AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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National Medication Management Plan User Guide

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Acknowledgement

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Abbreviations

NMMP	National Medication Management Plan
URN	Unit Record Number
MRN	Medical Record Number
ADR	Adverse Drug Reactions
SR	Slow release
MR	Modified release

Introduction

The National Medication Management Plan (NMMP) is an initiative of the Australian Commission on Safety and Quality in Health Care (the Commission). Designed for use in Australian health services, the NMMP is a standardised form to improve the accuracy and completeness of documented information to support continuity of medication management and medication reconciliation during transitions of care.

Communication problems and poor quality documentation between care settings are a significant factor in causing medication errors and adverse drug events. Recent information indicates that up to 42% of people may be prescribed a medicine that is potentially inappropriate while in hospital.[1] Medication reconciliation offers an opportunity to identify and address medicine-related problems, such as this before care is transferred.

Implementation of medication reconciliation and review processes in Australian health services are mandatory actions within the National Safety and Quality Health Service Standard for Medication Safety. Medication reconciliation has been defined as 'a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.'[2]

Implementation of a standardised form ensures a person's medication history is easy to recognise, access, reconcile and update when new information becomes available. The NMMP is a paper-based format for medication reconciliation processes to occur and could be used to inform a health services' transition to electronic format.

[1] Pharmaceutical Society of Australia 2019. Medicines Safety: Take care. Canberra: PSA.

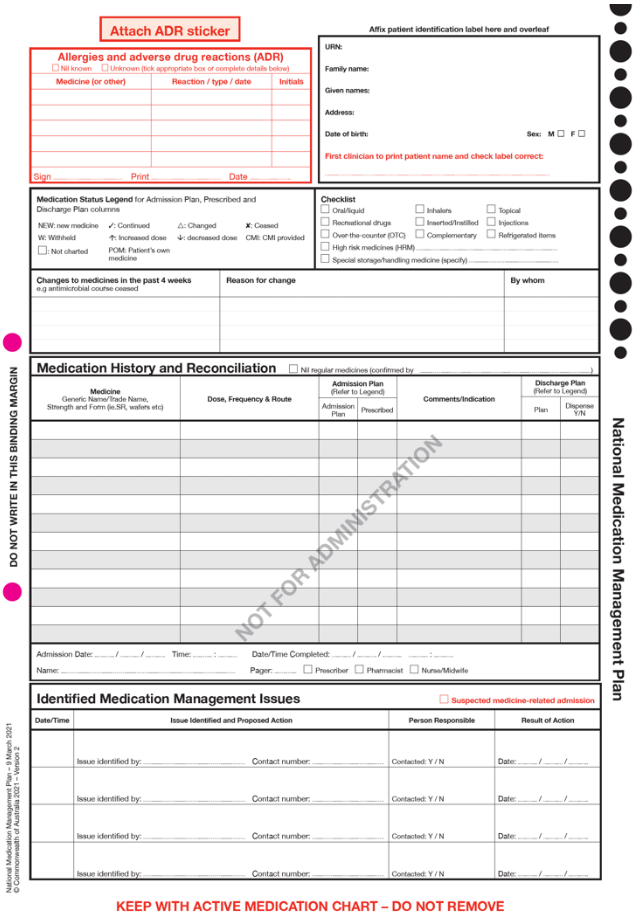
[2] Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for hospitals. Sydney: ACSHQC; 2017.

Principles of NMMP use

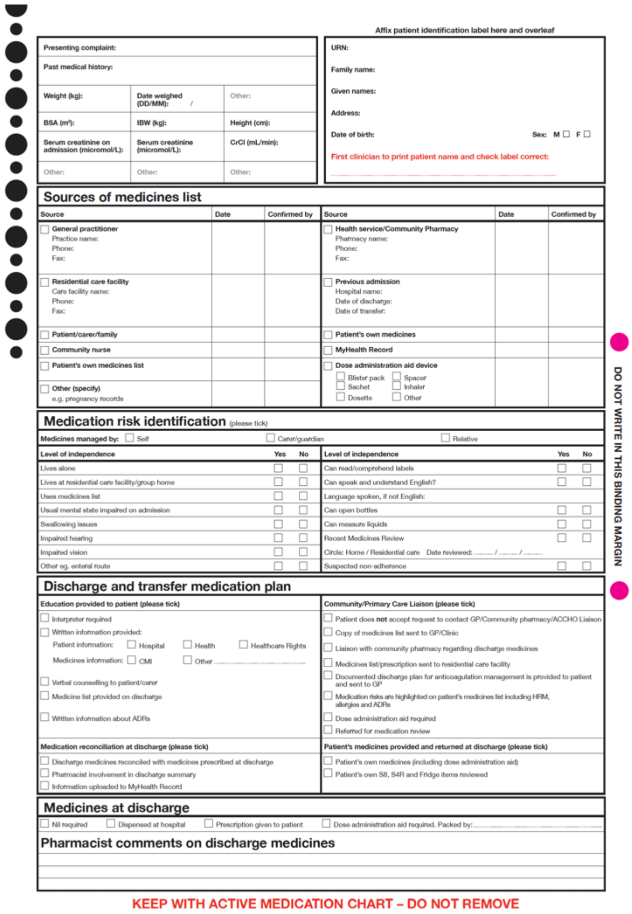
- The use of this standardised form is not mandatory, nor is the structure of this form a requirement for accreditation purposes.
- The NMMP can be used for adult or paediatric patients.
- Keep the NMMP with the active national standard medication chart(s) throughout the patient's admission.
- Consider 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. Documented information must be clear, objective, relevant, correct and within context.
- Avoid using unsafe abbreviations. Use only accepted abbreviations (see Resources section).
- Write legibly in ink. No matter how accurate or complete an order is, it may be misinterpreted if it cannot be read. Use ball point pen - black ink is preferable (check local guidance).
- Do not use water soluble ink (e.g. fountain pen) or erasable pen.
- Do not use erasers or "whiteout". Errors must be crossed out and corrections rewritten.
- **Any urgent medication issues should be brought to the attention of the patient's medical team as soon as possible using more direct forms of communication such as telephone, pager or face to face.**

This document refers directly to how the NMMP should be used and does not cover the broader aspects and approach to medication reconciliation. For more information about how to perform a medication reconciliation for an individual patient, please see the Commission's resources at www.safetyandquality.gov.au.

NMMP template



Page 1



Page 2

NMMP - Section by section

Modifications have been made to the NMMP in 2021. The revised NMMP (version 2.0) is two pages in A4 format and follows the patient journey. Page 1 of the NMMP provides support for medication history, reconciliation and review activities on admission, while Page 2 provides support for medication reconciliation on admission and at discharge.

Guidance on completing each section of this document is outlined below.

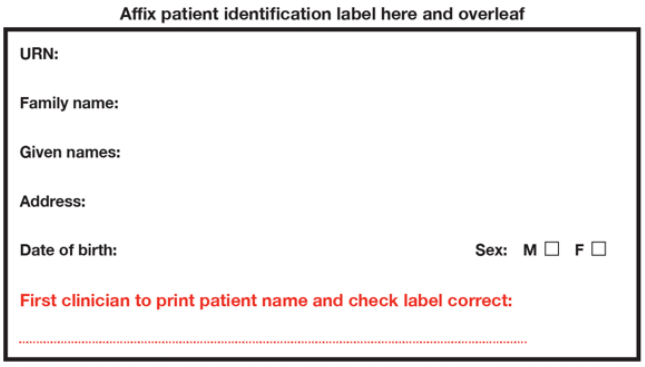
Patient identification

Complete the patient identification by either:

a. Affixing the current patient identification label, or

b. As a minimum, documenting the patient name, URN/MRN number, date of birth and gender.

The first clinician using the document should print the patient's name under the label to confirm the patient's identity and reduce the risk of the wrong label being applied.



Allergies and adverse drug reactions (ADR)

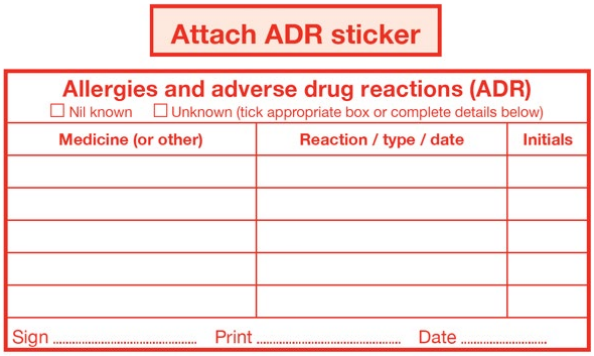
Complete this section in line with the national standard medication chart to document adverse reactions or allergies to medicines, food, latex, dressings or other agents.

- Doctors, nursing staff and pharmacists are required to document details in this section for all patients
- If the patient is not aware of any previous allergy or ADR, the **Nil known** box should be ticked
- If allergy and ADR status is unknown, tick the **Unknown** box. Review of the patient's allergy and ADR status should be checked regularly if unknown has been ticked.
- The person documenting the information must sign, print their name and date the entry

If a **previous or known ADR** exists, the following must be documented:

- Name of the medicine (or its active ingredient), substance, food or trigger
- Reaction details (for example, rash and nausea) and type of reaction (e.g. allergy, anaphylaxis)
- Date that the reaction occurred, or an approximate timeframe (e.g. 20 years ago)

If any information is added to this section after the initial patient interview, the person adding the information must initial the addition in the designated area.

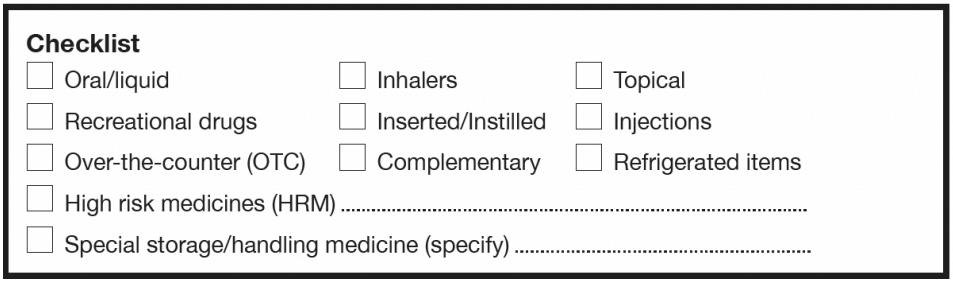


Checklist

The checklist can be used by the documenting individual to:

- Prompt patients to consider use of any other medicines not already listed in the medication history section, and/or
- Highlight to other clinicians the types of medicines the patient is using or might need special consideration due to the type of medicine they are, or any other specific storage or handling requirements, or other instructions.

Clinicians should document the types of medicines the patient was taking on admission and any specific information that needs to be highlighted regarding their use or storage/handling requirements.



Medication History and Reconciliation

This section is included to support documentation of a Best Possible Medication History and processes for medication reconciliation.

To obtain a complete and accurate medication history, information received should be confirmed with a minimum of two sources to ensure its accuracy. Refer to page 2 of the NMMP for potential information sources, which may include:

- asking the patient directly (primary source, where possible)
- using the patient's dose administration aid device or medicine labels
- using information provided by the patient's general practitioner; community pharmacist; referral letter; residential care facility; My Health Record or medicines list.

The medication history should be documented by a clinician or pharmacy technician who has been trained and assessed as competent in conducting medication history interviews with a patient. The patient's medication history should be documented on the NMMP before completing the medication reconciliation checks.

- For patients who are not taking any regular medicines, the:

  ☐ **Nil regular medicines (confirmed by…….)**

should be completed by ticking the box and signing to confirm.

- For patients who are taking regular medicines, the medication history table should be completed as soon as possible after admission, ideally within the first 24 hours.

  The individual that records the patient's medication history and performs the reconciliation should also document:

  - Their name, pager number or contact details and tick the box to confirm their designation
  - The date and time of the patient's admission
  - The date and time the form was completed.

Table 1: Medication information documentation requirements on the NMMP

Feature	Documentation requirement
Medicine	Document the active ingredient name of each medicine (as well as the brand name) the patient is taking on admission. Ensure important information about the medicine's formulation is included, particularly where the patient is taking a slow-release (SR) or modified-release (MR) formulation. Use the **Checklist** on page 1 of the NMMP to confirm with the patient that all medicines have been documented.
Dose, Frequency & Route	Document the corresponding dose, frequency and route of each medicine listed on admission.

Admission Plan	**Admission Plan** Refer to the patient's clinical record (or progress notes) to determine the plan for the patient's admission (as documented). • Reconcile the medicines documented in the admission plan against those documented in the medication history for this section. • Refer to the **Medication Status Legend** and use this to complete the Admission Plan column for each medicine documented in the medication history. Determine and document whether the medicine is to be continued, withheld or otherwise by applying the notations included in the legend against the documented plan. **Prescribed** Refer to the medicines documented on the medication chart and the Admission plan column labelled 'Prescribed'. Within the column labelled 'Prescribed,' note the status of each medicine as documented on the medication chart, for example, to indicate if there are any medicines that have not been charted.
Comments/Indication	Note any differences between medicines documented on the admission plan and the medicines prescribed on the medication chart. Identify and document any areas that require 'follow-up' actions.
Discharge Plan	**Plan** Refer to the patient's clinical record (or progress notes) and the discharge plan. Check the plan for each medicine on the medication chart (and documented in the medication history). Refer to the **Medication Status Legend** and make a notation in the column labelled 'Plan'. New medicines the patient has started, dose changes or ceased medicines should all be noted and reconciled prior to the patient's discharge. **Dispense (Y/N)** Indicate in the 'Dispense' column against each of the medicines whether they will need to be dispensed (or not) by the pharmacy to support the patients' transition of care. It may also be helpful to annotate on this list any medicines that the patient has brought in and need to be returned on discharge (i.e. patient's own medicines). When the discharge prescription is written, the medicines on the prescription and the requirement for ongoing supply of each should be reviewed for completeness against the medicines that have been annotated 'Y' in the 'Dispense' column.

Medication History and Reconciliation

☐ Nil regular medicines (confirmed by .....)

Medicine Generic Name/Trade Name, Strength and Form (ie.SR, wafers etc)	**Dose, Frequency & Route**	**Admission Plan** (Refer to Legend)		**Comments/Indication**	**Discharge Plan** (Refer to Legend)	
		Admission Plan	Prescribed		Plan	Dispense Y/N

Admission Date: ...../...../..... Time: ..... : ..... Date/Time Completed: ...../...../..... ..... : .....

Name: ..... Pager: ..... ☐ Prescriber ☐ Pharmacist ☐ Nurse/Midwife

Changes to medicines in the past 4 weeks

Prompt the patient to consider any changes that have been made to their medicines, specifically in the past four (4) weeks prior to their admission to hospital. Validate this information against other information sources where possible.

Document:

- The change and the reason for change in the relevant columns
- Which clinician initiated the change in the **By whom** column, for example, their general practitioner (GP).

Changes to medicines in the past 4 weeks e.g antimicrobial course ceased	Reason for change	By whom

Identified Medication Management Issues – on Admission

On review of the information documented in the previous sections, document any issues that have been identified through this process along with the proposed action(s) to address the issue(s).

Examples of medication issues may include:

- Regular medicines that have been omitted from the patient's medication chart
- Dose omissions or incorrect doses that need to be confirmed before requesting a modification.

This section may also be used to communicate medication management issues to clinicians at transitions of care, where actions are outstanding and information needs to be communicated to the next healthcare provider to address.

Tick the:

☐ Suspected medicine-related admission

box if the patient's admission to hospital is suspected to be medicine-related. This may be medication misuse or another reason that may have been documented by the admitting doctor in the patient's clinical notes.

For each issue identified, document the:

- Date and time of the entry
- Issue identified and the proposed action
- Person responsible for carrying out any proposed (follow-up) actions and whether this person has (Y) or has not (N) been contacted.

The person with responsibility for the proposed action (usually one of the doctors in the patient's medical team) should document the **Result of Action** and the date on which the action was carried out.

Ensure all information documented in this section is objective, discreet, respectful and non-critical of the patient and clinicians. Avoid phrases which might imply another clinician has made an error or missed something significant. Choose words such as "suggest" or "consider" rather than "do" or "needs".

Any urgent medication issues should be brought to the attention of the patient's medical team as soon as possible using direct forms of communication such as telephone, pager, or face to face communication.

Identified Medication Management Issues			☐ Suspected medicine-related admission
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: ..... / ..... / .....
	Issue identified by: ..... Contact number:	Contacted: Y / N	Date: ..... / ..... / .....

Clinical notes – on admission

The top left of page 2 has been included for the documenting individual to add relevant clinical notes. Sections should be documented as marked, where they are relevant to the patient's medication history, admission plan and/or medicines ordered on the chart. 'Other' data entry fields have been included to allow flexibility for other important notes to be documented.

Presenting complaint:		
Past medical history:		
Weight (kg):	**Date weighed (DD/MM):** /	Other:
BSA (m^2):	**IBW (kg):**	**Height (cm):**
Serum creatinine on admission (micromol/L):	**Serum creatinine (micromol/L):**	**CrCl (mL/min):**
Other:	Other:	Other:

Sources of medicines list – on Admission

Use in conjunction with **Medication History on Admission** to confirm the source of the medicines list. Confirming with a second information source improves accuracy and completeness of the medication history record.

If contact with the patient's primary healthcare provider(s) is (are) required to cross-check the medication history, confirm that the patient agrees to this request. Complete the fields in this section by:

- Ticking the box for source/s used
- Documenting any details relevant to the lists' source
- The date that the medicines list was confirmed
- Documenting who confirmed the medicines list.

Document the patient's agreement to the request for contact in the **Discharge and transfer medication plan** section, part of the Community/ Primary Care Liaison column.

It may be helpful to document contact details of the patient's GP, pharmacy or residential care facility (for example) in this section, (even if they were not used as an information source) to facilitate any medicines-related communication that may be required on discharge.

Regardless of whether a dose administration aid has been used as a medicines list source, any dose administration aids that the patient is using should be documented in this section. This information will help to streamline arrangements for the patient's medicines on discharge.

Sources of medicines list

Source	Date	Confirmed by	Source	Date	Confirmed by
☐ **General practitioner** Practice name: Phone: Fax:			☐ **Health service/Community Pharmacy** Pharmacy name: Phone: Fax:		
☐ **Residential care facility** Care facility name: Phone: Fax:			☐ **Previous admission** Hospital name: Date of discharge: Date of transfer:		
☐ **Patient/carer/family**			☐ **Patient's own medicines**		
☐ **Community nurse**			☐ **MyHealth Record**		
☐ **Patient's own medicines list**			☐ **Dose administration aid device** ☐ Blister pack ☐ Spacer ☐ Sachet ☐ Inhaler ☐ Dosette ☐ Other		
☐ **Other (specify)** e.g. pregnancy records					

Medication risk identification – on Admission

This section offers the documenting clinician an opportunity to record any medication risks that may have been identified during the medication reconciliation and review process on admission. Once complete, it will also provide information to support safe discharge and transfer of care.

Document, by ticking the relevant (Y/N) box(s) to indicate:

- Who currently manages the patient's medicines: self; carer/guardian; relative
- The patient's level of independence against the list of potential risks

Any risks not listed can be documented against 'Other'.

Medication risk identification (please tick)

Medicines managed by: ☐ Self ☐ Carer/guardian ☐ Relative

Level of independence	Yes	No	Level of independence	Yes	No
Lives alone	☐	☐	Can read/comprehend labels	☐	☐
Lives at residential care facility/group home	☐	☐	Can speak and understand English?	☐	☐
Uses medicines list	☐	☐	Language spoken, if not English:		
Usual mental state impaired on admission	☐	☐	Can open bottles	☐	☐
Swallowing issues	☐	☐	Can measure liquids	☐	☐
Impaired hearing	☐	☐	Recent Medicines Review	☐	☐
Impaired vision	☐	☐	Circle: Home / Residential care Date reviewed: ..... / ..... /		
Other eg. enteral route	☐	☐	Suspected non-adherence	☐	☐

Discharge and transfer medication plan

This section should be completed during the discharge planning phase of the patient's hospital stay. Consider the patient's medicine-related requirements and risks prior to their discharge. Complete the following sections by ticking the relevant box(s) to support safe discharge and transfer of care:

- Education provided to patient
- Community/Primary Care Liaison

Following completion of the patient's discharge prescription, consider the tasks for:

- Medication reconciliation at discharge

At the point of discharge, the following section should be completed by ticking the relevant boxes:

- Patient's medicines provided and returned at discharge

This section can also be used to prompt return of the patient's own medicines. Refer to the **Medication History** section for relevant annotations where a patient has brought in medicines that will need to be returned on discharge.

Discharge and transfer medication plan

Education provided to patient (please tick)	Community/Primary Care Liaison (please tick)
☐ Interpreter required ☐ Written information provided: Patient information: ☐ Hospital ☐ Health ☐ Healthcare Rights Medicines information: ☐ CMI ☐ Other ..... ☐ Verbal counselling to patient/carer ☐ Medicine list provided on discharge ☐ Written information about ADRs	☐ Patient does **not** accept request to contact GP/Community pharmacy/ACCHO Liaison ☐ Copy of medicines list sent to GP/Clinic ☐ Liaison with community pharmacy regarding discharge medicines ☐ Medicines list/prescription sent to residential care facility ☐ Documented discharge plan for anticoagulation management is provided to patient and sent to GP ☐ Medication risks are highlighted on patient's medicines list including HRM, allergies and ADRs ☐ Dose administration aid required ☐ Referred for medication review
Medication reconciliation at discharge (please tick)	**Patient's medicines provided and returned at discharge (please tick)**
☐ Discharge medicines reconciled with medicines prescribed at discharge ☐ Pharmacist involvement in discharge summary ☐ Information uploaded to MyHealth Record	☐ Patient's own medicines (including dose administration aid) ☐ Patient's own S8, S4R and Fridge items reviewed

Medicines at discharge

Following reconciliation of the patient's medicines against the discharge plan and the discharge prescription, indicate by ticking the relevant box(s) whether any medicines and/or a dose administration aid are required for the patient. Document how these medicines should be obtained by the patient, if these have not been/ will not be supplied by the hospital pharmacy, whether a prescription is given to the patient, and ensure the patient receives the appropriate advice, also with reference to the above **Discharge and transfer medication plan**.

Medicines at discharge
☐ Nil required ☐ Dispensed at hospital ☐ Prescription given to patient ☐ Dose administration aid required. Packed by: .....

Pharmacist comments on discharge medicines

This section can be used by the ward pharmacist to document any final comments to support communication with other clinicians about the patient's ongoing medication management which may require clarification or follow-up.

Pharmacist comments on discharge medicines

Useful resources

Australian Commission on Safety and Quality in Health Care

- Medication reconciliation
- Recommendations for terminology, abbreviations and symbols used in medicines documentation
- Venous Thromboembolism Prevention Clinical Care Standard

Society of Hospital Pharmacists of Australia

- Compiled Quick Guides

NSW Clinical Excellence Commission

- Guidelines on perioperative management of anticoagulant and antiplatelet agents December 2018.

Council of Australian Therapeutic Advisory Groups (CATAG)

- Optimising My Health Record utilisation. Position statement on the use of My Health Record by Australian public hospitals

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