MEDICATION SAFETY AND QUALITY
Continuity of medicines
Ensuring safe care

CLINICAL EXCELLENCE COMMISSION

COMPREHENSIVE AUDIT TOOL USER GUIDE

MEDICATION RECONCILIATION TOOLKIT

TABLE OF CONTENTS

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.

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 Reconciliation 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 *or* 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 *or* 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** (*name, dose, route, form, frequency*) 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 *or* 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 *or* 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** (*name, dose, route, form, frequency*) without reason documented and not identified *or* 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 *or* rectified within 48 hours of admission should be excluded from the count.

Question	Definition
2.6b) **Number** of these **possibly intentional** due to obvious patient/disease factors?	Count and enter the number of medications identified in 2.6a) that are possibly intentionally changed due to obvious patient/disease factors.
2.7a) **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?	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.
2.7b) **Number** of these **possibly intentional** due to obvious patient/disease factors?	Count and enter the number of medications identified in 2.7a) that are possibly intentionally omitted due to obvious patient/disease factors.
2.8a) **Number** 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?	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.
2.8b) **Number** of these **possibly intentional** due to obvious patient/disease factors?	Count and enter the number of medications identified in 2.8a) that are possibly intentionally changed due to obvious patient/disease factors.

Section 3 – Medication Reconciliation on Discharge	
Question	Definition
3.1 Was a **discharge summary** completed for this patient?	Select a Yes or No response.
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), the discharge summary and any documented plan for continued therapy?	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.
3.3 **Number** of medications **omitted** from the discharge summary?	Count and enter the number of medications to be continued on discharge that were omitted from the discharge summary.
3.4 **Number** of medications included on the discharge summary with a **discrepancy** *(name, dose, route, form, frequency)*?	Count and enter the number of medications to be continued on discharge that were documented on the discharge summary with an unexplained change.
3.5 **Number** of **unexplained extra** medications on the discharge summary?	Count and enter the number of medications documented in the discharge summary that were not identified to continue on discharge.
3.6a) **Number** of medications the patient had been taking prior to admission that were **ceased?** (i.e. not to be continued on discharge)	Count and enter the number of medications the patient had been taking prior to admission that were not to be continued on discharge.
3.6b) **Number** of these **documented as ceased** on the discharge summary?	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.
3.7a) **Number** of medications to be continued on discharge **either new**, **or differing in strength, dose or frequency?**	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.
3.7b) **Number** of these **documented** on the discharge summary **as either new, or differing in strength, dose or frequency?**	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.
3.8 **Number** of **new, changed or ceased** medications that had **reason/s for change documented** on the discharge summary?	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.
3.9 Was the **patient** provided with a **medication list** on discharge? (if **No** or **Not Applicable** do not proceed with data collection)	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.
3.10 **Number** of medications **omitted** from the patient medication list?	Count and enter the number of medications to be continued on discharge that were omitted from the patient medication list.

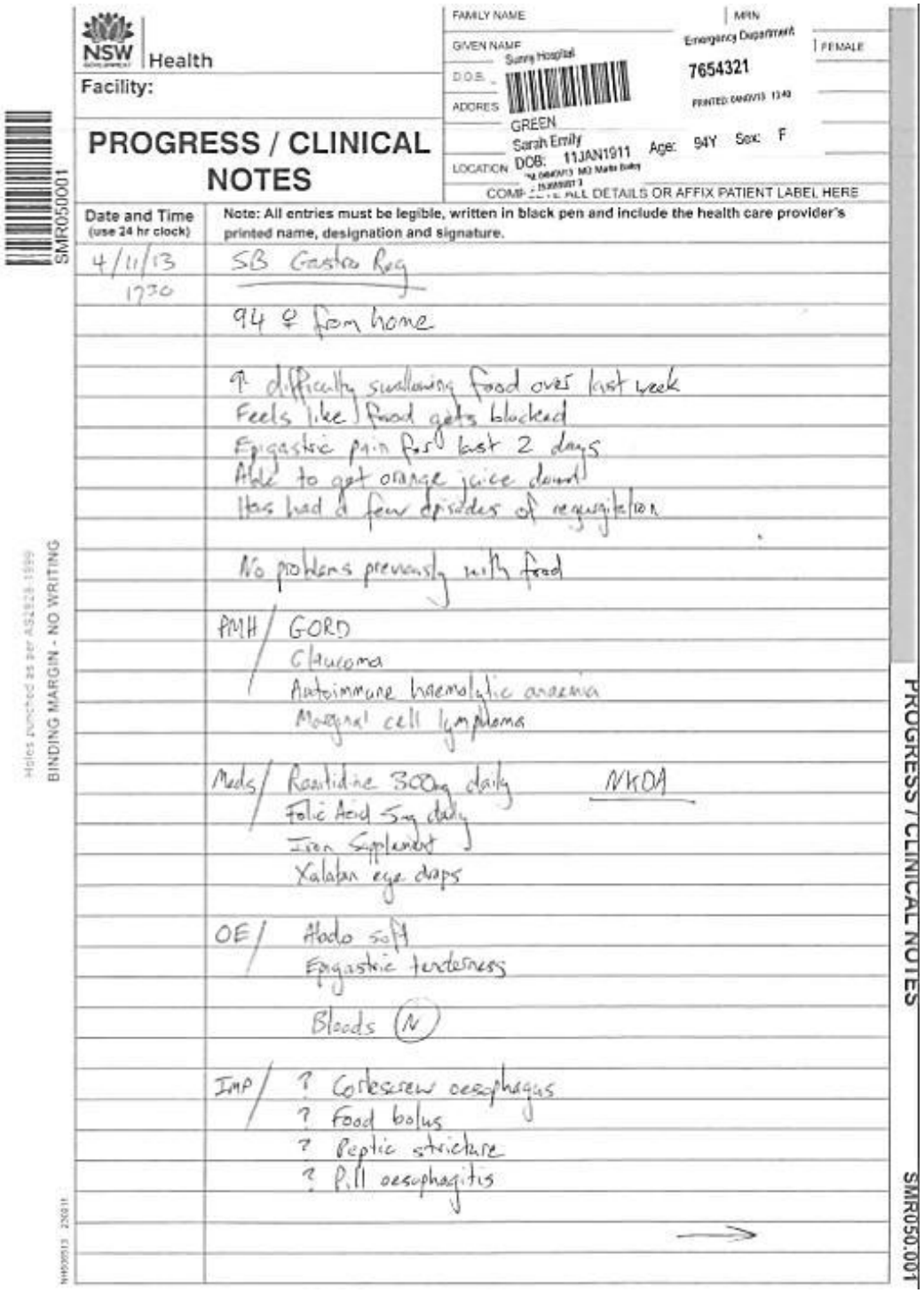
Question	Definition
3.11 **Number** of medications included in the patient medication list with a **discrepancy** *(name, dose, route, form, frequency)*?	Count and enter the number of medications to be continued on discharge that were documented on the patient medication list with an unexplained change.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

APPENDICES

MEDICATION SAFETY AND QUALITY
Continuity of medicines
Ensuring safe care

CLINICAL EXCELLENCE COMMISSION

Appendix 1 – Audit Tool Examples



NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME Sunny Hospital | Emergency Department | FEMALE

DOB | 7654321

ADDRES | PRINTED: 04/04/13 13:49

GREEN

Sarah Emily

LOCATION DOB: 11JAN1911 Age: 94Y Sex: F

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PROGRESS / CLINICAL NOTES

SMR050001

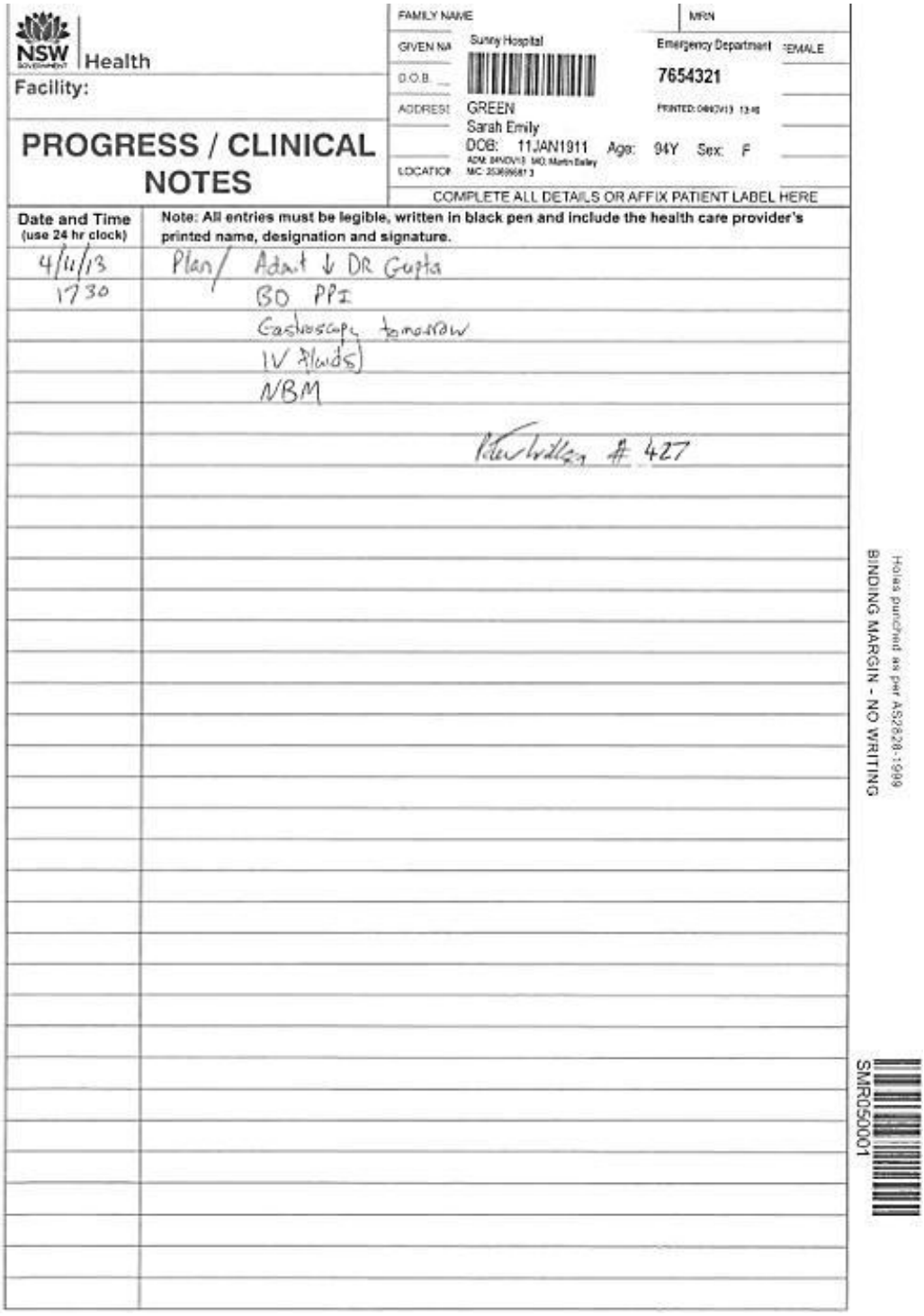
Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
4/11/13 1730	SB Gastro Reg
	94 ♀ from home
	↑ difficulty swallowing food over last week
	Feels like food gets blocked
	Epigastric pain for last 2 days
	Able to get orange juice down
	Has had a few episodes of regurgitation
	No problems previously with food
PMH/	GORD
	Glaucoma
	Autoimmune haemolytic anaemia
	Marginal cell lymphoma
Meds/	Ranitidine 300mg daily NKDA
	Folic Acid 5mg daily
	Iron Supplement
	Xalatan eye drops
OE/	Abdo soft
	Epigastric tenderness
	Bloods (N)
IMP/	? Corkscrew oesophagus
	? Food bolus
	? Peptic stricture
	? Pill oesophagitis

BINDING MARGIN - NO WRITING

Holes punched as per AS1828.1999

PROGRESS / CLINICAL NOTES SMR050.001

NHS0513 2/2011



NSW Health

Facility:

PROGRESS / CLINICAL NOTES

FAMILY NAME | MRN

GIVEN NA | Surrey Hospital | Emergency Department | EMALE

D.O.B.

ADDRES GREEN | 7654321

Sarah Emily

DOB: 11JAN1911 Age: 94Y Sex: F

LOCATIO

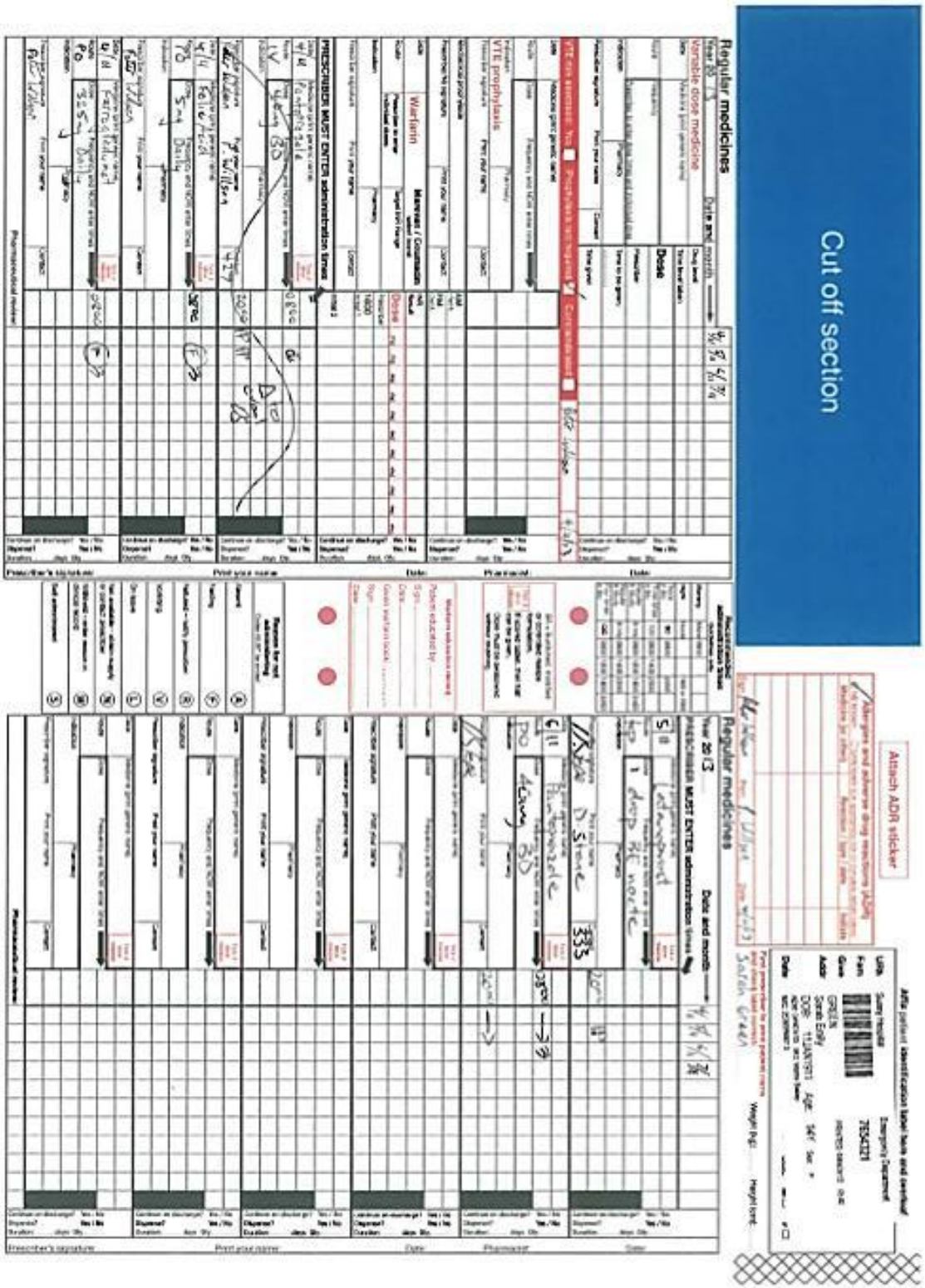
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
4/11/13	Plan/ Admit ↓ DR Gupta
1730	BD PPI
	Gastroscopy tomorrow
	IV fluids
	NBM
	# 427

Holes punched as per AS2828-1999

BINDING MARGIN - NO WRITING

SMR050001


Cut off section
Attach ADR sticker
Regular medicines
Variable dose medicine
Dose
Warfarin
PRESCRIBER MUST ENTER administration times
Regular medicines
PRESCRIBER MUST ENTER administration times

Cut off section
DO NOT WRITE IN THIS BINDING MARGIN
DO NOT WRITE IN THIS BINDING MARGIN
As required PRN medicines
Year: 20 13
Medication chart number
Once only and nurse initiated medicines and pre-medications
Telephone orders to be signed within 24 hours of order
NIMC (acute)

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

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	
AMO Provider No.:	12345H	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
Iron supplement

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

==========

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 67960018, 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

SUNNY HOSPITAL MEDICATION LIST

PHARMACY DEPARTMENT Phone: 02 9346 7596

MEDICATION LIST for Ms Sarah GREEN MRN 7654321

Medication Period From 06/11/2013

PRODUCT DESCRIPTION	BREAKFAST	LUNCH	TEA	BED TIME	COMMENTS
PANTOPRAZOLE (SALPRAZ) 40MG EC TABLETS	ONE		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-GRADUMENT) 325MG MR TABLETS	ONE				Iron supplement 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

Angus Winters (B.Pharm)

NOTE that while in hospital your Ranitidine was stopped.

Continuity of Medication Management Comprehensive Audit Tool

Auditor's Worksheet

Patient Number: 14

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'
Ranitidine 300mg d	No	—	—	Cease	Cease	Cease
Folic acid 5mg d	No	Folic acid 5mg d	Folic acid 5mg d	Cont	Folic acid 5mg d	Folic acid 5mg d
Iron supplement	No	FeroCard 325mg d	FeroCard 325mg d	Cont	Iron supplement	FeroCard 325mg d
Xalatan eye drops	No	Xalatan T 3E mode	Xalatan T 3E mode	Cont	Xalatan eyedrops	Xalatan eyedrops T 3E mode
		Pantoprazole IV 40mg BD	—	—	—	—
			Pantoprazole po 40mg BD	Cont	Pantoprazole po 40mg BD	Pantoprazole po 40mg BD

Continuity of Medication Management
Comprehensive Audit Tool

CLINICAL EXCELLENCE COMMISSION

Audit Period: 15/10-15/11/13	**Hospital:** Sunny Hospital	
Date of Audit: 21/11/13	**Auditor's names:** Kim Jones, Chris Collins	**Additional Notes:**
Patient Number: 16		
Male/Female (circle) Age: 84		
Department/Ward: Medical		

Section 1: Best Possible Medication History (BPMH)

1.1 Admission date: 04 / 11 / 2013	Admission time: 13:40
1.2 Discharge date: 06 / 11 / 2013	Discharge destination: Home

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** If **Yes**, where was it documented?
☐ **No**

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: 04 / 11 / 2013 **Time:** 17:30

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?	2	Comments:
1.9 b) Number with **name, dose and frequency?**	1	Comments: Xalatan - no dose or frequency
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?	2	Comments:
1.11 b) Number with **name, dose and frequency?**	1	Comments: 'Iron supplement' not clear

1.12 a) Was/were 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**

Continuity of Medication Management
Comprehensive Audit Tool

Audit Period: _____ **Date of Audit:** 21/11/13 **Patient** Number: 14 Male/Female (circle) **Age:** 54 Department/Ward: _____	**Hospital:** _____ **Auditor's names:**	**Additional Notes:**

Section 2: Medication Reconciliation on Admission	Response
This section compares the medications taken prior to admission to those prescribed on the medication chart	
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)	0
2.2 Number of **non-prescribed** medications taken prior to admission with a **documented plan?**	0
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?	a) 1
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 1
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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 0

Comments: Ranitidine omitted - likely intentional as started on PPI
Xalatan was initially omitted, but rectified the next day

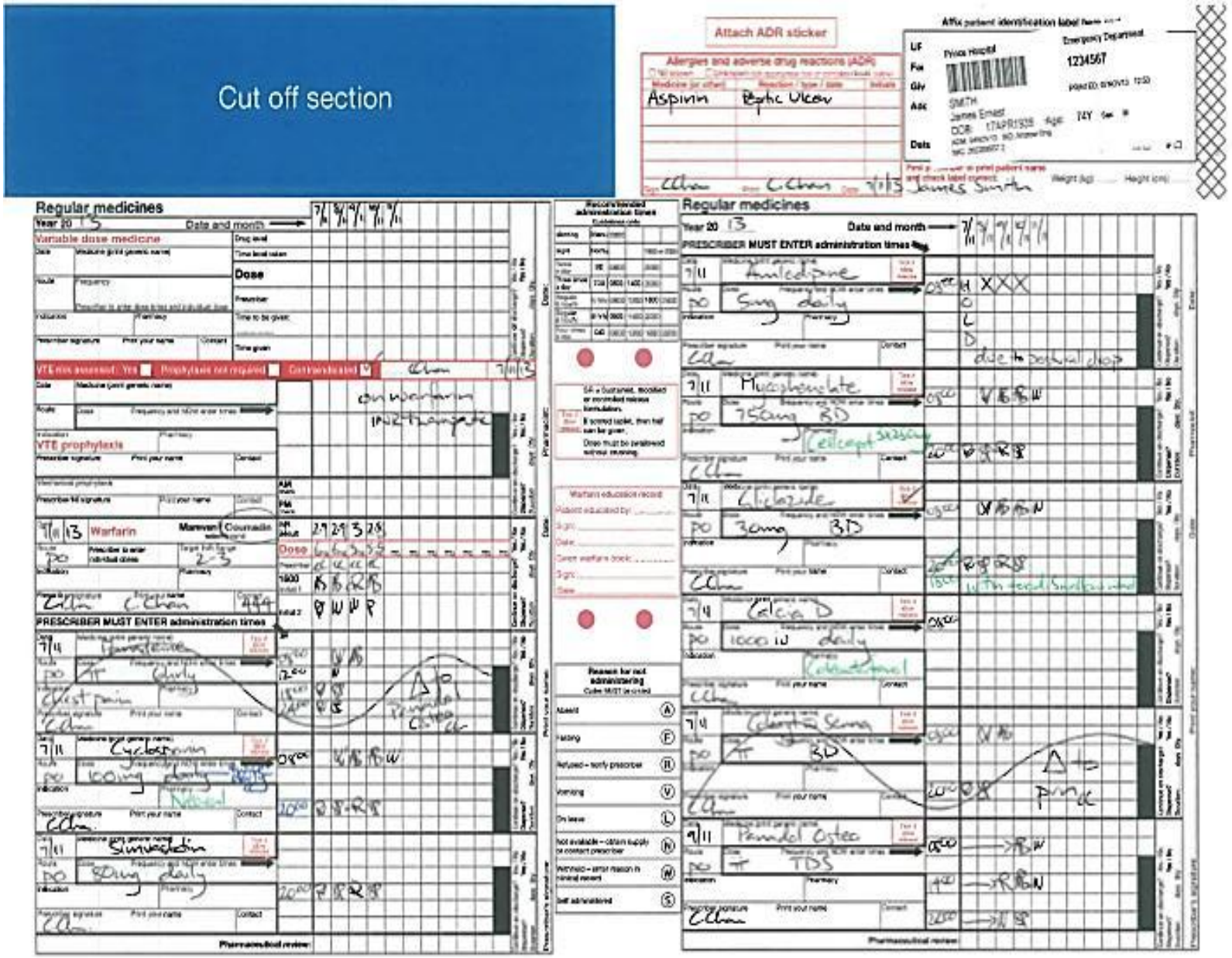
Continuity of Medication Management
Comprehensive Audit Tool

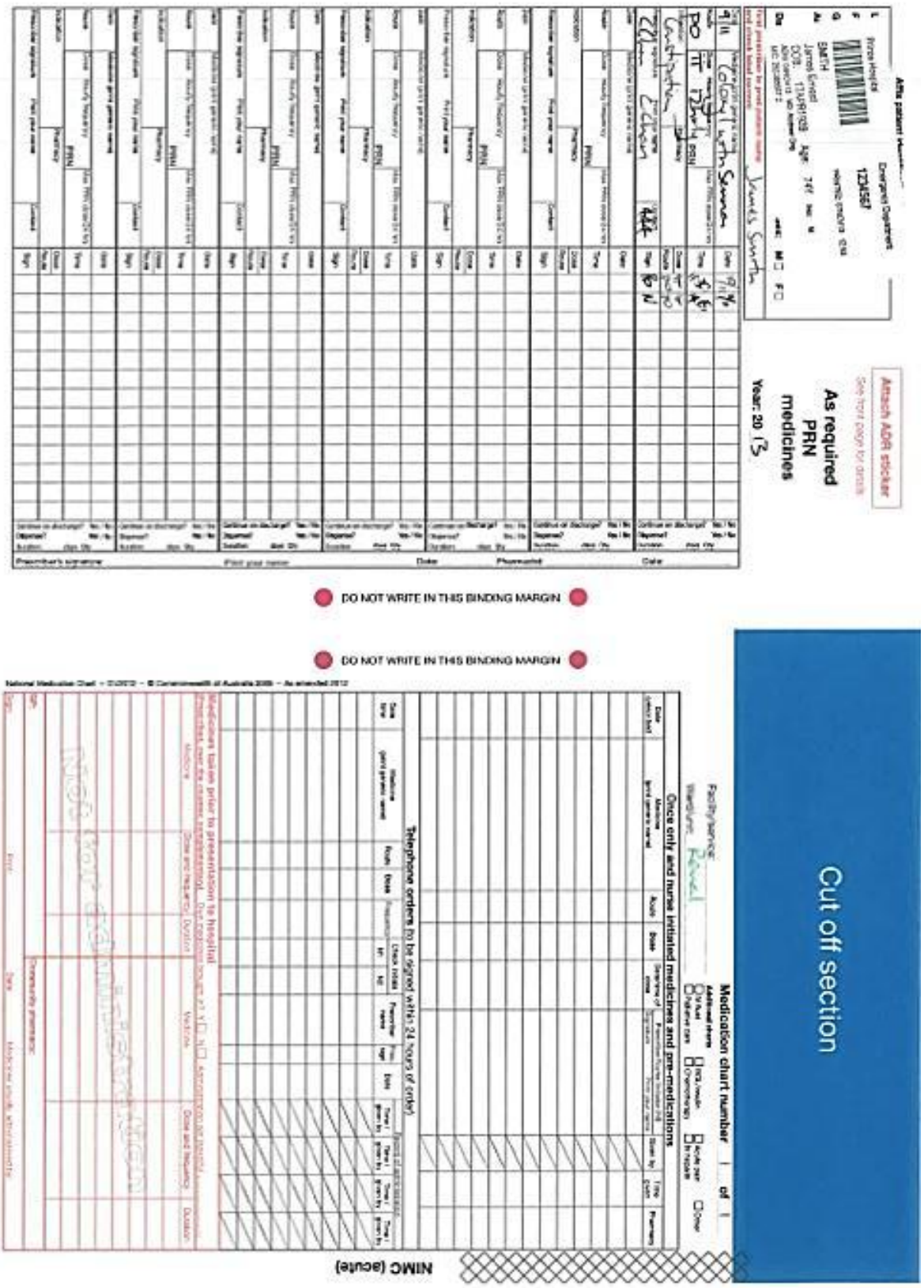
CLINICAL EXCELLENCE COMMISSION

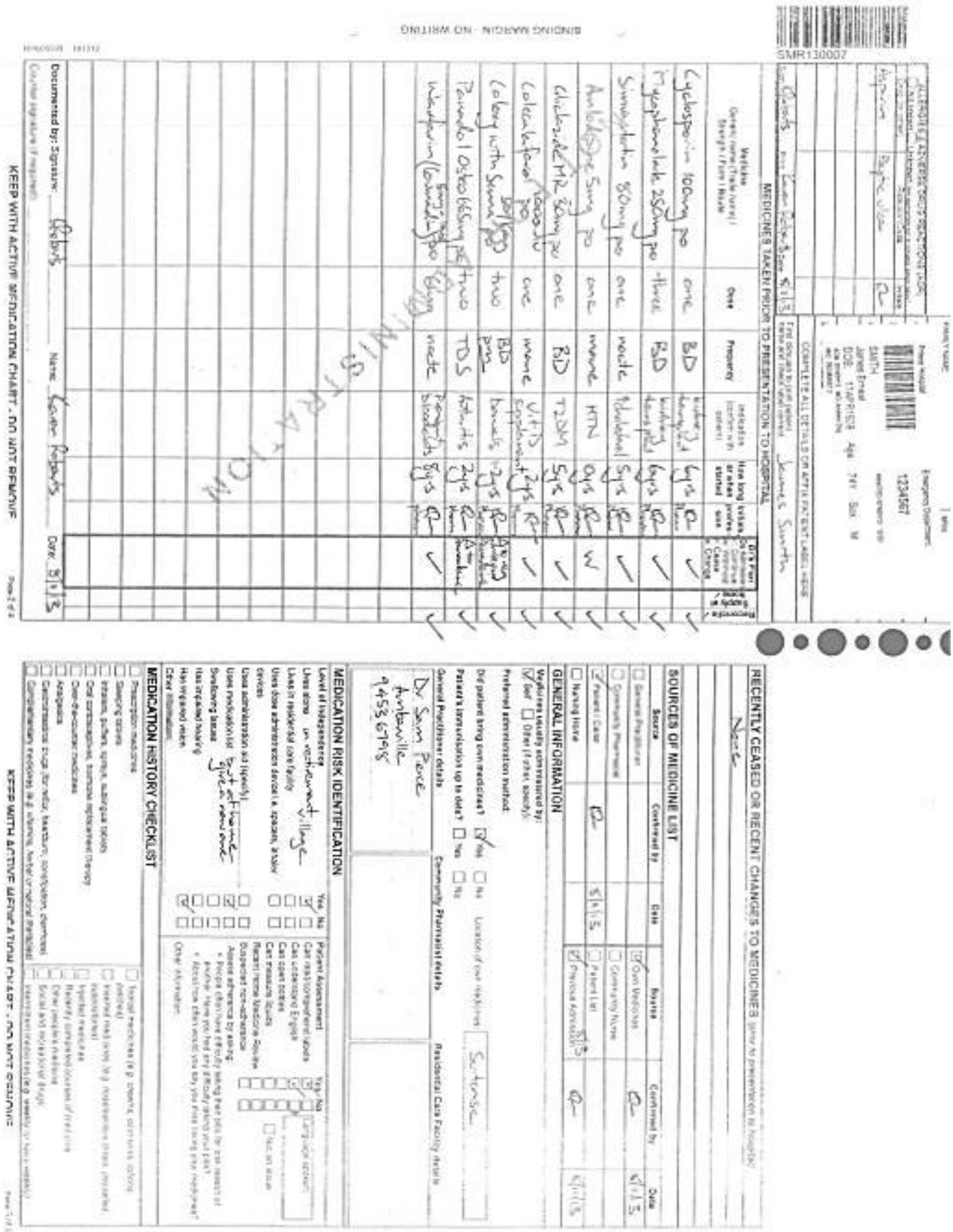
Audit Period: _____ **Date of Audit:** 21/11/13 **Patient Number:** 14 **Male/Female (circle)** **Age:** 94 **Department/Ward:** _____	**Hospital:** _____ **Auditor/s names:** _____	**Additional Notes:** _____

Section 3: Medication Reconciliation on Discharge	Response
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	
3.1 Was a **discharge summary** completed for this patient?	☑ Yes ☐ No
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?	4
3.3 Number of medications **omitted** from the discharge summary?	0
3.4 Number of medications included on the discharge summary with a **discrepancy** *(name, dose, route, form, frequency)*?	0
3.5 Number of unexplained extra medications on the discharge summary?	0
3.6 a) Number of medications the patient had been taking prior to admission **ceased?** (i.e. not to be continued on discharge)	a) 1
b) Number of these **documented as ceased** on the discharge summary?	b) 1
3.7 a) Number of medications to be continued on discharge **either new, or differing in strength, dose or frequency?**	a) 1
b) Number of these **documented** on the discharge summary **as either new, or differing in strength, dose or frequency?**	b) 1
3.8 Number of **new, changed or ceased** medications that had **reason/s for change documented** on the discharge summary?	0
3.9 Was the patient provided with a **medication list** on discharge? (**If No** or **Not Applicable** do not proceed with data collection)	☑ Yes ☐ No ☐ Not applicable
3.10 Number of medications **omitted** from the patient medication list that had been identified as to continue on discharge?	0
3.11 Number of medications included in the patient medication list with a **discrepancy** *(name, dose, route, form, frequency)*?	0
3.12 Number of **unexplained extra** medications on the patient medication list?	0
3.13 Number of medications **documented as ceased** on the patient medication list?	1 (ranitidine)
3.14 Number of medications **documented** on the patient medication list **as either new, or differing in strength, dose or frequency?**	1 (pantoprazole)
3.15 Number of **new, changed or ceased medications** that had **reason/s for change documented** on the patient medication list?	0
3.16 Does the list of medications in the **patient medication list** correspond identically with the list of medications in the **discharge summary?**	☐ Yes ☑ No

Comments: D/C summary does not have dose or frequency information for two medications, the pt med list does.


Cut off section
Attach ADR sticker
Allergies and adverse drug reactions (ADR)
Aspirin
Peptic Ulcer
Affix patient identification label here
Emergency Department
1234567
SMITH
James Ernest
Regular medicines
Year 20 13
Date and month
Variable dose medicine
Dose
VTE risk assessment: Yes
Prophylaxis not required
Contraindicated
on warfarin
INR therapeutic
VTE prophylaxis
Warfarin
Marevan
Coumadin
PRESCRIBER MUST ENTER administration times
Amlodipine
5mg daily
Mucosolvate
75mg BD
Celecoxib
Clozide
30mg BD
with food
Celcia D
1000 IU daily
Calcichew
Cyclosporin
100mg
Neoral
Chest pain
Simvastatin
20mg daily
Pramol Osteo
TDS
Reason for not administering
Pharmaceutical review:


As required PRN medicines
Year: 20 13
DO NOT WRITE IN THIS BINDING MARGIN
DO NOT WRITE IN THIS BINDING MARGIN
Medication chart number
Once only and nurse initiated medicines and pre-medications
Telephone orders to be signed within 24 hours of order
NIMC (acute)
Cut off section


MEDICINES TAKEN PRIOR TO PRESENTATION TO HOSPITAL
KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE
RECENTLY CEASED OR RECENT CHANGES TO MEDICINES
SOURCES OF MEDICINE LIST
GENERAL INFORMATION
MEDICATION RISK IDENTIFICATION
MEDICATION HISTORY CHECKLIST
BINDING MARGIN - NO WRITING

NSW Health

Medication Management Plan

Facility/Service: Prince Hospital

Date of admission: 7 / 11 / 2013

Ward / Clinic: Renal

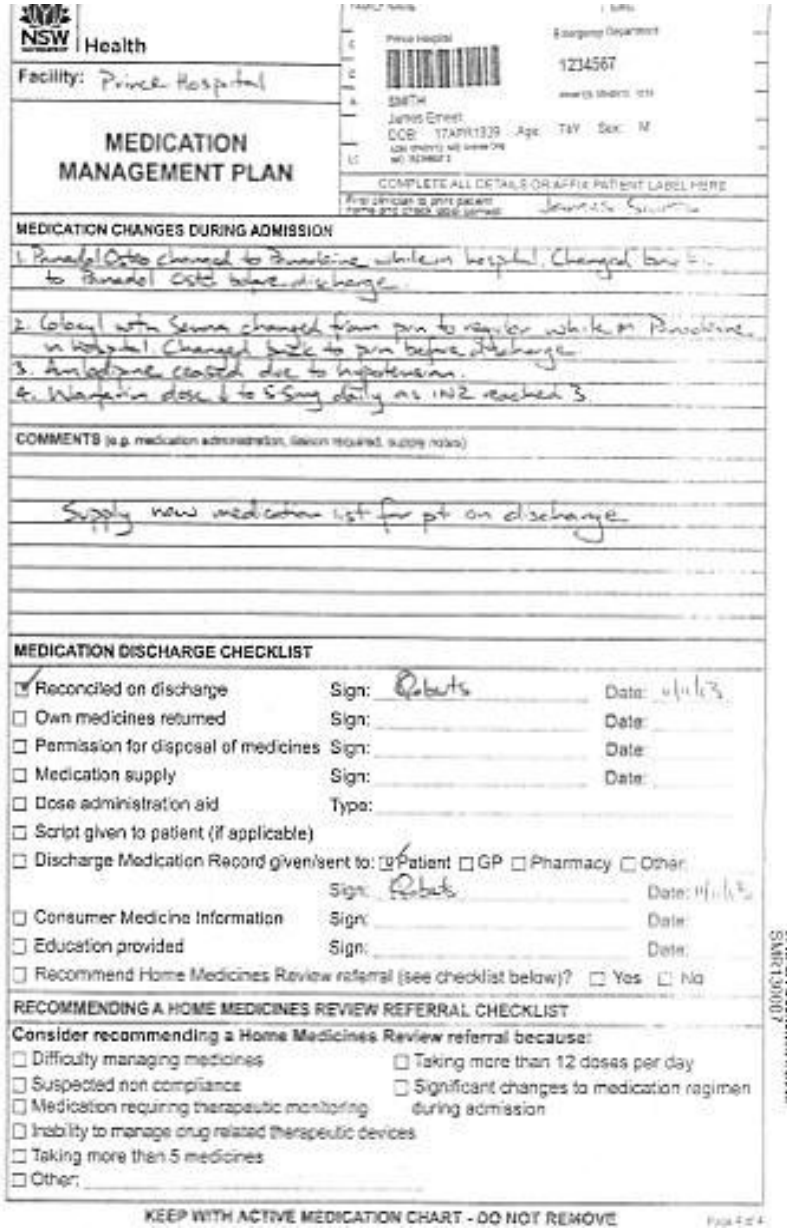
Consultant: P. Nguyen

Date / Time	Issue identified	Proposed Action	Person Responsible	Date of Action	Result of Action
8/11	Pt takes cyclosporin 100mg BD Currently charted 100mg daily.	R/v frequency and rectify or document if an intentional dose change. Issue identified by: Karen Roberts Contact number: 702	MO	8/11	Frequency corrected
8/11	Pt usually takes Pinadel-Osteo. Currently charted for Pinaldine	R/v and rectify or document if intentional change. Issue identified by: Karen Roberts Contact number: 702	MO	8/11	Intentional change to Pinaldine
8/11	Pt usually uses Celoxyl with Senna 2 tabs BD prn. Currently charted as regular	R/v and rectify or document if an intentional change Issue identified by: Karen Roberts Contact number: 702	MO	8/11	Intentional change to regular celoxyl with Senna Pinaldine
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			
		Issue identified by: Contact number:			

MEDICATION MANAGEMENT PLAN

SMR130.007

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE *Please see over* Page 1 of 4



NSW Health

Facility: Prince Hospital

Prince Hospital — Emergency Department

1234567

SMITH
James Ernest
DOB: 17APR1939 Age: 74Y Sex: M

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

MEDICATION MANAGEMENT PLAN

MEDICATION CHANGES DURING ADMISSION

1. Pinadel Osteo changed to Pinaldine while in hospital. Changed back to Pinadel Osteo before discharge.
2. Celoxyl with Senna changed from prn to regular while in Pinaldine in hospital. Changed back to prn before discharge.
3. Amlodipine ceased due to hypotension.
4. Warfarin dose 4 to 5 mg daily as INR reached 3.

COMMENTS (e.g. medication administration, liaison required, supply notes)

Supply new medication list for pt on discharge.

MEDICATION DISCHARGE CHECKLIST

- ☑ Reconciled on discharge — Sign: Roberts — Date: 8/11/13
- ☐ Own medicines returned — Sign: — Date:
- ☐ Permission for disposal of medicines — Sign: — Date:
- ☐ Medication supply — Sign: — Date:
- ☐ Dose administration aid — Type:
- ☐ Script given to patient (if applicable)
- ☐ Discharge Medication Record given/sent to: ☑ Patient ☐ GP ☐ Pharmacy ☐ Other — Sign: Roberts — Date: 8/11/13
- ☐ Consumer Medicine Information — Sign: — Date:
- ☐ Education provided — Sign: — Date:
- ☐ Recommend Home Medicines Review referral (see checklist below)? ☐ Yes ☐ No

RECOMMENDING A HOME MEDICINES REVIEW REFERRAL CHECKLIST

Consider recommending a Home Medicines Review referral because:

- ☐ Difficulty managing medicines
- ☐ Suspected non compliance
- ☐ Medication requiring therapeutic monitoring
- ☐ Inability to manage drug related therapeutic devices
- ☐ Taking more than 5 medicines
- ☐ Other:
- ☐ Taking more than 12 doses per day
- ☐ Significant changes to medication regimen during admission

SMR130.007

BINDING MARGIN - NO WRITING

KEEP WITH ACTIVE MEDICATION CHART - DO NOT REMOVE Page 4 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 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	
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

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 47966010, Final, Medical.
Allergies and Adverse Reactions
Allergic Reaction (Selected)
Severe
Aspirin – Ulcers.

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	Dose	Freq	Route	Start Date
WARFARIN (COUMADIN)	5.5mg	Daily	Oral	

Other Comment: as per INR aim INR 2-3
Status: Medication continued – dose reduced
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
GLYADE MR	30mg	BD	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
PANADOL OSTEO	2	TDS	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
CALCIA D	1000 units	Morning	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
SIMVASTATIN	80mg	Night	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
COLOXYL AND SENNA	2	Other: bd prn	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
MYCOPHENOLATE	750mg	BD	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

Medication Name	Dose	Freq	Route	Start Date
CYCLOSPORIN	100mg	BD	Oral	

Status: Medication continued – dose unchanged
Last Updated: 11/11/2013 14:12

CEASED MEDICATIONS

Medication Name	Dose	Freq	Route	Start Date
AMLODIPINE	5mg	Morning	Oral	

Status: Medication ceased
Last Updated: 11/11/2013 14:12

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 (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:** 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
```

PHARMACY DEPARTMENT - PRINCE HOSPITAL

PATIENT MEDICATION LIST

James SMITH DOB: 17 April 1939 Date: 11/11/2013 **Page 1 of 2**

Name of medicine	Brand names	Used for	Directions	Daily time table				Change	Comments
				 Morning 7–9am	 Noon 11-1pm	 Evening 4-6pm	 Bedtime 9-11pm		
Warfarin 5mg tablet	Coumadin	Prevent blood clots and stroke	Take 1 tablet in the evening			1		Decreased dose	Your dose many change, see your GP within 3 days.
Warfarin 1mg tablet			Take ½ a tablet in the evening			½ half			
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	1		1		Unchanged	
Mycophenolate 250mg capsule	Cellcept	Prevent kidney rejection	Take 3 capsules in the morning 3 capsules in the evening	3		3		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	1		1		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 1 capsule in the morning	1				Unchanged	

PHARMACY DEPARTMENT - PRINCE HOSPITAL
PATIENT MEDICATION LIST

James SMITH DOB: 17 April 1939 Date: 11/11/2013 **Page 2 of 2**

Name of medicine	Brand names	Used for	Directions	Daily time table: Morning 7–9am	Noon 11-1pm	Evening 4-6pm	Bedtime 9-11pm	Change	Comments
Docusate 50mg and Senna 8mg tablet	Coloxyl with Senna	Relieve constipation	Take 2 tablets in the morning 2 tablets in the evening	Take 2 tablets in the morning and 2 tablets in the evening when needed for constipation.				Unchanged	

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

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

Allergies and adverse drug reactions

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

Continuity of Medication Management Comprehensive Audit Tool

Auditor's Worksheet

Patient Number: 18

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'
Cyclosporin 100mg BD	✓	Same	Same	Cont	Same	Cyclosporin 100mg BD
Mycophenolate 750mg BD	✓	Same	Same	Cont	Same	Mycophenolate 750mg BD
Simvastatin 80mg n	✓	Same	Same	Cont	Same	Simvastatin 80mg n
Amlodipine 5mg m	✓ (W)	Same (W)	Same (W)	Cease	Cease	Cease
Gliclazide MR 30mg BD	✓	Same	Same	Cont	Same	Gliclazide MR 30mg BD
Colecalciferol 1000 units m	✓	Same	Same	Cont	Same	Colecalciferol 1000 units m
Coloxyl c Senna ii BD PRN	✓ Δ to regular	Coloxyl c Senna ii BD reg	Coloxyl c Senna ii BD PRN	Cont	Same	Coloxyl c Senna ii BD PRN
Panadol Osteo ii TDS	✓ Δ to Panadeine	—	Panadol Osteo ii TDS	Cont	Same	Panadol Osteo ii TDS
Warfarin 6mg n	✓	Same	Warfarin 5.5mg n	Cont ↓ dose	Warfarin 5.5mg n ↓ dose	Warfarin 5.5mg n
		Panadeine ii q6h	—	—	—	—

Continuity of Medication Management
Comprehensive Audit Tool

Audit Period: 15/10-15/11/13	**Hospital:** Prince Hospital
Date of Audit: 22/11/13	**Auditor/s names:** Kim Jones, Chris Collins
Patient Number: 18	**Additional Notes:**
Male/Female (circle) Age: 74	
Department/Ward: Medical	

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 this patient on **regular medications** prior to admission? (if **No**, do not proceed with data collection)
- [x] **Yes** [ ] **No** if **No**, was 'patient on nil medications' documented?
  - [ ] **Yes** If **Yes**, where was it documented?
  - [ ] **No**

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

1.5 Who documented the **most comprehensive** medication history? (select only one)

[ ] ED medical officer	[ ] Admitting medical team	[x] 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	[x] 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?
- [x] **Yes** [ ] **No**

1.8 b) Were **details documented?** (i.e. type of reaction **or nil or not known)**
- [x] **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/were the **source/s** of the information obtained for the medication history documented? [x] **Yes** [ ] **No**

b) Were **2 or more** sources used? [x] Yes [ ] **No** [ ] **Not applicable**

Continuity of Medication Management
Comprehensive Audit Tool

CLINICAL EXCELLENCE COMMISSION

Audit Period: _____ **Date of Audit:** 22/11/13 **Patient Number:** 18 **Male/Female (circle)** **Age:** 74 **Department/Ward:** _____	**Hospital:** _____ **Auditor/s names:** _____	**Additional Notes:** _____

Section 2: Medication Reconciliation on Admission	Response
This section compares the medications taken prior to admission to those prescribed on the medication chart	
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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 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?	a) 0
b) Number of these **possibly intentional** due to obvious patient/disease factors?	b) 0

Comments: Cyclosporin frequency rectified

Continuity of Medication Management
Comprehensive Audit Tool

Audit Period: _____	Hospital: _____	
Date of Audit: 22/11/13	Auditor/s names:	Additional Notes:
Patient Number: 18	_____	_____
Male/Female (circle) Age: 74	_____	_____
Department/Ward: _____	_____	_____

Section 3: Medication Reconciliation on Discharge	Response
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	
3.1 Was a **discharge summary** completed for this patient?	☑ Yes ☐ No
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?	8
3.3 Number of medications **omitted** from the discharge summary?	0
3.4 Number of medications included on the discharge summary with a **discrepancy** *(name, dose, route, form, frequency)*?	0
3.5 Number of **unexplained extra** medications on the discharge summary?	0
3.6 a) Number of medications the patient had been taking prior to admission **ceased?** (i.e. not to be continued on discharge)	a) 1
b) Number of these **documented as ceased** on the discharge summary?	b) 1
3.7 a) Number of medications to be continued on discharge **either new, or differing in strength, dose or frequency?**	a) 1
b) Number of these **documented** on the discharge summary **as either new, or differing in strength, dose or frequency?**	b) 1
3.8 Number of **new, changed or ceased** medications that had **reason/s for change documented** on the discharge summary?	1 (amlodipine)
3.9 Was the patient provided with a **medication list** on discharge? (if **No** or **Not Applicable** do not proceed with data collection)	☑ Yes ☐ No ☐ Not applicable
3.10 Number of medications **omitted** from the patient medication list that had been identified as to continue on discharge?	0
3.11 Number of medications included in the patient medication list with a **discrepancy** *(name, dose, route, form, frequency)*?	0
3.12 Number of **unexplained extra** medications on the patient medication list?	0
3.13 Number of medications **documented as ceased** on the patient medication list?	1 (amlodipine)
3.14 Number of medications **documented** on the patient medication list **as either new, or differing in strength, dose or frequency?**	1 (warfarin)
3.15 Number of **new, changed or ceased medications** that had **reason/s for change documented** on the patient medication list?	1 (amlodipine)
3.16 Does the list of medications in the **patient medication list** correspond identically with the list of medications in the **discharge summary**?	☑ Yes ☐ No

Comments: _____

Appendix 2 – Auditor's Work Sheet

Comprehensive Audit Tool

Auditor's Work Sheet

Patient Number:

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

CLINICAL
EXCELLENCE
COMMISSION