NSQHS Standard 4 Medication Safety
How to use the audit tools – Edition 2

Medication Safety Audit Tools Instructions

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, has developed audit tools for facilities and Hospital and Health Services (HHS) to use to collect data in support of evidence in meeting the National Safety and Quality Health Service (NSQHS) Standards. The audit tools have been updated to align to the second edition of the NSQHS Standards.

Purpose of the audit tools

The tools provide facilities and health services with additional support resources to use in conjunction with the existing NSQHS Standards workbooks and guides to be able to:

- Demonstrate detailed evidence for an action by providing specific verification rather than noting the action has been met and listing the source, i.e. self-assessment
- Collect information and evidence to a further level of detail at a patient, ward and facility level, delving down into specific requirements that further support meeting the action
    - collect patient level data using a number of methods, i.e. chart documentation, observational and asking the patient/carer questions to demonstrate that the evidence has been met, and to what extent
    - observe ward/unit staff undertaking a process, e.g. intravenous lines and recording individual results
- Determine actual performance results at a ward and facility level by rolling up data, i.e. auditing all patients in a ward for a ward result, auditing all wards for a facility result
- Clearly identify those detailed gaps/areas that need attention, in order to target improvements and build a robust action plan at the ward and facility level
- Track and monitor audit results at the three levels over time.

The tools can be used in conjunction with other resources and directly align to the criteria in the existing NSQHS Standards workbooks and guides. Depending on the size of the facility a number of audit questions may not be applicable, it is up to each facility/health service to determine the audit questions for review. Questions and responses can be adapted to suit the requirements of each facility/health service.

The suite of documents include the following:

1. A ‘how to’ guide on using the tools (this document)
2. A definitions guide to assist in completing the tools
3. Three specific audit tools that allow the collection and collation of information are provided that can be adapted for local use. An Excel workbook consists of tabs with the following:
    - *Facility Collection and Results*: collects facility level responses
    - *Ward/Unit Collection Audit Tool*: collects the ward/unit level responses, the excel spreadsheet can be used to collect up to 15 wards/units
    - *Patient Collection Audit Tool*: collects patient level responses (at a ward/unit level), the excel spreadsheet can be used to collect up to 20 patients
    - *Results for Ward/Unit*: collates the ward/unit level responses
    - *Results for Patient*: collates the patient level responses.
4. A measurement plan for each standard that defines the goals, questions and responses in the audit tools. The plan details each audit question and its alignment to the action in the standard and can be adapted for local use. Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Scope of the Medication Safety Audit Tools

The audit questions incorporate a number of key areas, such as governance committees, staff education and training, medication incidents, evaluation processes, documentation on the medication chart and medication action plan, medicine information leaflets and policies/procedures related to safe management and quality use of medicines.

How the tools were developed

An example is provided below using Action 4.5 in Standard 4

1. The NSQHS Standards workbooks and guides were used, i.e.
    a. Guide for Hospitals (November 2017) – Key tasks and Strategies for improvement

    https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Safety-and-Quality-Health-Service-Standards-Guide-for-Hospitals.pdf

Action 4.5

Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

Intent

Patients and carers are actively involved in taking a BPMH as the first step in the process of medication reconciliation.

Key task

- Implement a systematic process for obtaining the patient's actual medicine use and recording a BPMH.

Strategies for improvement

Complete a BPMH as early as possible on admission – this is the key first step of a formal process of medication reconciliation. At least two sources of information are needed to obtain and then confirm the patient's BPMH – for example, the patient and their nominated general practitioner or community pharmacist.

A BPMH should be completed, or the process supervised, by a clinician with the required skills and expertise. Policies, procedures and guidelines for obtaining a BPMH should include:

- A structured interview process
- The key steps of the process
- Documentation requirements (where and what should be documented, such as use of the MMP or equivalent; paper or electronic)
- Roles and responsibilities of clinicians
- Training requirements for clinicians
- Involvement of patients and carers (links to Action 4.3).

Use a standard form for recording the BPMH. This may be the MMP, the section for medicines taken before presentation to hospital on the front of the NIMC or PBS HMC, or an electronic or paper-based equivalent. This creates 'one source of truth', and acts as an aid to reconciliation on admission, clinical handover, transfer and discharge.

Consider training requirements to ensure that clinicians with responsibility for obtaining a BPMH are sufficiently competent. Learning modules and instructional videos are available from various state, national and international organisations – links are provided in the Resources section at the end of this standard. These can guide clinicians on using a systematic approach to obtain and record an accurate and complete history of the medicines taken by patients at home, noting that specific techniques for taking a BPMH can influence its accuracy.

Example of Key task for 4.5 'Implement a systematic process for obtaining the patient's actual medicine use and recording a BPMH'.

2. The questions in the audit tools (patient, ward, facility) assess and ask for verification of the examples of evidence and outputs to collect the detailed information necessary to meet that evidence. In addition, other examples of evidence may be used. The questions may directly ask if there is evidence to support, or may be broken down into a series of questions to delve deeper into whether the evidence has been met. In addition, questions may require the auditing of patients in order to demonstrate that the evidence has been met, and to what extent.

   Questions and responses have been developed in consultation with content area experts.

Example of Patient level audit questions for Action 4.5 in Standard 4

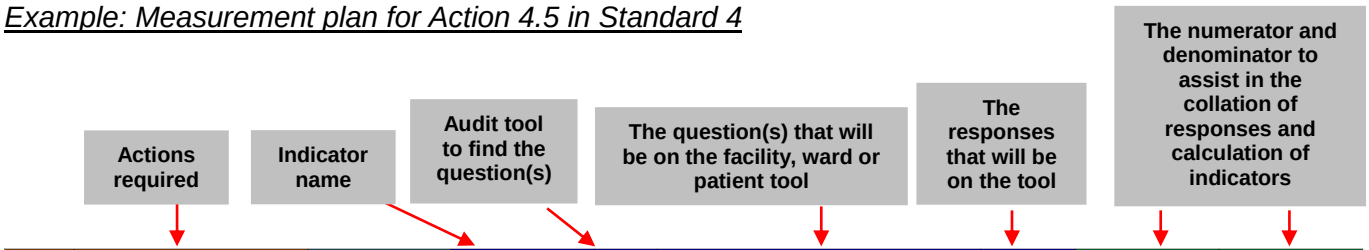
Documentation audit - Patient		Pt 1	Pt 2
	URN:		
1.0	Is there evidence that the (best possible) medication history was documented?		
1.1	If yes to 1.0		
	• where is the medication history documented?		
	• when was the medication history documented?		

In addition to the collection of information, the Excel spreadsheet collates data at the patient and ward/unit levels. The tab *Results for Ward/Unit* shows the number of wards/units that met the indicator and the total number audited, which are then used to calculate the percentage of wards/units that met that indicator. Subsequently, the tab *Results for Patient*, displays the percentage of patients that met the indicator. Details of the indicators can be found in the measurement plan.

3. The measurement plan details the criteria/action and those question(s)/responses that correspond to the action.

   Note: Some questions may be used by the facility to demonstrate evidence for other actions, in addition to the action it has been aligned with.

Example: Measurement plan for Action 4.5 in Standard 4



Action	Actions required	Goal	Indicator	Audit Tool	Question on Audit Tool	Response options	Numerator	Denominator
4.5	Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	Identify patients in the ward/unit that had a (best possible) medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside	% of patients that had a (best possible) medication history documented in the medication chart or the MAP (Medication Action Plan) at the bedside	Patient	1.0 Is there evidence at the bedside that the (best possible) medication history was documented? 1.1 If yes to 1.0 • where is the medication history documented? • when was the medication history documented?	Yes; No Medication chart; Medication Action Plan	Number of patients with the (best possible) medication history documented (Yes to 1.0)	Total number of eligible patients (Yes or No to 1.0)

Using the Excel tools

The audit tools are in different worksheets in the Excel document and these are accessed by the tabs at the bottom of the workbook or by clicking on the links in the Contents page.

In addition, we recognise that each facility will define when the audit will take place, how often, how many patients to audit and who will perform the audit.

Queensland Health facilities have the ability to enter their audit data online using an existing secure, electronic web-based system, Measurement, Analysis and Reporting System (MARS), available via the Queensland Health intranet. Please email mars@health.qld.gov.au for further information.

We recognise and appreciate that there may be gaps in the scope and questions included in these tools, however, as the audit tools are a constant **'Work in Progress'**, future versions will build upon the existing scope and questions, and incorporate staff feedback and suggestions for improvement.

Patient Safety and Quality Improvement Service, Clinical Excellence Queensland, welcomes feedback on the audit tools and the measurement plans, to ensure the tools meet the needs of Queensland Health facilities. We appreciate any feedback you can provide for the next version.

Please email Patient Safety and Quality Improvement Service on mars@health.qld.gov.au for feedback or comments.