NSQHS Standard 4 Medication Safety

How to use the audit tools

Medication Safety Audit Tools Instructions

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, in partnership with Medication Services Queensland (MSQ) have developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting the National Safety and Quality Health Service (NSQHS) standards.

Purpose of the audit tools

The tools provide facilities and health services additional supporting resources to use in conjunction with the existing NSQHS standards workbooks and guides to be able to:

- Demonstrate detailed evidence for an action by providing specific verification rather than noting the action has been met and listing the source i.e. self-assessment
- Collect information and evidence to a further level of detail at a patient, ward and facility level, delving down into specific requirements that further support meeting the action
    - Collect patient level data using a number of methods i.e. chart documentation, observational and asking the patient/carer questions to demonstrate that the evidence has been met, and to what extent
    - Observe ward/unit staff undertaking a process e.g. clinical handover and recording individual results
- Determine actual performance results at a ward and facility level by rolling up data i.e. auditing all patients in a ward for a ward result, auditing all wards for a facility result
- Clearly identify those detailed gaps/areas that need attention, in order to target improvements and build a robust action plan at the ward and facility level
- Track and monitor audit results at the three levels over time

The tools can be used in conjunction with other resources and directly align to the criteria in the existing NSQHS standards workbooks and guides. Depending on the size of the facility a number of audit questions may not be applicable, it is up to each facility / health service to determine the audit questions for review. Questions and responses can be adapted to suit the requirements of each facility / health service.

The suite of documents include the following:

1. A 'how to' guide on using the tools (this document)
2. A definitions guide to assist in completing the tools
3. Three specific audit tools that allow the collection and collation of information are provided that can be adapted for local use:
    - *Patient audit tool*: collects patient level data (at a ward/unit level), use one audit tool for each patient audited
    - *Ward/Unit audit tool*: collects ward/unit level data and collates the patient level responses
    - *Facility audit tool*: collects facility level data and collates the ward/unit level responses
4. A measurement plan summary for each standard that defines the goals, questions and responses in the audit tools. The plan details each audit question and its alignment to the action/criteria in the standard and can be adapted for local use. Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Scope of the Medication Safety Audit tools

The audit questions at this stage incorporate a number of key areas, such as governance committees, staff education and training, medication incidents, evaluation processes, documentation on the medication chart and medication action plan, medicine information leaflets and policies/procedures related to safe management and quality use of medicines.

How the tools were developed

An example is provided below using action 4.6.1 in Standard 4

1. The NSQHS standards workbooks and guides were used i.e.:
    a. Hospital Accreditation Workbook - In particular the 'Examples of Evidence' for each action required. (October 2012)
    http://www.safetyandquality.gov.au/publications/hospital-accreditation-workbook/

Example: Hospital Accreditation Workbook – Standard 4 Action 4.6.1(October 2012)

Documentation of patient information

The clinical workforce accurately records a patient's medication history and this history is available throughout the episode of care.

Actions required	Reflective questions	Examples of evidence – select only examples currently in use	Evidence available?
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care			
4.6.1 A best possible medication history is documented for each patient	How do we record a medication history in the patient's clinical record?	☐ Policies, procedures and protocols for obtaining and documenting a best possible medication history ☐ Patient clinical records, either hard copy or electronic, document best possible medication history listing current medicines (including prescription, over the counter and complementary medicines), medicines recently ceased or changed, and verification of history with one or more sources ☐ Best possible medication history documented on National Inpatient Medication Chart or a standard form (hard copy or electronic) such as the National Medication Management Plan ☐ Audit of admitted patients with a documented best possible medication history ☐ Audit of *Indictor 6.2 – Indicators for Quality Use of Medicines in Australian Hospitals* ☐ Education resources and records of attendance at training of workforce in obtaining and documenting a best possible medication history ☐ Other	☐ No → further action is required ☐ Yes → list source of evidence
4.6.2 The medication history and current clinical information is available at the point of care	How do we ensure a patient's medication history and clinical information is available to the relevant clinician when care is provided?	☐ Policies, procedures and protocols for accessing clinical information at the point of care ☐ Observation of patient clinical records accessible at point of patient care ☐ National Medication Management Plan or equivalent, including electronic versions is available with the patient clinical record at the point of care ☐ Medication management plan or equivalent kept with current National Inpatient Medication Chart ☐ Other	☐ No → further action is required ☐ Yes → list source of evidence

Example of Evidence for 4.6.1 'Audit of admitted patients with a documented best possible medication history'

b. Safety and Quality Improvement Guides (one per standard) – in particular under each action and key task there are 'Outputs' suggested. In addition, the suggested strategies may assist the facility in providing options for how an action can be improved. (October 2012) http://www.safetyandquality.gov.au/publications/safety-and-quality-improvement-guide-standard-4-medication-safety-october-2012/

Example:
Safety and Quality Improvement Guide - Standard 4 Action 4.6.1 (October 2012)

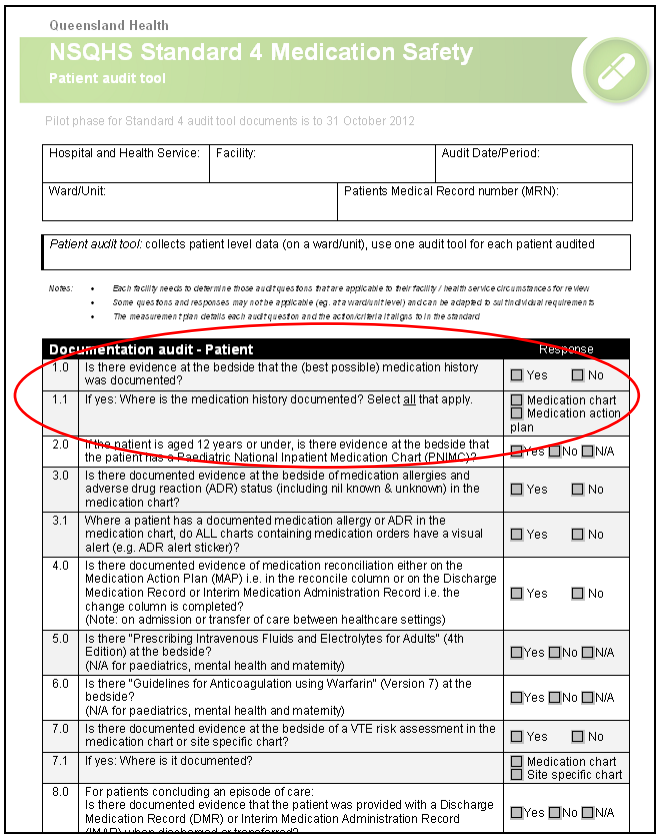
Actions required	Implementation strategies
4.6 The clinical workforce taking an accurate medication history when a patient presents to a health service organisation, or as early as possible in the episode of care, which is then available at the point of care	
4.6.1 A best possible medication history is documented for each patient	**Key task:** • **Implement a formal systematic process for obtaining and recording a best possible medication history** An up-to-date and accurate medication list is essential for ensuring safe prescribing and continuity of medication management. A best possible medication history (BPMH) is a list of all the medicines a patient is taking prior to admission (including prescribed, over the counter and complementary medicines) and obtained from interviewing the patient and/or their carer (where possible) and confirmed using a number of different sources of information. **Suggested strategies:** 1. Review current procedures for obtaining a history of medicines taken prior to admission. 2. Develop and implement a policy, procedure or guideline on obtaining and documenting a best possible medication history (BPMH). This should include: • a structured interview process • key steps of the process • where the BPMH should be documented • what information should be documented • roles and responsibilities for workforce. • The history should include: • prescription, over the counter and complementary medicines • allergies and previous adverse drug reactions **Outputs of improvement processes may include:** • policies, procedures and protocols on obtaining and documenting the BPMH • use of the national *Medication Management Plan* (MMP) or medication history form (electronic or hard copy) to document BPMH • MMP or equivalent kept with NIMC • results on use of the NIMC and/or MMP to document medication history from NIMC audit • audit of admitted patients with a documented BPMH • education resources on taking a BPMH

An output for 4.6.1 'Audit of admitted patients with a documented best possible medication history (BPMH)'

2. The questions in the audit tools (patient, ward, facility) assess and ask for verification of the examples of evidence and outputs to collect the detailed information necessary to meet that evidence. In addition, other examples of evidence may be used. The questions may directly ask if there is evidence to support, or may be broken down into a series of questions to delve deeper into whether the evidence has been met. In addition, questions may require the auditing of patients in order to demonstrate that the evidence has been met, and to what extent.

   Questions and responses have been developed in consultation with content area experts.

Example: Audit tool questions for Standard 4 Action 4.6.1



Queensland Health

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Patient audit tool

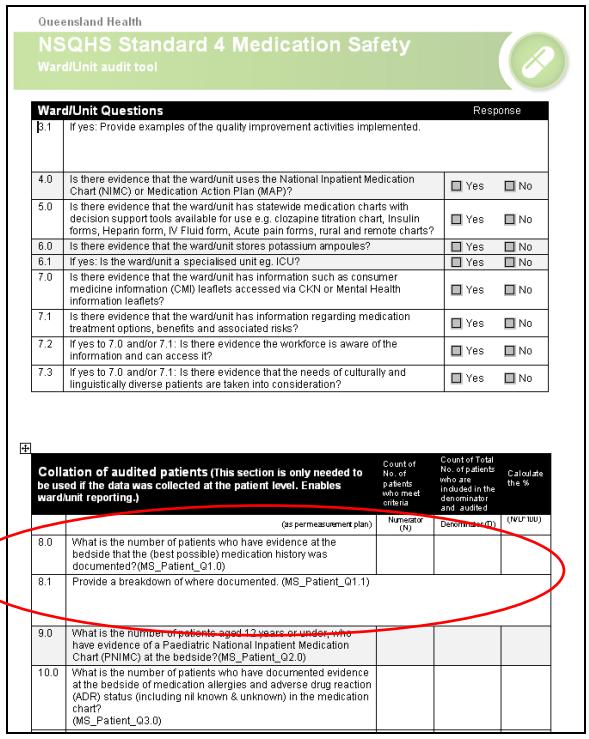
Pilot phase for Standard 4 audit tool documents is to 31 October 2012

Hospital and Health Service:	Facility:	Audit Date/Period:
Ward/Unit:	Patients Medical Record number (MRN):	

Patient audit tool: collects patient level data (on a ward/unit), use one audit tool for each patient audited

Notes:
- Each facility needs to determine those audit questions that are applicable to their facility / health service circumstances for review
- Some questions and responses may not be applicable (eg. at a ward/unit level) and can be adapted to suit individual requirements
- The measurement plan details each audit question and the action/criteria it aligns to in the standard

Documentation audit - Patient		Response
1.0	Is there evidence at the bedside that the (best possible) medication history was documented?	☐ Yes ☐ No
1.1	If yes: Where is the medication history documented? Select all that apply.	☐ Medication chart ☐ Medication action plan
2.0	If the patient is aged 12 years or under, is there evidence at the bedside that the patient has a Paediatric National Inpatient Medication Chart (PNIMC)?	☐ Yes ☐ No ☐ N/A
3.0	Is there documented evidence at the bedside of medication allergies and adverse drug reaction (ADR) status (including nil known & unknown) in the medication chart?	☐ Yes ☐ No
3.1	Where a patient has a documented medication allergy or ADR in the medication chart, do ALL charts containing medication orders have a visual alert (e.g. ADR alert sticker)?	☐ Yes ☐ No
4.0	Is there documented evidence of medication reconciliation either on the Medication Action Plan (MAP) i.e. in the reconcile column or on the Discharge Medication Record or Interim Medication Administration Record i.e. the change column is completed? (Note: on admission or transfer of care between healthcare settings)	☐ Yes ☐ No
5.0	Is there "Prescribing Intravenous Fluids and Electrolytes for Adults" (4th Edition) at the bedside? (N/A for paediatrics, mental health and maternity)	☐ Yes ☐ No ☐ N/A
6.0	Is there "Guidelines for Anticoagulation using Warfarin" (Version 7) at the bedside? (N/A for paediatrics, mental health and maternity)	☐ Yes ☐ No ☐ N/A
7.0	Is there documented evidence at the bedside of a VTE risk assessment in the medication chart or site specific chart?	☐ Yes ☐ No
7.1	If yes: Where is it documented?	☐ Medication chart ☐ Site specific chart
8.0	For patients concluding an episode of care: Is there documented evidence that the patient was provided with a Discharge Medication Record (DMR) or Interim Medication Administration Record (IMAR) when discharged or transferred?	☐ Yes ☐ No ☐ N/A



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Ward/Unit audit tool

Ward/Unit Questions		Response
3.1	If yes: Provide examples of the quality improvement activities implemented.	
4.0	Is there evidence that the ward/unit uses the National Inpatient Medication Chart (NIMC) or Medication Action Plan (MAP)?	☐ Yes ☐ No
5.0	Is there evidence that the ward/unit has statewide medication charts with decision support tools available for use e.g. clozapine titration chart, Insulin forms, Heparin form, IV Fluid form, Acute pain forms, rural and remote charts?	☐ Yes ☐ No
6.0	Is there evidence that the ward/unit stores potassium ampoules?	☐ Yes ☐ No
6.1	If yes: Is the ward/unit a specialised unit eg. ICU?	☐ Yes ☐ No
7.0	Is there evidence that the ward/unit has information such as consumer medicine information (CMI) leaflets accessed via CKN or Mental Health information leaflets?	☐ Yes ☐ No
7.1	Is there evidence that the ward/unit has information regarding medication treatment options, benefits and associated risks?	☐ Yes ☐ No
7.2	If yes to 7.0 and/or 7.1: Is there evidence the workforce is aware of the information and can access it?	☐ Yes ☐ No
7.3	If yes to 7.0 and/or 7.1: Is there evidence that the needs of culturally and linguistically diverse patients are taken into consideration?	☐ Yes ☐ No

Collation of audited patients (This section is only needed to be used if the data was collected at the patient level. Enables ward/unit reporting.)		Count of No. of patients who meet criteria	Count of Total No. of patients who are included in the denominator and audited	Calculate the %
	(as per measurement plan)	Numerator (N)	Denominator (D)	(N/D*100)
8.0	What is the number of patients who have evidence at the bedside that the (best possible) medication history was documented?(MS_Patient_Q1.0)			
8.1	Provide a breakdown of where documented. (MS_Patient_Q1.1)			
9.0	What is the number of patients aged 12 years or under, who have evidence of a Paediatric National Inpatient Medication Chart (PNIMC) at the bedside?(MS_Patient_Q2.0)			
10.0	What is the number of patients who have documented evidence at the bedside of medication allergies and adverse drug reaction (ADR) status (including nil known & unknown) in the medication chart? (MS_Patient_Q3.0)			

The patient audit tool allows you to collect the specific question/s that can be used for 4.6.1 in auditing patient level information.

The ward/unit audit tool allows you to collate all the patient results for a ward/unit level view.

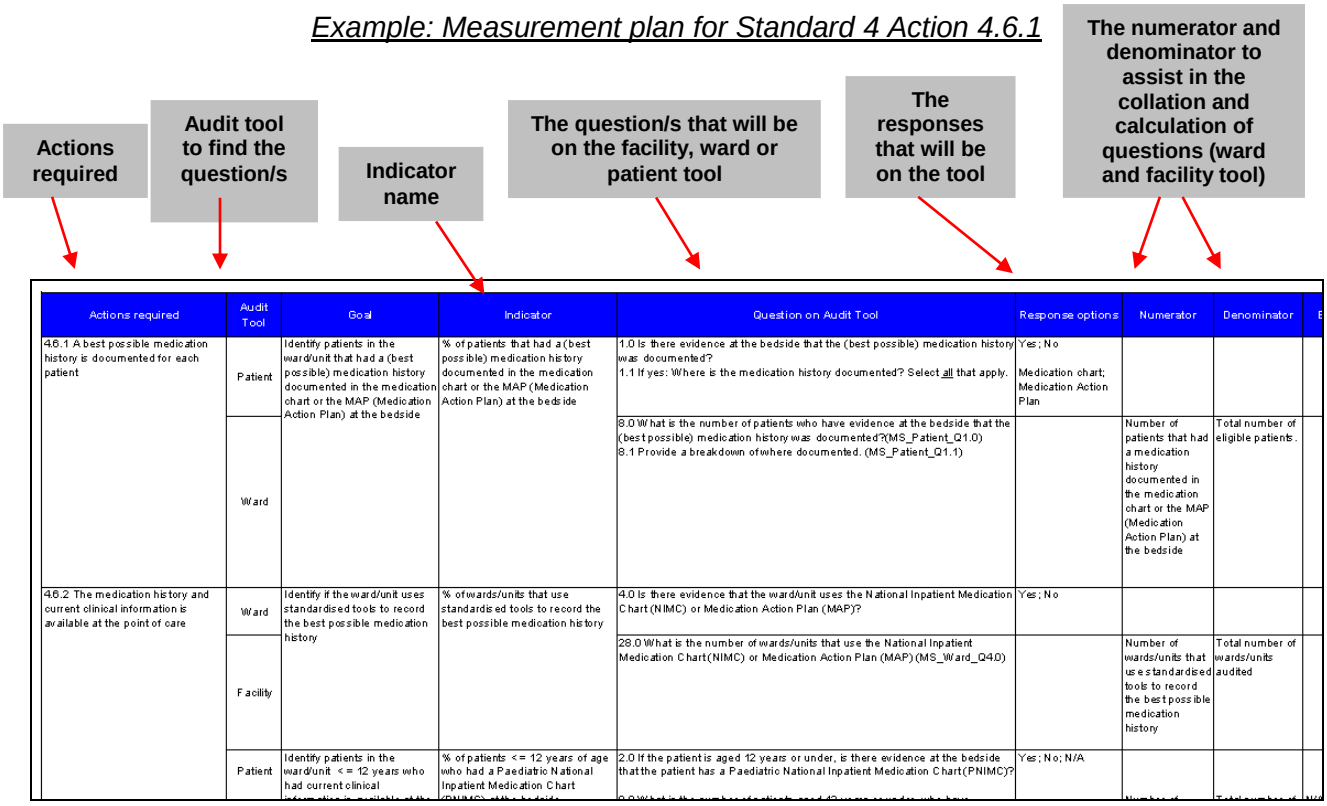
In addition to the collection of information, the ward/unit and facility tools include the ability to be able to collate data i.e.: collate the data collected at a patient level for a ward/unit view, collate the data collected at a ward/unit level for a facility view. Where this is the case, the collation questions refer to where the information can be found eg. MS_Patient_Q1.0 refers to Q1.0 in the Patient audit tool where the responses to collate the data will be found.

The last three columns in the collation sections i.e.: Num/Den/% allows for the calculation of the % result at a ward/unit and facility level (for reporting). Details of these can be found in the measurement plan. Future plans for the electronic capture of information will allow the collation of data to be automatic.

3. The measurement plan details the criteria / action and those question/s / responses that correspond to the action.

   Note : Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Example: Measurement plan for Standard 4 Action 4.6.1



Actions required	Audit Tool	Goal	Indicator	Question on Audit Tool	Response options	Numerator	Denominator
4.6.1 A best possible medication history is documented for each patient	Patient	Identify patients in the ward/unit that had a (best possible) medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside	% of patients that had a (best possible) medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside	1.0 Is there evidence at the bedside that the (best possible) medication history was documented? 1.1 If yes: Where is the medication history documented? Select all that apply.	Yes; No Medication chart; Medication Action Plan		
	Ward			8.0 What is the number of patients who have evidence at the bedside that the (best possible) medication history was documented?(MS_Patient_Q1.0) 8.1 Provide a breakdown of where documented. (MS_Patient_Q1.1)		Number of patients that had a medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside	Total number of eligible patients.
4.6.2 The medication history and current clinical information is available at the point of care	Ward	Identify if the ward/unit uses standardised tools to record the best possible medication history	% of wards/units that use standardised tools to record the best possible medication history	4.0 Is there evidence that the ward/unit uses the National Inpatient Medication Chart (NIMC) or Medication Action Plan (MAP)?	Yes; No		
	Facility			28.0 What is the number of wards/units that use the National Inpatient Medication Chart (NIMC) or Medication Action Plan (MAP) (MS_Ward_Q4.0)		Number of wards/units that use standardised tools to record the best possible medication history	Total number of wards/units audited
	Patient	Identify patients in the ward/unit <= 12 years who had current clinical	% of patients <= 12 years of age who had a Paediatric National Inpatient Medication Chart	2.0 If the patient is aged 12 years or under, is there evidence at the bedside that the patient has a Paediatric National Inpatient Medication Chart (PNIMC)?	Yes; No; N/A		

In addition, we recognise that each facility will define when the audit will take place, how often, how many patients to audit and who will perform the audit.

Queensland Health facilities have the ability to enter their audit data on-line using an existing secure electronic web-based system, Measurement Analysis & Reporting System (MARS), available via the Queensland Health intranet. Please email mars@health.qld.gov.au for further information.

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as this is a **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

The Patient Safety and Quality Improvement Service, Clinical Excellence Division, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Hospital and Health Services. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on PSQIS_Comms@health.qld.gov.au for feedback or comments.