NSQHS Standard 4 Medication Safety

Patient audit tool

Hospital and Health Service:	Facility:	Audit Date/Period:
Ward/Unit:	Patient 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 <u>all</u> 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	For patients on admission or transfer of care between healthcare settings: 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?	☐Yes ☐No ☐N/A
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

Documentation audit - Patient		Response
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

Bedside Patient Observation		Response
9.0	Does the patient have a peripheral IV line for administration of medication?	☐ Yes ☐ No
9.1	If yes: Are ALL peripheral IV lines labelled correctly with route (target tissue)?	☐ Yes ☐ No

Bedside Patient Questions		Response
10.0	For patients who have started new medicine therapy: **Ask the Patient/Carer**: Did the healthcare staff provide you with information about specific medication treatment options, benefits and associated risks prior to starting any new medications?	☐Yes ☐No ☐N/A
11.0	Is there documented evidence of a medication management plan in the patient's clinical notes?	☐ Yes ☐ No
11.1	If yes: **Ask the Patient/Carer**: Did the healthcare staff discuss your medication treatment plan with you?	☐ Yes ☐ No
11.2	If yes to 11.1: **Ask the Patient/Carer**: Were you in agreement with the plan?	☐ Yes ☐ No
12.0	For patients who have started new medicine therapy: **Ask the Patient/Carer:** Did the healthcare staff provide you with medicine information leaflets or booklets prior to starting any new medications? (Note: these may include consumer medicine information (CMI) leaflet, warfarin booklet, mental health information leaflets etc.)	☐Yes ☐No ☐N/A

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.