Government of **Western Australia**
Department of **Health**

Pharmaceutical Review

Data Collection Audit – Follow-up Audit 2010

HOSPITAL:

Please forward this completed form to:
Name:
Position:
Location/Address:
Contact Number:

Instructions

- A selection of newly admitted patients between **Sunday 17th October 2010 and Sunday 24th October 2010** are to have this audit form attached to their file notes.
- The audit period will run between *Sunday 17th October 2010 and Sunday 14th November 2010*, i.e. patients recruited to the audit are to be followed during this period.
- This audit form should be kept with the patient's notes until the patient is discharged from the hospital. If the patient is not discharged by the end of the audit period (*14th November 2010*), tick the '*Not discharged prior to audit completion date'* box overleaf, and return to the audit coordinator.
- Please make yourself familiar with the categories within this audit. When a component of the audit is completed, please mark off the relevant section within this form.
- The purpose of this audit is to gauge the current level of compliance by WA Health Services against the five standards of the WA Pharmaceutical Review Policy. To ensure that we have accurate data, please do not alter your behaviour for patients that are being audited.
- For more information about how to complete the audit, refer to the audit guidelines, or contact the Office of Safety and Quality in Healthcare via email safetyandquality@health.wa.gov.au or phone (08) 9222 0246.

All audit sheets to be returned to Office of Safety and Quality by Tuesday 30th November 2010.

Delivering a Healthy WA

Patient Demographic Details

AFFIX PATIENT IDENTIFICATION LABEL

UR Number: Family Name: Given Names: Address: DOB: Sex: ☐ M ☐ F	Ward: Date started/date of admission: Discharge date: OR Not discharged prior to audit completion date ☐

Patient's GP Name:

GP Contact Number:

Patient's Community Pharmacist Name (if applicable):

Community Pharmacist Contact Number:

Patient's Residential Care Facility Name (if applicable):

Residential Care Facility Contact Number:

Is this patient a high-risk patient? ☐ Yes ☐ No	Definition of a high-risk patient – A patient who has one or more of the following: • Currently prescribed five of more medications • Multiple co-morbidities • Prescribed a medication with a narrow therapeutic index (see guidelines for narrow therapeutic index medications) • Therapy with high-risk drugs (see guidelines for high-risk drugs) • Symptoms suggestive of a drug related admission • Difficulty managing medicines because of literacy, language difficulties, dexterity problems, impaired sight, dementia or other cognitive difficulties.

Pharmaceutical Review Standard		Section of the NIMC (where applicable)	Activity	Yes	No	NA	Unknown/ Not Documented	Comments Please reference relevant section of audit tool (e.g. 1.2.B)
1.	**Chart Review** – *All inpatient medication charts are to be reviewed, ideally on a daily basis, by an appropriately credentialled professional, such as a clinical pharmacist.*	1.1. Clinical Pharmacist Review – bottom of the 'Regular Orders' section (pg 2 & 3)	**A.** Was a chart review conducted for the patient by an appropriately credentialled professional? **If no, continue to section 1.2.**					
			B. Date of first signature indicating review	___ / ____ / 2010				
			Of the patient's **total admission period**:	**SUN**	**MON**	**TUES**	**WED**	**THUR**	**FRI**	**SAT**
			C. Indicate the number of each day that passed *eg total number of Mondays, Tuesdays etc.*							
			D. For each day of the patient's admission, how many of the corresponding 'Clinical Pharmacist Review' boxes had been signed by a: • Clinical Pharmacist OR • Other appropriately credentialled professional	**Comments:**						
		1.2. Allergies and Adverse Drug Reactions – ADR (pg 3)	**A.** Nil known/unknown box ticked **If yes, continue to question F. below.**					
			B. ADR sticker attached for all charts					
			C. Drug/allergen documented					
			D. Reaction details documented					
			E. Initials documented					
			F. ADR box signed and dated by clinician					

NOTE: THIS SECTION IS A SNAPSHOT AND SHOULD BE COMPLETED ON ONE DAY DURING THE AUDIT PERIOD. PRE AND POST CHART REVIEW MAY NOT BE APPLICABLE FOR ALL PATIENTS. CONSULT THE AUDIT GUIDELINES FOR MORE DETAILS. ONLY COUNT CURRENT MEDICATION ENTRIES, EXCLUDE CEASED ENTRIES.

Pharmaceutical Review Standard		Section of the NIMC (where applicable)	Activity	Pre Chart Review	Post Chart Review	Comments Please reference relevant section of audit tool (e.g. 1.3.C)
1.	**Chart Review** (continued) – *All inpatient medication charts are to be reviewed, ideally on a daily basis, by an appropriately credentialled professional, such as a clinical pharmacist.*	1.3. Prescription Entries (all orders – including once only, telephone, regular and PRN)	**A.** Total number of prescription entries – *i.e. once only + telephone + regular + PRN*			
			B. Number of prescriptions that **do not** use generic drug name (or agreed exceptions)			
			C. Number of prescriptions that **do not** meet legal requirements			
			D. Number of prescriptions that are **not** in accordance with hospital policy, guidelines and restrictions on use			
			E. Number of **illegible** prescriptions			
		*** A Clinical Pharmacist (or appropriately credentialled professional) should be involved in the calculation of these responses**	**F.** * Number of potential known drug interactions identified			
			G. * Number of potential known drug interactions identified with **no** documented action/monitoring			
			H. Number of prescriptions **not** using approved abbreviations			
			I. * Number of prescriptions **not** for an appropriate indication			
			J. * Number of unintentional dosage discrepancies identified			
			K. * Number of unintentional drug form discrepancies identified			
			L. * Number of route discrepancies identified			

Pharmaceutical Review Standard		Section of the NIMC (where applicable)	Activity	Yes	No	NA	Unknown/ Not Documented	Comments Please reference relevant section of audit tool (e.g. 2.1.B)
2.	**Medication Reconciliation on Admission** – *Medication reconciliation, including an accurate medication history, is to be conducted for all inpatients by an appropriately credentialled professional, ideally within 24 hours of admission for high-risk patients*	2.1. Medicines taken Prior to Presentation to Hospital (pg 1) * Note: Medication history could also be documented in the file notes if not on the NIMC	**A.** Medication history completed. *If the medication history is not fully completed, document this in the 'comments' section* **If no, continue to section 2.2.** **If yes:** Date: _____ / _____ / 2010 Completed by: • Pharmacist OR • Doctor OR • Appropriately credentialled nurse OR • Other (please specify) OR • Not identified					
			B. Medication history obtained from… (tick as many boxes as applicable) • Patient • Carer • General practitioner • Community pharmacist • Other (please specify)					

Pharmaceutical Review Standard		Section of the Policy	Activity	Yes	No	NA	Unknown/ Not Documented	Comments Please reference relevant section of audit tool (e.g. 2.2.D)
2.	**Medication Reconciliation on Admission (continued)** – *Medication reconciliation, including an accurate medication history, is to be conducted for all inpatients by an appropriately credentialled professional, ideally within 24 hours of admission for high-risk patients*	2.2.Supplementary activities (pg 9)	**A.** Did patient have, or get given, a Patient's Own medication bag on admission?					
			B. Did patient have a current medication profile on admission?					
			C. Did patient have a previous hospital discharge summary or nursing home summary on admission?					
			D. Did patient have St John Ambulance MedicAlert bracelet or MedicAlert wallet card on admission?					
			E. Did patient have a Home Medicines Review report on admission?					

Pharmaceutical Review Standard		Section of the Policy	Activity	Yes	No	NA	Unknown/ Not Documented	Comments Please reference relevant section of audit tool (e.g. 3.2.B)
3.	**Medication Education during Hospitalisation and on Discharge** – *Patients and/or their carers are to be provided with medication education during their hospitalisation to ensure that they have an understanding of their medications, and ideally be given a medication profile on discharge*	3.1. Required activities (pg 11)	**A.** Were there any changes (additions, cessations or alterations) made to the patient's medication management?					
			B. Was the provision of **education** for these changes in medication management documented in the medical record or on the medication chart? **If yes**: Medication education was provided by: • Clinical Pharmacist • Doctor • Appropriately Credentialled Nurse • Other (please specify)					
			C. Was the provision of a Consumer Medicine Information leaflet (or other appropriate literature) documented in medical record?					
			D. Was the provision of a 'Patient First' booklet documented in the medical record?					
			E. Where the patient was prescribed the following **high-risk** medications, was the provision of education documented in the medical record or on medication chart? • Anticoagulant(s) eg Warfarin • Immunosuppressant(s) • Medication with a narrow therapeutic index eg digoxin • Other 'high risk' drugs (please specify)					
			F. Was the patient provided with a medication profile on discharge?					

PLEASE DISREGARD THIS PAGE IF PATIENT IS NOT DISCHARGED AT THE COMPLETION OF THE AUDIT PERIOD								
Pharmaceutical Review Standard		**Section of the Policy**	**Activity**	**Yes**	**No**	**NA**	**Unknown/ Not Documented**	**Comments** Please reference relevant section of tool
4.	**Discharge Process: Communication with the General Practitioner and other Health Professionals** – *A patient's medication-related information is to be provided to his or her general practitioner and other health professionals upon discharge*	4.1. Required activities (pg 13)	**A.** Was a discharge summary prepared for the patient within the one-month audit period? **If no, continue to section 5.1.**					
			B. Were there any discrepancies between:					
			• NIMC and the discharge summary?					
			• Patient's medication profile and discharge summary?					
			C. Was the involvement of a clinical pharmacist in the medication component of the discharge summary documented in the medical record?					
			D. Did the patient receive a copy of the discharge summary within audit period?					
			E. Was the patient's general practitioner provided with discharge summary during the audit period?					
			If yes: Date GP provided with discharge summary:	____ / ____ / 2010				
			F. Was the patient's community pharmacist:					
			• Provided with discharge medication list? AND/OR					
			• Contacted to discuss patient's medications?					

Pharmaceutical Review Standard		Section of the Policy	Activity	Yes	No	NA	Unknown/ Not Documented	Comments Please reference relevant section of audit tool (e.g. 4.1.G)
4.	**Discharge Process: Communication with the General Practitioner and other Health Professionals (continued)** – *A patient's medication-related information is to be provided to his or her general practitioner and other health professionals upon discharge*	4.1. Required activities (pg 13) (continued)	**G.** Does the patient reside in a Residential Care Facility?					
			If yes: • Was the facility provided with patient's discharge medication list? AND/OR • Was the facility contacted to discuss patient's medications?					
			H. How many medications are listed on the patient's discharge summary?					
			I. How many of the medications in the discharge summary had the following documented?					
			• Generic drug name (or brand name where relevant)					
			• Dose					
			• Drug status					
			• Rationale for changes					
			• Monitoring requirements where relevant e.g. interactions, dose increased					
			• Expected outcomes					
			• Additional information (please specify)					

Pharmaceutical Review Standard		Section of the Policy	Activity	Yes	No	NA	Unknown/ Not Documented	Comments Please reference relevant section of audit tool (e.g. 5.1.C)
5.	**Quality Activities Promoting Medication Safety** – *Health services are to be involved in medication-related safety and quality activities.*	5.1. Required activities (pg 15)	**A.** Did the patient experience any adverse drug reactions (ADR) during this admission? **If yes:**					
			B. Was the ADR: • Life threatening OR • Non life threatening					
			C. Was the reaction documented: • In the patient's notes?					
			• On the patient's medication chart?					
			• In the discharge summary?					
			D. Is there evidence of the ADR being reported via the hospital's clinical incident management process (AIMS form completed)?					
			E. Was the ADR reported to the Adverse Drug Reaction Advisory Committee (ADRAC)?					