Chapter 4: Medication Management Plan

INTRODUCTION

A medication management plan (MMP), medication action plan or pharmaceutical care plan is a key principle in the continuity of medication management across the continuum of care as required by the *Guiding Principles to Achieve Continuity in Medication Management*.[1]

An MMP is a continuing plan developed and used by health professionals in collaboration with patients to develop strategies to manage the use of medicines for the patient. The MMP or equivalent may be used in inpatient, outpatient or non-admitted areas, emergency departments, subacute or for primary care.

The MMP lists issues identified during the assessment of the patient's current medication management and the medication management goals developed.[1] It should combine information, such as medication reconciliation, assessment of current medication management, clinical review, therapeutic drug monitoring (TDM) and adverse drug reaction (ADR) management.

The MMP, and the National Inpatient Medication Chart (NIMC) (or local equivalents including electronic information systems) form the main record of a patient's medicines use throughout their episode of care.

OBJECTIVE AND DEFINITION

Objective

An MMP supports health professionals, in collaboration with the patient, to develop strategies to manage the patient's medicines. Documenting the MMP requires an interdisciplinary approach that includes doctors, nurses, pharmacists and patients/carers across the continuum of care. In acute and subacute care it is also used to assist in discharge and transfer of care planning.[1,2]

Definition

An MMP is a continuing plan for the use and management of medicines developed in collaboration with the patient.[1] The MMP records medicines taken before admission and aids medication reconciliation throughout the patient's episode of care. It is a record of patient-specific medication issues, actions taken to resolve issues and medication management goals developed during the episode of care.

All health professionals are responsible for documenting on the MMP regardless of the setting.

EXTENT AND OPERATION

The ideal opportunity to initiate or review an MMP is during the medication history interview or as early as possible in the episode of care or presentation, see *Chapter 1: Medication reconciliation*. It is a working document that should be reviewed and updated throughout the episode of care.

Ideally, an MMP is completed for all patients. If an MMP cannot be completed for all patients, prioritise those where maximum benefit is likely to be obtained. Patients most at risk of medicines-related problems include those who:

- have medication misadventure as the known or suspected reason for their presentation or admission to the health service organisation
- are aged 65 years or older
- take 5 or more medicines
- take more than 12 doses of medicines per day
- take a medicine that requires therapeutic monitoring or is a high-risk medicine
- have clinically significant changes to their medicines or treatment plan within the last 3 months
- have suboptimal response to treatment with medicines
- have difficulty managing their medicines because of literacy or language difficulties, dexterity problems, impaired sight, confusion/dementia or other cognitive difficulties
- have impaired renal or hepatic function
- have problems using medication delivery devices or require an adherence aid
- are suspected or known to be non-adherent with their medicines
- have multiple prescribers for their medicines
- have been discharged within the last 4 weeks from or have had multiple admissions to a health service organisation.

The MMP must be accessible and should be kept with the current medication chart or with the patient's active health record throughout the episode of care. After transfer or discharge it must be filed with the patient's permanent health record. In outpatients or emergency department the MMP must be filed with the patient's permanent health record.

The *National Medication Management Plan* is a standardised document that aims to improve the completeness of the information documented to ensure the continuity of medicines management in acute and subacute care.[2]

POLICY AND PROCEDURE

Minimum components of an MMP for an individual patient are listed in the *Guiding Principles to Achieve Continuity in Medication Management*, Guiding principle 6: medication action plan and include:[1]

- patient identification and general information
- a current list of medicines (and recent changes)
- risk assessment, e.g. allergies, visual impairment
- action plan, e.g. goals of therapy
- documentation of concordance and relevant discussions with other health professionals
- communication details, e.g. who and where the MMP was sent to.

Ideally, an MMP for an individual patient would also document:[2]

- medication history checklist
- medication reconciliation on admission
- medicines taken prior to presentation to hospital
- recently ceased or recent changes to medicines
- sources of medicines list
- allergies and ADRs
- medication risk identification
- medication issues and management plan
- medication changes during admission
- medication discharge checklist
- who usually administers the patients medicines

- preferred administration methods, e.g. gastrostomy tube
- location of patient's own medicines
- immunisation status
- details of GP, community pharmacy and residential care facility
- recommendation for a Home Medicines Review or other follow-up in primary care.

The patient-specific background information recorded in the MMP is used to support the following clinical pharmacist activities.[3]

Interpreting Patient-Specific Information

Patient-specific information assists in establishing the goals of therapy and management plan and helps pharmacists to identify medicines-related problems and assess the appropriateness of therapy.

Collect and review relevant information, such as age, comorbidities, allergies and ADRs, laboratory results and renal and hepatic function. For a comprehensive list see Table 1.1. Organise and document patient-specific information on the NIMC, MMP or local equivalent. See *Chapter 13: Documenting clinical activities*.

Identifying Medicine-Related Problems

Identify actual or potential medicines-related problems when reviewing patient-specific information. Examples of medicines-related problems might include:

- medicines which have no clear indication
- untreated conditions
- inappropriate medicines
- inappropriate doses considering patient factors, e.g. renal function
- therapeutic duplication
- clinically significant interactions.[3]

See comprehensive list in Table 2.1. See *Chapter 13: Documenting clinical activities*.

Assess the patient's current medication management and conduct clinical review regularly to identify medicines-related problems as they arise.

Prioritise problems according to significance, severity and relevance in order to optimise patient care and outcome. Establish a proactive problem-orientated approach to patient care rather than a reactive response to isolated changes in medicines management.

Individualising Therapy

Together with the patient and other health professionals, identify achievable goals for the patient's management, e.g. cure, symptom control, prevention.

Choice of a particular therapy is based on the planned therapeutic goal, the evidence available and patient preference. Also consider the efficacy, safety, availability and costs. See *Chapter 2: Assessment of current medication management*.

Where multiple therapeutic options exist, the suitability of each treatment must be weighed against individual patient factors and cost to ensure the best possible outcome. Throughout this process, the pharmacist's role is to support the team along with the patient to make informed decisions about the treatment plan.

Monitoring Patient Outcomes

Use a structured and responsive approach and consider potential planned and unplanned outcomes when monitoring patient outcomes. Monitoring should be patient focused and directed to the key endpoints relating to therapy and the clinical problems identified. The frequency of monitoring will vary between patients according to complexity of therapies, timeframe for expected changes and the potential risks associated with the treatment. See *Chapter 3: Clinical review, therapeutic drug monitoring and adverse drug reaction management* and *Chapter 13: Documenting clinical activities*.

Documenting Outcomes

Use the MMP or equivalent to record details of outcomes when goals are achieved, modify goals when outcomes are not achieved and when there are other changes to medication management. See *Chapter 13: Documenting clinical activities*.

On discharge or transfer ensure a copy of the MMP remains with the patient's permanent health record and details of ongoing management are communicated to the patient/carer and other health professionals. See *Chapter 6: Facilitating continuity of medication management on transition between care settings*.

Table 4.1 lists the competencies and accreditation frameworks that are relevant to this chapter.

References

1. Australian Pharmaceutical Advisory Council. Guiding principles to achieve continuity in medication management. Canberra: The Council; 2005.
2. Australian Commission on Safety and Quality in Health Care. National medication management plan user guide. Sydney: The Commission; 2010.
3. Pharmaceutical Reforms SA Health. Continuity in medication management – a handbook for South Australian hospitals. Adelaide: Department of Health, Government of South Australia; 2010.
4. Society of Hospital Pharmacists of Australia. Clinical competency assessment tool (shpaclinCAT version 2). In: SHPA standards of practice for clinical pharmacy services. J Pharm Pract Res 2013; 43 (suppl): S50-S67.
5. Australian Pharmacy Profession Consultative Forum. National competency standards framework for pharmacists in Australia. Deakin: Pharmaceutical Society of Australia; 2010.
6. Australian Commission on Safety and Quality in Health Care. National safety and quality health service standards. Sydney: The Commission; 2012.

Table 4.1 Competencies and accreditation frameworks

Relevant national competencies and accreditation standards and shpaclinCAT competencies
shpaclinCAT[4]
Competency unit 1.1 Medication history
1.1.1 Relevant patient background
1.1.2 Introduction to consultation
1.1.3 Questioning technique
1.1.4 Patient consent
1.1.5 Allergy and adverse drug reaction review
1.1.6 Accurate medication details
1.1.7 Patient's understanding of illness
1.1.8 Patient's experience of medicines use
1.1.9 Documentation of medication history
1.1.11 Adherence assessment
Competency unit 1.2 Assessment of current medication management and clinical review
1.2.2 Drug–drug interactions
1.2.3 Drug–patient interactions
1.2.4 Drug–disease interactions
1.2.5 Drug–nutrient interactions
1.2.6 Appropriate choice of medicine
1.2.7 Medicine order/prescription clarity
1.2.8 Medicine order/prescription legality
1.2.9 Dose review
1.2.10 Route and timing of dose
1.2.11 Selection of formulation, concentration or rate
1.2.12 Review and interpretation of patient-specific data
1.2.13 Therapeutic drug concentration monitoring

Competency unit 1.3 Identification, prioritisation and resolution of medicines-related problems
1.3.2 Identification of medicines-related problems 1.3.3 Prioritisation of medicines-related problems 1.3.4 Resolution of medicines-related problems 1.3.5 Documentation of medicines-related problems 1.3.7 Documentation of clinical pharmacy activities
Competency unit 2.1 Problem solving
2.1.2 Access information 2.1.3 Abstract information 2.1.4 Evaluation and application of information 2.1.5 Appraisal of therapeutic options 2.1.6 Formulation of a clear decision
Competency unit 2.2 Therapeutic understanding
2.2.1 Justification of therapeutic choice
Competency unit 2.4 Communication
2.4.1 Patient and carer 2.4.3 Prescribing staff 2.4.4 Nursing staff 2.4.5 Other health professionals
Competency unit 2.5 Personal effectiveness
2.5.1 Prioritisation 2.5.3 Efficiency 2.5.4 Logic 2.5.5 Assertiveness 2.5.6 Negotiation 2.5.7 Confidence
Competency unit 2.6 Team work
2.6.2 Interdisciplinary team 2.6.4 Promotion of rational medicines use
Competency unit 2.7 Professional qualities
2.7.2 Confidentiality 2.7.4 Responsibility for patient care
National competency standards framework for pharmacists[5]
Standard 1.1 Practise legally
1 Comply with statute law, guidelines, codes and standards 2 Respond to common law requirements 3 Respect and protect consumer's right to privacy and confidentiality 4 Support and assist consumer consent
Standard 1.3 Deliver 'patient-centred' care
1 Maintain primary focus on the consumer 2 Address consumer needs
Standard 1.4 Manage quality and safety
1 Protect and enhance consumer safety 2 Respond to identified risk
Standard 2.1 Communicate effectively
1 Adopt sound principles for communication 2 Adapt communication for cultural and linguistic diversity 3 Manage the communication process 4 Apply communication skills in negotiation
Standard 2.2 Work to resolve problems
1 Analyse the problem/potential problem 2 Act to resolve the problem/potential problem
Standard 2.3 Collaborate with members of the health care team
Standard 4.2 Consider the appropriateness of prescribed medicines
1 Gather relevant information 2 Review the prescribed medicines 3 Promote optimal medicines use
Standard 7.1 Contribute to therapeutic decision-making
1 Obtain accurate medication history 2 Assess current medication management 3 Recommend change in medication management 4 Support and assist consumer self-management
Standard 7.2 Provide ongoing medication management
1 Seek consumer support 2 Review clinical progress 3 Initiate monitoring and intervention 4 Manage medication management records
National safety and quality health service standards[6]
Standard 4 Medication safety: documentation of patient information
4.6 Accurate medication history 4.7 Documentation of adverse drug reactions 4.8 Medication reconciliation
Standard 4 Medication safety: continuity of medication management
4.12 Documented medicines list and changes
Standard 4 Medication safety: communicating with patients and carers
4.13 Informing patients about treatment options 4.14 Medication management plan