MEDICATION SAFETY AND QUALITY
Continuity of medicines
Ensuring safe care

CLINICAL EXCELLENCE COMMISSION

SNAPSHOT AUDIT TOOL USER GUIDE

MEDICATION RECONCILIATION TOOLKIT

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INTRODUCTION

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

This audit tool captures six components of continuity of medication management:

1. Documentation of a medication history
2. Confirmation or verification of the medication history
3. Accessibility of the medication history at the point of care
4. Reconciliation of medications in the medication history with the medications actually prescribed
5. Medication list and changes had been provided for the next care provider on discharge
6. Medication list and changes had been provided for the patient on discharge.

METHOD

Each Snapshot Audit Tool can be used to review 20 patient records. 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. These 20 patients do not need to be reviewed on the same day, the tool allows for collection over a period of time (e.g. five patients could be reviewed each week for a month). Frequent small samples have been shown to be more manageable and provide sufficient data to support ongoing quality improvement activities.

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 component definitions. As the six components of continuity of medication management captured in the tool span across admission to discharge, the data needs to be collected retrospectively after discharge.

The Snapshot Audit Tool provides an alternative to the Comprehensive Audit Tool and can be used by hospitals that:

- Wish to monitor their existing formal medication reconciliation processes
- Do not have the resources to conduct a detailed audit, to obtain an indication of whether formal processes of medication reconciliation are evident.

AUDIT INSTRUCTIONS

1. Read this Snapshot Audit Tool User Guide. Familiarise yourself with the component definitions.
2. Read/revise local guidelines and procedures regarding medication history taking, recording medication-related information and transfer of medication information on discharge or make enquiries in regards to current practices.
3. Decide on the wards/units and number of patient records to review.
4. Circle whether this is a collection to determine a baseline or progress.
5. Enter the audit period i.e. discharge date range of the records audited.
6. A tick or cross should be entered for each component on the Snapshot Audit Tool.
7. The total number of components ticked for each patient should be added.
8. A tick or cross should be entered in the last row to indicate whether all components have been completed.
9. The final column can be used to identify components that require improvement.

COMPONENT DEFINITIONS

In the table below are the definitions for each of the six components of continuity of medication management.

Component	Definition
Medication history	Tick if there was a documented list of medications taken prior to admission that included the name, dose and frequency of each medication. This also includes documentation of any allergies, adverse drug reactions, as well as nil or not known.
Confirmation	Tick if there was documentation of a least two sources of information used to confirm the history.
Accessibility at point of care	Tick if the medication history was documented on a dedicated form (either paper or electronic) which according to protocol is kept with the active medication chart or is recorded in an electronic medication reconciliation program which links to electronic prescribing.
Reconciliation	Tick if there was evidence that a formal medication reconciliation process had occurred i.e. there was documentation to support that the medications in the confirmed history had been used to ensure that the medications 'actually' prescribed match those that 'should' be prescribed. Evidence may include documented changes to orders resulting from identified discrepancies or documentation that reconciliation had been completed on a form dedicated for this purpose.

Component	Definition
Medication list and changes for the next care provider on discharge	Tick if when the patient was discharged an accurate list of medicines and the reason/s for any change, was provided to the next care provider. This may be contained in a discharge summary or transfer documents.
Medication list and changes for the patient on discharge	Tick if when the patient was discharged an accurate list of medicines and the reason/s for any change, was provided to the patient. The list provided to the patient should be in a format that is easily understood by laypersons (if a discharge summary is provided to the patient the medicines information within it must be easily understood and not contain medical terminology or jargon).

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