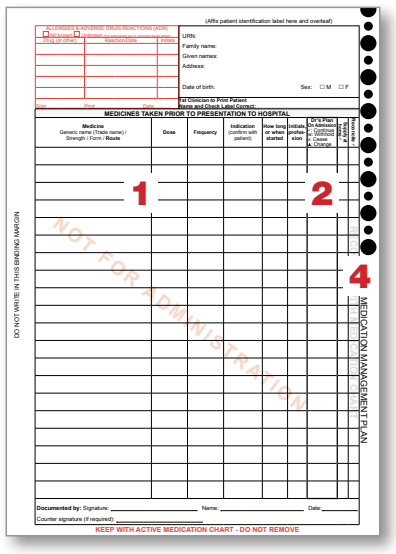
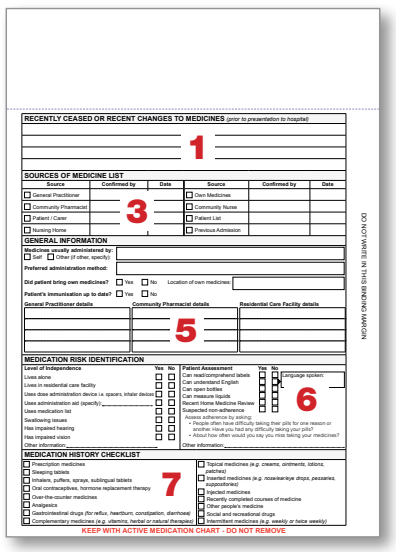
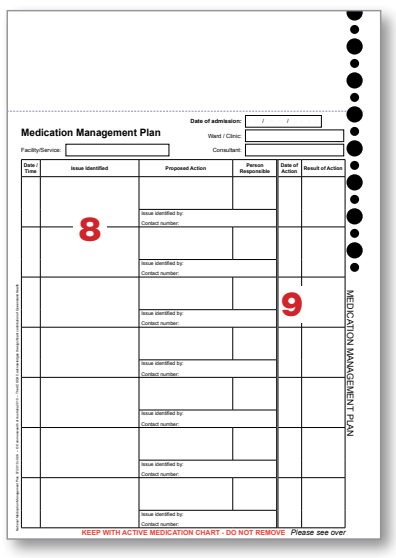
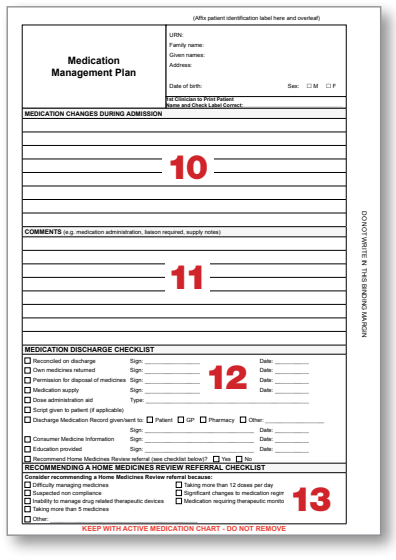
MATCH UP medicines

Guide to using the Medication Management Plan









1. On admission all patients require a best possible medication history
- Prescriber, pharmacist or nurse to document medicines taken prior to admission including non-prescription and complementary medicines.
- Include previous adverse drug reactions and allergies, and any recently ceased or changed medications.
- Pharmacist/nurse to refer to list and clarify or add additional information obtained from patient/carer.

2. Doctor's plan
- Prescriber to document plan for each medication i.e. handover of medication management decisions (continue, withhold, cease) or pharmacist/nurse to confer with prescriber and document plan.

3. Confirm history with at least two sources
- Prescriber, pharmacist or nurse to confirm with at least two sources (e.g. GP, pharmacist, patient's own medicines) that the information is correct.
- Record source of confirmation.

4. Medication reconciliation
- Pharmacist/nurse to compare medicines listed with medication chart. This should take place as soon as possible after admission. Consider doctor's plan and clarify any discrepancies with prescriber.
- Tick when reconciled.

5. GP & community pharmacy details
- Pharmacist/nurse to record details of community healthcare providers.

6. Medication risk identification
- Pharmacist/nurse to assess patient and complete this section.

7. Checklist
- Use to assist to obtain a best possible medication history.

8. Medication issues
- Nurse/pharmacist/prescriber to record issues identified during medication review and action required by appropriate clinician.
- Identifier to record contact details.

9. Document date and result of action
- Clinician performing the action to document this.

10. Medication changes during admission
- Prescriber/pharmacist/nurse to document any changes made during admission which may need to be communicated on discharge.

11. Comments (e.g. medication administration and supply notes)
- Pharmacist/nurse to document any administration or supply notes e.g. patient requires dose administration aid or patient to return to hospital for future supply.

12. Discharge checklist
- Pharmacist/nurse to complete this section.

13. Referral for Home Medicines Review
- Pharmacist/nurse to complete and follow local processes for referral if a Home Medicines Review is required.

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Medrec
matching medicines at transitions of care