Government of Western Australia
Department of Health

WA Medication Reconciliation Audit Tool

NSQHSS – Standard 4 Medication Safety	Methodology: Retrospective Audit	Ward:	Date of Admission: __/__/__ Date of Discharge: __/__/__ Patient Date of Birth __/__/__ UMRN:

Documentation of ADR 4.7.1/2	Allergy/ADR to drug/s identified: Y/N	ADR status documented NIMC (includes NKDA, Unknown, ADR) Y/N	ADR status documented notes Y/N	If patient has had past ADR/s is reaction/s documented? Y/N is ADR sticker/s on NIMC? Y/N

Reconciliation on Admission – Question in red to be reported to Department of Health

1	Is there a medication history documented by a **doctor?** Medical record ☐ on the NIMC ☐ on medication management plan ☐? (Nil Regular ☐) If medication history is documented,is it complete? (i.e. drug, dose, frequency +/- route)	Yes☐ No ☐ Yes☐ No ☐ NA☐	
2	Is there a medication history documented by a **pharmacist?** Medical record ☐ on the NIMC ☐ on medication management plan ☐ ? (Nil Regular ☐) If medication history is documented,is it complete? (i.e. drug, dose, frequency +/- route)	Yes☐ No ☐ Yes☐ No ☐ NA☐	
3	Is there a medication history documented by a **nurse?** Medical record ☐ on the NIMC ☐ on medication management plan ☐? (Nil Regular ☐) If medication history is documented,is it complete? (i.e. drug, dose, frequency +/- route)	Yes☐ No ☐ Yes☐ No ☐ NA☐	
4	**Is a complete medication history documented by a health professional?** (Nil Regular ☐)	Yes☐ No ☐ 4.6.1, 4.6.2	1A
5	**Is confirmation of medication history with a second source documented?** Interview ☐ GP ☐ CP ☐ Patient's Own ☐ Websterpak ☐ Med profile ☐ Transfer/discharge summary ☐ Other ☐ _____ **(Ideally two different sources)** NA ☐	Yes☐ No ☐ NA ☐ 4.6.1	1B
6	**Is a reconciled list of medications documented on the WA MMP or NIMC?**	Yes☐ No ☐ Nil reg☐	1C
7	**Are all three admission steps(1A & 1B & 1C) of medication reconciliation documented?**	Yes☐ No ☐ 4.6.1, 4.6.2 If [1B=Y/NA] + [1C=Y/Nil reg] +[1A=Yes] then 1D=Yes	1D
8	**Was patient admitted just prior to (ie Friday 12 noon onwards), during a weekend or public holiday?**	Yes☐ No ☐	1 E
9	**Are all three admission steps(1A & 1B & 1C) of medication reconciliation documented? (by End of Next Calendar Day (ENCD))** ☐ by end of next calendar day [Yes] ☐ 48 hours ☐ 72 hours ☐ >72 hours [No]	Yes☐ No ☐ 4.6.1, 4.6.2 If [1B=Y/NA] + [1C=Y/Nil reg] +[1A=Yes] AND completed by ENCD then 1 = Yes	1
10	Were any medication discrepancies documented? Number of unintentional discrepancies ___ No. High Risk Meds ____ (i.e. omissions, wrong dose/frequency/route, drug no longer taken) List high risks medications involved: _____	Yes ☐ No ☐ 4.11.1 No. of Discrepancies Resolved ___	

Reconciliation on Discharge or Transfer– Question in red to be reported to Department of Health

1	Has a discharge summary been created for patient at time of discharge?	Yes☐ No ☐	
2	**Are the medications planned for the patient post discharge the same as the information in the discharge summary with all recommendations resolved?** **(ie Medications required at post discharge = Discharge summary medications)**	Yes☐ No ☐ 4.8.1 Patient Deceased ☐	2A
3	Is there evidence that a pharmacist was involved in checking and / or reconciling the discharge summary medication list?	Yes☐ No ☐	
4	Were any medication discrepancies on discharge identified? Number of unintentional discrepancies ___ No. High Risk Meds ____ (ie omissions, wrong dose/frequency/route, drug no longer taking) List high risks medications involved:_____	Yes☐ No ☐ 4.11.1 No. of Discrepancies Resolved ___	
5	**Were changes in medication therapy communicated :** **(i) in the discharge summary ?**	Yes☐ No ☐ 4.12.3	2B
	(ii) to the ☐ patient ☐ carer ☐ community pharmacy ☐ RACF ?	Yes☐ No ☐	
6	**Was patient discharged or transferred during a weekend, public holiday or Monday morning up until 12 noon?**	Yes☐ No ☐	2C
7	**Are both steps (2A & 2B) of medication reconciliation on discharge or transfer documented?**	Yes☐ No ☐ (if 2A = Y and 2B = Y, then 2 = Y)	2
8	Is there documentation to confirm that the patient has been provided education/counselling on their medication? (e.g. Check page 2 on WA MMP or in the patient's medical record) Patient Information Leaflet ☐ CMI ☐ Verbal ☐ Medication List ☐	Yes☐ No ☐ 4.12.1, 4.12.2, 4.13.1	

Comments:

Developed and endorsed by Medication Safety Network July 2017

National Safety and Quality Health Service Standard 4 addressed in this audit tool.

4.6.1 A best possible medication history is documented for each patient

4.6.2 The medication history and current clinical information is available at the point of care

4.7.1 Known medication allergies and adverse drug reactions are documented in the patient clinical record

4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings

4.11.1 The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed

4.12.1 A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines

4.12.2 A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care

4.12.3 A current comprehensive list of medicines is provided to the receiving clinician during clinical handover

4.13.1 The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks