tr>
<tr>
<td>TF – Transfer</td>
<td>POM – Patient’s Own Medications</td>
<td></td>
</tr>
</tbody>
</table>

### Patient Presentation

<table>
<thead>
<tr>
<th>Presenting Complaint</th>
<th>Past Medical History</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Renal Function on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Pre-Admission Medication History Has Been Confirmed with Two Sources

<table>
<thead>
<tr>
<th>CP</th>
<th>Sign</th>
<th>Patient</th>
<th>Relative</th>
<th>Carer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pl</td>
<td>Fax</td>
<td>Name if not patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pl</td>
<td>Fax</td>
<td>Previous admission at</td>
<td>Hospital</td>
<td></td>
</tr>
<tr>
<td>Pl</td>
<td>Fax</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medication Risk Assessment on Admission

- Can open bottles/measure liquids: Yes | No
- Compliance with medications: Yes | No
- Medications managed by: Can read | Can understand English: Yes | No

### Swallowing Status on Admission

- Nasogastric Tube: Yes | No
- NG – Gastrostomy: Yes | No
- Oral liquid preferred: Yes | No

### Discharge and Transfer Medication Plan

<table>
<thead>
<tr>
<th>Education Provided to Patient</th>
<th>Community Liaison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter required</td>
<td>Patient denied consent to contact GP/CP</td>
</tr>
<tr>
<td>Patient information leaflet</td>
<td>Copy of medication list faxed to GP/CP</td>
</tr>
<tr>
<td>Consumer Medicines Information (CMI)</td>
<td>Liaison with CP regarding D/C medications</td>
</tr>
<tr>
<td>Oral counseling to patient / carer</td>
<td>Verbal counseling to patient / carer</td>
</tr>
<tr>
<td>Medication list provided on discharge</td>
<td>Medication list prescription faxed to CP</td>
</tr>
<tr>
<td>Medication Reconciliation at Discharge</td>
<td>Fax sheet of WA Anticoagulation Chart to CP</td>
</tr>
</tbody>
</table>

### Medications at Discharge

- Patients’ Medications at Discharge: Yes | No
- Patients’ Own Medications reviewed: Yes | No
- Pharmacist involved in discharge summary: Yes | No

### Medications at Discharge

- NIT medications required: Yes | No
- Discontinued at hospital: Yes | No

### Pharmacist Comments and Medication Issues

- Medication plan: Yes | No
- Medication list: Yes | No

**Version 3 2017** Developed in the WA Medication Safety Network together with the Office of Safety and Quality WA. WA Health acknowledges contributions from the Alfred Hospital, The Queen Elizabeth Hospital, Queensland Health Medication Management Services and Adelaide Kenrick Memorial Hospital.
Patient Identification and Location

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

<table>
<thead>
<tr>
<th>Abbreviation Key</th>
<th>SURNAME</th>
<th>URN</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP – General Practitioner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP – Community Pharmacist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CF – Care Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CMI – Consumer Medicines Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D/C – Discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADR – Adverse Drug Reaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T/F – Transfer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POM – Patient’s Own Medications</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GIVEN NAMES</th>
<th>D.O.B.</th>
<th>SEX</th>
</tr>
</thead>
</table>
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.
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.

**Community Liaison**

- Patient denied consent to contact GP/CP
- Copy of medication list faxed to GP/Clinic
- Liaison with CP regarding D/C medications
- Medication list/prescription faxed to CF
- Fax front of WA Anticoagulation Chart to GP
- Given to patient
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](image-url)
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: 30/08/2016

- 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)

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

<table>
<thead>
<tr>
<th>Medication Risk Assessment on Admission</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Can open bottles/measure liquid: Yes  No</td>
<td>Can understand English: Yes No</td>
</tr>
<tr>
<td>Compliance with medications: Yes No</td>
<td>Can read: Yes No</td>
</tr>
<tr>
<td>Medications managed by:</td>
<td>Can see/read labels: Yes No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Swallowing Status on Admission</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasogastric Tube  PEG  Gastrostomy</td>
<td>Oral liquid preferred: Yes No</td>
</tr>
<tr>
<td>Thickened Fluids L150 L400 L900</td>
<td>Crushing required: Yes No</td>
</tr>
</tbody>
</table>
## 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.

<table>
<thead>
<tr>
<th>Discharge and Transfer Medication Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education Provided to Patient</strong></td>
</tr>
<tr>
<td>☐ Interpreter required</td>
</tr>
<tr>
<td>☐ Patient information leaflet</td>
</tr>
<tr>
<td>☐ Consumer Medicine Information (CMI)</td>
</tr>
<tr>
<td>☐ Verbal counselling to patient / carer</td>
</tr>
<tr>
<td>☐ Medication list provided on discharge</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Reconciliation at Discharge</th>
<th>Patient’s Medications at Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Discharge medications reconciled with medications prescribed at discharge on NIMC</td>
<td>☐ Patient’s Own Medications reviewed</td>
</tr>
<tr>
<td>☐ Pharmacist involvement in discharge summary</td>
<td>☐ Patient’s Own S8, S4R and Fridge items reviewed</td>
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<td>☐ Dose Administration Aid required - Packed by:</td>
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- Patient information leaflets include specific medication advice leaflets or the WAMSG “How to manage your medicines after going home from hospital”
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

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<th>Pharmacist Comments and Medication Issues</th>
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- 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.

Delivering a Healthy WA
Pharmacists Comments and Medication Issues (continued)

- When the medicines on the WA MMP have been reconciled against the NIMC, 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


Contact Information

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  Email : safetyandquality@health.wa.gov.au
  Web : http://www.safetyandquality.health.wa.gov.au

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  presentation.