Medication Reconciliation Discharge Quality Audit – Acute Care and Rehab
Instructions for Completing the Discharge MedRec Quality Audit Tool

Purpose of the Audit Tool

The tool is designed for use in Acute Care and Rehab. It was developed to allow organizations to assess the quality of their medication reconciliation practices at discharge and determine the areas requiring process improvement.

Data Collection Methodology

- A chart review performed as close to the day of discharge as possible.
- Collect information **monthly** on all patients 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.

Patient #

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

Question by Question Explanation

A. **Discharged to: (select the most appropriate location)**
   - Identify the discharge location for each 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. Organizations can opt out of this question and will not be penalized if left blank.
   - **Long term care:** discharged to a long term care or extended care facility
   - **Home Care:** discharged home with home care services in place
   - **Home without care:** discharged home without professional care services in place
   - **Another acute care facility:** patient discharged and admitted to another acute care facility
   - **Other:** patient discharged to another facility such as rehabilitation facilities, retirement homes, respite care or any others that do not fit with the aforementioned options.

B. **Discharge MedRec performed Select YES, NO, N/A - no admission or discharged Meds**
   - Fill in "**YES**" –if Discharge MedRec was performed according to the organization's policy. The aggregated data from this column is used as a measure of "Percent (%) Reconciled at Discharge" however, we recommend you use this data in conjunction with the five quality elements (Columns C-H).
   - Fill in "**NO**" – if Discharge MedRec was not performed according to the organization's policy.
   - Fill in "**N/A**" – no admission or discharged meds – if the patient was admitted and discharged home on no medications. STOP here; proceed to the next patient.

C. **All medications on the admission BPMH are accounted for on the discharge medication documentation (BPMDP)***. Select YES, NO, N/A – No Home Meds.
   - Fill in **"YES"** – if all medications on the admission BPMH were accounted for on the discharge medication documentation.

- Fill in "**NO**" – if not all medications on the admission BPMH were accounted for on the discharge medication documentation.
- Fill in "**No admission BPMH**" – if there was no admission BPMH completed or it cannot be located on chart.
- Fill in "**N/A - No Home Meds on Admission**" – if, at the time of admission, the patient was not taking any medications at home or from the previous facility.

D. **Were there any outstanding discrepancies between latest 24 hour Medication Administration Record (MAR) (or medication profile) and the discharge medication documentation (BPMDP)?** Select YES, NO
  - Fill in "**YES**" – if there are any outstanding discrepancies between the BPMDP and the most recent last 24 hour MAR (or medication profile) e.g. name, dose +/- strength, route, or frequency, and the discrepancies could not be clarified with the prescriber.
  - Fill in "**NO**" – if there are no outstanding discrepancies between the discharge medication documentation and the most recent medication profile/last 24 hour MAR (include the most recent medication orders on the chart).

E. **Each medication on the discharge medication documentation has: drug name, dose ± strength, route, and frequency.** Select YES, NO.
  - Fill in "**YES**" – if all applicable medication information is complete.
  - Fill in "**NO**" – if applicable medication information is incomplete.

F. **Prescriber has documented rationale for added, changed and/or discontinued medications on the discharge medication documentation.** Select YES, NO, N/A – No Changes to BPMH Meds
  - Fill in "**YES**" – if there has been documented rationale provided for all changed and/or discontinued medications on the discharge medication documentation.
  - Fill in "**NO**" – if there is no documented rationale provided for all changed and/or discontinued medications on the BPMDP or discharge documentation.
  - Fill in "**N/A – No change to BPMH medications**" – if, at the time of discharge, the medications on the admission BPMH had not been changed and/or discontinued and no new medications were added.

G. **Discharge medication documentation* has been provided and reviewed with the patient/caregiver.** Select YES, NO, Not Documented
  - Fill in "**YES**" – if the discharge medication documentation (e.g. updated medication list and prescriptions) has been provided and reviewed with the patient/caregiver.
  - Fill in "**NO**" – if the discharge medication documentation (e.g. updated medication list and prescriptions) has NOT been provided and reviewed with the patient/caregiver.
  - Fill in "**Not Documented**" – if there is no documentation that the discharge medication documentation has been provided and reviewed with the patient/caregiver.

H. **The discharge medication documentation* has been communicated to the next healthcare provider(s).** Select YES, NO, Not documented
  - Fill in "**YES**" – if the discharge medication documentation has been provided to the next healthcare provider(s) e.g. primary care physician, home care coordinator, most responsible physician or member

of healthcare team at the receiving institution.

- Fill in "**NO**" – if the discharge medication documentation has NOT been provided to the next healthcare provider(s).
- Fill in "**Not Documented**" – if there is no documentation that the discharge medication documentation has been provided to the next healthcare provider(s).

*Discharge medication documentation (or Best Possible Medication Discharge Plan (BPMDP)) may include: an up-to-date and accurate list of medications the patient should be taking on discharge, a medication information transfer letter or discharge summary, a structured discharge prescription, a patient information grid, wallet card or a discharge MedRec form. (MedRec in Acute Care Getting Started Kit 2017, page 45). Each organization should determine the documents to be audited for each column.