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INTRODUCTION

System improvement activities are supported by the collection of relevant data to motivate health services and professionals. This guide has been developed to assist hospitals conduct audits to establish a baseline for data comparison, meet indicator criteria for accreditation (NSQHS Standards 4.6, 4.8 and 4.12), identify areas for improvement and monitor improvement over time.

AUDIT TOOLS

The CEC has developed two audit tools for hospitals to use. The first is a Comprehensive Audit Tool, which will be referred to as the Audit Tool throughout this document. It is the focus of this user guide and collects key information to determine whether:

- A Best Possible Medication History (BPMH) is documented for every patient within 24 hours of admission
- All medicines taken prior to admission which were intended to continue were prescribed on the patient’s medication chart, with documented reason/s for any change
- On discharge, the discharge summary contains an accurate medication list
- On discharge, the discharge summary contains the reason/s for any change in medicines
- On discharge the patient is provided with an accurate medication list.

This audit tool requires the collection of detailed data and provides an indication of the quality of the medicines information in the patient record. It captures, separately, information regarding regular prescribed medicines, prn medicines and non-prescribed medicines, as well as demographic information of the patient sample to enable stratification of findings.

The second is a Snapshot Audit, an observational tool that collects information on whether all components of continuity of medication management are evident for each patient. This provides a quick overview of the processes which are occurring and those which are not. It does not provide detail regarding the quality of the information in the patient’s medical record.

Other indicators and tools which can be used to provide an indication of whether processes of medication reconciliation are occurring can be found in the National Quality Use of Medicines Indicators for Australian Hospitals.
METHOD

The number of medical records reviewed will depend on the site. It is recommended that at least 20 randomly selected records, distributed evenly across the wards/units to be included in the quality improvement activity, be reviewed. Frequent small samples have been shown to be more manageable and provide sufficient data to support ongoing quality improvement activities. However, the proportion of patient records audited at a site may be altered depending on the purpose of the audit (i.e. more records may be required for accreditation purposes).

The following patients should be excluded from the audit:
- Admitted for less than 24 hours
- Transferred from other hospitals (other than direct from ED to ED)
- Died during the admission
- Were provided palliative care only
- Admitted directly to ICU (unless specifically targeting these patients).

Auditing may be conducted by intern and registered pharmacists, registered nurses and doctors who are familiar with the concepts of medication reconciliation and quality improvement methodology. They must familiarise themselves with the audit instructions and definitions as well as complete at least two audit forms with an experienced auditor or complete two audit tool examples (see Appendix 1).

Modular Audit Tool

As continuity of medication management spans across the entire patient’s inpatient stay, the audit tool has been developed to capture medication data from admission to discharge for a typical patient journey (i.e. admitted through ED or directly to the ward from their place of residence). The tool has been divided into three sections to enable various modes of data collection.

Depending on the area being targeted, sites can select which sections of the audit tool to complete. For example if the aim is to improve the number of patients that have a BPMH documented, only Section 1 of the tool requires completion. If the aim is to improve medication reconciliation on admission, Section 1 and 2 would require completion. Both Section 1 and Section 2 may be completed prospectively or retrospectively. If the entire journey is being audited (i.e. completion of all three sections) the audit can only be completed retrospectively (after discharge).

Audit Instructions

1. Read this Audit Tool User Guide. Familiarise yourself with the definitions and audit tool questions and definitions.

2. Read/revise local guidelines and procedures regarding medication history taking, recording medication-related information and transfer of medicines information on discharge or make enquiries in regards to current practices.

3. Decide on the wards/units and number of medical records to review. Decide whether to include all types of medication or regular prescribed medication only. If only regular prescribed medications are chosen the following audit questions do not require completion and should be struck out on the Audit Tool: Q1.10, 1.11, 2.5, 2.6, 2.7 and 2.8.
4. Decide whether to use the Audit Tool to collect data and then enter responses into the Audit Tool Data Spread Sheet (preferable) or enter responses directly into the Audit Tool Data Spread Sheet using the Audit Tool as a guide.

5. Demographic data including patient randomised number, gender, age, department/ward, name of hospital and auditor/s names will need to be entered for each medical record. If using the paper Audit Tool to collect data the audit period i.e. discharge date range of the records audited and the audit date will also need to be entered.

6. When entering data into the Audit Tool Data Spread Sheet, responses should be entered underneath each question in a horizontal direction. The response for a question (yes, no or not applicable) should be selected from the drop-down list in the column marked for that question.

7. A response should be entered for each question. If the question is not applicable and this option is not available, a ‘0’ should be entered.

8. For questions that require items to be counted, enter the total number ‘count’ in the column underneath the section marked for that question.

9. For example:
   - If the response for Q1.7 is ‘MMP’, click on the box and select ‘MMP’ from the drop-down list underneath the column for Q1.7 in the row corresponding to the responses for that record
   - If the response for Q1.8a) is ‘Yes’, click on the box and select ‘Yes’ from the drop-down list underneath the column for ‘Q1.8a’ in the row corresponding to the responses for that record
   - If the response for Q1.9 is ‘5’, enter the digit ‘5’ in the box underneath the column for Q1.9 in the row corresponding to the responses for that record.

   NOTE: Do not enter any spaces or symbols after digits, and only enter data into the WHITE section of the Data Entry Sheet of the Audit Tool Data Spread Sheet. If a wrong response is entered, it can be cleared by using the ‘delete’ or ‘backspace’ keys, or re-select the correct response by clicking on the box again. Also note that the BLUE section labelled, ‘Time to history’ needs to be MANUALLY selected for each patient record from the drop-down list.

10. Data from the Data Entry Sheet should automatically feed into the Data Analysis Sheet within the Audit Tool Data Spread Sheet. Click the Data Analysis Sheet to ensure that each coloured section has been filled in with a value, including ‘0’. Do not alter any of the values within this sheet.

11. Click the Tables and Graphs Sheet within the Audit Tool Data Spread Sheet to view selected data from the Data Analysis Sheet in tabular or graphical format.
DEFINITIONS

The following terms and definitions are used throughout the Audit Tool:

**Best Possible Medication History**  A medication history that has each medicine clearly identified and with clear directions i.e. dose and frequency; allergies and/or adverse drug reactions recorded; and evidence of at least two sources used.

**Regular prescribed medication**  A medicine that would require a prescription or would normally form part of a prescribed treatment plan (e.g. aspirin in a patient with cardiovascular risk factors). This excludes medicines used only when necessary.

**prn prescribed medication**  A medicine used only when necessary that would require a prescription.

**Non-prescribed medication**  A medicine that does not require a prescription or form part of a prescribed treatment plan e.g. over-the-counter medicines, vitamins and complementary medicines.

**Discrepancy**  An omission or change in a medication that has no documented reason and has not been identified or rectified within 48 hours.

**Unintentional discrepancy**  A discrepancy that has not been identified by the auditors as probably intentional due to the patient’s condition or circumstances.
The Audit Tool allows the collection of data relating to a single patient record. It is divided into three sections.

<table>
<thead>
<tr>
<th>Section 1 – Best Possible Medication History (BPMH)</th>
<th>Question</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Admission date and time</td>
<td>Enter the date in the format dd/mm/yyyy. Enter the time in 24 hour clock format i.e. 20:18 rather than 8:18pm.</td>
<td></td>
</tr>
<tr>
<td>1.2 Discharge date and destination</td>
<td>Enter the date in the same format as Q1.1. Select the discharge destination from the list provided.</td>
<td></td>
</tr>
<tr>
<td>1.3 Was this patient on regular medications prior to admission? (if No, do not proceed with data collection)</td>
<td>Select a Yes response if there is evidence in the record that the patient was on regular medications prior to admission. Select a No response if there is no evidence that they were on any medication. If No, do not proceed with data collection but indicate whether ‘patient on nil medications’ was documented by entering a Yes or No response. If Yes, indicate where it was documented.</td>
<td></td>
</tr>
<tr>
<td>1.4 Has a medication history been documented? (if No, do not proceed with data collection)</td>
<td>Select a Yes response if there is a list of medications the patient was taking prior to admission documented in the patient record. Do not include medications entered in the administration section of the medication chart or any list provided by an external healthcare provider or patient. Select a No response if there is no documentation of a medication list in the patient record. If No, do not proceed with data collection.</td>
<td></td>
</tr>
<tr>
<td>1.5 Who documented the most comprehensive medication history? (select only one)</td>
<td>Select who documented the most comprehensive medication history for the patient from the list provided. The most comprehensive list refers to the list that includes more medications or provides the most information about the medications e.g. strength, dose and frequency. If the histories are the same select the history documented first. If the history selected is documented by more than one clinician, select ‘Multidisciplinary Team.’ If someone documented the medication history other than those listed, provide details in the ‘Other’ section.</td>
<td></td>
</tr>
<tr>
<td>1.6 Date and time (if available) medication history was documented</td>
<td>Enter the date and time in the same format as Q1.1. If there is no time documented then enter using free-text, Not Applicable.</td>
<td></td>
</tr>
<tr>
<td>1.7 Where was the medication history documented?</td>
<td>Select where the comprehensive medication history was documented from the list provided, or if other than those listed, provide details in the ‘Other’ section.</td>
<td></td>
</tr>
<tr>
<td>1.8a) Were the patient’s allergies, adverse drug reactions, or lack of, documented as part of the history?</td>
<td>Select a Yes response if an allergy, adverse drug reaction, nil or not known was documented. Select a No response if there is no mention of allergies and/or adverse drug reactions either existing or not-existing.</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Definition</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1.8b) Were details documented? (i.e. type of reaction or nil or not known)</td>
<td>Select a Yes response if as well as the agent causing the allergy and/or adverse drug reaction, the type of reaction is documented, or in the case where nil or not known had been selected for Q1.8b). Select a No response if an allergy and/or adverse drug reaction had been documented but no details were given. Select a Not Applicable response if the response for Q1.8a was No.</td>
<td></td>
</tr>
<tr>
<td>1.9a) Number of regular prescribed medications?</td>
<td>Count and enter the number of medications that would require a prescription or would normally form part of a prescribed treatment plan (e.g. aspirin in a patient with cardiovascular risk factors), excluding medications used only when necessary.</td>
<td></td>
</tr>
<tr>
<td>1.9b) Number with name, dose and frequency?</td>
<td>Count and enter the number of these medications that have been clearly identified and have clear directions (generic or trade name, dose and frequency as a minimum). For combination products available in only one strength the dose can be expressed as a number e.g. two at night.</td>
<td></td>
</tr>
<tr>
<td>1.10a) Number of prn prescribed medications?</td>
<td>Count and enter the number of prescribed ‘when necessary’ medications (e.g. medications used only when necessary that would require a prescription).</td>
<td></td>
</tr>
<tr>
<td>1.10b) Number with name, dose and frequency?</td>
<td>Count and enter the number of these medications that have been clearly identified and have clear directions (generic or trade name, dose and frequency as a minimum). For combination products available in only one strength the dose can be expressed as a number e.g. two at night.</td>
<td></td>
</tr>
<tr>
<td>1.11a) Number of non-prescribed medications?</td>
<td>Count and enter the number of medications not included in Q1.9 or Q1.10, inclusive of over-the-counter and complementary medications.</td>
<td></td>
</tr>
<tr>
<td>1.11b) Number with name, dose and frequency?</td>
<td>Count and enter the number of these medications that have been clearly identified and have clear directions (generic or trade name, dose and frequency as a minimum). For combination products available in only one strength the dose can be expressed as a number e.g. two at night.</td>
<td></td>
</tr>
<tr>
<td>1.12a) Was/were the source/s of the information obtained for the medication history documented?</td>
<td>Select a Yes response if the source/s of information obtained for the medication history were documented.</td>
<td></td>
</tr>
<tr>
<td>1.12b) Were 2 or more sources used?</td>
<td>Select a Not Applicable response if the response to Q1.12a) was No.</td>
<td></td>
</tr>
</tbody>
</table>
## Section 2 – Medication Reconciliation on Admission

<table>
<thead>
<tr>
<th>Question</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Number of regular and prn prescribed medications taken prior to admission with a documented plan? (i.e. to continue, change, withhold or cease)</td>
<td>Count and enter the number of prescribed medications that have a documented plan in the record to continue, change, withhold or cease. This includes both regular and prn prescribed medications. The medications do not have to be individually mentioned, a plan to ‘continue all medications’ is acceptable. ‘As charted’ does not reflect a clear plan and should not be considered a documented plan.</td>
</tr>
<tr>
<td>2.2 Number of non-prescribed medications taken prior to admission with a documented plan?</td>
<td>Count and enter the number of non-prescribed medications that have a documented plan as described in the definition for Q2.1.</td>
</tr>
<tr>
<td>2.3a) Number of regular prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>Count and enter the number of regular prescribed medications that have been omitted from the medication chart without a documented reason for the omission. Omissions that were identified or rectified within 48 hours of admission should be excluded from the count.</td>
</tr>
<tr>
<td>2.3b) Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>Count and enter the number of medications identified in 2.3a) that are possibly intentionally omitted due to obvious patient/disease factors (e.g. NSAID omitted in patient presenting with a GI bleed).</td>
</tr>
<tr>
<td>2.4a) Number of regular prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>Count and enter the number of regular prescribed medications that have been written on the medication chart with a change that has no documented reason for the change. Medication changes that had no documented reason that were identified or rectified within 48 hours of admission should be excluded from the count.</td>
</tr>
<tr>
<td>2.4b) Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>Count and enter the number of medications identified in 2.4a) that are possibly intentionally changed due to obvious patient/disease factors.</td>
</tr>
<tr>
<td>2.5a) Number of prn prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>Count and enter the number of prn prescribed medications that have been omitted from the medication chart without a documented reason for the omission. Omissions that were identified or rectified within 48 hours of admission should be excluded from the count.</td>
</tr>
<tr>
<td>2.5b) Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>Count and enter the number of medications identified in 2.5a) that are possibly intentionally omitted due to obvious patient/disease factors.</td>
</tr>
<tr>
<td>2.6a) Number of prn prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>Count and enter the number of prn prescribed medications that have been written on the medication chart with a change that has no documented reason for the change. Medication changes that had no documented reason that were identified or rectified within 48 hours of admission should be excluded from the count.</td>
</tr>
<tr>
<td>Question</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2.6b) <strong>Number</strong> of these possibly intentional due to obvious patient/disease factors?</td>
<td>Count and enter the number of medications identified in 2.6a) that are possibly intentionally changed due to obvious patient/disease factors.</td>
</tr>
<tr>
<td>2.7a) <strong>Number</strong> of non-prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>Count and enter the number of non-prescribed medications that have been omitted from the medication chart without a documented reason for the omission. Omissions that were identified or rectified within 48 hours of admission should be excluded from the count.</td>
</tr>
<tr>
<td>2.7b) <strong>Number</strong> of these possibly intentional due to obvious patient/disease factors?</td>
<td>Count and enter the number of medications identified in 2.7a) that are possibly intentionally omitted due to obvious patient/disease factors.</td>
</tr>
<tr>
<td>2.8a) <strong>Number</strong> of non-prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) and not rectified or identified within 48 hours?</td>
<td>Count and enter the number of non-prescribed medications that have been written on the medication chart with a change that has no documented reason for the change. Medication changes that had no documented reason that were identified or rectified within 48 hours of admission should be excluded from the count.</td>
</tr>
<tr>
<td>2.8b) <strong>Number</strong> of these possibly intentional due to obvious patient/disease factors?</td>
<td>Count and enter the number of medications identified in 2.8a) that are possibly intentionally changed due to obvious patient/disease factors.</td>
</tr>
<tr>
<td>Question</td>
<td>Definition</td>
</tr>
<tr>
<td>----------</td>
<td>------------</td>
</tr>
<tr>
<td>3.1 <strong>Was a discharge summary completed for this patient?</strong></td>
<td>Select a Yes or No response.</td>
</tr>
<tr>
<td>3.2 <strong>Number of medications to be continued on discharge</strong>, determined by reviewing medications taken prior to admission, the medication chart, discharge prescriptions (if available), the discharge summary and any documented plan for continued therapy?</td>
<td>Use the Auditor’s Work Sheet to determine the ‘intended regimen on discharge’ for each patient (see Appendix 2). List the medications taken prior to admission, the plan for admission medicines, the medications on the medication chart at admission and discharge, any documented plan for continued therapy and medications on the discharge summary. Count and enter the number of medications listed in the ‘intended regimen on discharge’ column of the Auditor’s Work Sheet.</td>
</tr>
<tr>
<td>3.3 <strong>Number of medications omitted from the discharge summary?</strong></td>
<td>Count and enter the number of medications to be continued on discharge that were omitted from the discharge summary.</td>
</tr>
<tr>
<td>3.4 <strong>Number of medications included on the discharge summary with a discrepancy (name, dose, route, form, frequency)?</strong></td>
<td>Count and enter the number of medications to be continued on discharge that were documented on the discharge summary with an unexplained change.</td>
</tr>
<tr>
<td>3.5 <strong>Number of unexplained extra medications on the discharge summary?</strong></td>
<td>Count and enter the number of medications documented in the discharge summary that were not identified to continue on discharge.</td>
</tr>
<tr>
<td>3.6a) <strong>Number of medications the patient had been taking prior to admission that were ceased?</strong> (i.e. not to be continued on discharge)</td>
<td>Count and enter the number of medications the patient had been taking prior to admission that were not to be continued on discharge.</td>
</tr>
<tr>
<td>3.6b) <strong>Number of these documented as ceased on the discharge summary?</strong></td>
<td>Count and enter the number of medications identified in 3.6a) that were documented as having been ceased during the admission on the discharge summary.</td>
</tr>
<tr>
<td>3.7a) <strong>Number of medications to be continued on discharge either new, or differing in strength, dose or frequency?</strong></td>
<td>Count and enter the number of medications to be continued on discharge that were new for the patient or the patient had been taking but had been changed to a different strength, dose or frequency.</td>
</tr>
<tr>
<td>3.7b) <strong>Number of these documented on the discharge summary as either new, or differing in strength, dose or frequency?</strong></td>
<td>Count and enter the number of medications identified in 3.7a) that were documented as being new or changed during the admission on the discharge summary.</td>
</tr>
<tr>
<td>3.8 <strong>Number of new, changed or ceased medications that had reason/s for change documented on the discharge summary?</strong></td>
<td>Count and enter the number of medications identified in Q3.7a) and Q3.6a) that had a documented reason for the addition, changing or ceasing of these medications on the discharge summary.</td>
</tr>
<tr>
<td>3.9 <strong>Was the patient provided with a medication list on discharge?</strong> (if No or Not Applicable do not proceed with data collection)</td>
<td>Select a Yes, No or Not Applicable response. A patient medication list may not be applicable in the case of inter-hospital transfers or nursing home discharge destinations.</td>
</tr>
<tr>
<td>3.10 <strong>Number of medications omitted from the patient medication list?</strong></td>
<td>Count and enter the number of medications to be continued on discharge that were omitted from the patient medication list.</td>
</tr>
<tr>
<td>Question</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3.11 <strong>Number</strong> of medications included in the patient medication list with a <strong>discrepancy</strong> (name, dose, route, form, frequency)?</td>
<td>Count and enter the number of medications to be continued on discharge that were documented on the patient medication list with an unexplained change.</td>
</tr>
<tr>
<td>3.12 <strong>Number</strong> of <strong>unexplained extra</strong> medications on the patient medication list?</td>
<td>Count and enter the number of medications documented in the patient medication list that were not identified to continue on discharge.</td>
</tr>
<tr>
<td>3.13 <strong>Number</strong> of medications <strong>documented as ceased</strong> on the patient medication list?</td>
<td>Count and enter the number of medications identified in 3.6a) that were documented as having been ceased during the admission on the patient medication list.</td>
</tr>
<tr>
<td>3.14 <strong>Number</strong> of medications <strong>documented</strong> on the patient medication list <strong>as either new, or differing in strength, dose or frequency</strong>?</td>
<td>Count and enter the number of medications identified in 3.7a) that were documented as being new or had changed during the admission on the patient medication list.</td>
</tr>
<tr>
<td>3.15 <strong>Number</strong> of <strong>new, changed or ceased</strong> medications that had <strong>reason/s for change documented</strong> on the patient medication list?</td>
<td>Count and enter the number of medications identified in Q3.7a) and Q3.6a) that had a documented reason for the addition, changing or ceasing of these medications on the patient medication list.</td>
</tr>
<tr>
<td>3.16 Does the list of medications in the <strong>patient medication list</strong> correspond identically with the list of medications in the <strong>discharge summary</strong>?</td>
<td>Select a Yes or No response.</td>
</tr>
</tbody>
</table>
Appendix 1 – Audit Tool Examples
Date and Time
(use 24 hr clock)
4/11/13
9:45 AM

PROGRESS / CLINICAL NOTES

Note: All entries must be legible, written in black pen and include the health care provider’s printed name, designation and signature.

SB 87 West Reg.

94 y. fam home.

Difficult swallowing food over last week

Feels like food gets blocked

Excessive pain for last 2 days

Able to eat orange juice 1 day

Has had a few episodes of regurgitation

No problems previously with food

PND / GORD

Chronic

Autoimmune haemolytic anaemia

Magnetic cell lymphoma

Med/ Rec: Lithium 300mg daily

Folic acid 5mg daily

Iron supplement

Vitamin B12 drops

OE / Asthma

Excoriation

Bleeds (X)

Imp? / Gastroesophageal reflux

? Food bolus

? Peptic ulcer

? PCL oesophagitis
<table>
<thead>
<tr>
<th>Date and Time (Use 24 hr clock)</th>
<th>Note: All entries must be legible, written in black pen and include the health care provider’s printed name, designation and signature.</th>
</tr>
</thead>
</table>
| 9/4/18 1:30 PM                  | Plan/Adult W Dr Gupta
|                                 | PO PR
|                                 | Caffeine, Bonnef 1/2
|                                 | IV fluids
|                                 | NBM
|                                 | [Handwritten: Dr. Gupta]
GREEN, Ms Sarah – 7654321

**Discharge Referral Baseline**

Patient: GREEN Ms Sarah  
MRN: 7654321
Age: 94 years  
Sex: Female  
DOB: 11/01/1919
Associated Diagnoses: Dysphagia; Schatzki’s ring
Author: David STONE

**Visit Information**

Facility: Sunny Hospital
Admission Date: 04/11/2013
Medical Service: Gastroenterology
Attending Medical Officer: Dr Raj Gupta
A/MO Provider No.: 123456H
Local Medical Officer: Dr Catherine King
LMO Provider No.: 23456H
LMO Address: Dr Catherine King  
2/45 Arthur Street  
Happyville, 2786, NSW
LMO Phone: 9345 9876
Language spoken at home: English
Interpreter Required: No

Dear Dr Catherine King,

Thank you for reviewing Sarah Green, a 94 year old female to be discharged on 06/11/2013 from Sunny Hospital. Sarah presented to this facility with dysphasia.

**Summary of Care**

Ms Green presented on the 4/11/13 with dysphasia and subsequently discovered to have a mild schatzki ring.

**PMH**
- GORD
- glaucoma
- autoimmune haemolytic anaemia – cold type
- ?marginal cell lymphoma

No surgeries, AMI, DVT/PE

**Medications:**
- Zantac 300mg daily
- Folic acid 5mg daily
- Iron supplement

To be discharged: 06/11/2013
Indigenous Status: Neither Aboriginal/Torres Strait Is
Consulting Clinician:
GREEN, Ms Sarah – 7654321

Result Type: Discharge Referral Note
Result Date: 06 November 2013 14:18
Result Status: Auth (Verified)
Result Title: Discharge Referral Baseline
Performed By: David STONE (JMO) on 06 November 2013 14:30
Verified By: David STONE (JMO) on 06 November 2013 16:24

Xalatan eye drops

SHx
- retired nurse
- lives alone in house
- no children
- independent in ADLs – no longer drives

HPC
- 1 week increasing difficulty swallowing food with epigastric discomfort
- 2 days of inability to completely swallow, food/liquid regurgitating
- able to manage very small amounts of liquid and saliva
- mild epigastric pain in waves, better when sitting up
- mostly comfortable at rest
- otherwise feels well (but hungry)
- background of GORD

Relevant negatives
- not regurgitating blood or green/bilious material
- no ongoing chest pain, shortness of breath, coughing, forceful vomiting, change in bowel habits, fevers
- no history of peptic ulcer disease

On Examination in ED
afibrile, obs stable and normal SBP 155, HR 80, Sat 96 RA
Resp: good air entry bilaterally, no added sounds – transmitted bowel sounds heard
CVS: heart sounds dual, no murmurs heard, JVP not elevated, mild pitting oedema to mid shin
Abdomen: soft, mild epigastric tenderness to deep palpitation; no hepatosplenomegaly or masses; bowel sounds present
No focal neurology

Initial Inx
CXR – clear
FBC/EUC/LFT/CMP normal
lactate 329
GREEN, Ms Sarah – 7654321

Result Type: Discharge Referral Note
Result Date: 06 November 2013 14:18
Result Status: Auth (Verified)
Result Title: Discharge Referral Baseline
Performed By: David STONE (JMO) on 06 November 2013 14:30
Verified By: David STONE (JMO) on 06 November 2013 16:24

PROGRESS
-she was admitted under Dr Gupta
-commenced on pantoprazole 40mg twice daily aiming to continue for 2 weeks then daily (ranitidine stopped)
-she underwent endoscopy on the same day and tolerated the procedure well

Endoscopy (5/11/13)
LA Grade D (one or more mucosal breaks involving at least 75% of oesophageal circumference)
oesophagitis with bleeding was found 35 to 40cm from the incisors. A mild Schatzki ring (acquired) was found in the lower third of the oesophagus. There was mild resistance initially but the scope was able to pass through easily. Contact bleeding occurred. The entire examined stomach was normal. Biopsies were taken with a cold forceps for histology. The examined duodenum was normal. A small hiatus hernia was present.

-she tolerated soft diet post endoscopy and has been upgraded successfully to full diet without further issues

==================================

PLAN
-dischARGE home
-continue oral pantoprazole 40mg twice daily for 2 weeks then reduce to daily
-ranitidine ceased, continue other meds as usual
-follow up in gastroenterology clinic with Dr Gupta on 18/Nov/13 at 3pm, staff station 2 (bring medicare card)

Health Status
Principle and Other Diagnosis
Dysphagia : SNMCT 67950018, Final Medical.
Schatzki's ring : SNMCT 11100017, Final, Medical.
Allergies and Adverse Reactions
No active allergies have been recorded.

Discharge Information
Performed by
Dr David Stone; Medical Officer

Completed Action List:
*Performed by David STONE on 06 November 2013 14:30
*Signed by David STONE on 06 November 2013 16:32
*Verified by David STONE on 06 November 2013 16:32

Page 3 of 3
NOTE: That while in hospital you continued your medication.

Prepared by: A.W.

Bring this list on each visit to your doctor, pharmacist, dentist or other Health Care Provider.

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somacem Eye Drops (Latanoprost)</td>
<td>ONE</td>
</tr>
<tr>
<td>Latanoprost (KALATAN)</td>
<td></td>
</tr>
<tr>
<td>Tablets</td>
<td>ONE</td>
</tr>
<tr>
<td>Ferrous Sulphate (Ferrero)</td>
<td>ONE</td>
</tr>
<tr>
<td>Folic Acid and Folic Acid Supplementation</td>
<td>ONE</td>
</tr>
<tr>
<td>Folic Acid and Folic Acid Supplementation</td>
<td>ONE</td>
</tr>
<tr>
<td>Doctor in 2 weeks. Dose to be reviewed by your doctor in 2 weeks.</td>
<td>ONE</td>
</tr>
<tr>
<td>Pantoprazole (SalpraZ)</td>
<td>ONE</td>
</tr>
<tr>
<td>Product Description</td>
<td></td>
</tr>
<tr>
<td>Medication Period from 08/11/2013</td>
<td></td>
</tr>
<tr>
<td>Medication List for Ms. Sarah Green. MRN 7654321</td>
<td></td>
</tr>
<tr>
<td>Sunny Hospital Medication List</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Department Phone: 02 9346 7596</td>
<td></td>
</tr>
</tbody>
</table>
Continuity of Medication Management Comprehensive Audit Tool

Auditor's Worksheet

<table>
<thead>
<tr>
<th>Patient Number:</th>
<th>Medications taken prior to admission</th>
<th>Plan for medication chart at admission</th>
<th>Medications on medication chart at discharge</th>
<th>Medications on discharge summary</th>
<th>Intended regimen on discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Patient Name:** Jane Doe
- **Medications Taken Prior to Admission:**
  - **Paracetamol**
  - **Ibuprofen**
- **Plan for Medication Chart at Admission:**
  - **Yes**
- **Medications on Medication Chart at Discharge:**
  - **Yes**
- **Medications on Discharge Summary:**
  - **Yes**
- **Intended Regimen on Discharge:**
  - **Yes**

**Notes:**
- **Admit Reason:** Fever, cough, sore throat
- **Admit Date:** 2023-01-01
- **Discharge Date:** 2023-01-07

**Observations:**
- **Medication Compliance:** 100%
- **Adherence to Treatment Plan:** 95%
- **Side Effects:** Mild nausea

**Conclusion:**
- **Recommendations:**
  - Increase hydration
  - Monitor fever closely

**Signatures:**
- **Medical Staff:** Dr. John Doe
- **Pharmacist:** Jane Smith

**Date:** 2023-01-10
Continuity of Medication Management
Comprehensive Audit Tool

Audit Period: 12/1/15 - 1/1/15
Date of Audit: 2/11/15
Patient Number: 14
Gender: Male
Age: 64
Department/Ward: Medical

Hospital: Sunny Hospital
Auditor's names: Kim Jones, Chris Collins
Additional Notes:

Section 1: Best Possible Medication History (BPMH)

1.1 Admission date: 04/11/2013
1.2 Discharge date: 06/11/2013
1.3 Was this patient on regular medications prior to admission? (if No, do not proceed with data collection)
   - Yes
   - No
   If No, was "patient on nil medications" documented?
   - Yes
   - No
   If Yes, where was it documented?

1.4 Has a medication history been documented? (if No, do not proceed with data collection)
   - Yes
   - No

1.5 Who documented the most comprehensive medication history? (select only one)
   - ED medical officer
   - Admitting medical team
   - Registered nurse
   - Nurse practitioner
   - Pharmacist
   - Multidisciplinary team
   - Other (provide details):

   N.B. Use selected comprehensive history to complete data collection

1.6 Date and time (if available) medication history was documented
   - Date: 04/11/2013
   - Time: 17:30

1.7 Where was the medication history documented?
   - History section of NIMC
   - MMP
   - Paper progress notes
   - Other dedicated form
   - Electronic progress notes
   - Medication table
   - Other (provide details):

1.8 a) Were the patient's allergies, adverse drug reactions, or lack of, documented as part of the history?
   - Yes
   - No

1.8 b) Were details documented? (i.e. type of reaction or nil or not known)
   - Yes
   - No
   - Not applicable

1.9 a) Number of regular prescribed medications?
   - Yes: 2
   - Comments: [Xanthine, no dose or frequency]

1.9 b) Number with name, dose and frequency?
   - Yes: 1
   - Comments: [Xanthine, no dose or frequency]

1.10 a) Number of prn prescribed medications?
   - Yes: 0
   - Comments:

1.10 b) Number with name, dose and frequency?
   - Yes: 0
   - Comments:

1.11 a) Number of non-prescribed medications?
   - Yes: 2
   - Comments:

1.11 b) Number with name, dose and frequency?
   - Yes: 1
   - Comments: [Iron supplement, not clear]

1.12 a) Was/were the source(s) of the information obtained for the medication history documented? (if No, do not proceed with data collection)
   - Yes
   - No
   - Not applicable

b) Were 2 or more sources used?
   - Yes
   - No
   - Not applicable
## Section 2: Medication Reconciliation on Admission

This section compares the medications taken prior to admission to those prescribed on the medication chart.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Number of regular and prn prescribed medications taken prior to admission with a documented plan? (i.e., to continue, change, withhold or cease)</td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Number of non-prescribed medications taken prior to admission with a documented plan?</td>
<td></td>
</tr>
<tr>
<td>2.3 a)</td>
<td>Number of regular prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>a)</td>
</tr>
<tr>
<td>2.3 b)</td>
<td>Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>b)</td>
</tr>
<tr>
<td>2.4 a)</td>
<td>Number of regular prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>a)</td>
</tr>
<tr>
<td>2.4 b)</td>
<td>Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>b)</td>
</tr>
<tr>
<td>2.5 a)</td>
<td>Number of prn prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>a)</td>
</tr>
<tr>
<td>2.5 b)</td>
<td>Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>b)</td>
</tr>
<tr>
<td>2.6 a)</td>
<td>Number of prn prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>a)</td>
</tr>
<tr>
<td>2.6 b)</td>
<td>Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>b)</td>
</tr>
<tr>
<td>2.7 a)</td>
<td>Number of non-prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?</td>
<td>a)</td>
</tr>
<tr>
<td>2.7 b)</td>
<td>Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>b)</td>
</tr>
<tr>
<td>2.8 a)</td>
<td>Number of non-prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) and not identified or rectified within 48 hours of admission?</td>
<td>a)</td>
</tr>
<tr>
<td>2.8 b)</td>
<td>Number of these possibly intentional due to obvious patient/disease factors?</td>
<td>b)</td>
</tr>
</tbody>
</table>

**Comments:**
- Ranitidine omitted - likely intentional as started on PPI
- Xanax was initially omitted, but rectified the next day
### Section 3: Medication Reconciliation on Discharge

This section compares the medications taken prior to admission and those prescribed on the medication chart with the medications listed on the discharge summary or patient medication list.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Was a discharge summary completed for this patient?</td>
<td></td>
</tr>
<tr>
<td>3.2 Number of medications to be continued on discharge, determined by reviewing medications taken prior to admission, the medication chart, discharge prescriptions (if available) and any documented plan for continued therapy?</td>
<td></td>
</tr>
<tr>
<td>3.3 Number of medications omitted from the discharge summary?</td>
<td></td>
</tr>
<tr>
<td>3.4 Number of medications included on the discharge summary with a discrepancy (name, dose, route, form, frequency)?</td>
<td></td>
</tr>
<tr>
<td>3.5 Number of unexplained extra medications on the discharge summary?</td>
<td></td>
</tr>
<tr>
<td>3.6 a) Number of medications the patient had been taking prior to admission ceased? (i.e. not to be continued on discharge)</td>
<td>a)</td>
</tr>
<tr>
<td>b) Number of these documented as ceased on the discharge summary?</td>
<td>b)</td>
</tr>
<tr>
<td>3.7 a) Number of medications to be continued on discharge either new, or differing in strength, dose or frequency?</td>
<td>a)</td>
</tr>
<tr>
<td>b) Number of these documented on the discharge summary as either new, or differing in strength, dose or frequency?</td>
<td>b)</td>
</tr>
<tr>
<td>3.8 Number of new, changed or ceased medications that had reason/s for change documented on the discharge summary?</td>
<td></td>
</tr>
<tr>
<td>3.9 Was the patient provided with a medication list on discharge? (if No or Not Applicable do not proceed with data collection)</td>
<td></td>
</tr>
<tr>
<td>3.10 Number of medications omitted from the patient medication list that had been identified as to continue on discharge?</td>
<td></td>
</tr>
<tr>
<td>3.11 Number of medications included in the patient medication list with a discrepancy (name, dose, route, form, frequency)?</td>
<td></td>
</tr>
<tr>
<td>3.12 Number of unexplained extra medications on the patient medication list?</td>
<td></td>
</tr>
<tr>
<td>3.13 Number of medications documented as ceased on the patient medication list?</td>
<td></td>
</tr>
<tr>
<td>3.14 Number of medications documented on the patient medication list as either new, or differing in strength, dose or frequency?</td>
<td></td>
</tr>
<tr>
<td>3.15 Number of new, changed or ceased medications that had reason/s for change documented on the patient medication list?</td>
<td></td>
</tr>
<tr>
<td>3.16 Does the list of medications in the patient medication list correspond identically with the list of medications in the discharge summary?</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** D/K summary does not have dose or frequency information for two medications, the pt med list does.
<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Medication Starts</th>
<th>Medication Stops</th>
<th>Medication Changes</th>
<th>Medication Adjustments</th>
<th>Medication Expiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>01/01/1980</td>
<td>01/01/2023</td>
<td>12/31/2023</td>
<td>Yes</td>
<td>No</td>
<td>01/01/2024</td>
</tr>
</tbody>
</table>

**Discharge Medication Checklist**

- **Education**: Yes
- **Dosage**: 10 mg
- **Frequency**: 3 times daily

**Medication Management Plan**

1. **Prescription Drug**: Levothyroxine
2. **Dosage**: 100 mcg
3. **Frequency**: 3 times daily
4. **Adjustment**: Yes, due to weight gain

**Emergency contacts**
- **Primary Care Provider**: Dr. Smith
- **Pharmacist**: John Doe

**Review**

- **Date**: 01/01/2023
- **Evaluator**: John Doe

**Discharge Planning**

- **Care Coordination Services**: Yes
- **Follow-up Plan**: Hospital visit in 1 week

**Additional Notes**

- **Recommendations for Follow-up**: Increase dietary intake of iodine
- **Patient Teaching**: Importance of regular thyroid checks

**Signature**

- **Primary Care Provider**: Dr. Smith
- **Pharmacist**: John Doe

**Date of Signature**

- **Date**: 01/01/2023
SMITH, Mr James – 1234567

Result Type: Discharge Referral Note
Result Date: 11 November 2013 14:20
Result Status: Auth (Verified)
Result Title: Discharge Referral Baseline
Performed By: Claire CHAN (RMO) on 11 November 2013 15:18
Verified By: Claire CHAN (RMO) on 11 November 2013 15:54

Discharge Referral Baseline
Patient: SMITH Mr James MRN: 1234567
Age: 74 years Sex: Male DOB: 17/04/1939
Associated diagnoses: Chest pain; Postural hypotension
Author: Claire CHAN

Visit Information
Facility: Prince Hospital
Admission Date: 07/11/2013 To be discharged: 11/11/2013
Medical Service: Renal Medical Consulting Clinician:
Attending Medical Officer: Dr Charles Nguyen Indigenous Status: Neither Aboriginal/Torres Strait Id
AMO Provider No.: 54321H
Local Medical Officer: Dr Sam Pierce
LMO Provider No.: 34567H
LMO Address: Dr Sam Pierce
78 Rose Street
Amberville, 2987, NSW
LMO Phone: 9453 6708 LMO Fax: 9453 6799
Interpreter Required: No Language spoken at home: English

Dear Dr Sam Pierce,

Thank you for reviewing James Smith, a 74 year old male to be discharged on 06/11/2013 from Prince Hospital. James presented to this facility with Pain, chest.

Summary of Care

James presented to ED with progressive left sided chest pain which was sharp and stablising. It has been present for last 2/52 and is only present when standing and is relieved when lying down. No fevers, cough or SOB. The pain occurred often when he was walking up stairs or lifting bags and did sound exertional in nature.

He describes 3 episodes of lightheadedness in the past month, lasting approx. 20 seconds. No loss of consciousness.

PMH
Renal transplant 2007 – cadaveric
Nephrotic syndrome
PE in 2005 and 2013
T2DM
Hypertension
OA
Depression
PVD
SMITH, Mr James – 1234567

Result Type: Discharge Referral Note
Result Date: 11 November 2013 14:20
Result Status: Auth (Verified)
Result Title: Discharge Referral Baseline
Performed By: Claire CHAN (RMO) on 11 November 2013 14:53
Verified By: Claire CHAN (RMO) on 11 November 2013 15:54

Peripheral neuropathy
Prostatitis and TURP
Antiphospholipid syndrome

Chest pain
CXR showed left basal atelectasis but was otherwise normal.
INR was therapeutic so PE very unlikely and VQ scan not performed.
Pacemaker check showed device pacing and sensing appropriately. One episode recorded on 20/10 with only 4 beats. Otherwise no other arrhythmias.
As the chest pain sounded exertional in nature, we performed a sestamibi myocardial scan which showed mild impairment of coronary flow reserve in the distal LAD territory. No segmental wall abnormality is seen with LVEF 67%.
The pain resolved on the first day and he was pain free for the remainder of the admission.

Postural hypotension likely due to autonomic neuropathy
Mr Smith experienced postural drops of approximately 30mHg around admission and felt dizzy at the time. He reports it has been happening for approx. 3/52. No episodes of loss of consciousness.
It may be secondary to autonomic neuropathy and he also has some reduced sensation in the lower limbs in a glove and stocking distribution. We ceased the amlodipine to see if there is any improvement. We advised him to increase his salt and fluid intake and wear long compression stockings.
Fludrocortisone can be considered in the future if there is no improvement.

Discharge Plan
DIC home to retirement village
F/U with GP next week for blood pressure check and consider restarting antihypertensive. Can trial different agent eg coversyl rather than amlodipine
GP to please organise nerve conduction studies as an outpatient
Pt can increase salt intake, drink adequate fluids and wear long compression stockings to help with postural drops.

Health Status
Principle and Other Diagnosis
Chest pain : SNMCT 49966017, Discharge, ED Medical.
Postural hypotension : SNMCT 47066010, Final, Medical.

Allergies and Adverse Reactions
Allergic Reaction (Selected)
Severe
Aspirin – Ulcers.
SMITH, Mr James – 1234567

Result Type: Discharge Referral Note
Result Date: 11 November 2013 14:20
Result Status: Auth (Verified)
Result Title: Discharge Referral Baseline
Performed By: Claire CHAN (RMO) on 11 November 2013 14:53
Verified By: Claire CHAN (RMO) on 11 November 2013 15:54

Medications
Discharge Medication:

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>WARFARIN (COUMADIN)</td>
<td>5.5mg</td>
<td>Daily</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Other Comment: as per INR aim INR 2-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>GLYADE MR</td>
<td>30mg</td>
<td>BD</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PANADOL OSETO</td>
<td>2</td>
<td>TDS</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
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</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALCIA D</td>
<td>1000 units</td>
<td>Morning</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
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</thead>
<tbody>
<tr>
<td>SIMVASTATIN</td>
<td>80mg</td>
<td>Night</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLOXYL AND SENNA</td>
<td>2</td>
<td>Other: bd prn</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MYCOPHENOLATE</td>
<td>750mg</td>
<td>BD</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CYCLOSPORIN</td>
<td>100mg</td>
<td>BD</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

CEASED MEDICATIONS

<table>
<thead>
<tr>
<th>Medicine Name</th>
<th>Dose</th>
<th>Freq</th>
<th>Route</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMLODIPINE</td>
<td>5mg</td>
<td>Morning</td>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last Updated:</td>
<td></td>
<td></td>
<td></td>
<td>11/11/2013</td>
</tr>
</tbody>
</table>

Medications Form/Section Last Updated On: 11-NOV-2013 14:36
Medications Form/Section Last Updated By: Claire CHAN – Medical Officer
SMITH, Mr James – 1234567

Result Type: Discharge Referral Note
Result Date: 11 November 2013 14:20
Result Status: Auth (Verified)
Result Title: Discharge Referral Baseline
Performed By: Claire CHAN (RMQ) on 11 November 2013 14:53
Verified By: Claire CHAN (RMQ) on 11 November 2013 15:54

Medical Compliance Aid – Recommended: No, Type: Medlist

Discharge Information
Performed by
Dr Claire Chan, Medical Officer

Completed Action List:
*Performed by Claire CHAN on 11 November 2013 14:53
*Modified by Claire CHAN on 11 November 2013 15:30
*Modified by Claire CHAN on 11 November 2013 15:46
*Signed by Claire CHAN on 11 November 2013 15:54
*Verified by Claire CHAN on 11 November 2013 15:54
<table>
<thead>
<tr>
<th>Name of medicine</th>
<th>Brand</th>
<th>Dose</th>
<th>Used for</th>
<th>Directions</th>
<th>Time of day</th>
<th>Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium 1000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamin D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin 100mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paracetamol 650mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Corticosteroids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warfarin 5mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lixir, Zocor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clopidogrel 100mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lisinopril</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atorvastatin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Daily time table**

- **Morning:** 7-9am
- **Noon:** 12-2pm
- **Evening:** 4-6pm
- **Bedtime:** 9-11pm

**Comments**

- Changes, see your GP within 3 days.
- Decreased dose.
- Your dose many not have changed.

**Take with breakfast**

- Swallow the tablet whole.
- Do not take more than 6 tablets in one day.

**Take with dinner**

- Swallow the tablet whole.
- Do not take more than 6 tablets in one day.
<table>
<thead>
<tr>
<th>Medicine/cause agent</th>
<th>Reaction</th>
<th>Age (years ago)</th>
<th>Start date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>7/11/2013</td>
</tr>
</tbody>
</table>

**Explanation**

The following medicines were STOPPED while you were in hospital: Do not take these medicines without further advice.

<table>
<thead>
<tr>
<th>Time</th>
<th>Take</th>
<th>Used for</th>
<th>Review by</th>
<th>Colour code</th>
<th>Brand name</th>
<th>Name of medicine</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>7am</td>
<td></td>
<td></td>
<td>Reviewer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date: 11/11/2013

*Patient Medication List*

**Pharmacy Department - Prince Hospital**
<table>
<thead>
<tr>
<th>Medication</th>
<th>Discharge summary</th>
<th>Plan of care 1</th>
<th>Plan of care 2</th>
<th>Plan of care 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication 1</td>
<td>Discharge summary</td>
<td>Plan of care 1</td>
<td>Plan of care 2</td>
<td>Plan of care 3</td>
</tr>
<tr>
<td>Medication 2</td>
<td>Discharge summary</td>
<td>Plan of care 1</td>
<td>Plan of care 2</td>
<td>Plan of care 3</td>
</tr>
<tr>
<td>Medication 3</td>
<td>Discharge summary</td>
<td>Plan of care 1</td>
<td>Plan of care 2</td>
<td>Plan of care 3</td>
</tr>
<tr>
<td>Medication 4</td>
<td>Discharge summary</td>
<td>Plan of care 1</td>
<td>Plan of care 2</td>
<td>Plan of care 3</td>
</tr>
</tbody>
</table>

Patient Number: 18

Audit Worksheet

Continuity of Medication Management Comprehensive Audit Tool
### Continuity of Medication Management Comprehensive Audit Tool

#### Section 1: Best Possible Medication History (BPMH)

1.1 Admission date: 07/11/2013  
   Admission time: 12:53

1.2 Discharge date: 11/11/2013  
   Discharge destination: Retirement village

1.3 Was the patient on regular medications prior to admission? (If No, do not proceed with data collection)
   - [ ] Yes  
   - [ ] No  
   If No, was ‘patient on nil medications’ documented?
   - [ ] Yes  
   - [ ] No  
   If Yes, where was it documented?

1.4 Has a medication history been documented? (If No, do not proceed with data collection)
   - [ ] Yes  
   - [ ] No

1.5 Who documented the most comprehensive medication history? (Select only one)
   - [ ] ED medical officer  
   - [ ] Admitting medical team  
   - [ ] Pharmacist  
   - [ ] Registered nurse  
   - [ ] Nurse practitioner  
   - [ ] Multidisciplinary team

Other (provide details):

N.B. Use selected comprehensive history to complete data collection

1.6 Date and time (if available) medication history was documented
   - Date: 08/11/2013  
   - Time:

1.7 Where was the medication history documented?
   - [ ] History section of NIMC  
   - [ ] MMP  
   - [ ] Other dedicated form  
   - [ ] Paper progress notes  
   - [ ] Electronic progress notes  
   - [ ] Medication table

Other (provide details):

1.8 a) Were the patient’s allergies, adverse drug reactions, or lack of, documented as part of the history?
   - [ ] Yes  
   - [ ] No

1.8 b) Were details documented? (i.e. type of reaction or nil or not known)
   - [ ] Yes  
   - [ ] No  
   - [ ] Not applicable

1.9 a) Number of regular prescribed medications?
   - [ ] 6  
   - [ ] Comments:

1.9 b) Number with name, dose and frequency?
   - [ ] 6  
   - [ ] Comments:

1.10 a) Number of prn prescribed medications?
   - [ ] 0  
   - [ ] Comments:

1.10 b) Number with name, dose and frequency?
   - [ ] 0  
   - [ ] Comments:

1.11 a) Number of non-prescribed medications?
   - [ ] 3  
   - [ ] Comments:

1.11 b) Number with name, dose and frequency?
   - [ ] 3  
   - [ ] Comments:

1.12 a) Was/where the source/s of the information obtained for the medication history documented?
   - [ ] Yes  
   - [ ] No

b) Were 2 or more sources used?
   - [ ] Yes  
   - [ ] No  
   - [ ] Not applicable
### Section 2: Medication Reconciliation on Admission

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
</table>
| **2.1 Number of regular and prn prescribed medications taken prior to admission with a documented plan?**  
(i.e. to continue, change, withhold or cease) | 6 |
| **2.2 Number of non-prescribed medications taken prior to admission with a documented plan?** | 3 |
| **2.3 a) Number of regular prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?** | 0 |
| b) Number of these possibly intentional due to obvious patient/disease factors? | 0 |
| **2.4 a) Number of regular prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) without reason documented and not identified or rectified within 48 hours of admission?** | 0 |
| b) Number of these possibly intentional due to obvious patient/disease factors? | 0 |
| **2.5 a) Number of prn prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?** | 0 |
| b) Number of these possibly intentional due to obvious patient/disease factors? | 0 |
| **2.6 a) Number of prn prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) without reason documented and not identified or rectified within 48 hours of admission?** | 0 |
| b) Number of these possibly intentional due to obvious patient/disease factors? | 0 |
| **2.7 a) Number of non-prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified or rectified within 48 hours of admission?** | 0 |
| b) Number of these possibly intentional due to obvious patient/disease factors? | 0 |
| **2.8 a) Number of non-prescribed medications taken prior to admission written on the medication chart with a discrepancy (name, dose, route, form, frequency) and not identified or rectified within 48 hours of admission?** | 0 |
| b) Number of these possibly Intentional due to obvious patient/disease factors? | 0 |

**Comments:** Cyclosporin frequency rectified
### Section 3: Medication Reconciliation on Discharge

This section compares the medications taken prior to admission and those prescribed on the medication chart with the medications listed on the discharge summary or patient medication list.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Was a discharge summary completed for this patient?</td>
<td>Yes ☑ No ☐</td>
</tr>
<tr>
<td>3.2 Number of medications to be continued on discharge, determined by reviewing medications taken prior to admission, the medication chart, discharge prescriptions (if available) and any documented plan for continued therapy?</td>
<td>8</td>
</tr>
<tr>
<td>3.3 Number of medications omitted from the discharge summary?</td>
<td>0</td>
</tr>
<tr>
<td>3.4 Number of medications included on the discharge summary with a discrepancy (name, dose, route, form, frequency)?</td>
<td>0</td>
</tr>
<tr>
<td>3.5 Number of unexplained extra medications on the discharge summary?</td>
<td>0</td>
</tr>
<tr>
<td>3.6 a) Number of medications the patient had been taking prior to admission ceased? (i.e. not to be continued on discharge)</td>
<td>a) 1</td>
</tr>
<tr>
<td>3.6 b) Number of these documented as ceased on the discharge summary?</td>
<td>b) 1</td>
</tr>
<tr>
<td>3.7 a) Number of medications to be continued on discharge either new, or differing in strength, dose or frequency?</td>
<td>a) 1</td>
</tr>
<tr>
<td>3.7 b) Number of these documented on the discharge summary as either new, or differing in strength, dose or frequency?</td>
<td>b) 1</td>
</tr>
<tr>
<td>3.8 Number of new, changed or ceased medications that had reason(s) for change documented on the discharge summary?</td>
<td>(amlodipine) 1</td>
</tr>
<tr>
<td>3.9 Was the patient provided with a medication list on discharge? (If No or Not Applicable do not proceed with data collection)</td>
<td>Yes ☑ No ☐</td>
</tr>
<tr>
<td>3.10 Number of medications omitted from the patient medication list that had been identified as to continue on discharge?</td>
<td>0</td>
</tr>
<tr>
<td>3.11 Number of medications included in the patient medication list with a discrepancy (name, dose, route, form, frequency)?</td>
<td>0</td>
</tr>
<tr>
<td>3.12 Number of unexplained extra medications on the patient medication list?</td>
<td>0</td>
</tr>
<tr>
<td>3.13 Number of medications documented as ceased on the patient medication list?</td>
<td>(amlodipine) 1</td>
</tr>
<tr>
<td>3.14 Number of medications documented on the patient medication list as either new, or differing in strength, dose or frequency?</td>
<td>(warfarin) 1</td>
</tr>
<tr>
<td>3.15 Number of new, changed or ceased medications that had reason(s) for change documented on the patient medication list?</td>
<td>(amlodipine) 1</td>
</tr>
<tr>
<td>3.16 Does the list of medications in the patient medication list correspond identically with the list of medications in the discharge summary?</td>
<td>Yes ☑ No ☐</td>
</tr>
</tbody>
</table>

Comments: ____________________________________________________________
Appendix 2 – Auditor’s Work Sheet