



COMPREHENSIVE AUDIT TOOL USER GUIDE

MEDICATION RECONCILIATION TOOLKIT

TABLE OF CONTENTS

	3
AUDIT TOOLS	3
METHOD	4
Modular Audit Tool	4
Audit Instructions	4
DEFINITIONS	6
AUDIT TOOL QUESTIONS AND DEFINITIONS	7
Section 1 – Best Possibile Medication History (BPMH)	7
Section 2 – Medication Reconciliation on Admission	
Section 3 – Medication Reconciliation on Discharge1	1
APPENDICES1	3
Appendix 1 – Audit Tool Examples 1	4
Sarah Green1	5
James Smith	27
Appendix 2 – Auditor's Work Sheet4	1

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 medicationrelated information and transfer of medicines information on discharge or make enquiries in regards to current practices.
- 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.

- 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.

AUDIT QUESTIONS AND DEFINITIONS

The Audit Tool allows the collection of data relating to a single patient record. It is divided into three sections.

Section 1 – Best Possible	Medication History (BPMH)
Question	Definition
1.1 Admission date and time	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.
1.2 Discharge date and destination	Enter the date in the same format as Q1.1. Select the discharge destination from the list provided.
1.3 Was this patient on regular medications prior to admission? (if No , do not proceed with data collection)	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.
1.4 Has a medication history been documented ? (if No , do not proceed with data collection)	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.
1.5 Who documented the most comprehensive medication history? (select only one)	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.
1.6 Date and time (if available) medication history was documented	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.
1.7 Where was the medication history documented?	Select where the comprehensive medication history was documented from the list provided, or if other than those listed, provide details in the 'Other' section.
1.8a) Were the patient's allergies , adverse drug reactions, or lack of, documented as part of the history?	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.

Question	Definition
1.8b) Were details documented? (i.e. type of reaction or nil or not known)	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.
1.9a) Number of regular prescribed medications?	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.
1.9b) Number with name, dose and frequency?	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.
1.10a) Number of prn prescribed medications?	Count and enter the number of prescribed 'when necessary' medications (e.g. medications used only when necessary that would require a prescription).
1.10b) Number with name, dose and frequency?	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.
1.11a) Number of non-prescribed medications?	Count and enter the number of medications not included in Q1.9 or Q1.10, inclusive of over-the-counter and complementary medications.
1.11b) Number with name, dose and frequency?	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.
1.12a) Was/were the source/s of the information obtained for the medication history documented?	Select a Yes response if the source/s of information obtained for the medication history were documented.
1.12b) Were 2 or more sources used?	Select a Not Applicable response if the response to Q1.12a) was No.

Section 2 – Medication Re	conciliation on Admission		
Question	Definition		
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)	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.		
2.2 Number of non-prescribed medications taken prior to admission with a documented plan?	Count and enter the number of non-prescribed medications that have a documented plan as described in the definition for Q2.1.		
2.3a) Number of regular prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified <i>or</i> rectified within 48 hours of admission?	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 <i>or</i> rectified within 48 hours of admission should be excluded from the count.		
2.3b) Number of these possibly intentional due to obvious patient/disease factors?	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).		
2.4a) Number of regular prescribed medications taken prior to admission written on the medication chart with a discrepancy (<i>name</i> , <i>dose</i> , <i>route</i> , <i>form</i> , <i>frequency</i>) without reason documented and not identified or rectified within 48 hours of admission?	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 <i>or</i> rectified within 48 hours of admission should be excluded from the count.		
2.4b) Number of these possibly intentional due to obvious patient/disease factors?	Count and enter the number of medications identified in 2.4a) that are possibly intentionally changed due to obvious patient/disease factors.		
2.5a) Number of prn prescribed medications taken prior to admission omitted from the medication chart without reason documented and not identified <i>or</i> rectified within 48 hours of admission?	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.		
2.5b) Number of these possibly intentional due to obvious patient/disease factors?	Count and enter the number of medications identified in 2.5a) that are possibly intentionally omitted due to obvious patient/disease factors.		
2.6a) Number of prn prescribed medications taken prior to admission written on the medication chart with a discrepancy (<i>name, dose, route,</i> <i>form, frequency</i>) without reason documented and not identified <i>or</i> rectified within 48 hours of admission?	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 <i>or</i> rectified within 48 hours of admission should be excluded from the count.		

Question	Definition
2.6b) Number of these possibly	Count and enter the number of medications identified in 2.6a) that are
intentional due to obvious	possibly intentionally changed due to obvious patient/disease factors.
patient/disease factors?	
2.7a) Number of non-prescribed	Count and enter the number of non-prescribed medications that have
medications taken prior to admission	been omitted from the medication chart without a documented reason
omitted from the medication chart	for the omission.
without reason documented and not	Omissions that were identified or rectified within 48 hours of admission
identified or rectified within 48 hours	should be excluded from the count.
of admission?	
2.7b) Number of these possibly	Count and enter the number of medications identified in 2.7a) that are
intentional due to obvious	possibly intentionally omitted due to obvious patient/disease factors.
patient/disease factors?	
2.8a) Number of non-prescribed	Count and enter the number of non-prescribed medications that have
medications taken prior to admission	been written on the medication chart with a change that has no
written on the medication chart with	documented reason for the change.
a discrepancy (name, dose, route,	Medication changes that had no documented reason that were
form, frequency) and not rectified or	identified or rectified within 48 hours of admission should be excluded
identified within 48 hours?	from the count.
2.8b) Number of these possibly	Count and enter the number of medications identified in 2.8a) that are
intentional due to obvious	possibly intentionally changed due to obvious patient/disease factors.
patient/disease factors?	

Section 3 – Medication Re	conciliation on Discharge
Question	Definition
3.1 Was a discharge summary	Select a Yes or No response.
completed for this patient?	
3.2 Number of medications to be	Use the Auditor's Work Sheet to determine the 'intended regimen on
continued on discharge, determined	discharge' for each patient (see Appendix 2).
by reviewing medications taken prior	List the medications taken prior to admission, the plan for admission
to admission, the medication chart,	medicines, the medications on the medication chart at admission and
discharge prescriptions (if available),	discharge, any documented plan for continued therapy and
the discharge summary and any	medications on the discharge summary.
documented plan for continued	Count and enter the number of medications listed in the 'intended
therapy?	regimen on discharge' column of the Auditor's Work Sheet.
3.3 Number of medications omitted	Count and enter the number of medications to be continued on
from the discharge summary?	discharge that were omitted from the discharge summary.
3.4 Number of medications included	Count and enter the number of medications to be continued on
on the discharge summary with a	discharge that were documented on the discharge summary with an
discrepancy (name, dose, route,	unexplained change.
form, frequency)?	
3.5 Number of unexplained extra	Count and enter the number of medications documented in the
medications on the discharge	discharge summary that were not identified to continue on discharge.
summary?	
3.6a) Number of medications the	Count and enter the number of medications the patient had been taking
patient had been taking prior to	prior to admission that were not to be continued on discharge.
admission that were ceased? (i.e.	
not to be continued on discharge)	
3.6b) Number of these documented	Count and enter the number of medications identified in 3.6a) that were
as ceased on the discharge	documented as having been ceased during the admission on the
summary?	discharge summary.
3.7a) Number of medications to be	Count and enter the number of medications to be continued on
continued on discharge either new ,	discharge that were new for the patient or the patient had been taking
or differing in strength, dose or	but had been changed to a different strength, dose or frequency.
frequency?	Count and antar the number of madiantians identified in 9.7a) that ware
3.7b) Number of these documented	Count and enter the number of medications identified in 3.7a) that were
on the discharge summary as either	documented as being new or changed during the admission on the
new, or differing in strength, dose or frequency?	discharge summary.
3.8 Number of new, changed or	Count and enter the number of medications identified in Q3.7a) and
ceased medications that had	Q3.6a) that had a documented reason for the addition, changing or
reason/s for change documented on	ceasing of these medications on the discharge summary.
the discharge summary?	coasing or these medications on the discharge summary.
3.9 Was the patient provided with a	Select a Yes, No or Not Applicable response.
medication list on discharge? (if No	A patient medication list may not be applicable in the case of inter-
or Not Applicable do not proceed	hospital transfers or nursing home discharge destinations.
with data collection)	
3.10 Number of medications omitted	Count and enter the number of medications to be continued on
from the patient medication list?	discharge that were omitted from the patient medication list.
	1

Question	Definition
3.11 Number of medications	Count and enter the number of medications to be continued on
included in the patient medication list	discharge that were documented on the patient medication list with an
with a discrepancy (name, dose,	unexplained change.
route, form, frequency)?	
3.12 Number of unexplained extra	Count and enter the number of medications documented in the patient
medications on the patient	medication list that were not identified to continue on discharge.
medication list?	
3.13 Number of medications	Count and enter the number of medications identified in 3.6a) that were
documented as ceased on the	documented as having been ceased during the admission on the
patient medication list?	patient medication list.
3.14 Number of medications	Count and enter the number of medications identified in 3.7a) that were
documented on the patient	documented as being new or had changed during the admission on
medication list as either new, or	the patient medication list.
differing in strength, dose or	
frequency?	
3.15 Number of new, changed or	Count and enter the number of medications identified in Q3.7a) and
ceased medications that had	Q3.6a) that had a documented reason for the addition, changing or
reason/s for change documented on	ceasing of these medications on the patient medication list.
the patient medication list?	
3.16 Does the list of medications in	Select a Yes or No response.
the patient medication list	
correspond identically with the list of	
medications in the discharge	
summary?	



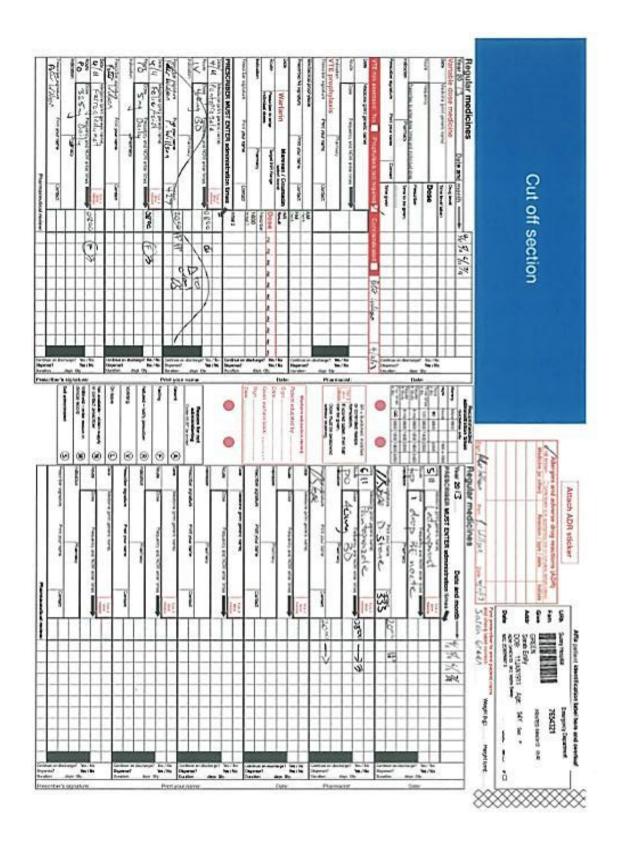


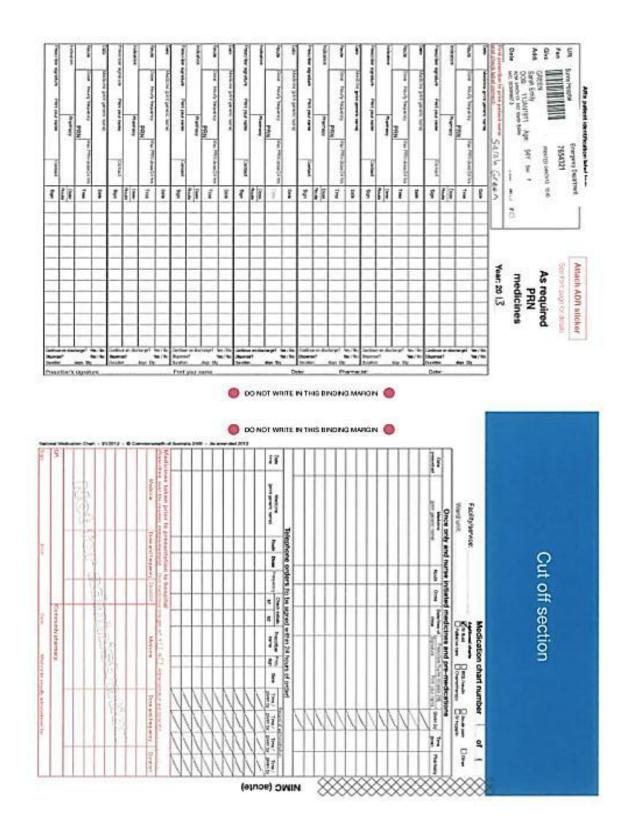


Appendix 1 – Audit Tool Examples

1001		FAMILY NAME	Energency Department
NSW Healt	h	GIVEN NAME Survey Hospital	7654321
Facility: PROGRESS / CLINICAL NOTES Date and Time (use 24 hr clock) Printed name, designation and s H ////3		ADDRES WINNIN	PRINTED: CANDINIS 1340
		GREEN Sarah Emily LOCATION DO Nate Date COMPLETE ALL DETAILS OR	
Date and Time		, written in black pen and include t	
4/11/13	SB Gasto Reg	Signature.	
1730	SD Casho Ma		
	94 & from home		2
	9 difficulty sudlewin	ng food over last week	
	Feels like I food g	iets blocked	
	Epigastic pain for	last 2 days	
	Able to get oninge	N N	
	this had a few of	rides of regulation	
	No problems prevens!	1 with food	
	PMH/ GORD)	
	Glaucoma		
		emplatic anaemia	
	MORGANI CELL	lumploma	
	0	21	
	Meds/ Roartidine 300.	a daily NKDA	
	/ Folic Acid Sig d	dy	
	Iron September	1	
	Xalalan eye do	ps	
	OCL ALL N		
	OE/ Hodo Soft	Jan	
	/ Epigastic for	demuss	
	Bloods (N)	0	
	Preeds (W)		
	IMP/ ? Corestew	cesophagus	
	1 2 End hale		
	7 Peptic st	richare	
	? Pill Desuph	agitis	
	te la	1	
1			\rightarrow

Kealth Facility:		FAMILY NA	VIE Sunny Hospital		MRN	
		GIVEN NA			Emergency Department 7654321	EMALE
		ADDREST	GREEN		FUNTED ONICV13 12-10	
PROGR	ESS / CLINICAL		Sarah Emily DOB: 11JAN1911	Acres		
PROGRESS / CLINICAL NOTES		LOCATION MC 2000001 10 Methodaley				
Date and Time	Note: All entries must be legible	and the second second second	PLETE ALL DETAILS (and the second second	the state of the s	the second se
(use 24 hr clock)	printed name, designation and	signature.	mack per and more	ie nie	nearth care provid	
4/4/13	Plan/ Adait & DR	Gupta				
1730	BO PPI					
	and the second se	tomosilan	/			
	IV Aludos)					
	NBM					
			Paul willen		1	
			Teles willigg	#	+2/	
						E E
						NIC N
				_		MA
						RG
						- Z
						BINDING MARGIN - NO WRITING
						TIP
						NG NG
						ω=
						MR
						MR050007
						2





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	
Encounter Info;	Inpatient, 04/11/2013 - 06/11/2013	

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	To be discharged: 06/11/2013
Medical Service:	Gastroenterology	Consulting Clinician:
Attending Medical Officer:	Dr Raj Gupta	C. C
AMO Provider No.:	12346H	Indigenous Status: Neither Aboriginal/Torres Strait is
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	LMO Fax: 9345 9877
Interpreter Required;	No	Language spoken at home: English

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 tron supplement

Page 1 of 3

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
Encounter Info;	Inpatient, 04/11/2013 - 06/11/2013	

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

afebrile, 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 Ix CXR – clear FBC/EUC/LFT/CMP normal lactate 329

Page 2 of 3

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
Encounter Info:	Inpatient, 04/11/2013 - 06/11/2013	

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 111100017, 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

SUNNY HOSPITAL MEDICATION LIST

PHARMACY DEPARTMENT Phone: 02 9346 7596

MEDICATION LIST for Ms Sarah GREEN MRN 7654321

Medication Period From 06/11/2013

	Ł				
40MG EC TABLETS	ONE	PORO!	ONE		NEW For relieving heartburn
					Dose to be reviewed by your doctor in 2 weeks
FOLIC ACID 5MG TABLETS	ONE				Folic acid supplement
FERROUS SULFATE (FERRO-	ONE				Iron supplement
TABLETS					Swallow tablet whole
LATANOPROST (XALATAN) 50MCG/ML EYE DROPS				ONE	For treating glaucoma
					Instil into both eyes.

Bring this list on each visit to your Doctor, Pharmacist, Dentist, or other Health Care Provider.

Prepared By: AW

NOTE that while in hospital your Railisine was stopped. Angus Winters (B.Pharm)

Continuity of Medication Management Comprehensive Audit Tool

Auditor's Worksheet

Patient Number: (4

	Plan for admission medicines	Medications on medication chart at admission	Medications on medication chart at discharge	Any documented plan for continued therapy (check last medical round notes, prescriptions)	Medications on discharge summary
Rentifice 300mgd	No	1	1	lease	Cease
Tok and Smy L	No	Tolic reid Sung &	Folicaed Sund	(art	Folicaed Sun &
Le che 2		E / Inv	T L' and I	1 H	
conselection and	10	N I I I I I I I I I I I I I I I I I I I	VII I Share a strate and the	lon	VIII 0
particulation	NO	Parter 1 20 moor	Acleman Listerary	1	1
			Reference = 40. B	Cent	Butomazie reacher Butomaie po 4000
			C I I I		



Audit Period: 15 10-15 11 13	Hospital:	Sunny Ha	spital	COMMISSI
Date of Audit: 21 113	Auditor/s names:	Ad	ditional Notes:	
Patient Number:	Chris Colling			
MaleFemale (circle) Age: 94 Department/Ward: Mcdical		<u> </u>		
Section 1: Best Possib	le Medication	History (I	BPMH)	
1.1 Admission date: Of 1 11	1 2013	Admission	n time: 13:40	
1.2 Discharge date: 06 / ()	1 2013	Discharge	destination: Home	
1.4 Has a medication history be	No en documented? (if	No, do not pro	ceed with data collection)	
1.5 Who documented the most c	comprenentsive medic	Exercise contracts	States and a state of the second states and the	
ED medical officer Registered nurse Other (provide details):	Admitting	A CONTRACTOR OF A	m 🗌 Pharmacist	nary team
C Registered nurse Other (provide details): N.B. Use se	Nurse pro	actitioner sive history	STATES CONTRACTOR STATES	nary team
Registered nurse Other (provide details): N.B. Use sel 1.6 Date and time (if available) m	Nurse pro-	sive history	🗌 Multidisciplir	nary team
C Registered nurse Other (provide details): N.B. Use sel 1.6 Date and time (if available) m Date: 04/111/2013	Nurse pro- lected comprehen redication history was Time: (7 : 3	sive history	🗌 Multidisciplir	nary team
C Registered nurse Other (provide details): N.B. Use se	□ Nurse providence of the sected comprehen- redication history was Time: (7 : 3 story documented? □ MMP	sive history	Multidisciplin to complete data collection	ted form
Registered nurse Other (provide details): N.B. Use sel 1.6 Date and time (if available) m Date: 04/1 (1/20/3 1.7 Where was the medication his History section of NIMC Paper progress notes Other (provide details): 1.8 a) Were the patient's allergies Yes No	Nurse providence of the sector of the secto	actitioner sive history documented o hic progress r stions, or lack	Multidisciplin to complete data collection Other dedicat Other dedicat Medication ta of, documented as part of the his	ted form able
Registered nurse Other (provide details): N.B. Use sel 1.6 Date and time (if available) m Date: 04/1 (1/2013 1.7 Where was the medication his History section of NIMC Paper progress notes Other (provide details): 1.8 a) Were the patient's allergies Yes No 1.8 b) Were details documented	Nurse providence of the sector of the secto	actitioner sive history documented o hic progress r stions, or lack	Multidisciplin to complete data collection Other dedicat Other dedicat Medication ta of, documented as part of the his	ted form able
□ Registered nurse Other (provide details): N.B. Use set 1.6 Date and time (if available) m Date: 04 / 11 / 2013 1.7 Where was the medication his □ History section of NIMC ☑ Paper progress notes Other (provide details): 1.8 a) Were the patient's allergies ☑ Yes No 1.8 b) Were details documented ☑ Yes No 1.9 a) Number of regular prescription	Nurse provident of the sector	actitioner sive history documented o hic progress r stions, or lack	Multidisciplin to complete data collection Other dedica Other dedica Medication ta of, documented as part of the his known) Comments:	ted form able story?
Registered nurse Other (provide details): N.B. Use sel 1.6 Date and time (if available) m Date: 04 / 11 / 2013 1.7 Where was the medication his History section of NIMC Paper progress notes Other (provide details): 1.8 a) Were the patient's allergies Yes No 1.8 b) Were details documented Yes No	Nurse provide the second comprehense of the second complex of t	actitioner sive history documented o hic progress r stions, or lack n or nil or not 2 1	Multidisciplin to complete data collection Other dedica Other dedica Other dedica of, documented as part of the his known) Comments:	ted form able story?
Registered nurse Other (provide details): N.B. Use sel 1.6 Date and time (if available) m Date: 04 / 11 / 2013 1.7 Where was the medication his History section of NIMC Paper progress notes Other (provide details): 1.8 a) Were the patient's allergies	Nurse providence of the sector of the secto	actitioner sive history documented o hic progress r stions, or lack	Multidisciplin to complete data collection Other dedical Other dedical Medication to of, documented as part of the his known) Comments: Comments: Comments: Yaladayya	ted form able story?
□ Registered nurse Other (provide details): N.B. Use set 1.6 Date and time (if available) m Date: 0.4 / 111 / 2.013 1.7 Where was the medication his □ History section of NIMC ☑ Paper progress notes Other (provide details): 1.8 a) Were the patient's allergies ☑ Yes No 1.8 b) Were details documented ☑ Yes No 1.9 a) Number of regular prescription	Nurse providence of the sector of the secto	actitioner sive history documented o tic progress r tions, or lack n or nil or not 2 1 0	Multidisciplin to complete data collection Other dedicat Other dedicat Medication ta of, documented as part of the his known) Comments: Comments: Comments: Comments:	ted form able story?

Continuity of Medication Management Comprehensive Audit Tool



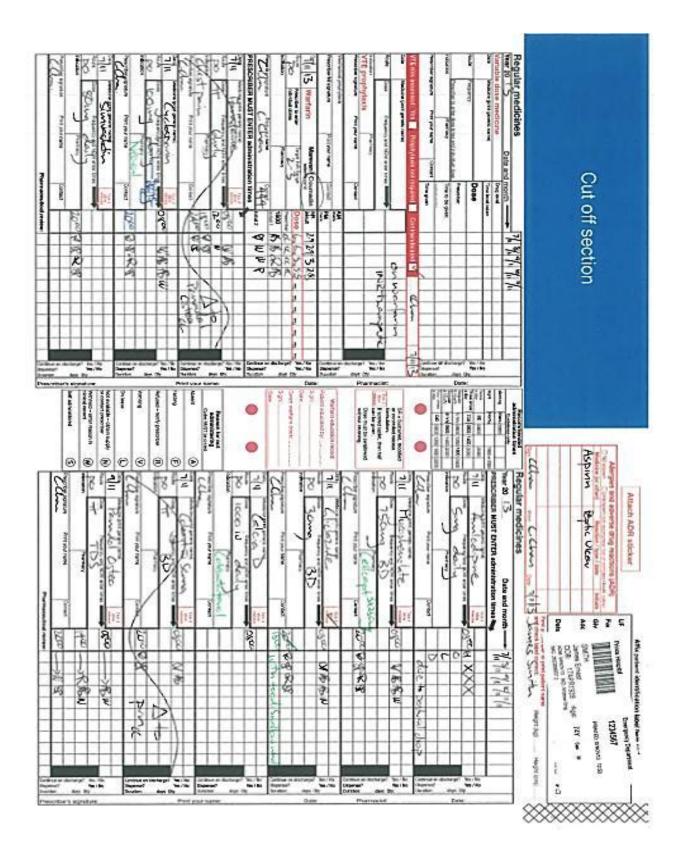
Audit Period:	Hospital:			COMMISSIO
Date of Audit: 2-1 11 13 Patient Number: 14 Male Female (circle) Age: 64 Department/Ward:	Auditoris names:	Additional Notes:		
Section 2: Medication I	Reconciliation or	Admission	Resp	onse
This section compares the m medication chart	edications taken prio	r to admission to those prescribe	d on the	10
2.1 Number of regular and prn p documented plan? (i.e. to continu			C	, ,
2.2 Number of non-prescribed m	edications taken prior to	admission with a documented plan?	C	>
2.3 a) Number of regular prescri medication chart without reason de admission?		rior to admission omitted from the ified or rectified within 48 hours of	a)	t
b) Number of these possibly inte	ntional due to obvious p	atient/disease factors?	b)	
2.4 a) Number of regular prescrimedication chart with a discrepandocumented and not identified or r	cy (name, dose, route, fo	orm, frequency) without reason	a)	c
b) Number of these possibly inte	ntional due to obvious p	atient/disease factors?	b)	>
2.5 a) Number of prn prescribed medication chart without reason de admission?			a)	2
b) Number of these possibly inte	ntional due to obvious p	atient/disease factors?	b)	5
	dose, route, form, frequei	to admission written on the medication ncy) without reason documented and	a)	0
b) Number of these possibly inte	ntional due to obvious p	atient/disease factors?	b) (C
2.7 a) Number of non-prescribed medication chart without reason de admission?	1 You Ala Tao China 2000 You Albor 100 You 2014 Carl	to admission omitted from the fied or rectified within 48 hours of	a)	D.
b) Number of these possibly inte	ntional due to obvious p	atient/disease factors?	b) (>
2.8 a) Number of non-prescribed chart with a discrepancy (name, o within 48 hours of admission?		to admission written on the medication ncy) and not identified or rectified	a)	0
b) Number of these possibly inte	ntional due to obvious p	atient/disease factors?	b)	0

Rantidine omitted -likely intentional as started an PPI Xalatan was initially anitted, but rectified the next day Comments:

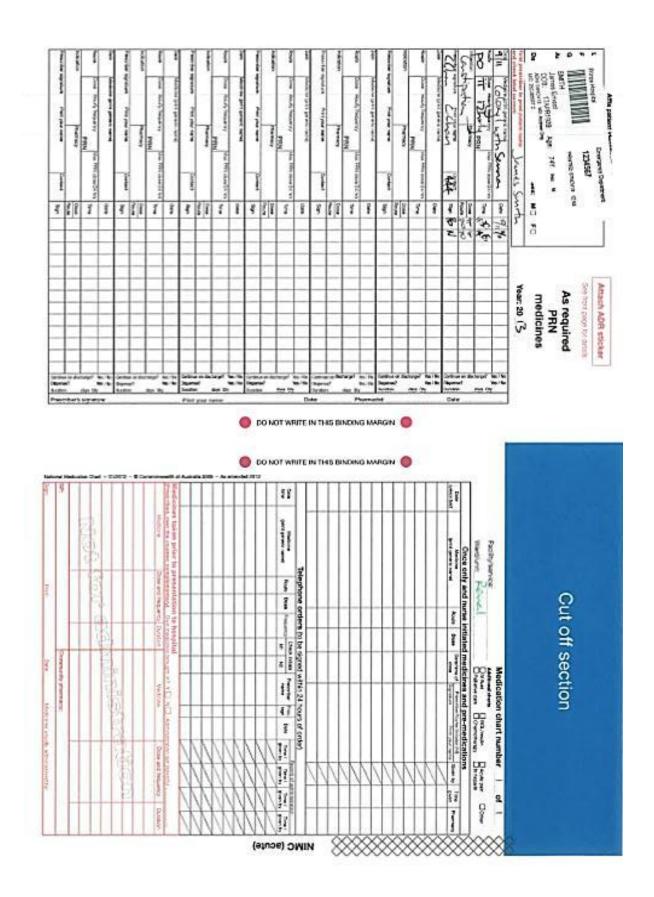
Continuity of Medication Management Comprehensive Audit Tool



Audit Period:	Hospital:		-	COMMISSIO
Date of Audit: 21 3 Patient Number: 14 Male/Fernale (circle) Age: 94 Department/Ward:	Auditor/s names:	Additional Notes:		
Section 3: Medication	Reconciliation or	n Discharge	Response	1
		or to admission and those p te discharge summary or p		
1 Was a discharge summary	completed for this patient?	?	Yes No	
1.2 Number of medications to be nedications taken prior to admis available) and any documented prior to admise a statement of the statement	sion, the medication chart,	discharge prescriptions (if	4	
.3 Number of medications omit	tted from the discharge su	mmary?	0	
I.4 Number of medications inclunation inclusion in the second state of the second s		mary with a discrepancy	0	
.5 Number of unexplained ext	ra medications on the disc	charge summary?	0	
I.6 a) Number of medications the i.e. not to be continued on disch	2. Phys. Rev. D 400 (1991) 111 (1992) 114 (1991) 114 (1992)	prior to admission ceased?	a)	
) Number of these documente	d as ceased on the disch	arge summary?	b)	
3.7 a) Number of medications to strength, dose or frequency?			a) }	
 Number of these documentee n strength, dose or frequency 	7		b)	
3.8 Number of new, changed o documented on the discharge s		had reason's for change	,0	
3.9 Was the patient provided with Applicable do not proceed with		charge? (if No or Not	Yes No	
.10 Number of medications on dentified as to continue on disch	NY 60 (1997)	lication list that had been	O Not applicab	18
1.11 Number of medications inc name, dose, route, form, freque		ation list with a discrepancy	0	
.12 Number of unexplained ex	dra medications on the pa	tient medication list?	0	
.13 Number of medications do	cumented as ceased on t	he patient medication list?	1 (vartid	inel
.14 Number of medications do or differing in strength, dose o	r frequency?		1 (panloj	made
1.15 Number of new, changed documented on the patient med	lication list?		0	
3.16 Does the list of medications with the list of medications in the		n list correspond identically	Yes No	
pr two media		t have dose or fra- med list does.	equency info	mati



CONTINUITY OF MEDICATION MANAGEMENT COMPREHENSIVE AUDIT TOOL USER GUIDE CLINICAL EXCELLENCE COMMISSION



Documented by: Signature							washer	Periodo	(plany W	Coleculatora	Chickey de MR	Anloug	Simophetin	Hypphan	Cyclosper	General In	Contraction of	214		Aspen	Contraction of the
Sprine Gebry							~ (built po	1 Osteo 665mg ps	with Same	Crecheronia	5.0	pre Sura po	the sound po	phonolack 250mg pe	- 100mm 20	Nephake Gereau ranes (Trake Avera) / Severgiti (Frans Heave	MEDICINES TAKEN PRIOR TO PRESENTATION TO HOGERTA	1		Baptic ulos	COLUMN TRACTOR INCOME
						Co-	Com Com	two	two	Sie	ONE	tent	2110	-Howen	ONC	1	KEN PRIOR	4		9	Cashing March
Natis				3	0.1	1	nete	SQL	BBB	wome	30	mound	rocte	BB	Š	Instant	TO PRESENT	TV 343 MINUT	Francis	THE REAL PROPERTY IN	
have			 20	2			Finder	ないよう	breeks	South's	TINA	HTZ	Advalations	tores and	have be	Indication (contention collect)	TATION TO	Carry 2 Control of the Control of th	1953	1 March	
Reberts		10				¢	2 243	C.N.	17	ant 245	5	20	SP2	645	50	Nas long ar stan sturted	HOSPITAL	1111110	Apr 717 Box W	-	1234567
-			_				2	9	P	P	97	9	(P)	ζÞ.	řΡ	and the second	- Ster	NURSE OF	1	10,000.00	-1
Own S							5	t	10	1	1	٤	1	1	1	Canad	15	the 13Der			

Name Outcome (Internal Internal Intern	RECENTLY GEASED	OR RECENT CI	IANGES T	RECENTLY CEASED OR RECENT CHANGES TO MEDICINES three to preserve on the	electron III house	a
First Buyers Constraint by Constrainty human S[h[1]5] Prevent Automation Bit Learston of over Highlines Bit Constrainty human Bit Bit Bit Constrainty human Bit Bit Bit Bit Bit Bit Bit B	Ners					
Enn Burne Continued by Conservicy Nume Ships > numerical conserved Q Int Location of our supported by the Support Q Int Location of our supported by the Support Q Interest to the Previous Advectable Q Interest to the Car numerical conserved conserved to the previous services conserved to the previous services to conserved to the previous services to the previous	SOUTH THE STATE STATE	100				
Image: Ship S Constant of the ship harms Constant of the ship harms Ship S P sheet har Constant of the ship harms Internet by Parmania Ship S Previous Addreadanced Constant of the ship harms Internet by Parmania Ship S Previous Addreadanced Ship Marmania Internet by Parmania Ship S Previous Addreadanced Ship Marmania Internet by Parmania Ship S Previous Addreadanced Ship Marmania Internet by Parmania Ship S Previous Addreadanced Ship Marmania Internet by Parmania Ship S Previous Addreadanced Ship Marmania Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Previous Addreadanced Internet by Parmania Ship S Previous Addreadanced Pr	Seurce of the second	Contrand by		Barte	Continued by	244
N Number of constants Number of constants N Visco in the planter of constants Subject of Constants N N Subject of Constants Number of Constants N N Subject of Constants Number of Constants N N Subject of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants Number of Constants N Number of Constants Number of Constants	NUMBER OF STREET		1	D'Own WedGhat	9	415
Style Provision Active Subject Interneting Provision of cost study and the study of the st	1			Constantly Note		
Internation of our highlowed SurfaceSurface Internation of our highlowed SurfaceSurface Internative Provention of Control Network Provident SurfaceSurface Internative Provide Network Provide SurfaceSurface Internative Provide Network Provide Network Internative Network Provide Network Internativ		p	-	C Anteritar		
N Subsection of lower resplaying N Number of lower resplaying N Property Researched Notation P	Naming Home		-1	Provinsi Anna Mar	P	2002
Internation of now insplayment Survey Survey Internation of now insplayment insplayment Survey Internation of now insplayment insplayment Survey Internation of now insplayment insplayment Survey Internation of now insplayment Survey Internation of now insplayment Survey	GENERAL INFORMAT	NOL				
N Subscription N Numberly N Propert Advancement Care resource Research Care resource Research Research Research Rese	Verfisites usually administrate	Dech/k				
Instrumenty Francesson Instrumenty Francesson Instrumenty Francesson Instrumenty Francesson Instrumenty Francesson Instrument Francesson Instrume	Prefamed administration ins	that				
Image: National State Sta	Did patient bring com made			S Issuiden working	trase	1
	Patient's immunisation up t	3	D'na	Contraction of the second s		-
N No.	General Proclasses details	201	munity Pharm		Sec 1	
N Wey Na Wey Na Property Kapensmert Wey Na Car constructions were and the second secon	DY JAM LOVE					
N Properti Autonamenti Tay Ma "Model" Cara concupor Explais Tay Ma Cara concupor Explais Tay Ma Cara concupor Explais Cara concupor Explais Tay Ma Tay Ma Das concupor Explais Tay Ma Tay Ma Das concupor Explais Tay Ma Tay Ma Das concupor Explain Tay Ma Tay Ma Das concupor T	Antonile					
N N N N N N N N N N N N N N N N N N N		_				
The project Advancement We project Advancement We project We project Advancement	MEDICATION RISK ID	ENTIFICATION				
Construction Reserved Tables Construction Reserved Tables Construction Reserved Tables Construction Reserved Tables Construction Reserved Tables Construction Reserved Tables Construction Reserved Construction	Lives along un vezhielar	wit llone		Patent Assessment	LIE A	
Property terms in Maderia Rouge a Property terms in Maderia Rouge Provide the sector and the secto	Uses dose administration device	All Andread and All		Can reaction and labels		1004
Algoret adversersal by starking the set of the set of deconvert effecting starking the set of	aninistration and fu			Call read up with a construction of a construction of the construc		1 Million
Cheve average average processory of the start of decody participation of pro- Cheve adversariation Cheve adversariation and you area running pro- Cheve adversariation Cheve	eT :	51		Cat rest/competent labels Cat untercitive English Cat unterter Cat reasons lights Cat reasons lights Cat reasons Middres Route React received annual competence		(pear)
	L	Fiend		Can crashionypereri jubels Can crashionypereri jubels Can crashing Ergels Can reason Sigars Can reason Sigars Can reason Sigars Can reason Sigars Sigar Can reason Alexan schemenza by subso Process channess etters to		(and
Theorem medicines (if g. charact, start is it) Theorem medicines (if g. charact, start is it) Theorem medicines Theorem medicines Theorem medicines Construction Construction Construction	Hao weaved mich	Flink		Can unability of pipels Can unaversity of pipels Can unaversity of pipels Can creating the Can remain Signific Can remain Signific Can remain Signific Can remain Signific Can remain Signific Dispected run-adhermonic Dispected run-adhermonic Alexest adhermonic by asking Pipels dishurpan Alexest adher Pipels dishurpan Alexest adher Pipels dishurpan Alexest adhered Pipels di pipels dishurpan Alexest adhered Pipels dishurpan Alex		spear) spear) same's of
Transit medicines (in p. charact, start in the period of the period		Fland	0,000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Car case story English Can case using English Car spare batters Car spare batters Daged on trained story Social Staged on trained story a Process date story of the sectory date space of the sectory da	Mang has plat by an any year has plat to any to a set	of relation
Anderson (A	MELINATION TIGION	AFFISACE	0,000,000	Car rash lowanewer lauda Can conveye (Ergel) Can conveye (Ergel) Can conveye (Ergel) Can conveye Can conveye (Ergel) Can convert retron (Ergel) Reaction retron (Ergel) Can end of the retron (Ergel) Can end of the retron (Ergel) Can end of the retron (Ergel) Sector (Ergel) and (Ergel) and (Ergel) Sector (Ergel) and (Ergel) and (Ergel) Sector (Ergel) and (Ergel)	March Les burges	A ventra d
Albert Generices	Sunday we have	Y CHECKLIST		Car rash lowanewer lada Car care tades Car part bates Car part atter Reactive reme Active Mappeder networks by salag Active atternets atternets by a Active atternets atternets by a Active atternets atternets by a Active atternets atternet by a Active atternets atternets atternets atternet Active atternets atternets atternets atternets atternets Active atternets atternets atternets atternet Active atternets atternets atternets atternets atternets Active atternets atternets atternets atternets atternets Active atternets atternets atternets atternets atternets Active atternets atternets atternets atternets Active atternets atternets atternets atternets atternets Active atternets atternets atternets atternets Active atternets atternets atternets atternets Active atternets atternets atternets atternets atternets atternets Active atternets atternet	A theory of the second of the second	Notes to the second sec
Provide reverse as Reserve unique a restaura Other property and provide a restaura	Simple and	Y CHECKLIST	R0080	Car rash lowspeerer laads Car carevayor (E-pipe Car carevayor (E-pipe Car carevayor (E-pipe Carevasa) Repart reme (Careva) Supporter reme damantos Annos adversaria (P salady - Porcea discriment effective androne adversaria androne discriment effective androne discriment effective androne adversaria androne discriment effective androne discriment effective and effective	and the provide state of the p	Nova National Constitution
data zuga (Tarandar, Nanthuro, constitution, eterritores)	Principles medicine Principles medicine Principles policy, units, a Principle policy, units, a	Y CHECKLIST		Car russ lowspeere laads Car carevasy of Englis Car creativerse Network Care research Care Society Dispecter research bases Support research by sales Support research by sales Support research research research Support research research research Support research research research Support research research research Support research research research sectory Support reserves in Support research research research sectory Support reserves in Support research research research Constructions in Support research research research sectory of the sector research sectory of the sector research sectory of the sector research sectory of the sector research sector research research research sector research research research sector research research research sector research research research sector research resea	b concert on the second	a barragan Man
	Deptember 1000 1000 1000 1000 1000 1000 1000 10	V CHECKLIST		Car rash lowspeer local Car care today Car core today Car core today Care result with Care So Superior res- advance Assess adversed by sales Assess adversed res- devote dan the relation avoid a sales and so Char Assess Char Assess Assess adversed by sales avoid a sales and so Char Assess Assess adversed avoid a sale and so Char Assess Assess adversed Assess adversed Assess adversed Assess adversed Assess adversed Assess adversed Assess Assess adversed Assess adversed Assess adversed Assess Assess adversed Assess Assess adversed Assess Assess adversed Assess	and the second s	a proving a prov

	Constant Are in				2	<u></u>	Date/	Neulic
	_		_	P+ usually usas Galayti and Sterra ars 2 take Bit pro- Consulty chartedas vegular	Pt vs.unlly takes Brandal-Bakes Currondly chested for Parameters	174 Lates cyclosporta locan 255 Canhady danted locang daly	lesse litertified	NSW Health NSW Health Aledication Management Plan
tanun lubri (far) (g	topartice/ed by Consult system	shak kerdinal lar Canitat namine	lase travition by Donatin runder	HV and resting at observation from the management from the constructor from the	Ale and recently and alonge findered investments 702	Riving young and section of descent	Propage Action	Date of aprelation Ward/Cans Consultant
				\$ J	10	NO	Numeral State	7V 82 -
				황	5j.	- <mark>1</mark> 2	Dans of	- 1-
				dende to	hadan 1	trapany concord	Susat of Autom	12013

er Warterin des i te Song deily as 142 reached 3. COMMENTE has metador anomenant anomenant acceptions) Signing now wedication list for pt an alsolveringe.
--

CONTINUITY OF MEDICATION MANAGEMENT COMPREHENSIVE AUDIT TOOL USER GUIDE CLINICAL EXCELLENCE COMMISSION

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
Encounter Info:	Inpatient, 07/11/2013 - 11/11/2013	

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	18 M 19 M 2 M 19 M 19 M 19 M
AMO Provider No.:	54321H	Indigenous Status: Neither Aboriginal/Torres Strait Is
Local Medical Officer:	Dr Sam Pierce	
LMO Provider No.:	34567H	
LMO Address:	Dr Sam Pierce	
	78 Rose Street	
	Amberville, 2867, NSW	
LMO Phone:	9453 6798	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 stabling. 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

Page 1 of 4

 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

 Encounter Info:
 Inpatient, 07/11/2013 – 11/11/2013

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

D/C 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 47956010, Final, Medical. Allergies and Adverse Reactions <u>Allergic Reaction (Selected)</u> Severe Asoirin – Ulcers.

Page 2 of 4

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	
Encounter Info:	Inpatient, 07/11/2013 - 11/11/2013		

Medications

Discharge Medications:				
Medication Name	Duse	Freq	Route	Start Date
WARFARIN (COUMADI	N) 5.5mg	Daily	Oral	0//0500000
Other Comment: as per INF	t aim INR 2-3			
Status:	Medication continued - de	ese reduced		
Last Updated:	11/11/2013 14:12			
Medication Name	Dose	Freq	Route	Start Date
GLYADE MR	30 mg	BD	Oral	2010/02/02/02
Status:	Medication continued - da	ise unchanged		
Last Updated:	11/11/2013 14:12	a san an a than c		
Medication Name	Dase	Freq	Route	Start Date
PANADOL OSTEO	2	TDS	Oral	
Status:	Medication continued - de			
Last Updated:	11/11/2013 14:12			
Medication Name	Dose	Freq	Route	Start Date
CALCIA D	1000 units	Morning	Oral	and a second
Status:	Medication continued do			
Last Updated:	11/11/2013 14:12	8		
Medication Name	Dose	Freq	Route	Start Date
SIMVASTATIN	Sing	Night	Oral	- Aller Aller
Shaton:	Medication continued - do		1. 50,000	
Last Updated:	11/11/2013 14:12	the strategy Bank.		
Medication Name	Dose	Freq	Route	Start Date
COLOXYL AND SENNA	2	Other: bd prn	Oral	
Status:	Medication continued - de		1117075	
Last Updated:	11/11/2013 14:12	10107 1007 19 00 C		
Medication Name	Dose	Freq	Route	Start Date
MYCOPHENOLATE	750mg	BD	Onil	5110204
Status:	Medication continued - do	ise unchanged	State -	
Last Updated:	11/11/2013 14:12			
Medication Name	Dose	Freq	Route	Start Date
CYCLOSPORIN	100 mg	BD	Oral	
Status:	Medication continued - do	ise unchanged		
Last Updated	11/11/2013 14:12	101210101056011		
CEASED MEDICAT	2,00000			Page 1997
Medication Name	Dise	Freq	Raute	Start Date
AMLODIPINE.	5mg	Morning	Oral	
Status:	Medication censed			
Last Updated:	11/11/2013 14:12			

Medications Form/Section Last Updated On: Medications Form/Section Last Updated By: 11-NOV-2013 14: 36 Claire Chan – Medical Officer

Page 3 of 4

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

 Encounter Info:
 Inpatient, 07/11/2013 – 11/11/2013

Medical Compliance Aid - Recommended: No, Type: Medilist

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

Page 4 of 4

			PHARMACY DEPARTMENT - PRINCE HOSPITAL PATIENT MEDICATION LIST James SMITH DOB: 17 April 1939 Date: 11/11/:	CY DEPARTMENT - PRINCE PATIENT MEDICATION LIST DOB: 17 April 1939 Dai	INCE HOSPITAL N LIST Date: 11/11/2013	TAL 11/2013			Page 1 of 2
					Daily time table	ne table			
Name of medicine	Brand	Used for	Directions	Morning 7-9am	Noon 11-1pm	Evening 4-6pm	Bedtime 9-11pm	Change	Comments
Warfarin 5mg tablet	Coumadin	Prevent blood clots	Take 1 tablet in the evening			1		Decreased	Your dose many change, see your GP
Warfarin 1mg tablet		and stroke	Take ½ a tablet in the evening			half		0.000	within 3 days.
Simvastatin 80mg tablet	Lipex Zocor	Reduce cholesterol levels in the blood	Take 1 tablet at bedtime				1	Unchanged	
Cyclosporin 100mg capsule	Neoral	Prevent kidney rejection	Take 1 capsule in the morning 1 capsule in the evening	-		÷		Unchanged	
Mycophenolate 250mg capsule	Cellcept	Prevent kidney rejection	Take 3 capsules in the morning 3 capsules in the evening	3		ω		Unchanged	
Cliclazide 30mg modified release tablet	Glyade MR	Control amount of sugar in the blood	Take 1 tablet in the morning 1 tablet in the evening			H		Unchanged	Take with breakfast and dinner. Swallow the tablet whole.
Paracetamol 665mg modified release tablet	Panadol Osteo	To reduce arthritis pain	Take 2 tablets in the morning 2 tablets at noon 2 tablets in the evening	2	2	2		Unchanged	Do not take more than 6 tablets in one day. Swallow the tablets whole.
Colecalciferol 1000 IU capsule	Calcia D Ostelin	Vitamin D supplement	Take I capsule in the morning	1				Unchanged	

	Unchanged	in the n	Take 2 tablets in the morning and 2 tablets in the evening when needed for constipation.	the morning on needed fo	Take 2 tablets in the morning and 2 tablets in evening when needed for constipation.	Relieve Take constipation 2 tablets in the morning 2 tablets in the evening	Relieve constipation	Coloxyl with Senna	Docusate SOmg and Senna 8mg tablet
Comments	Change	Bedtime 9-11pm	Evening 4-6pm	Noon 11-1pm	Morning 7-Sam	Directions	Used for	Brand	Name of medicine
			ne table	Daily time table					
Page 2 of 2			TAL 11/2013	I LIST Date: 11/	DOB: 17 April 1939 Dat	PHARMACY DEPARTMENT - PRINCE HOSPITAL PATIENT MEDICATION LIST James SMITH DOB: 17 April 1939 Date: 11/11/2013			

1 8 4

Amlodipine 5mg tablet	Name of medicine
Amlo Norvasc	Brand names
7/11/2013	Date stopped
Making blood pressure too low when standing up, causing dizziness.	Explanation

Allergies and adverse drug reactions

Many years ago	Date
Aspirin	Medicine/causal agent
Stomach ulcer	Reaction

Continuity of Medication Management Comprehensive Audit Tool

Auditor's Worksheet

Patient Number: 18

Medications laken Plan for admission Medications on medication chart at medication chart at medication prescriptions) And chart chart medications on medication prescriptions) Medications on medications medication prescriptions) Medications on medications prescriptions) Medications on therepy (check last medication prescriptions) Medications on medications prescriptions) Medications on therepy (check last prescriptions) Medications therepy (check last prescriptions) <t< th=""></t<>
ocumented or continued yy (check last al round with with with with with with with with



Audit Period: 15 10-15 11 13	Hospital:	ince they	>+1-==1	COVINSI
Date of Audit: 22/11/13 Patient Number: 18 Male/Female (circle) Age: 74 Department/Ward: Medical	Auditor/s names:	S	ditional Notes:	_
Section 1: Best Possib	le Medication	History (E	3PMH)	
1.1 Admission date: 07 / 11	a service and the second second	Admission	time: 12.153	
	1 2013	Discharge	destination: Retirement	Village
Yes D No If No, w	☐ Yes If Ye ☐ No	e, where was i	it documented?	
Yes 🗌 No				
1.5 Who documented the most co	mprehensive medic	ation history?	(select only one)	
ED medical officer	Admitting	g medical tear	n 🖪 Pharmacist	
Registered nurse	🗋 Nurse pra	actitioner	Multidisciplin	ary team
Other (provide details):				
N.B. Use sele	acted comprehens	sive history t	to complete data collection	
.6 Date and time (if available) me	dication history was	documented		
Date: 08/11/2013	Time:			
1.7 Where was the medication his	tory documented?		No. of the second second	
History section of NIMC	MMP		Other dedicate	ed form
Paper progress notes	Electron	ic progress n	otes 🗌 Medication ta	ble
Other (provide details):	212			
	? (i.e. type of reaction		of, documented as part of the hist known)	lory?
.8 a) Were the patient's allergies. Yes No .8 b) Were details documented? Yes No No	(i.e. type of reaction t applicable			lory?
.8 a) Were the patient's allergies. Yes No .8 b) Were details documented? Yes No No .9 a) Number of regular prescrit	? (i.e. type of reaction t applicable bed medications?	or nil or not	known)	lory?
.8 a) Were the patient's allergies. Yes No No No Yes No No No No No No No No No No	? (i.e. type of reaction t applicable bed medications? nd frequency?	or nil or not	known) Comments:	lory?
.8 a) Were the patient's allergies. Yes No No No Yes No Yes No No 9 a) Number of regular prescribed .9 b) Number with name, dose a .10 a) Number of prn prescribed	? (i.e. type of reaction t applicable bed medications? and frequency? I medications?	6	known) Comments: Comments:	lory?
I.8 a) Were the patient's allergies, Yes No I.8 b) Were details documented?	? (i.e. type of reaction t applicable bed medications? and frequency? I medications? and frequency?	6 6 0	known) Comments: Comments: Comments:	lory?

Continuity of Medication Management Comprehensive Audit Tool

Audit Period:	Hospital:			COMMISSI
Date of Audit: <u>72/11/13</u> Patient Number: <u>18</u> Male/Female (circle) Age: <u>74</u> Department/Ward:	Auditor/s names:	Additional Notes:		-
Section 2: Medication	Reconciliation on	Admission	Res	ponse
This section compares the n nedication chart	nedications taken prio	r to admission to those prescribe	d on th	e
2.1 Number of regular and prn p locumented plan? (i.e. to contin		CONCERNMENT OF A CONCERNMENTA CONCERNENT OF A CO		.6
.2 Number of non-prescribed r	nedications taken prior to a	admission with a documented plan?		3
		for to admission omitted from the fied or rectified within 48 hours of	a)	0
b) Number of these possibly int	entional due to obvious pa	atient/disease factors?	b)	0
2.4 a) Number of regular prescr medication chart with a discrepan documented and not identified or	ncy (name, dose, route, fo	rm, frequency) without reason	a)	0
) Number of these possibly int	entional due to obvious p	atlent/disease factors?	b)	0
2.5 a) Number of prn prescribed medication chart without reason of admission?	그는 물건이 있는 것은 것을 많은 것 같은 것을 다 했다. 것 같아요. ? 것 같아요. ? ? ? ??????????????????????????????	o admission omitted from the fied or rectified within 48 hours of	a)	0
b) Number of these possibly interest of these possibly interest of these possibly interest of the possible p	entional due to obvious pa	atient/disease factors?	b)	0
	dose, route, form, frequen	o admission written on the medication cy) without reason documented and	a)	0
) Number of these possibly interesting the possibly interesting the possibly interesting the possible possib	entional due to obvious p	atient/disease factors?	b)	0
2.7 a) Number of non-prescribe nedication chart without reason d idmission?	일을 가지 않는 것 같은 것을 가지 않는 것이 같아요. 같이 잘 많아야 한다. 것 같은 것을 같이 많이	to admission omitted from the fied or rectified within 48 hours of	a)	0
) Number of these possibly inte	entional due to obvious p	atient/disease factors?	b)	0
		to admission written on the medication icy) and not identified or rectified	a)	0
) Number of these possibly inte	entional due to obvious pa	atient/disease factors?	b)	0

Continuity of Medication Management Comprehensive Audit Tool

Audit Period:	Hospital:			COMMISSIO
Date of Audit:13 Patient Number:18 MalerPemale (circle) Age: Department/Ward:	Auditor/s names:	Additional Notes:		
Section 3: Medication	Reconciliation on	Discharge	Response	1
This section compares the medication chart with the n	and the second se			
3.1 Was a discharge summary	completed for this patient?		Yes No	
3.2 Number of medications to be nedications taken prior to admis available) and any documented	e continued on discharge ision, the medication chart,	, determined by reviewing discharge prescriptions (if	8	
3.3 Number of medications omi	tted from the discharge sur	nmary?	0	
3.4 Number of medications incluiname, dose, route, form, freque		mary with a discrepancy	0	
3.5 Number of unexplained ext	tra medications on the discl	harge summary?	0	
 6 a) Number of medications the i.e. not to be continued on disched on disched on the intervention of these documenter of these documenter of these documenter of these documenter of the intervention of the interven	harge)		a) b)	
 A) Number of medications to strength, dose or frequency? b) Number of these documenter in strength, dose or frequency 	ed on the discharge summa		a) b)	
3.8 Number of new, changed o locumented on the discharge s		had reason/s for change	I (an	-ladip.
9.9 Was the patient provided with Applicable do not proceed with		harge? (If No or Not	Yes No	
1.10 Number of medications on dentified as to continue on disch	harge?		0	
I.11 Number of medications inc name, dose, route, form, freque		tion list with a discrepancy	0	
1.12 Number of unexplained ex	ctra medications on the pat	lent medication list?	0	
.13 Number of medications do	cumented as ceased on th	e patient medication list?	1 (anda	lipne
14 Number of medications do or differing in strength, dose o	or frequency?		1 (warf	anin
3.15 Number of new, changed locumented on the patient met	lication list?		1 Camb	alipin
16 Does the list of medications with the list of medications in the		list correspond identically	Yes 🗆 No	

Appendix 2 – Auditor's Work Sheet

Comprehensive Audit Tool

Auditor's Work Sheet

Patient Number:

		T			
					Medications taken prior to admission
					Plan for admission medicines
					Medications on medication chart at admission
					Medications on medication chart at discharge
					Any documented plan for continued therapy (check last medical round notes, prescriptions)
					Medications on discharge summary
					'Intended regimen on discharge'



Correspondence Locked Bag 8 Haymarket NSW 1240 Tel 61 2 9269 5500 Fax 61 2 9269 5599 www.cec.health.nsw.gov.au

