Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Guidance for health and social care providers

Principles of good practice in medication reconciliation

May 2014

About the Health Information and Quality Authority

The Health Information and Quality Authority (HIQA) is the independent Authority established to drive high quality and safe care for people using our health and social care services. HIQA's role is to promote sustainable improvements, safeguard people using health and social care services, support informed decisions on how services are delivered, and promote person-centred care for the benefit of the public.

The Authority's mandate to date extends across the quality and safety of the public, private (within its social care function) and voluntary sectors. Reporting to the Minister for Health and the Minister for Children and Youth Affairs, the Health Information and Quality Authority has statutory responsibility for:

- **Setting Standards for Health and Social Services** – Developing person-centred standards, based on evidence and best international practice, for those health and social care services in Ireland that by law are required to be regulated by the Authority.

- **Supporting Improvement –** Supporting health and social care services to implement standards by providing education in quality improvement tools and methodologies.

- **Social Services Inspectorate** – Registering and inspecting residential centres for dependent people and inspecting children detention schools, foster care services and child protection services.

- **Monitoring Healthcare Quality and Safety** – Monitoring the quality and safety of health and personal social care services and investigating as necessary serious concerns about the health and welfare of people who use these services.

- **Health Technology Assessment** – Ensuring the best outcome for people who use our health services and best use of resources by evaluating the clinical and cost effectiveness of drugs, equipment, diagnostic techniques and health promotion activities.

- **Health Information** – Advising on the efficient and secure collection and sharing of health information, evaluating information resources and publishing information about the delivery and performance of Ireland's health and social care services.

Contents

Subject	**Medication reconciliation**
Audience	Service providers

Standards and Regulations relevant to this guidance include			
Standard	**No.**	**Regulation**	**No.**
National Standards for Safer Better Healthcare	3.1		
National Quality Standards for Residential Care Settings for Older People in Ireland	14 15	Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended)	25 33
National Standards for Residential Services for Children and Adults with Disabilities	4.3	Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013	21(1)(b) [Sch3(3)(h)] 21(3) [Sch3] 29
National Standard for Patient Discharge Summary Information			

This guidance contains explanations of concepts, illustrative examples and templates that may assist in meeting regulations and implementing standards. There may be other requirements relevant to particular services that are not addressed in this guidance and it is for service providers to identify the regulations, standards and best available evidence relevant to their service. This guidance is current at the time of printing. Please check www.hiqa.ie for the latest version of this guidance.

1. Introduction

Medication management refers to the safe, clinically effective and economic use of medicines to ensure that people using health and social care services get the maximum benefit from the medicines they need, while at the same time minimising potential harm.

Medication safety involves giving the right person the right medication in the right dose at the right time and by the correct route.

In line with the relevant national standards,[a] service providers are expected to have arrangements in place to ensure the safe and effective use of medicines, including assessing, prescribing, dispensing, administering, documenting, reconciling, reviewing and assisting people with their medications. The Authority has produced this guidance to aid service providers in achieving this. In Ireland, the medication incidents most commonly reported to the Clinical Indemnity Scheme (CIS) in 2012 were medication reconciliation incidents.

2. What is medication reconciliation (MR)?

Medication reconciliation is the process of creating and maintaining the most accurate list possible of all medications a person is taking – including drug name, dosage, frequency and route – in order to identify any discrepancies and to ensure any changes are documented and communicated, thus resulting in a complete list of medications.

Medication reconciliation aims to provide patients and service users with the correct medications at all points of transfer within and between health and social care services. It can be considered complete when each medication that a person is taking has been actively continued, discontinued, held or modified at each point of transfer, and these details have been communicated to the next care provider.[1]

There are three steps in the medication reconciliation process:[b]

- **Collecting:** This involves the collection of the medication history and other relevant information.
- **Checking:** This is the process of ensuring that the medicines, doses, frequency and routes, etc. that are prescribed for a patient or service user are correct.
- **Communicating:** This is the final step in the process where any changes that have been made to a patient or service user's prescription are documented,

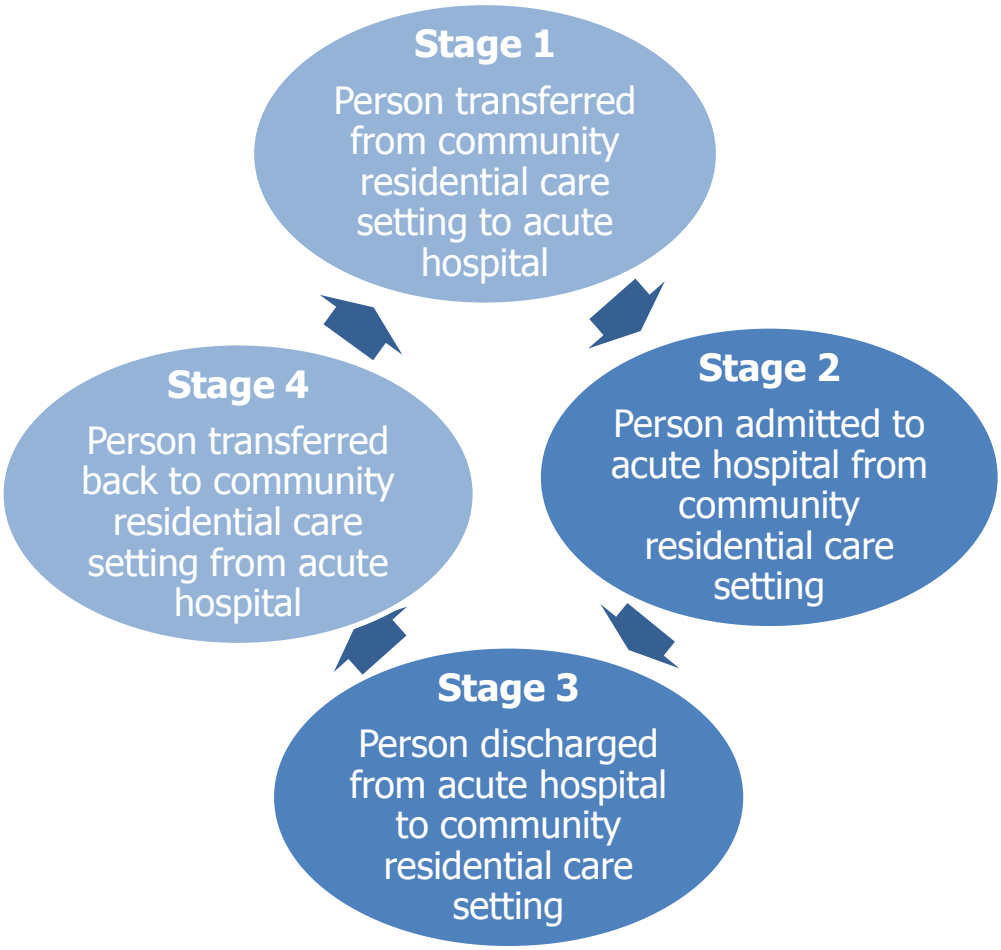
[a] The *National Standards for Safer Better Healthcare*; the *National Quality Standards for Residential Care Settings for Older People in Ireland*; the *National Standards for Residential Services for Children and Adults with Disabilities* and the *National Standard for Patient Discharge Summary Information*.
[b] The Institute for Healthcare Improvement describes these three steps as 'verification, clarification and reconciliation.'

dated and communicated to the person to whom the patient's or service user's care is being transferred.[2]

The medication reconciliation process starts when the need arises to transfer or move a person from one service to another. Medication reconciliation is a continuous process and takes place when a patient or service user is **admitted** to a service, continues whenever the patient or service user is **moved or transferred** to a different level of care within that service, and occurs again when the patient or service user is **discharged** from the service.

2.1 Stages for medication reconciliation

Where a person is transferred, for example, from a community residential health or social care setting to an acute hospital and then subsequently discharged back to that setting, four stages for medication reconciliation can be identified. These are laid out below:



The three steps in the medication reconciliation process are required at each one of these four stages. In addition, the definition of a goal or desired outcome for each stage of the medication reconciliation process is essential to facilitate tracking of progress towards those goals.

An example of a goal for Stage 1 would be: 'the complete, correct and up-to-date medication list is provided for **100%** of people transferred from a community residential care setting to an acute setting'.

The three steps in the medication reconciliation process, the four stages at which medication reconciliation is required in this example, and sample goals for each stage are laid out in Table 1 on page 10.

Additional information is available in a recent publication from the Health Service Executive (HSE) that provides practical guidance on the medication reconciliation process as part of the wider discharge and transfer process from hospital.[3]

3. Background to the medication reconciliation project

In order to provide support to the Irish health and social care system, and help services to implement standards developed by HIQA, the Authority has collaborated with the Institute for Healthcare Improvement (IHI) Open School for Healthcare Professionals to provide education and training, free of charge, to front-line health and social care staff in basic quality improvement science (tools and methodologies).

In 2013, staff from four acute hospitals and six care of the elderly providers undertook the IHI Open School for Healthcare Professionals Programme.

The 2013 programme also involved an action learning component where the staff from the pilot acute hospitals and care of the elderly providers applied the quality improvement knowledge and tools they were learning, via the IHI Open School Programme, to a medication reconciliation quality improvement project.

The purpose of the project was to improve medication reconciliation for residents of nursing homes/community hospitals transferred to acute hospitals for treatment when they became acutely unwell, and who were subsequently discharged back to the nursing home/community hospital.

As part of this project a baseline measurement exercise took place in June 2013 to ascertain the extent to which medication reconciliation was taking place when residents of nursing homes/community hospitals were being transferred to acute

hospitals for treatment and subsequently being discharged back to the nursing homes/community hospitals.

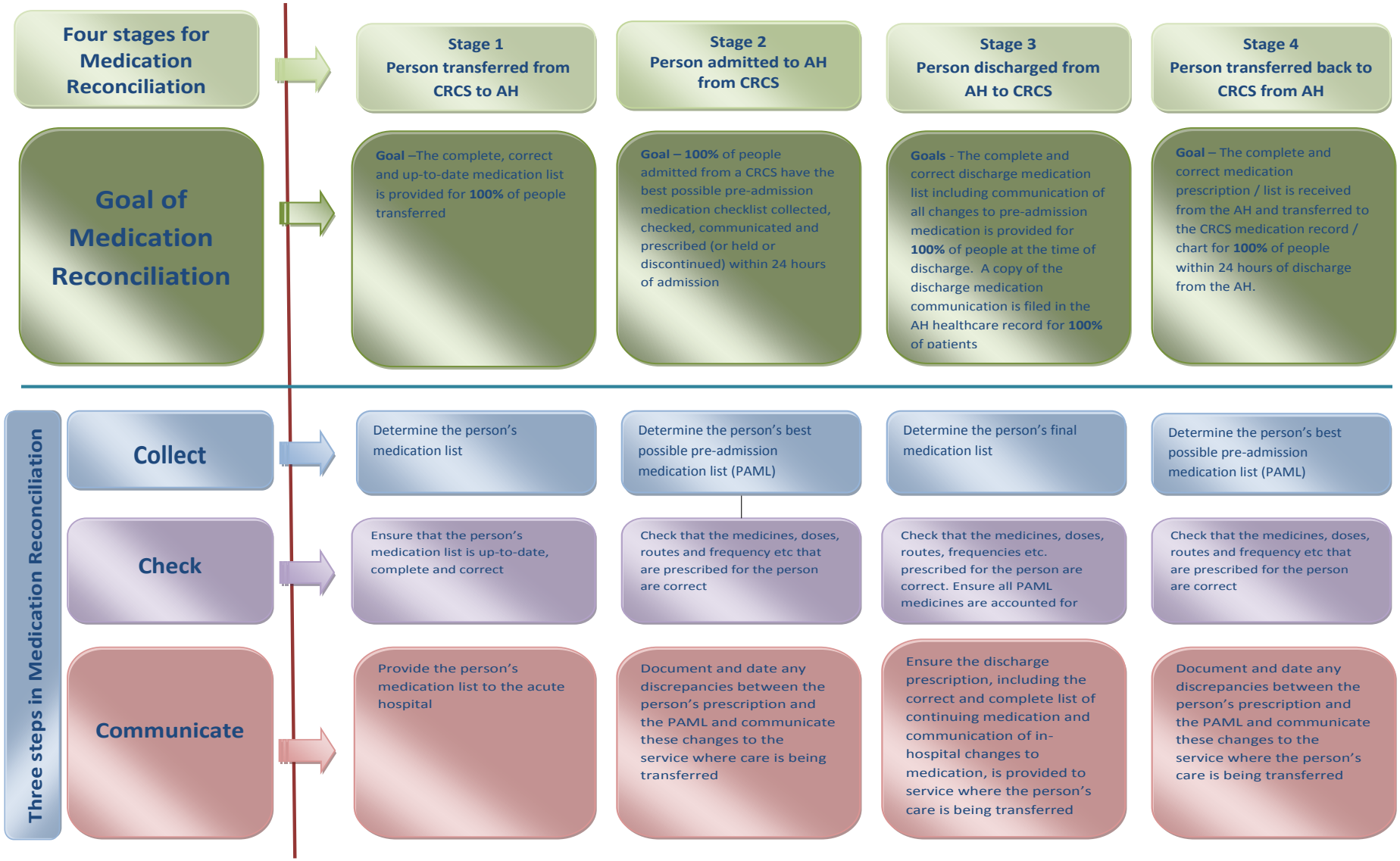
The findings from the baseline measurement exercise highlighted areas that nursing homes/community hospitals and acute hospitals could focus on to improve the overall medication reconciliation process.

The pilot nursing homes/community hospitals and acute hospitals subsequently implemented changes to improve their medication reconciliation processes using plan-do-study-act (PDSA) quality improvement cycles between July and December 2013.

Data from the baseline measurement exercise, and a review of the PDSA cycles undertaken by the pilot sites, highlighted further areas for learning during the 2013 medication reconciliation (MR) project.

Table 1. Medication reconciliation – four stages, goals and three steps:

Example of the transfer of a person from a community residential care setting (CRCS) to an acute hospital (AH) and discharge back to the community care setting (CRCS).



4. Learning points

This document outlines the learning from the medication reconciliation quality improvement project undertaken in 2013 and is intended to provide guidance on principles of good practice in medication reconciliation.

The learning points have been grouped around three areas of practice: organisation / structure, communication and documentation. Within each area principles of good practice derived from this project are listed below:

4.1 Organisational-level structure and process to underpin medication reconciliation (MR)

There is a need:

- for each service to review its own requirements for MR – i.e. to ask when and for whom MR is required, identify who completes the MR process, if it happens in/out of hours, what equipment/supplies are required to allow for efficient MR (such as pre-printed checklists, a photocopying facility that is accessible 24 hours a day and produces legible photocopied documents).
- to have an organisational policy and procedure in place on MR.
- for this policy to define a timeframe for completion of the MR process, for example within 24 hours of a person's entry to a hospital/nursing home/other care setting – regardless of the person's location within that setting, such as an emergency department or ward.
- to educate staff about the MR process.
- to define and implement the MR process/outcomes/policy and procedure review intervals.
- for continuous quality improvement. It is recommended that progress towards the goals of the MR process be tracked on an active and continuous basis (see Table 1 on page 10).

4.2 Communications around the MR process

- Service user/family involvement is paramount to the MR process. Generally the service user/family should be the first source of information for the MR process and this information can be verified with a second reliable source (such as a medication record from a residential care setting or community pharmacy or general practitioner). Where sufficient clarity is not achieved a third source may be required. Where the service user does

not have the capacity to provide medication information, or is in a residential care setting, the medication record from that setting may act as the first source of information.

- Provide service users/family with both verbal and written information about their medication regime and any changes made.
- An effective MR process involves regular direct communication between hospital pharmacy services, community pharmacy services, GP services, nursing homes, and other care settings as indicated by the location of the person at the time of MR.
- Regular communication helps build relationships between these stakeholders, which can serve to improve and sustain the MR process.
- 'Close the Loop' – when a person is transferred from a care setting, and the appropriate documentation is transferred with the person, the transferring service should call and speak to the receiving service to ensure that all documentation has been received, is complete and has been understood.
- Where complex or unusual prescription items are required for a person (for example, drugs requiring advance notice to the Primary Care Reimbursement Service, dispensed under the High-Tech scheme, unlicensed or off-label medications), where possible advance notice should be given to the receiving service to avoid delays in the person receiving the prescribed treatment.

4.3 Transfer documentation – checklist

- Use of a checklist to facilitate MR at transition points is advisable, such as at the point of transfer from a nursing home/social care setting to an acute hospital, or at the time of discharge from an acute hospital to a nursing home/social care setting.
- The availability of pre-printed service or ward-specific forms may facilitate the MR process.
- Suggested items for inclusion on a checklist are outlined in the table in section 5 below. Some of these items may not be relevant for your service or there may be additional items to include depending on the particular service setting and whether you are transferring or receiving care of a person. There are some examples of checklists included in Appendix 2 of this document, provided by nursing home, acute hospital and palliative care settings.

5. Items to consider for inclusion on a checklist to facilitate MR

Patient demographics and characteristics	**Other information required**
▪ name ▪ date of birth ▪ address ▪ allergy status ▪ note of swallowing difficulties, if any, and if liquid or crushed medicines are required ▪ date and time of transfer ▪ person completing checklist (signature).	▪ list of pages from medication record to include on transfer (see below) ▪ ensure all pages being sent as part of the transfer are numbered – i.e. page 1 of 4 etc. ▪ contact name and number of the prescriber ▪ contact names and numbers for relevant acute hospital (ward), nursing home, community pharmacy, GP.
Record of communication	**Pages from medication record to photocopy, number and send with patient**
▪ note of call made to receiving service to confirm they received the MR information sent ▪ time that MR was completed, and name and signature of person who completed it ▪ note of two sources of verification used for the MR process (i.e. patient/carer, medication record from residential setting, community pharmacy, GP, other) ▪ record of queries raised during MR process and resolution of same ▪ at discharge – note and rationale for new medications started or of changes to pre-admission medications.	▪ current regular medication list ▪ PRN medication (as required) list ▪ administration record of regular and PRN medications **up to point of transfer** ▪ three/six-monthly medications and when last administered ▪ include oxygen prescription and rate/nebulisers ▪ include nutritional supplements ▪ include anticoagulant dose and target international normalised ratio (INR) ▪ recent antibiotic history ▪ other medication history relevant to presenting complaint.

References

(1) *How-to Guide: Prevent Adverse Drug Events by Implementing Medication Reconciliation*. Cambridge: MA: Institute for Healthcare Improvement; 2011. Available online from: www.ihi.org. Accessed on: 7 March 2013.

(2) *Five Minute Guide Series: Medicines Reconciliation*. Available online from: http://www.npc.nhs.uk/improving_safety/medicines_reconciliation/resources/5mg_reconciliation.pdf.

(3) *Integrated Care Guidance: A practical guide to discharge and transfer from hospital*. Dublin: Ireland: Health Services Executive; 2014. Available online from: http://www.hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/integratedcareguidance/IntegratedCareGuidancetodischargefulldoc.pdf.

Additional resource:

Technical patient safety solutions for medicines reconciliation on admission to hospitals (PSG001) December 2007 (NICE Guideline). Available online from: http://guidance.nice.org.uk/PSG001

Appendix 1. Medication Reconciliation Project Advisory Group membership

Marie Kehoe-O'Sullivan	Chair, Director, Safety and Quality Improvement, HIQA
Ailis Quinlan	Head of Clinical Indemnity Scheme
Anne Marie Cushen	Chief II Pharmacist and Medication Safety Officer Beaumont Hospital
Brigid Doherty	Patient Focus
Ciara Kirke	Drug Safety Co-ordinator, Tallaght Hospital
Clare Mac Gabhann	Interim Director Nursing/Midwifery (Prescribing), HSE
Colin Bradley	Professor of General Practice, UCC
Christine Brennan	Department of Health
Denis O'Mahony	Consultant Geriatrician, CUH, Senior Lecturer in Medicine, UCC
Elaine O'Connor	Programme Manager, HIQA (resigned April 2014)
Kevin O'Carroll	Manager, Standards and Technology, HIQA
Mike Scott	(External Advisor) Head of Pharmacy and Medicines Management, Northern Health and Social Care Trust
Niamh Arthur	Pharmacovigilence Officer, Irish Medicines Board
Nuala Prendeville	Community Pharmacist, HSE West
Tamasine Grimes	Associate Professor, Faculty of Health Sciences, TCD
Tim Delaney	Head of Pharmacy, Tallaght Hospital/former National Lead, Medication Safety Programme, HSE

Appendix 2. Examples of checklists

See the following pages for four examples of checklists. (Please note that these checklists were produced by the pilot sites and not the Authority).

These checklists were developed by the pilot sites in the medication reconciliation project during 2013. The Authority is very grateful to these sites for their willingness to share their work:

1. **St Vincent's Hospital, Athy** – this checklist was developed to facilitate the medication reconciliation process when a person is transferred from the residential care setting for older people at St Vincent's to the acute care setting.

2. **Naas General Hospital to St Vincent's Hospital, Athy** – this checklist was developed to facilitate the medication reconciliation process when a person is transferred back to their residential care setting from Naas General Hospital.

3. **St Brendan's Community Nursing Unit, Loughrea, Co. Galway and Portiuncula Hospital, Ballinasloe, Co. Galway** – this two-page checklist was developed to support the medication reconciliation process between these two care settings, i.e. transfer from a residential care setting for older people to the acute setting at Portiuncula and the re-transfer back.

4. **Marymount University Hospital and Hospice** (St Patrick's Hospital) developed this checklist for when a person is transferred from hospice care to the acute setting

Examples of checklists

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

St. Vincent's Hospital, Athy, Co. Kildare
Oispidéal Naomh Uinseant, Áth í, Co. Chill Dara
Tel. 059 8643000 Fax. 059 8632024

PATIENT TRANSFER FORM

Name: _____ **Le Chéile Ward -** **Ext. No: 059 8643016**

Addressograph

Marital Status: _____ **Religion:** _____

N.O.K: _____ **Relationship:** _____ **Contact Phone No:** _____

Notified of Transfer: **Yes** **No** **Comment:** _____

Reason for transfer: _____

_____

Doctor's Letter enclosed: **Yes** **No** **K.Doc** / Doctor's Name: _____

Comments: _____

Past Medical/Surgical History: _____

_____

_____

Medication History: ***A photocopy of all current prescribed medication and administration records (see list below) must accompany the patient/resident.***

Front cover page of Medication Record	**Yes**	**No**
PRN Medication Sheet	**Yes**	**No**
Short term Drug Orders Sheet	**Yes**	**No**
Regular Drug Orders Sheet (s)	**Yes**	**No**
Drug Administration Record of drugs given on day of transfer	**Yes**	**No**
Warfarin Prescription/Administration Sheet	**Yes**	**No**
Long Acting Injection Prescription/Administration Sheet	**Yes**	**No**

Known Drug Allergies/Reactions: _____

_____

Braden Score ☐ **Date last completed**: _____

MMSE Score ☐ **Date last completed** _____

Examples of checklists

Barthel Activity of Daily Living Scale – Current Status					
		Score			Score
Bowels:	0- Incontinent 1-Occasional incontinence 2-Continent		**Mobility:**	0-Immobile 1-Wheelchair independent 2-Walks with the help of 1 person 3-Independent	
Bladder:	0-Incontinent or catheterised & unable to manage 1-Occasional accidents (max x 1 per 24 hrs) 2-Continent (for over 7 days)		**Dressing:**	0-Dependent 1-Needs Help 2-Independent	
Grooming:	0-Needs help 1-Independent		**Cooking/Feeding**	0-Unable 1-Needs Help 2-Independent	
Bathing:	0-Dependent 1-Independent		**Stairs:**	0-Unable 1-Needs Help 2-Independent	
Transfers:	0-Unable 1-Major help 2-Minor help 3-Independent		**Toilet Use:**	0-Dependent 1-Needs some help 2-Independent	

Total Score /20

Diet

Regular: Soft : Diabetic: Other:

Swallowing Difficulties? **Yes** **No**

Infectious Conditions / Current Status

MRSA Positive **Yes** **No** C.Diff Positive **Yes** **No** Other:

Comment: _____

_____

Falls Risk **Med** ☐ **High** ☐ **Falls Risk Programme in Place?** **Yes** **No**

Bed Alarm ☐ **Chair Alarm** ☐ **Low Bed** ☐ **Falling Star** ☐

Wounds _____

Comments: _____

Additional Information _____

_____

Signature: _____ **Date:** _____

Examples of checklists

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

St. Vincent's Hospital, Athy, Co. Kildare
Oispidéal Naomh Uinseant, Áth í, Co. Chill Dara
Tel. 059 8643000 Fax. 059 8632024

Patient/Resident's Transfer/Admission from Naas Hospital.

Medication Reconciliation Check List

Addressograph

Name: _____

Date of Transfer: _____ **Ward:**_____

Notified of Transfer: Yes No

Comment:_____

_____

Doctor's Transfer Letter enclosed Yes No

_____

_____

Medication History:

Medication Prescription sent back with Resident.	**Yes**	**No**	**N/A**
Changes to prescription documented	**Yes**	**No**	**N/A**
Rationale for any changes to prescription documented	**Yes**	**No**	**N/A**
Details of Drugs administered on day of transfer back to SVH.	**Yes**	**No**	**N/A**
Supply of medicines sent with resident	**Yes**	**No**	**N/A**

Prescribing in St Vincent's Hospital

Resident seen and admitted by hospital medical officer on day of admission	**Yes**	**No**
Medication review completed by SVH medical officer.	**Yes**	**No**
Medications accurately prescribed on to resident's Drug Kardex on day of admission	**Yes**	**No**

Signature: _____ **Date:** _____

Examples of checklists

St. Brendans Community Nursing Unit, Lake Road, Loughrea Co. Galway
Telephone No.: (091) 871200 Fax No(091) 847310

PATIENT MEDICATION ADMISSION CHECKLIST REFERRAL

Patient Name: (affix addressograph here)		**Retail Pharmacy Name:**
D.O.B.:	**Ward Name:** **Direct Tel. No.:**	
Chart No:	**Board No:**	**Contact No.:**
Weight (kg):	**Height (cm):**	

PHB STAFF ONLY - ADMISSION DATA: NOTE - All Pre-admission details below must be verified with the source and documented on page 3 of the Drug Chart.
Ensure to identify 2 sources and number as appropriate on the medication reconciliation section of the drug chart.
Indicate also if information received by Phone / Fax / Letter.
NOTE: Any discrepancies with regard to medications prescribed should be documented in Comments/ Communication section of the Drug Chart - pages 2 & 3.
If there is any discrepancy between the 2 sources used, a third source i.e. GP surgery may be required.
Sources should be made aware of any discrepancies in the medication history their facility provided.
Documentation should clearly explain this on page 3 in the medication reconciliation section of the drug chart.

Allergies/Sensitivities (please detail):

Please tick as appropriate:

- No swallowing difficulties ☐
- PO with swallowing problems - Tablet/capsules only (crushing required) ☐
  - Crushing & thickened liquids required ☐
- NG Tube ☐ PEG Feeding ☐ or Other ☐ Please specify: _____

CHECKLIST	√
Have all the active page numbers of drug chart been checked	
Copy of Medication chart checked to include (*tick to indicate you have checked each item below*):	
Front cover page of medication record	
Drug / Dose /Frequency/Route for all regular medications	
PRN medication	
Warfarin / Anticoagulants if applicable. Specify Indication_____ Target INR_____ Also last reading of INR: _____ & usual Warfarin dose _____	
Injectables - IV/IM/Subcut injections or infusions if applicable	
Inhalers/Nebules if applicable	
Patches if applicable Specify last administration time: _____	
Depot injections if applicable Specify last administration date: _____	
Topical if applicable Specify site of application:_____	
Eye/ear/nose if applicable Specify site of application:_____	
Feeds/Nutritional Supplements if applicable. Product: _____Frequency:_____	
Oxygen Therapy: Specify details - _____	
Double check of time that drugs were administered up to prior to transfer. **NOTE: Photocopy of kardex should indicate administration times . Specify last admin time Time: __**	
Previous recent antibiotic history if relevant for an infective admission (Note past 12 weeks particularly in the case of C.Diff infection)	

Relevant Comments:

Name of Pharmacist Med. Rec. on Admission:_____ **Date**: _____ **Time:** _____

Examples of checklists

Portiuncula Hospital, Ballinasloe, Co. Galway
Pharmacy Department Telephone No.: (090) 96 48221 Fax No(090) 96 48221
PATIENT MEDICATION DISCHARGE CHECKLIST REFERRAL

Patient Name: affix addressograph here)	**Chart No:** **Board No:**	**NB: PLEASE PHOTOCOPY & SEND A COPY BACK TO THE NURSING HOME**
D.O.B.:	**Consultant:**	**Ward Name:** **Direct Tel. No.:**
Weight (kg):	**Height (cm):**	**Discharge Date & Time:**

DISCHARGE DATA:
The following checklist should be used to ensure that all medication related discharge information is communicated to the Care Facility and the Retail Pharmacy as appropriate.

Allergies/Sensitivities (please detail):

Please tick as appropriate:

- No swallowing difficulties ☐
- PO with swallowing problems - Tablet/capsules only (crushing required) ☐
  - Crushing & thickened liquids required ☐
- NG Tube ☐ PEG Feeding ☐ or Other ☐ Please specify: _____

CHECKLIST	√
Copy of Discharge Prescription faxed to nursing home and retail pharmacy. Ensure number of active pages are clearly identified i.e. 1 of 2, 2 of 2.	
Tick to indicate you have checked each item below has been prescribed below on discharge	
Drug / Dose /Frequency/Route for all regular medications	
PRN medication	
Warfarin / Anticoagulants if applicable. **Attach a photocopy of relevant information if applicable**	
Injectables - IV/IM/Subcut injections or infusions if applicable	
Inhalers/Nebules if applicable	
Patches if applicable Specify last administration time: _____	
Depot injections if applicable Specify last administration date: _____	
Topical if applicable Specify site of application:_____	
Eye/ear/nose if applicable Specify site of application:_____	
Feeds/Nutritional Supplements if applicable	
Oxygen Therapy	
Indicate times that drugs were administered up to on the day of discharge. **NOTE: Discharge Prescription should clearly indicate all administration times for all drugs and clearly indicate drugs that are stopped or changed and the reason why.**	

Retail Pharmacy contacted if necessary. **Name:**	**Contact No.:**
Care Facility contacted if necessary. **Name:**	**Contact No.:**

Relevant Comments:

Name of Pharmacist Med. Rec. on Discharge:_____ **Date**: _____ **Time:** _____

Examples of checklists

Marymount
University Hospital & Hospice
Curraheen Road, Cork
Tel: 021-4501201
Fax: 021-4501619

Resident/Patient Transfer Form

Transferring To: _____ Date of Transfer: _____

Name: _____ Date of Birth: _____

Address: _____

Medical Card No: _____ Religion: _____

Marital Status: _____ Last Received Sacrament of the Sick on: _____

Admitted to St Patrick's Hospital for: Continuing Care Palliative Care Respite Care on .../.../...

Next of Kin: _____ Phone No: _____

Address: _____

Family Member Informed of Transfer: Yes No Name: _____

G.P: _____ Phone No: _____

Address: _____

Previous History: _____

_____

_____

MRSA Status: Positive □ Negative □ Not Known. □ Other Known Infections _____

Current Symptoms / Reasons for Transfer: _____

_____

_____

_____

_____

Medications (to include Nutritional Supplements)

All medications due today have been administered up until _____am/pm (see copy of drug chart enclosed)

With the exception of the follow:

1. _____ Last Given _____ 2. _____ Last Given _____
3. _____ Last Given _____ 4. _____ Last Given _____
5. _____ Last Given _____ 6. _____ Last Given _____

Examples of checklists

Mental State: _____

Skin: _____

Mobility: _____

Risk of Falling: Yes No **History of Wandering**: Yes □ No □ Not Known □

Sight: _____ Hearing: _____

Diet: _____

Assistance with Meals Required: Yes No Dentures: Yes No

Assistance with Personal Hygiene: Yes No

Continence: **Urine**: Yes No Occasional Incontinence **Faecal**: Yes No Occasional Incontinence
Catheterised: Yes No

Further Information: _____

Transfer check list:		**Yes**	**No**	Not applicab
1.	Photocopy and fax front cover and all completed pages of the drug chart to include:			
	PRN medications			
	Anticoagulant medications (e.g. warfrin)			
	Syringe driver prescriptions (on a separate CSCI prescription chart)			
	Patches (eg fentanyl) and date they are due to be next changed			
	Depot injections (and the date they are next due)			
	Antibiotics (past history where possible)			
2.	**Drs Transfer letter** (including printed name and contact number of prescribing Dr)			
3.	**A photocopy of DNAR form**			

Form Completed By:

Print name: _____ **Sign name:** _____ **Position:** RGN /other **Date:** _____

Transferring from: _____ Ward/Department, St Patrick's Hospital (Cork).

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For further information please contact:

Health Information and Quality Authority
Dublin Regional Office
George's Court
George's Lane
Smithfield
Dublin 7

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