Medication Reconciliation Quality Audit Tool - Acute Care, Long-Term Care and Rehab

Instructions and Legend for Completing the MedRec Quality Audit Form

Purpose of the Audit Tool

The tool is designed for use in **Acute Care, Long-Term Care and Rehab** and was developed to allow organizations to assess the quality of their medication reconciliation practices and determine the areas requiring process improvement(s**).**

Data Collection Methodology

- Concurrent or retrospective chart review to collect data.
- Collect information monthly on all patients/residents or a subset as recommended by your organization. Quarterly data collection is not recommended until you have reached goal and sustained it for three (3) consecutive data points.

Pt./Res #

- Each row represents an individual patient/resident that is included in the audit

Question by Question explanation

A. Admit via (select the most appropriate for your Health Care sector)

- Identify the admission route for each chart audited chart. The data provided in this column, along with the data from the remainder of the tool, will allow organizations to identify if there are specific patient flow routes that require process improvements.

ACUTE CARE

- **Emerg**: The patient was admitted via the Emergency Department of your healthcare facility.
- **Pre-Adm:** The patient underwent pre-operative admission assessment in a **Pre-Admission Clinic**
- **Direct**: The patient was admitted directly to the nursing unit without assessment in the Emergency Department or a Pre-Admission Clinic.
- **Other**: The patient was not admitted via in the Emergency Department or a Pre-Admission Clinic or Direct to the nursing unit.

LONG TERM CARE

- **Acute**: The patient was admitted from an Acute Care facility e.g. hospital.
- **Home:** The patient admitted from their home excluding another Residential Care facility
- **Res Care**: The patient was admitted from another Residential Care facility including Long-term care, or Supportive Care.
- **Other**: The patient was not admitted via Acute Care, directly from the Home or from another Residential Care facility.

B. MedRec Performed? (MedRec-Acute 5 / MedRec-LTC 4)

- Fill in "**YES**" (score as 1) if MedRec was performed according to your organization's policy. The aggregated data from this column is used as a measure of "Percent (%) Reconciled at Admission" however, we recommend you use this data in conjunction with the five quality elements (Columns C-G).
- Fill in "**NO**" (score as 0) if MedRec was not performed according to your organization's policy

- Fill in "**NO MEDS**" (score as 1) if the patient/resident has no medications prescribed prior to admission
    - Select "**No Meds**" and proceed to the next patient.
    - **Do not** complete MedRec elements C through H.

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- Fill in "**YES**" if MedRec form is located in the correct location in the chart and form has been completed (or the BPMH has been completed in an IT system).
- Fill in "**NO**" if there is no form in the chart, the form is blank or incomplete, or the BPMH has not been completed in the IT system yet.
- Fill in "**NO MEDS**" if the patient has no medications prescribed prior to admission.
- **If "NO" or "NO MEDS" is filled out, do not fill in bubbles for Columns C to H.**

C. BPMH >1 source? (MedRec-Acute 13 / MedRec-LTC 8)

- The Best Possible Medication History (BPMH) has been developed based on information obtained from more than one source. Sources may include: patient's own medication list (hand-written or electronic); list of medications generated from patient's list of drugs; community pharmacy or primary care physician; Electronic provincial medication/community pharmacy record ; Medication vials or pill-packs/community pharmacy records; Home care reconciled medication list; Previous admission records/discharge summary; Prescriber referral/consultation notes; Ambulatory clinic medication records. For patients admitted directly from a setting where medications have been administered sources may also include: most current Medication Administration Record (MAR) and Best Possible Medication Discharge Plan (BPMDP).
- Fill in "**YES**" (score as 1) when the BPMH has been developed based on information obtained from **more** than one source.
- Fill in "**NO**" (score as 0) when more than one source is not documented in the patient chart i.e. only one source recorded.
- Fill in "**UNCLEAR**" (score as 0) if the chart documentation does not allow the auditor to respond confidently "yes/no" i.e. no sources recorded.

D. Actual Med Use Verified by Pt/Res/Caregiver source (MedRec-Acute 14 / MedRec-LTC 9)

- Patient or Resident involvement/interview to confirm actual medication use.
- Fill in "**YES**" (score as 1) if there has been verification of medication use through patient or caregiver interview OR if the source includes a MAR or BPMDP for those coming from structured care settings
- Fill in "**NO**" (score as 0) if there has not been verification through an interview
- Fill in "**UNCLEAR**" (score as 0) if the chart documentation does not allow you to respond confidently "yes/no".
- Fill in "**UNABLE TO PERFORM**" (score as 1) if the interview was not possible due to patient specific factors (e.g. non-verbal patient, unable to contact a caregiver)

E. Each med has drug name, dose, strength, route, frequency on BPMH and Admission Orders (MedRec-Acute 15 / MedRec-LTC 10)

- Completeness of the medication information for each medication
- Fill in "**YES**" (score as 1) if all applicable medication order components are provided (i.e. drug name, dose ± strength, route and frequency)
- Fill in "**NO**" (score as 0)if there is missing components in the medication order
- **Note**: In a proactive model whereby the documentation of the BPMH leads directly to admission orders, the documentation of the BPMH and the admission orders may be the same. In a retroactive model, this assessment should focus primarily on the documentation of the BPMH.
- **Note**: In situations where the auditor identifies a medication listed without a specified route or strength AND the medication is only available by a particular route (i.e. by mouth/p.o), at the discretion of the auditor/organization they may wish to indicate a "yes" response.

F. Every med in BPMH is accounted for in Admission Orders (MedRec-Acute 16 / MedRec-LTC 11)

- Auditors assess whether all of the medications, as listed in the BPMH, have been accounted for in the admission documentation. An unaccounted for difference could include the lack of: i) an explicit admission order to either discontinue, hold, change or continue a medication that is listed in the BPMH or ii) a clear* clinical reason/documentation for the difference (e.g. stopping warfarin in a patient admitted with an acute bleed). Clarity of documentation is at the discretion of end users and should incorporate some clinical judgment
- Fill in "**YES**" (score as 1) if there are NO unaccounted for differences between the BPMH (as collected) and the admission orders.
- Fill in "**NO**" (score as 0) if there are outstanding unaccounted for differences between the BPMH (as collected) and the admission orders.
- **Note**: In a proactive model, this assessment should be relatively easy to complete. This is because by virtue of completing a proactive form, whereby each BPMH medication is "actioned" with an order (i.e. indicating continue/discontinue/hold/change), the comparison is effectively occurring as the admission orders are being "written". This assessment will take considerably longer in a retroactive model as the auditor will need to assess whether despite the previously conducted comparison process there are unaccounted for differences between the admission orders and the BPMH.

G. Prescriber has documented rationale for 'Holds' and 'Discontinued' meds (MedRec-Acute 17 / MedRec-LTC 12)

- Auditors assess whether prescriber has included a rationale for discontinuing or holding any medication listed in the BPMH (as applicable).
- Fill in "**YES"/ "N/A**" (score as 1) if all BPMH medications that have been discontinued or held in the admission orders include documentation on a rationale for this action OR if there are no BPMH medications that were discontinued or held on admission
- Fill in "**NO**" (score as 0) if there are any BPMH medications that are discontinued or held in the admission orders that lack an accompanying rationale for this action
- Fill in "**UNCLEAR**" (score as 0) if the chart documentation does not allow you to respond confidently "yes/no"

H. Discrepancy communicated, resolved, and documented?

- This column will not always be required to be completed (AHS see below). It is only required if there was a previously identified difference(s) between the admission order and the BPMH. The auditor is assessing whether this difference has been appropriately communicated, documented and resolved.
- Fill in "**YES / N/A**" (score as 1) if adequate evidence (documentation such as progress note or prescriber order) is identified to support the resolution of any identified differences between the BPMH and the Admission Orders
- Fill in "**NO**" (score as 0) if there are outstanding identified differences that do not appear to have been resolved.
- Fill in "**Unclear**" (score as 0) if the chart documentation does not allow you to respond confidently "yes/no"

For Alberta Health Services

- Always complete column H.

Best Practice Answers

Pt #	A. Admit via	B. MedRec Performed	C. BPMH >1 source	D. Actual Med use verified by Pt/Caregiver source	E. Each med has drug name, dose, strength, route, frequency on BPMH and Admission Orders	F. Every med in BPMH is accounted for in Admission Orders	G. Prescriber has documented rationale for 'Holds' and 'Discontinued' meds	H. Discrepancy communicated, resolved, and documented
1 VOID	EMERG PRE-ADM DIRECT OTHER	YES NO NO MEDS	YES NO UNCLEAR	YES NO UNCLEAR UNABLE TO PERFORM	YES NO	YES NO	YES, N/A NO UNCLEAR	YES, N/A NO UNCLEAR

Green bubbles = best practice criteria

MedRec Quality Score (MedRec-Acute 12 / MedRec-LTC 7)

Step 1 – Calculate the **patient-level** MedRec Quality Score

The **patient-level MedRec Quality Score** is calculated by adding the quality elements on the audit form (questions C, D, E, F, G). This corresponds to SHN measures MedRec-Acute 12 and MedRec-LTC 7.

You get 1 point for meeting the best practice criteria for each MedRec Quality indicator (question):

- C. BPMH based on >1 source. = **Yes**
- D. Actual medication use verified by pt./caregiver interview. = **Yes** OR **Unable to perform**
- E. Each medication has drug name, dose +/- strength, route, frequency on BPMH and Admission Orders. = **Yes**
- F. Every medication in the BPMH is accounted for in the admission orders. = **Yes**
- G. Prescriber has documented rationale for 'holds' and 'discontinued' medications. = **Yes/NA**

If **all five** MedRec Quality indicators are met as described above, the patient's **MedRec Quality Score** = 5 (100%)

Step 2 – Calculate the **overall** MedRec Quality Score

Sum the total number of patients for whom all five MedRec Quality indicators were met on admission in the patient sample, and divide by the total number of patients in the patient sample (e.g. 6 of 10 patient received a perfect score of 5; Score = 6/10 = 60%)