

Western Australian Medication History and Management Plan

User Guide

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Version 2

Developed by the
Western Australian Medication Safety Network
in collaboration with the
Quality Improvement and Change Management Unit

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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 Network to meet WA Health requirements for medication reconciliation.

The WA Medication Safety Network, a network established through Safety and Quality Investment for Reform (SQuIRe) Medication Reconciliation program in 2007, has been involved in reviewing medication reconciliation tools used throughout WA Health. The WA Medication Safety Network has representatives across WA Health. These include regional Chief Pharmacists, regional pharmacists, Co-ordinators of Clinical Pharmacy Services, senior pharmacists from tertiary and secondary sites, a Safety and Quality Director, safety and quality project officers, and medical and nursing representatives.

The WA Medication History and Management Plan is designed to meet the requirements of:

- the Australian Pharmaceutical Advisory Council's Guiding principles to achieve continuity in medication management incorporating the minimum data set for a medication history outlined in guiding principle 4 - accurate medication history¹
- the WA Pharmaceutical Review Policy – Standard 2²
- the National Safety and Quality Health Service Standards - Standard 4³
- the Australian Safety and Quality Goals for Health Care Priority Area 1.1- Medication Safety.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 accurately and comprehensively record a best possible medication history on admission that is available to the clinician responsible for therapeutic decision making.

A medication history and management plan should be available at the point of care. It is recommended that it is kept with the current National Inpatient Medication Chart (NIMC) 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 NIMC (ideally the preceding number) so that once the patient is discharged the plan is filed with the NIMC for that admission.

It can be used as an alternative to the "**Medications taken prior to Presentation to Hospital**" section on the NIMC. 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 be referred to during the patient's episode of care and used during the preparation of the 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**

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)). Over-the-counter medications and complementary therapies should also be enquired about and 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 medication history with the patient and (where possible) an additional source of information that the details obtained in the medication history are correct. If clinical judgment determines this is not necessary, this decision should be explicitly documented.

- **Reconciliation**

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 (includes discharge prescriptions and discharge summary) to the medication history and NIMC to ensure that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.

- **Medication liaison**

Ensuring that frequent and accurate communication regarding the patient's medications occurs between all clinicians involved in the patient's care and 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, 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.⁵

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 pharmacist 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 NIMC, 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 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 chose and align with NIMC/medication chart process for patient identification

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX
private box)	1st user to print patient name and check label correct:

5.2 Patient location

Clearly indicate the patient’s ward location and team on the front page of the WA MMP.

SITE _____
MEDICATION HISTORY AND MANAGEMENT PLAN
WARD _____ TEAM _____

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 NIMC.

Medical officers, nursing staff and pharmacists are required to complete “**Allergies and Adverse Drug Reactions (ADR)**” details for all patients on the [NIMC](#). (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 NIMC.

ALLERGIES & ADVERSE DRUG REACTIONS (tick appropriate box) <input type="checkbox"/> Nil Known <input type="checkbox"/> Unknown <input type="checkbox"/> Reaction – refer to NIMC
--

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 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: _____
	Issue identified by: _____ Contact number: _____	Contacted Y / N	Date: _____
	Issue identified by: _____ Contact number: _____	Contacted Y / N	Date: _____

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
1/7/16 10.15	<i>Patient states he takes aspirin 100mg mane Please review if required for this admission</i> Issue identified by: <i>Pharmacist</i> Contact number: <i>1234</i>	<i>Dr Heart</i> Contacted <input checked="" type="radio"/> Y <input type="radio"/> N	<i>Charted</i> Date: <i>2/7/16</i>
	Issue identified by: Contact number:	Contacted Y / N	Date:
	Issue identified by: Contact number:	Contacted Y / N	Date:

5.5 Medication history checklist

<p>Checklist:</p> <input type="checkbox"/> Oral medications/liquids <input type="checkbox"/> Inhalers <input type="checkbox"/> Topical <input type="checkbox"/> Eye/Ear/Nose <input type="checkbox"/> Injections <input type="checkbox"/> OTC <input type="checkbox"/> 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	Reason for change	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.

- 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 in the “**Reconciled with NIMC**” column.
- 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 Status Legend Reconciled with NIMC and Discharge Plan columns
 NEW: New medication √ : Continued Δ : Changed X: Ceased
 W: Withheld ↑ : Increased dose ↓ : Decreased dose CMI: CMI provided
 □: Not charted

The “**Comments**” section may be used to document extra information that may be pertinent. Refer to examples below.

Medication History – Medications Taken Prior to Admission <input type="checkbox"/> Nil Regular Medications (confirmed by _____)				
Medication Generic Name / Trade Name, Strength and Form (i.e. SR, wafers etc.)	Dose, Frequency & Route	Reconciled with NIMC at admission	Comments	Discharge Plan (Refer to Legend)
EXAMPLES ONLY (Not full medication history)				
Tiotropium Cap 18microg	18microg mane (inhale)	W	Withheld whilst on Ipratropium 2.5mg (neb) qid	
Temazepam Tab 10mg	10mg nocte (po)	Δ	Decreased to PRN only	

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: _____ <input type="checkbox"/> Doctor <input type="checkbox"/> Pharmacist <input type="checkbox"/> Nurse

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. 1/2, 2/2.

On discharge:

Document the doctor’s plan for each medication on discharge (refer to Medication Status Legend). Medications on discharge/transfer are to be reconciled with the NIMC, prescription, the discharge summary and the consumer medication list if prepared. Use the Medication Status Legend to complete this column.

6. BACK PAGE OF WA MEDICATION HISTORY AND MANAGEMENT PLAN

6.1 Patient identification

Complete this section as per the front of the form.

SURNAME	URN
GIVEN NAMES	
D.O.B.	SEX

First user to print patient name and check label correct” to ensure correct addressograph is chose and align with NIMC/medication chart process for patient identification

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 Presentation			
Presenting Complaint _____	Wt _____ kg	RENAL FUNCTION ON ADMISSION	
Past Medical History _____	IBW _____ kg	Date	
_____	Ht _____ cm	Serum Creatinine (micromol/L)	
_____	BSA _____ m ²	Cr Cl (mL/min)	

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	
<input type="checkbox"/>	Patient denied consent to contact GP/CP
<input type="checkbox"/>	Copy of medication list faxed to GP/Clinic
<input type="checkbox"/>	Liaison with CP regarding D/C medications
<input type="checkbox"/>	Medication list/prescription faxed to CF
<input type="checkbox"/>	Fax front of WA Anticoagulation Chart to GP
<input type="checkbox"/>	Given to patient

If consent provided, tick the source(s) used, and document who 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 (<input type="checkbox"/> Nil Regular Medications <input type="checkbox"/> Second Source deemed unnecessary Sign _____)					
<input type="checkbox"/> CP Ph: _____ Fax: _____	Sign _____	<input type="checkbox"/> Patient <input type="checkbox"/> Relative <input type="checkbox"/> Carer Name if not patient _____	Sign _____	<input type="checkbox"/> Own Medications <input type="checkbox"/> POM S8/S4R <input type="checkbox"/> POM Fridge	Sign _____
<input type="checkbox"/> CF Ph: _____		<input type="checkbox"/> Previous admission at: _____ Hospital: _____ Date of D/C / T/F: ____ / ____ / ____		<input type="checkbox"/> Patient List	
<input type="checkbox"/> GP Ph: _____ Fax: _____ <input type="checkbox"/> GP letter Date: ____ / ____ / ____		Dose Administration Aid (D.A.A.) <input type="checkbox"/> Nil <input type="checkbox"/> Blister Pack <input type="checkbox"/> Sachet <input type="checkbox"/> Dosette <input type="checkbox"/> Other: _____ Date Packed: ____ / ____ / ____		<input type="checkbox"/> Other: _____	

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 GP, Community Pharmacy or Nursing Home/Hostel for future reference for medication reconciliation at discharge, even if not used as a source.

Where the 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 by the CF, 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. If discharged from same hospital:

Previous admission at: Bentley
 Hospital : Ward X
 Date of D/C / T/F: 30/08/2016

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

Pre-Admission Medication History Has Been Confirmed with Two Sources (<input type="checkbox"/> Nil Regular Medications <input type="checkbox"/> Second Source deemed unnecessary Sign _____)					
<input checked="" type="checkbox"/> CP <i>SQ Pharmacy</i> Ph: <i>9345 6789</i> Fax: <i>9345 6790</i>	Sign <i>AB</i>	<input type="checkbox"/> Patient <input checked="" type="checkbox"/> Relative <input type="checkbox"/> Carer Name if not patient <i>Wife = Jan</i>	Sign <i>AB</i>	<input checked="" type="checkbox"/> Own Medications <input type="checkbox"/> POM S8/S4R <input type="checkbox"/> POM Fridge	Sign <i>AB</i>
<input type="checkbox"/> CF Ph:		<input checked="" type="checkbox"/> Previous admission at: <i>XCH</i> Hospital: Date of D/C T/F: <i>13, 07, 16</i>		<input type="checkbox"/> Patient List	
<input checked="" type="checkbox"/> GP <i>Dr A Smith</i> Ph: <i>9234 5678</i> Fax: <i>9234 5670</i> <input type="checkbox"/> GP letter Date: / /	Sign <i>AB</i>	Dose Administration Aid (D.A.A.) <input checked="" type="checkbox"/> Nil <input type="checkbox"/> Blister Pack <input type="checkbox"/> Sachet <input type="checkbox"/> Dosette <input type="checkbox"/> Other: Date Packed: / /		<input type="checkbox"/> Other:	

6.4 Medication risk assessment

The medication risk assessment allows documentation of the patient's level of independence prior to admission and at discharge, the patient's ability to self-administer medicines, ability to swallow medicines and other barriers to adherence.

It assists in the identification of issues which require some form of action by nursing, pharmacy or medical staff. For example, if the patient uses a blister pack (e.g. Webster-Pack) as a dose administration aid, a new pack will be required when the patient is discharged (refer also to section 6.3).

Medication Risk Assessment on Admission	
Can open bottles/measure liquid: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can understand English: <input type="checkbox"/> Yes <input type="checkbox"/> No
Compliance with medications: <input type="checkbox"/> Yes <input type="checkbox"/> No	Can read: <input type="checkbox"/> Yes <input type="checkbox"/> No
Medications managed by:	Can see/read labels: <input type="checkbox"/> Yes <input type="checkbox"/> No
Swallowing Status on Admission	
<input type="checkbox"/> Nasogastric Tube <input type="checkbox"/> PEG <input type="checkbox"/> Gastrostomy	Oral liquid preferred: <input type="checkbox"/> Yes <input type="checkbox"/> No
Thickened Fluids <input type="checkbox"/> L150 <input type="checkbox"/> L400 <input type="checkbox"/> L900	Crushing required: <input type="checkbox"/> Yes <input type="checkbox"/> No

6.5 Discharge and Transfer medication plan

This checklist outlines common tasks which occur on discharge. Each task should be considered, completed if appropriate and documented i.e. provision of the [WA Health Consumer Adverse Drug Reaction Brochure](#)

Discharge and Transfer Medication Plan	
Education Provided to Patient <input type="checkbox"/> Interpreter required <input type="checkbox"/> Patient information leaflet <input type="checkbox"/> Consumer Medicine Information (CMI) <input type="checkbox"/> Verbal counselling to patient / carer <input type="checkbox"/> Medication list provided on discharge	<input type="checkbox"/> ADR Brochure Community Liaison <input type="checkbox"/> Patient denied consent to contact GP/CP <input type="checkbox"/> Copy of medication list faxed to GP/Clinic <input type="checkbox"/> Liaison with CP regarding D/C medications <input type="checkbox"/> Medication list/prescription faxed to CF <input type="checkbox"/> Fax front of WA Anticoagulation Chart to GP <input type="checkbox"/> Given to patient
Medication Reconciliation at Discharge <input type="checkbox"/> Discharge medications reconciled with medications prescribed at discharge on NIMC <input type="checkbox"/> Pharmacist involvement in discharge summary	Patient's Medications at Discharge <input type="checkbox"/> Patient's Own Medications reviewed <input type="checkbox"/> Patient's Own S8, S4R and Fridge items reviewed <input type="checkbox"/> Dose Administration Aid required - Packed by: _____

Patient information leaflets include specific medication advice leaflets or the [WAMSG "How to manage your medicines after going home from hospital"](#)

6.6 Medication Reconciliation 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		
<input type="checkbox"/> Nil Medications required	<input type="checkbox"/> Dispensed at hospital	<input type="checkbox"/> Prescription given to patient

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

7. REFERENCES

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