MedRec Quality Audit

Long-Term Care Medication Reconciliation Quality Audit Tool

Purpose of the Audit Tool

The tool is designed for use in Long-Term Care and was developed to allow LTC Homes to assess the quality of their medication reconciliation (MedRec) practices. The results of the quality audit can then be used to determine potential areas for process improvement(s).

Data Collection Methodology

- Retrospective (past admissions and readmissions) chart review to collect data.
- **A Word version tool for collecting the audit information (Data Collection Form) will be provided to all Champion Homes with an Excel Spreadsheet to compile the results (MedRec LTC Audit Results).**
- All Champion Homes are asked to audit each of the charts for the most recent 20 residents that were admitted/readmitted in the past 6 months.
    - If there are less than 20 residents admitted/readmitted in this time period, proceed with the reduced number for the audit and do not extend past the 6 -month historical timeline.

Audit Process - Question by Question Explanation

Question A. Where was the resident admitted/readmitted from?

Identify the admission route (Admit Via) for each resident chart audited. The information provided in this column of the Data Collection Form, along with the data from the remainder of the tool, will allow organizations to identify if there are specific resident flow routes that may require process improvements.

Admit Via Options for Selection:

- Acute: The resident was admitted/readmitted from an Acute Care facility (e.g., hospital).
- Home: The resident was admitted from their home (excluding another long-term care home).
- Res Care: The resident was admitted from another long-term care home.
- Other: The resident was not admitted via Acute, Home or Res Care.

Question B. Was MedRec performed within 48 hours of admission/readmission?

- Fill in “YES”, if MedRec was performed within 48 hours.
- Fill in “NO (done after 48 hours)”, if MedRec was performed after 48 hours.
- Fill in “NO”, if MedRec was not done
    - If “No” is selected, stop audit, and proceed to the next resident chart.

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Question C. Was BPMH obtained with more than 1 source of information?

- The Best Possible Medication History (BPMH) is most accurate when developed based on information obtained from more than one source. See 'Sources of Information Resource to Use' infographic for the possible sources of information.
- Fill in "YES" if the BPMH has been developed based on information obtained from more than one source.
- Fill in "NO" if more than one source is not documented in the resident chart (i.e. only one source recorded).
- Fill in "UNCLEAR" if the chart documentation does not allow the auditor to respond confidently "yes/no" (i.e. no sources recorded).

Question D. Was actual medication use verified?

- Fill in "YES" if there has been verification of medication use through resident or caregiver interview OR if sources include a medication administration record (MAR).
- Fill in "NO" if there has not been verification through an interview or MAR.
- Fill in "UNCLEAR" if the chart documentation does not allow you to respond confidently "yes/no".
- Fill in "UNABLE TO PERFORM" if the interview was not possible due to resident specific factors (e.g., non-verbal resident, unable to contact a substitute decision maker).

Question E. Do the BPMH and Admission Orders specify drug name, dose, strength, route, and frequency for each medication?

- Fill in "YES" if all applicable medication order components are provided in the BPMH and Admission Orders.
- Fill in "NO" if there are missing components in the BPMH or Admission Orders.
    - 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 (e.g., by mouth/PO), at the discretion of the auditor/organization they may wish to indicate a "yes" response.

Question F. Is every medication in the BPMH accounted for in the Admission Orders?

- Fill in "YES" if there are NO unaccounted for differences between the BPMH (as collected) and the admission orders.
- Fill in "NO" if there are outstanding unaccounted for differences between the BPMH (as collected) and the admission orders.

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Question G. Has the prescriber documented a rationale for 'Holds' and 'Discontinued' meds?

- Fill in "YES"/ "N/A" if all BPMH medications that have been discontinued or held in the admission orders include documentation of a rationale for this action OR if there are no BPMH medications that were discontinued or held on admission.
- Fill in "NO" 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" if the chart documentation does not allow you to respond confidently "yes/no".

Question H. Have all discrepancies been communicated, resolved, and documented?

- Fill in "YES / N/A" if there were no discrepancies identified between the BPMH and the admission orders.
- Fill in "YES / N/A" 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" if there are outstanding identified differences that do not appear to have been resolved.
- Fill in "Unclear" if the chart documentation does not allow you to respond confidently "yes/no".

Adapted with permission from SHN! Medication Reconciliation Quality Audit Tool - Acute Care, Long-Term Care and Rehab Instructions and Legend for Completing the MedRec Quality Audit Form. Accessed: https://www.patientsafetyinstitute.ca/en/toolsResources/psm/Documents/Packages/MedRec/MedRec-LTC_Quality-Audit_Instructions.pdf