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
  o 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
  o 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)
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.

<table>
<thead>
<tr>
<th>Actions required</th>
<th>Reflective questions</th>
<th>Examples of evidence – select only examples currently in use</th>
<th>Evidence available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.6.1 A best possible medication history is documented for each patient</td>
<td>How do we record a medication history in the patient’s clinical record?</td>
<td>Policies, procedures and protocols for obtaining and documenting a best possible medication history</td>
<td>No further action is required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient clinical records, either hard copy or electronic, document best possible medication history listing current medications (including prescription, over the counter and complementary medicines), medicines recently ceased or changed, and verification of history with one or more sources</td>
<td>Yes list source of evidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Best possible medication history documented in National Inpatient Medication Chart or a standard form (hard copy or electronic) such as the National Medication Management Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audit of admitted patients with a documented best possible medication history</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Audit of Indicators 6.2 – Indicators for Quality Use of Medicines in Australian Hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Education resources and records of attendance at training of workforce in obtaining and documenting a best possible medication history</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Example of Evidence for 4.6.1 ‘Audit of admitted patients with a documented best possible medication history’**

Example:

<table>
<thead>
<tr>
<th>Actions required</th>
<th>Implementation strategies</th>
</tr>
</thead>
</table>
| 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 of 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) allow you to collect the specific question/s that can be used for 4.6.1 in auditing patient level information.

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 level, 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 Q.1.0 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

<table>
<thead>
<tr>
<th>Action required</th>
<th>Audit tool</th>
<th>Goal</th>
<th>Indicator name</th>
<th>Question on Audit Tool</th>
<th>Responses options</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.6.1 Audit tool: Medication history is documented on each patient</td>
<td>Patient</td>
<td>Identify patient in the medication history that has a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>% of patients that have a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>Does the patient meet the criteria?</td>
<td>Yes</td>
<td>No</td>
<td>Number of patients that met criteria</td>
</tr>
<tr>
<td></td>
<td>Ward</td>
<td>What is the number of patients who have evidence of a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>% of patients that have a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>Does the patient meet the criteria?</td>
<td>Yes</td>
<td>No</td>
<td>Number of patients that met criteria</td>
</tr>
<tr>
<td></td>
<td>Facility</td>
<td>Identify patient in the medication history that has a best possible medication</td>
<td>% of patients that have a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>Does the patient meet the criteria?</td>
<td>Yes</td>
<td>No</td>
<td>Number of patients that met criteria</td>
</tr>
<tr>
<td></td>
<td>Ward</td>
<td>What is the number of patients that have evidence of a best possible medication</td>
<td>% of patients that have a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>Does the patient meet the criteria?</td>
<td>Yes</td>
<td>No</td>
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<td>Facility</td>
<td>Identify patient in the medication history that has a best possible medication</td>
<td>% of patients that have a best possible medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside</td>
<td>Does the patient meet the criteria?</td>
<td>Yes</td>
<td>No</td>
<td>Number of patients that met criteria</td>
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</table>

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.

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