Community and Direct Support –
Medication Management Plan and Medication Charts

The *Medication Management Plan and Medication Charts* document a current and accurate list of all medications being taken by the person accessing community and direct support services.

There are two parts:

1. The **Medication Management Plan** completed and signed by the Doctor
2. **Medication Charts** listing all prescription and non-prescription medications completed and signed by the Doctor.

Medication Administration Consent

Name:

Address:

Date of birth: **Date of completion:**

A new authorisation is required to be completed every 12 months from the date of signing.

I [Insert name], being the parent/guardian/person responsible of [insert name of person receiving support] **consent/do not consent** the following:

I ☐ **CONSENT,** ☐ **DO NOT CONSENT** to Ability Options staff to administer medications to [insert supported person's name] that a doctor has charted on the long-term medication chart or management plan.

I ☐ **CONSENT,** ☐ **DO NOT CONSENT** to Ability Options staff to apply sunscreen to the skin of [insert supported person's name] if required.

I understand it is my responsibility to supply Ability Options updated medication charts/plans if/when [insert name of person receiving support] has medication changes. I understand Ability Option staff cannot administer any medications to [insert name of person receiving support] without a current medication chart/plan filled out by the prescribing doctor.

Print name:

Signature: Date:

Informed Consent

I, [insert name] being parent/guardian/person responsible acknowledge that [insert name] (Team Leader) has explained this consent form to me and I understand what I am signing and giving consent to.

Signature: Date:

I, [insert name] (Team Leader), have explained the above to [insert name] and to the best of my knowledge they understand what they are giving consent for.

Signature: Date:

Name: _____ D.O.B: _____

Medication Management Plan

All sections in red to be completed by prescribing medical professional

Participant Details			
Name			
Address			
Phone		DOB	
Parent / Guardian Details			
Name		Phone	
General Practitioner Details			
Name		Phone	
Address			
Pharmacy Details			
Name		Phone	
Address			
Emergency Contacts			
Name		Phone	
Name		Phone	

Allergies:

Prescribed Routine Medication

Name and dosage of medication	Dose Required	No. of tablets	Reason for medication	Interaction with other medications and/or food	Special instructions for administration or storage
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					

Name: _____ D.O.B: _____

Prescribed Routine Medication (Continued)					
Name and dosage of medication	Dose Required	No. of tablets	Reason for medication	Interaction with other medications and/or food	Special instructions for administration or storage
12.					
13.					
14.					

Prescribed PRN Medication					
Name and dosage of medication (Including intervals between dosages)	No. of tablets	Maximum dose in 24 hours	Reason / circumstance for medication	Interaction with other medications and/or food	Special instructions for administration or storage
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Authorisation				
Name and signature of prescribing medical professional	Print Name			
	Signature		Date	
1st Quarter Review	Print Name			
	Signature		Date	
2nd Quarter Review	Print Name			
	Signature		Date	
3rd Quarter Review	Print Name			
	Signature		Date	

Name: _____ D.O.B: _____

Prescribed Short Term Medication e.g. antibiotics						
Name and dosage of medication (each medication to be signed by prescriber)		Dose Required	No. of tablets	Reason for medication	Interaction with other medications and/or food	Special instructions for administration or storage
1.						
Date Started	Signature					
Date Ceased	Signature					
2.						
Date Started	Signature					
Date Ceased	Signature					
3.						
Date Started	Signature					
Date Ceased	Signature					
4.						
Date Started	Signature					
Date Ceased	Signature					
5.						
Date Started	Signature					
Date Ceased	Signature					
6.						
Date Started	Signature					
Date Ceased	Signature					
7.						
Date Started	Signature					
Date Ceased	Signature					
8.						
Date Started	Signature					
Date Ceased	Signature					

Plans attached			
Asthma Management Plan	☐ Yes ☐ No ☐ N/A	Mealtime Management Plan	☐ Yes ☐ No ☐ N/A
Epilepsy Management Plan	☐ Yes ☐ No ☐ N/A	My Medication Support Plan	☐ Yes ☐ No ☐ N/A
Diabetes Management Plan	☐ Yes ☐ No ☐ N/A	Hospital Support Plan	☐ Yes ☐ No ☐ N/A
Allergy / Anaphylaxis Plan	☐ Yes ☐ No ☐ N/A	Other:	☐ Yes ☐ No ☐ N/A

Name: _____ D.O.B: _____

The following procedure is to be followed in the event of a medication error or incident.

1. Don't panic
2. Stay calm
3. DO NOT automatically administer the correct medication

4.	Check that the person is OK	
5.	If the person is NOT OK – call an ambulance **000** immediately and follow first aid principles as required	
6.	If the person is OK, ensure they are comfortable and regularly monitored	
7.	Seek medical advice from the person's medical practitioner or pharmacist	
8.	If unavailable contact one of the following	Healthdirect Australia on **1800 022 222** 24 hours Medicines Line on **1300 MEDICINE (1300 633 424)** Mon-Fri 0900 to 1700 Poisons Information Centre (suspected poisoning only) **13 11 26** 24 hours
9.	Act on any medical advice given and refer staff via the Communication Book to any instructions given and noted in the WeConnect Case Notes	
10.	Once the persons needs are attended to, complete an Incident Report via myReporting and advise the appropriate line manager or on-call manager and follow up further as directed	
11.	Contact parent/guardian or person responsible and notify	
12.	Notify other stakeholders as necessary, e.g. day program, work, school	

In the case of Person, A receiving Person B's medication:

Ensure Person B receives the correct dose of medication by administering the next identical dose blister e.g. if PM medication – ensure blister is identical to dose missed – (PM medication) and administer. If any concerns please contact appropriate line manager or on-call manager as necessary.

If a person vomits after ingesting medication at any time before the next dose is due, a medical practitioner or pharmacist is to be contacted for advice about what action to take, if they are unavailable the Medicines Line is to be contacted as outlined above. See point 8 above.

Name: _____ D.O.B: _____

1. Write the administration times on the lines marked "1 to 8."
2. Administer the contents of the individual compartment of the websterpak, according to the time required and adhering to Ability Options Medication Policy.
3. Initial the square below the date on the appropriate "time line" to indicate that all medicines have been given at that particular time.
4. If Medication is unable to be administered complete an incident report within myReporting and my reporting to management.
   Record number of tablets given in the No. tablets given box.

1 MONTH	Month Of																													
TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MORNING 1																															
No. of Tablets:																															
MORNING 2																															
No. of Tablets:																															
AFTERNOON 3																															
No. of Tablets:																															
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No. of Tablets:																															
DINNER 5																															
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DINNER 6																															
No. of Tablets:																															
BEDTIME 7																															
No. of Tablets:																															
BEDTIME 8																															
No. of Tablets:																															

2 MONTH	Month Of																													
TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MORNING 1																															
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3. **Initial the square below the date on the appropriate "time line" to indicate that all medicines have been given at that particular time.**
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   Record number of tablets given in the No. tablets given box.

3 MONTH Month Of

	TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MORNING	1																															
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	No. of Tablets:																															
DINNER	5																															
	No. of Tablets:																															
	6																															
	No. of Tablets:																															
BEDTIME	7																															
	No. of Tablets:																															
	8																															
	No. of Tablets:																															

4 MONTH Month Of

	TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MORNING	1																															
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5 MONTH Month Of

	TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MORNING	1																															
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BEDTIME	7																															
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	No. of Tablets:																															

6 MONTH Month Of

	TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
MORNING	1																															
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7 MONTH	Month Of																													
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8 MONTH	Month Of																													
TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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9 MONTH	Month Of																												
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10 MONTH	Month Of																												
TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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11 MONTH	Month Of																													
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12 MONTH	Month Of																													
TIMES	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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No. of Tablets:																															

Name: _____ D.O.B: _____

Staff Sign-off

Date	Print Name	Signature	Initial

Dose Omitted Codes to Be Written In Red			
Absent	(A)	Not Required	(N/R)
Adjusted Administration	(A/T)	Refused – Raise Incident	(R)
Fasting	(F)	Self-Administering	(S)
Hospital	(H)	Vomiting	(V)
On Leave	(L)	Withheld – Raise Incident	(W)
Refer to WeConnect Case Note	(M)	Withheld – Pending Results	(W/R)

24 Hour Clock			
AM - Morning		PM – Afternoon	
1.00	0100	1.00	1300
2.00	0200	2.00	1400
3.00	0300	3.00	1500
4.00	0400	4.00	1600
5.00	0500	5.00	1700
6.00	0600	6.00	1800
7.00	0700	7.00	1900
8.00	0800	8.00	2000
9.00	0900	9.00	2100
10.00	1000	10.00	2200
11.00	1100	11.00	2300
12.00	1200	12.00	2400

Document Title: Operations - Disability – Community and Direct Supports - Medication Management Plan and Medication Charts - Form	Document Custodian: Chief Quality, Practice and Outcomes Officer - Disability
Last Review Date: 6 December 2022	Next Review Date: 6 December 2024