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

Medication Reconciliation Audit Guidelines

June 2024

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Contents

Introduction 3
Rationale and Aim 3
Eligible Patient Populations 3
Measurement Methods 3
Random Sampling 4
Department of Health Reporting Requirements 4
WA Medication Reconciliation Audit Measures 5
Compliance with medication reconciliation process on admission (Indicators 1 and 5) 5
Indicators to be reported to the Department of Health 6
Compliance with medication chart review process (Indicator 3) 6
Indicators to be reported to the Department of Health 6
Provision of medication education to the patient during hospital and on discharge (Indicator 4) 6
Indicators to be reported to the Department of Health 7
Medication reconciliation (including medication liaison) at discharge/transfer of care (Indicator 2) 7
Indicators to be reported to the Department of Health 7
Appendix 1: REDCap® Audit Tool User Guide 8
Introduction 8
Section 1 – Hospital and Audit Details 8
Section 2 – Patient Details 9
Section 3 – Adverse Drug Reaction (ADR) Documentation 10
Section 4 – Medication Reconciliation on Admission 12
Section 5 – Clinical Pharmacist Review 15
Section 6 – Medication Reconciliation on Discharge 16
Section 7 – ACHS Clinical Indicators 20
Section 8 –Comments and Submission 21

Introduction

Rationale and Aim

Medication reconciliation is recognised as an important safety initiative in the National Safety and Quality Health Service Medication Safety Standard[1]. WA Health has developed an electronic audit tool to assist hospitals and health services to monitor compliance with the standards of medication review, as outlined in the MP 0104/19 Medication Review Policy.

All patients should receive a comprehensive medication assessment by the medical team and pharmacist if available prior to any decision to prescribe a new medicine. A key component of this assessment is obtaining a thorough medication history. The medication history is used:

1. as the basis for therapeutic decision making
2. for ensuring continuity of regular medicines while a patient is in hospital
3. to identify adverse medicines events.

Medication histories are often incomplete, with medicines, strengths, frequencies and doses missing. Over the counter or complementary medicines (including vitamins and supplements), medicines for topical use, inhalers, and scheduled injections are often omitted. If not corrected, the errors can persist throughout the episode of care and at discharge. Inaccurate medication histories can lead to discontinuation of therapy, recommencement of medicines that have been ceased, inappropriate orders and failure to identify a medication related problem.

The aim of medication reconciliation is to ensure that a patient’s medication information is as complete as possible, easily accessible, and communicated effectively to all involved in the patient’s care to ensure continuity of medication management at all transition points:

- On admission to a hospital
- Moving within the hospital
- Being discharged home or transferred to another hospital or care facility.

By ensuring a patient receives all the medications they are supposed to be receiving, at the appropriate dose and times, medication reconciliation reduces medication errors.

Eligible Patient Populations

- All hospital inpatients that have been admitted for greater than 24 hours are eligible for inclusion.
- Patients who die during hospital admission are excluded.
- Please note that audit periods are assigned to patients based on their date/time of admission. i.e. if Patient A admitted in March 2023, they will appear in H1-23 (half one of 2023 i.e. Jan-Jun 2023) and if Patient B admitted in September they will appear in H2-23 (half two of 2023, Jul-Dec 23).

Measurement Methods

- Over the 6-month collection period a total of 5 - 10 patients per ward at the hospital should be audited to ensure that data is collected from each clinical area.

[1] Australian Commission on Safety and Quality in Health Care, “Medication Safety Standard,” ACSQHC, 2023. [Online]. Available: https://www.safetyandquality.gov.au/standards/nsqhs-standards/medication-safety-standard. [Accessed 22 Dec 2023].

- Sample size will depend on available resources and facility size, but the following recommendations are based on the number of beds included in the program:

Number of inpatient beds	Sample size
150 or more	20% of patients
30 – 149	30 patients
Less than 30	Actual number of beds

Random Sampling

- Selection of a random sample of current inpatients is recommended to ensure every patient within your audit population has an equal chance of selection.
- Random sampling is an example of a probability sampling method. It should result in your sample being representative of the characteristics of the whole population, due to random selection reducing the possibility of any systematic bias that would make the selected group different in character from the overall population.
- A random number table (e.g. generated in Microsoft Excel®) can be used to select cases from a list of all the patients within your population.

Department of Health Reporting Requirements

- WA Health hospitals and health services will continue to monitor compliance with their process reporting the following measures on a 6 monthly basis:

Reporting Period	Due
January – June	August 31
July – December	March 1

- Sites are to use the electronic WA Medication Reconciliation Audit Tool (via REDCap®) to enter data either prospectively during the audit period or retrospectively.
- When using REDCap® for data collection, reports will be automatically generated via the WA Medication Reconciliation Audit Dashboard (via Power BI®).
- Contact DOH.MedicinesandTechnologyUnit@health.wa.gov.au for further information regarding data collection and entry. The WA Medication Reconciliation Audit Tool – Single Patient form (available in Microsoft Word® on the Medication Review Policy webpage) may be used as part of downtime procedures if needed.
- The Medicines and Technology Unit (MTU) within the Department of Health's Patient Safety and Clinical Quality Directorate is responsible for the maintenance of the electronic WA Medication Reconciliation Audit tool and Power BI® dashboard and for liaising with local medication reconciliation leads and data validators to ensure accuracy and currency of information provided in the Power BI® dashboard.
- For further information about reporting requirements, contact MTU via DOH.MedicinesandTechnologyUnit@health.wa.gov.au.

WA Medication Reconciliation Audit Measures

Refer to Appendix 1 for full instructions about how to enter data into the REDCap® tool.

The below measures are designed to assess compliance with the Standards of Medication Review, outlined in the MP 0104/19 Medication Review Policy and Best Practice Principles for Medication Review.

Compliance with medication reconciliation process on admission (Indicators 1 and 5)

TIP

'On admission' means this documentation is completed by the *end of the next calendar day after admission (ENCD).*

Medication reconciliation performed at a pre-admission clinic is acceptable if the medication history is confirmed with the patient as current on admission to hospital.

Medication reconciliation on admission is the formal process of:

1. **Documentation of Previous Adverse Drug Reactions/Allergies to medications**
   The administration of medicines to patients with a known allergy or prior adverse drug reaction (ADR) is highly preventable by putting systems in place to alert clinicians who prescribe, dispense and administer medicines to previous adverse reactions. A patient should be interviewed to determine whether he/she has experienced a previous ADR or allergy to a medication. This should be clearly documented per the Patient Alert Procedure for Adverse Drug Reactions (ADRs) within the *MP 0053/17 Patient Alert Policy*.
2. **Obtaining and documentation of medication history**
   Obtaining a complete and accurate medication history of each patient's current medications (details include generic medication name, dosage, frequency and route). Medications should include prescribed medications (includes medications for oral, topical, inhaled or injectable routes), medicines available over-the-counter, and supplements.
3. **Confirmation of medication history**
   A patient's medication history should be confirmed where possible to ensure details of the medication history are correct. At least two sources of information should be used. Once the medication history has been confirmed with at least two sources, the list is then known as the Best Possible Medication History (BPMH).
   If clinical judgement determines that confirmation is not necessary, this decision should be explicitly documented in the medical record, or on the WA Medication History and Management Plan (WA MMP).
4. **Reconciliation of medications**
   The clinician's admission orders are to be compared to the medication history. Any discrepancies observed must be brought to the attention of the prescriber and, if appropriate, changes are made to the orders. This can be completed by an appropriately credentialed health professional.

Indicators to be reported to the Department of Health

Indicator	Description
1A	Percentage (%) of inpatients with a complete medication history documented by a health professional.
1B	Percentage (%) of inpatients with a medication history confirmed with a second source documented.
1C	Percentage (%) of inpatients with a reconciled list of medications documented.
1D	Percentage (%) of inpatients with all three admission steps (1A & 1B & 1C) of medication reconciliation documented.
1E	Percentage (%) of patients admitted just prior to or during a weekend or public holiday.
1	Percentage (%) of inpatients with all steps of Medication Reconciliation on ADMISSION documented by the next calendar day after admission (1A + 1B + 1C completed by ENCD).
(or)	If all three admission steps of medication reconciliation were NOT documented by ENCD;
5A	Percentage (%) of inpatients with all steps of Medication Reconciliation on ADMISSION documented within 48 hours of admission.
5B	Percentage (%) of inpatients with all steps of Medication Reconciliation on ADMISSION documented between 48 and 72 hours of admission.
5C	Percentage (%) of inpatients with all steps of Medication Reconciliation on ADMISSION documented after 72 hours of admission.
5D	Percentage (%) of inpatients who did not have all steps of Medication Reconciliation on ADMISSION documented during admission.

Compliance with medication chart review process (Indicator 3)

The assessment of a patient's current medications and other therapies should be continually re-evaluated during hospital admission. The frequency of chart review should be dependent on the acuity or clinical risk of the patient.

Once the review has occurred, documentation on the patient's chart is required.

Indicators to be reported to the Department of Health

Indicator	Description
3	Percentage (%) of inpatients that are reviewed by a clinical pharmacist by the ENCD after admission.

Provision of medication education to the patient during hospital and on discharge (Indicator 4)

Providing medication information ensures that patients/carers/families have sufficient information to make informed choices about their medications and use their medications safely and effectively. This can be provided as either written (e.g. patient information leaflet) and/or verbal education to the patient/carer/family and includes discussions about medication management including consent to treatment. Education also includes providing the patient/carer/family with a medication profile/list on discharge which details the medications the patient is to take and how to take them after discharge from hospital. The medication profile/list should ideally be shared with other health care providers as appropriate.

Indicators to be reported to the Department of Health

Indicator	Description
4	Percentage (%) of inpatients that receive medication education/counselling on discharge.

Medication reconciliation (including medication liaison) at discharge/transfer of care (Indicator 2)

Medication reconciliation on discharge or transfer is the formal process of:

1. **Medication reconciliation**
    - Comparing the doctor's discharge or transfer orders to the medication history and ensuring that any discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders.
    - Checking the admission BPMH (as documented on the WA MMP) for any un-actioned discrepancies.
    - Comparing what is on the medication chart/s with medications required at discharge (to see if any medication is missing).
    - Comparing the medication list on the WA MMP (once all discrepancies have been identified) with the medication list in the discharge summary.
2. **Preparing an accurate medication list**
   This helps with ensuring that the medications prescribed for the patient at discharge are correct and reconciled with the information provided in the discharge summary.
3. **Discharge liaison**
   Ensuring accurate communication about the patient's medications between all clinicians involved in the patient's care and that relevant information is also communicated to the patient/carer/family.

Indicators to be reported to the Department of Health

Indicator	Description
2A	Percentage (%) of inpatients with a discharge summary that accurately reflects the medications planned for the patient upon discharge.
2B	Percentage (%) of inpatients with a discharge summary that explicitly communicates changes in medication therapy (e.g. ceased, withheld, new, reduced, increased, other specific change).
2C	Percentage (%) of patients discharged or transferred during a weekend, public holiday or Monday morning up until 12 noon.
2	Number of patients with all steps of Medication Reconciliation on DISCHARGE/TRANSFER completed and documented.

Appendix 1: REDCap® Audit Tool User Guide

Access the REDCap® tool via: https://datalibrary-rc.health.wa.gov.au/surveys/?s=WN7WHYW7K3

This link is also available on the Medicines and Technology HealthPoint page and the Department of Health's Medication Reconciliation webpage.

M/O dictates whether a question is mandatory (M) or optional (O).

Introduction

Content
Welcome to the WA Medication Reconciliation Electronic Audit Tool! The biannual WA Medication Reconciliation Audit assists sites in determining compliance with the mandatory MP 0104/19 Medication Review Policy. This electronic tool has been designed to assist sites when completing the audit by improving data collection and reporting. Guidelines, downtime audit tools and reporting forms for the WA Medication Reconciliation Audit, are available on the Medication Reconciliation website. If completing the audit questions about adverse drug reactions (ADRs), you may wish to refer to the MP 0053/17 Patient Alert Policy. A reminder that only patients who are admitted for more than 24 hours should be included in this audit. Patients who die during hospital should be excluded. If you require any further assistance, please contact DoH.MedicinesandTechnologyUnit@health.wa.gov.au. Happy auditing!

Section 1 – Hospital and Audit Details

Question	M/O	Question type	Question restrictions	Explanation/Comments
Health Service	M	Single choice selection		Select your health service e.g. NMHS.
(HSP) Executive Group or WACHS Region	O	Single choice selection		Select your executive group e.g. SCGOPHCG or Select your WACHS region e.g. Great Southern.
Site	M	Single choice selection		Select your site e.g. SCGH.
Audit Methodology	M	Text (manual form only)		Provide a brief explanation of how your data was collected e.g. retrospective, sample size calculated based on average number of admissions, random number generator used.

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Section 2 – Patient Details

Question	M/O	Question type	Question restrictions	Explanation/Comments
Is this a Group 1 or Group 2 patient?	O	Single choice selection	Rockingham Peel Group sites only	
Patient UMRN	M	Text		Records that do not contain a UMRN will not be counted in the WA Medication Reconciliation Audit Dashboard (Power BI®).
Patient DOB	O	Date selection		
Date/Time of Admission	M	Date and time selection		Refer to i.ClinicalManager. Audit periods are assigned to patients based on their date/time of admission. i.e. if Patient A admitted in March 2023, they will appear in H1-23 (half one of 2023 i.e. Jan-Jun 2023) and if Patient B admitted in September they will appear in H2-23 (half two of 2023, Jul-Dec 23).
Ward admitted to	O	Text		
Was the patient directly admitted to hospital or transferred from another facility?	O	Single choice selection		If transferred from another facility, select the facility from the dropdown list (or select other and type the facility name).
Date/Time of Discharge	M	Date and time selection		Refer to i.ClinicalManager. As this audit assesses compliance with medication reconciliation process on discharge/transfer, patients must have been discharged to be included in the audit. If a long-stay patient is being audited and they have been admitted in one audit period but discharged in a later audit period, use the “Save & Return Later” button at the end of the audit tool to complete the discharge questions at a later time. The patient will still appear in the audit period in which they were admitted.
Ward discharged from	O	Text		
Was the patient discharged to a primary care setting (e.g. home, residential aged care), to another facility or other?	O	Single choice selection		If transferred to another facility, select the facility from the dropdown list (or select other and type the facility name). Select "Other" for patients who have discharged against medical advice (DAMA) or accessed a transitional care program (TCP) and type the reason/program name.

Section 3 – Adverse Drug Reaction (ADR) Documentation

Question	M/O	Question type	Question restrictions	Explanation/Comments
Have any pre-existing ADR(s) been identified?	O	Yes/No	This whole section is optional; only sites participating in ADR documentation compliance auditing need complete these questions.	Review the medical record and medication charts (remember to include additional or specialised charts) to determine if there has been any previous allergy or ADR identified for the patient. The emergency triage record, anaesthetic record or pre-admission clinic records should also be reviewed if available. Select No if “NKDA” or “Unknown” has been documented.
If the patient has pre-existing ADR(s), has an ADR sticker been placed on the WA HMC / WA Paediatric HMC?	O	Yes/No		The use of an ADR alert label/sticker is a visual reminder to reduce the risk of patients being prescribed, administered or dispensed a medicine to which they have previously experienced an adverse reaction. There should be an ADR alert label/sticker placed on the front and back page of all current HMCs for the patient.
If the patient has pre-existing ADR(s), what proportion of the WA HMCs/WA Paediatric HMCs have stickers on both sides?	O	Calculation based on numbers entered.	Only appears if answer “Yes” to the above question.	Enter the number of charts in use (e.g. 4) and the number of charts full stickered (e.g. 1) and the proportion will calculate automatically (e.g. 25%).
Have ADR details (including for NKDA or Unknown) been documented on the WA HMC / WA Paediatric HMC?	O	Single choice selection	Only appears if answer “Yes” to the first question in this section.	This includes documenting either the patient’s previous ADR/allergy in full or selecting “NKDA” or “Unknown” on the HMC. Refer to the Patient Alert Procedure for Adverse Drug Reactions (ADRs) within the *MP 0053/17 Patient Alert Policy* for a definition of complete ADR documentation.

				Examples of complete ADR documentation: Attach ADR sticker Allergies and adverse drug reactions (ADR) ☑ Nil known ☐ Unknown (tick appropriate box or complete details below) Medicine (or other) / Reaction / type / date / Initials Sign AT Print A.Townsend Date 4/10/23 Adverse Drug Reaction Allergies and adverse drug reactions (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below) Medicine (or other) / Reaction / type / date / Initials Penicillin / Swelling of tongue / AT Rash to body as a child Sign AT Print A.Townsend Date 4/10/23 *Examples of partially complete ADR documentation:* Attach ADR sticker Allergies and adverse drug reactions (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below) Medicine (or other) / Reaction / type / date / Initials Penicillin / Swelling of tongue / AT Rash to body as a child Sign AT Print A.Townsend Date 4/10/23 Adverse Drug Reaction Allergies and adverse drug reactions (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below) Medicine (or other) / Reaction / type / date / Initials Penicillin / AT Sign AT Print A.Townsend Date 4/10/23 *Example of nil ADR documentation:* Attach ADR sticker Allergies and adverse drug reactions (ADR) ☐ Nil known ☐ Unknown (tick appropriate box or complete details below) Medicine (or other) / Reaction / type / date / Initials Sign Print Date
Have ADR details (including for NKDA or Unknown) been documented in the medical record?	O	Single choice selection	Only appears if answer "Yes" to the first question in this section.	The patient's medication history, including previous allergies or ADRs, must be documented by the medical officer on presentation to hospital in the medical record. This could be either by the emergency team or the admitting medical team. The triage nurse may also document this information on the hospitals nursing triage form. See notes and examples of complete and partial ADR documentation above.

Have ADR details (including for NKDA or Unknown) been documented in the most recent discharge summary?	O	Single choice selection	Only appears if answer “Yes” to the first question in this section.	The patient’s medication history, including previous allergies or ADRs, must be documented in the discharge summary to ensure effective communication to other healthcare providers. See notes and examples of complete and partial ADR documentation above.
Has ADR status been identified on the WA MMP?	O	Yes/No	Only appears if answer “Yes” to the first question in this section.	This refers to ticking either “NKDA” or “Unknown” or “Reaction – refer to WA HMC / WA Paediatric HMC”

Section 4 – Medication Reconciliation on Admission

Question	M/O	Question type	Question restrictions	Explanation/Comments
Is there a medication history documented?	M	Yes/No		
Medication history documented by	M	Multiple choice selection		
Where was the medication history documented?	O	Multiple choice selection		This question will appear for each health professional who documented a medication history.
Is the medication history “complete”?	M	Yes/No		This question will appear for each health professional who documented a medication history. Definition of complete medication history: the medication history contains clear details for each medication including generic medication name, dosage, frequency and, where relevant, formulation and route. If at least one essential detail is missing, select “No”. If the patient takes nil regular medications and this is clearly documented, select “Yes”.
INDICATOR 1A: Is a complete medication history documented by a health professional?	M	Calculation based on previous answers.		If at least one health professional has documented a complete medication history, the answer to this question automatically calculates as “Yes”. If there is no complete medication history documented, the answer to this question automatically calculates as “No”.

INDICATOR 1B: Is confirmation of medication history with a second source documented?	M	Single choice selection		Check documentation on the front of the WA HMC or back of the WA MMP for confirmation with a second source of information. Select N/A if nil regular medications, or if is explicitly documented that a second source was deemed unnecessary.
Second source used	O	Multiple choice selection		Select all options sources used.
INDICATOR 1C: Is a reconciled list of medications documented on the WA HMCs/WA Paediatric HMCs or MMP?	M	Single choice selection		It should be clear that the final list of a patient's medications has been reconciled once: • It has been confirmed with a second source • Any differences are documented as part of the best possible medication history (WA MMP or front of HMC) • Any discrepancies between the BPMH and the medicines charted for admission have been identified are communicated. Select "Nil reg" if nil regular medications.
INDICATOR 1D: Are all three admission steps of medication reconciliation documented?	M	Calculation based on previous answers.		If answers are "Yes" to indicators 1A, 1B and 1C, the answer to this question automatically calculates as "Yes". If there is at least one answer "No" to any of the indicators 1A, 1B and 1C, the answer to this question automatically calculates as "No".
Was the patient admitted via Birth and Labour Suite?	O	Yes/No	WNHS sites only	
INDICATOR 1E: Was patient admitted just prior to (i.e. Friday 12 noon onwards) or during a weekend or public holiday?	M	Yes/No		This is used to evaluate weekend pharmacy services. When viewing the WA Medication Reconciliation Audit Dashboard (Power BI®), patients who are admitted on weekends/public holidays may be included or excluded depending on how sites wish to evaluate their service. A weekend/public holiday calendar is embedded within the audit tool for reference.
INDICATOR 1: Are all three admission steps of medication reconciliation documented by End of	M	Yes/No		If [1A=Yes] + [1B=Y/NA] + [1C=Y/Nil reg] + all three steps have been completed by ENCD after admission, then 1=Yes. Cross check the date of the completing the WA MMP against the date of admission.

Next Calendar Day (ENCD)?				
INDICATOR 5: If all three admission steps of medication reconciliation were NOT documented by End of Next Calendar Day (ENCD), when were they completed?	O	Single choice selection	Only appears if answer "No" to the above question.	
Were any medication discrepancies on admission identified?	O	Yes/No		A medication discrepancy may be either *intentional* or *unintentional*. An example of an *intentional* discrepancy would be when a medication has been intentionally withheld due to it causing an adverse side effect or prior to surgery. Intentional discrepancies and their reason should be documented either in the medical record or on the WA MMP. These are not considered discrepancies for the purpose of this audit. An *unintentional* discrepancy is defined as an error or omission in the medication history. The medication may have been omitted from the list, or the wrong medicine, dose, frequency, formulation or route may have been documented or prescribed. *Unintentional* discrepancies should be discussed with the medical team and can be documented in the medical record or on the WA MMP. Select "Yes" or "No" accordingly for any *unintentional* discrepancies that have been documented in the medical record or on the WA MMP.
How many discrepancies were identified?	O	Text (integer)		
How many discrepancies were resolved during the reconciliation?	O	Text (integer)		
Which medications were involved in the discrepancies?	O	Text		This can be used for targeted local medication safety/medication education initiatives.

How many discrepancies involved high risk medications (APINCH)?	O	Single choice selection		The intent of this question is to determine consequence of the patient receiving an incorrect medication, dose, frequency or via the wrong route. The assumption is that if the medication is deemed a high risk medication, then an error may have a higher significance to a patient's outcome to the error. *APINCH* = Antimicrobials, Potassium and other electrolytes, Insulin, Narcotics (opioids) and other sedatives, Chemotherapeutic agents, Heparin and other anticoagulants Refer to MP 0131/20 High Risk Medication Policy.
Which high risk medications were involved?	O	Multiple choice selection		Refer to MP 0131/20 High Risk Medication Policy.

Section 5 – Clinical Pharmacist Review

Question	M/O	Question type	Question restrictions	Explanation/Comments
INDICATOR 3: Has a clinical pharmacist reviewed the patient's medication chart by the end of the next calendar day?	M	Yes/No		
Pharmacist review indicated by		Multiple choice selection	Only appears if answer "Yes" to the above question.	
Was the patient admitted through ED?	O	Yes/No	Rockingham Peel Group sites only	
Was the medication history obtained and documented by an ED pharmacist?	O	Yes/No	Rockingham Peel Group sites only	
Is the patient considered high risk?	O	Yes/No	Rockingham Peel Group sites only	Definition: Is currently prescribed five or more medications. Having multiple co-morbidities. Is prescribed a medication with a narrow therapeutic index.

				Is receiving therapy with high-risk drugs (eg. anticoagulants and immunosuppressants). Has symptoms suggestive of a drug-related admission; and is having difficulty managing medicines because of literacy, language difficulties, dexterity problems, impaired sight, cognitive impairment.

Section 6 – Medication Reconciliation on Discharge

Question	M/O	Question type	Question restrictions	Explanation/Comments
Has a discharge summary, which includes a medication list, been created within 24 hours of the patient's discharge?	O	Yes/No		If a long-stay patient is being audited and they have been admitted in one audit period but discharged in a later audit period, used the "Save & Return Later" button at the end of the audit tool to complete these questions at a later time. The patient will still appear in the audit period in which they were admitted. Compare the day/time of the discharge summary finalisation with the day/time of the patient's discharge on i.ClinicalManager. The patient's discharge day/time has been piped through from Section 2 – Patient Details for ease of reference.
INDICATOR 2A: Does the discharge summary accurately reflect the medications planned for the patient upon discharge?	M	Yes/No		The medications required at discharge for the patient should be identical to the medications listed in the discharge summary. The discharge summary list should include any unchanged regular medications, changed/ceased regular medications or medications initiated during admission that are to be continued post-discharge. This also includes if nil medications are required on discharge. If there were any requirements for medications to be reviewed for the patient on admission (i.e. medications withheld on admission) these must be resolved, or documentation is required for continued management in the discharge summary.
If the answer to INDICATOR 2A is "No",	O	Text	Only appears if answer "No" to the above question.	Outline why the medication list in the discharge summary does not accurately reflect the medications planned for the patient upon discharge.

please describe any discrepancies.				
Is there evidence that a pharmacist was involved in checking and/or reconciling the discharge summary medication list?	O	Single choice selection		Evidence that a pharmacist has been involved in the checking and/or reconciling medications on discharge includes: • at a minimum the discharge prescription has been reconciled with the medication chart at discharge • documentation that a pharmacist has checked the discharge summary on a medication management plan • electronic signature on NaCS (or equivalent discharge summary program) where available. Select “N/A” if nil regular medications and nil medications on discharge.
Were any medication discrepancies on discharge identified?	O			A medication discrepancy may be either *intentional* or *unintentional*. Both types of discrepancies should be documented either in the medical record or on the WA MMP. *Intentional* discrepancies are not considered discrepancies for the purpose of this audit. An *unintentional* discrepancy is defined as an error or omission in the discharge summary. The medication may have been omitted from the list, or the wrong medicine, dose, frequency, formulation or route may have been documented or prescribed. A discrepancy on discharge may include: • medications prescribed on HMC intended for post-discharge therapy not included in the discharge summary • medications that were intentionally withheld on admission and not included for review or recommencement in the discharge summary (e.g. warfarin therapy recommenced post-surgery) • an omission of a medication prescribed on a specialised medication chart (e.g. warfarin on WA Anticoagulation Medication Chart) but not included in the medication list in the discharge summary.
How many discrepancies were identified?	O	Text (integer)		

How many discrepancies were resolved?	O	Text (integer)		
Which medications were involved in the discrepancies?		Text		This can be used for targeted local medication safety/medication education initiatives.
How many discrepancies involved high risk medications (APINCH)?	O	Single choice selection		The intent of this question is to determine consequence of the patient receiving an incorrect medication, dose, frequency or via the wrong route. The assumption is that if the medication is deemed a high risk medication, then an error may have a higher significance to a patient's outcome to the error. *APINCH* = Antimicrobials, Potassium and other electrolytes, Insulin, Narcotics (opioids) and other sedatives, Chemotherapeutic agents, Heparin and other anticoagulants Refer to MP 0131/20 High Risk Medication Policy.
Which high risk medications were involved?	O	Multiple choice selection		Refer to MP 0131/20 High Risk Medication Policy.
INDICATOR 2B: Were changes in medication therapy (e.g. ceased, withheld, new, reduced, increased, other specific change) explicitly communicated in the discharge summary?	M	Single choice selection		Changes to be documented in the discharge summary may include: • whether the medication is "New" for the patient, or increased/decreased in dose/frequency compared with medications prior to admission • monitoring requirements • length of therapy (e.g. antibiotics) • increasing/decreasing dosage regimes (e.g. amiodarone or prednisolone therapy) • prior to admission medications that have been intentionally ceased. Select "No" if the answer to Indicator 2A is "No". Select "N/A" if there are nil changes to the patient's medications upon discharge.
If the answer to INDICATOR 2B is "No", please describe any discrepancies.	O	Text	Only appears if answer "No" to the above question.	This can be used for targeted local medication safety/medication education initiatives.

Were the *reasons* for changes in medication therapy (e.g. reduced dose due to renal impairment, increased dose as previous dose ineffective) explicitly communicated in the discharge summary?	O	Single choice selection		This question has been added to help sites assess completeness of medication management plans on discharge; sites have received anecdotal feedback from GPs that they may be advised of what has changed but not why. This can be critical information in their ongoing management of the patient's medicines. Select "No" if the answer to Indicator 2A is "No". Select "N/A" if there are nil changes to the patient's medications upon discharge.
Were changes in medication therapy communicated to the…	O	Multiple choice selection		Refer to "community liaison" on the back of the WA MMP. Communication may include: • providing the patient/carer/family with a medication profile where appropriate • providing the community pharmacy with a medication profile and/or phoning/emailing to convey any changes that have been made to pre-admission medications • providing the residential aged care home with a medication profile and/or phoned to convey any changes that have been made to pre-admission medications. Selecting general practitioner refers to specific communication about mediation changes outside the usual practice of sending the discharge summary.
INDICATOR 2C: Was patient discharged or transferred during a weekend, public holiday or Monday morning up until 12 noon?	M	Yes/No		This is used to evaluate weekend pharmacy services. When viewing the WA Medication Reconciliation Audit Dashboard (Power BI®), patients who are discharged/transferred on weekends/public holidays may be included or excluded depending on how sites wish to evaluate their service. A weekend/public holiday calendar is embedded within the audit tool for reference.
INDICATOR 2: Are both steps (2A & 2B) of medication reconciliation on discharge or transfer documented?	M	Calculation based on previous answers.		If answers are "Yes" or "N/A" to indicators 2A and 2B, the answer to this question automatically calculates as "Yes". If there is at least one answer "No" to indicators 2A or 2B, the answer to this question automatically calculates as "No".

INDICATOR 4: Is there documentation to confirm that the patient has been provided education/counselling on their medication(s)?	M	Single choice selection		Check page 2 on WA MMP or in the patient's medical record. Select “N/A” if there are nil changes to the patient’s medications upon discharge.
What type of education was provided?	O	Multiple choice selection		Check page 2 on WA MMP or in the patient's medical record.
Who provided the education?	O	Multiple choice selection		

Section 7 – ACHS Clinical Indicators

Question	M/O	Question type	Question restrictions	Explanation/Comments
Has the patient been prescribed an appropriate dosing schedule of enoxaparin?	O	Single choice selection	Rockingham Peel Group sites only	
Has the patient been initiated on warfarin with a loading dose consistent with a DTC-approved protocol?	O	Single choice selection	Rockingham Peel Group sites only	
Has empirical aminoglycoside therapy been continued beyond 48 hours?	O	Single choice selection	Rockingham Peel Group sites only	
Has the patient been prescribed sedatives at discharge that they weren't taking at admission?	O	Single choice selection	Rockingham Peel Group sites only	

Section 8 –Comments and Submission

Question	M/O	Question type	Question restrictions	Explanation/Comments
Any other comments?	O	Text		Provide any other comments relevant to this patient
Save/Submit	M	Single choice selection		Select "Submit" to finalise record. This must be done to ensure data is automatically transferred to the WA Medication Reconciliation Audit Dashboard (Power BI®). Select "Save & Return Later" if you are not ready to submit the record (e.g. if your patient has not yet been discharged or if you require further information before completing the audit). You will be prompted to provide an email address and a link to the draft record will be sent to you. Once you have finalised the record, select "Submit".

This document can be made available in alternative formats on request for a person with disability.

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