Error Prevention
Measurement Methodology

January 1 to June 30, 2008
Version 9.0a
Updated for ICD-9 CM and CPT Code Changes Effective
January 1, 2008

Questions or comments can be directed to Bob Beaverson
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Changes to Error Prevention Methodology

January 1, 2008 to June 30, 2008

- No changes made to the CheckPoint Error Prevention Measurement Methodology. Changes made to ICD-9 CM codes and CPT codes for Measures #1 and #2 effective January 1, 2008.

July 1, 2007 to December 31, 2007

- No changes made to the CheckPoint Error Prevention Measurement Methodology. Next changes anticipated until early 2008 to incorporate changes to ICD-9 CM codes effective October 1, 2007 and updated CPT codes effective January 1, 2008.

January 1, 2007 to June 30, 2007

- ICD-9 codes, 55.54 bilateral nephrectomy and 66.63 bilateral partial salpingectomy, were deleted from the code list as they are bilateral procedures. CPT codes with a 50 modifier should also be excluded from surgical site marking lists since they are bilateral procedures.

- The Scoring Methodology has been changed so that only demonstrated success rates (DSR) will be reported for each measure. There is no longer a requirement as of January 1, 2007 to report whether:
  - a written document has been developed that includes all components of the goal;
  - the requirements of the written document have been implemented in all areas;
  - a compliance monitoring process is in place with the results reported to an oversight committee.

- Additional clarification has been provided to simplify dangerous abbreviation counting. In general, all instances of dangerous abbreviations being used correctly or incorrectly should be counted, regardless of the number of times they are written in an order.

- For Medication Reconciliation purposes, the home medication record should be considered reconciled if a patient is admitted and has no prescribed medications ordered prior to admission and is not currently taking any medications.

July 1, 2006 to December 31, 2006

- Updated Measure #1 and #2 ICD-9 and CPT code lists to include several new codes as well as corrections. See Addition column for changes.
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- Clarification: For audit purposes, there is a requirement to keep a list of the cases or medication orders used in the calculation of demonstrated success rates for 1 year after the end of the reporting period.

- Clarification: The direction to exclude surgical cases performed in a clinic was clarified. Cases should be excluded if they were performed in a clinic or other setting not managed by your hospital’s organization structure. If your hospital does not have the authority to enforce policies or standards in an area where surgical procedures are performed, these cases should be excluded from CheckPoint reporting.

- Appendix F – ICD-9 Codes for measures #1 and 2:
  - Reformatted the list to show the codes and the descriptions rather than the ranges
  - Removed duplicate ICD-9 codes 02.91 – 02.93 and clarified an overlapping range of codes, previously 84.00 – 84.99 and 94.91 to 84.00 to 84.69 and 84.91
  - Clarification: The procedure code can be either the principal or secondary procedure to qualify as a surgical case

- Appendix G – CPT Code list
  - Due to a new reporting requirement that hospitals need to submit CPT codes for outpatient surgical cases effective January 1, 2008, a CPT code list has been added for those hospitals who have moved to this new requirement.

- Additional guidance has been provided on whether to include laparoscopic surgeries or surgeries where interoperative imaging is used. In situations where the operative procedure involves an organ or structure with laterality, these cases should be included in the numerator and denominator of the demonstrated success rate for Measure #1, Site Marking.

- Clarification was given on what constitutes a medication order. If your hospital has a policy that excludes herbals, vitamins, and nutritional supplements as medication orders, these should not be counted for the purposes of Measure #3, Dangerous Abbreviations.

- Additional guidance has been provided on how to count medication abbreviations. Examples have been provided to ensure consistent counting by hospitals.

- The scoring for #3, Compliance Monitoring, has been changed for Measures #1, #2, and #3. If your hospital decides that CheckPoint reporting satisfies the need for compliance monitoring of these measures, you do not need to do additional compliance monitoring to score full points for this measure. However, you must report CheckPoint results to an oversight committee on a regular basis. The need for additional compliance monitoring is still required for Measure #6, Medication Reconciliation on Admission.

January 1, 2006 – June 30, 2006

- The term “safety goal” has been changed to “measure” except where a JCAHO goal is referenced. This standardizes the terminology in this document with the terms used on the CheckPoint Web site.
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- The data collection timeframe for all measures has been broadened to include the entire six months of the current data collection period.

- Measure #6:
  - Minimum number of required cases lowered for hospitals that have less than 75 cases in the six-month reporting period.
  - Clarification: A medication reconciliation form may be one or more forms that document your hospital’s medication reconciliation process in either a paper or electronic format.
  - Clarification: If after reasonable effort has been made, you are not able to accurately collect all required elements (name, dose, frequency and route) of a medication for the medication history, you can consider this medication reconciled if the corresponding order contains all four elements or the medication is addressed through other documentation.
  - Clarification: The prescriber does not need to state why a medication was not ordered, but must address all medications with an order or documentation that the medication was addressed. For example, documentation that a medication was addressed would be a hold or discontinuation statement in the provider notes.
  - Reduce to one the number of signatures required indicating that the reconciliation process is complete.

- Appendix F – ICD9 Codes for measure #1 and #2 updated.

July 1, 2005 – December 31, 2005

- Measure # 1 & 2:
  - Minimum number of required cases lowered for hospitals that have less than 75 cases in the six month reporting period.

- Measure # 5:
  - Eliminated measure “Ensure free-flow protection on all general-use PCA and intravenous pumps used in the organization” because of 100% achievement of the goal by all participating hospitals.

- Measure # 6:
  - Added measure “Medication Reconciliation upon admission.”

- Appendix F – ICD9 Codes for measures #1 and 2 deleted
  - Nail bed debridement: 86.27
  - Laceration suturing:
    - 02.11 33.43 66.71
    - 03.59 34.71 81.93-81.96
    - 04.3 34.72 82.41
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January 1, 2005 – June 31, 2005

- **Measure #2:***
  - Added to the verification process “the correct position(s) and ensuring the availability of correct implants and any special equipment or special requirements.”
  - Clarification – the verification process should be implemented in all relevant patient care areas. This includes any unit where procedures are conducted, such as in radiology, emergency department, cath lab, etc.

- **Measure #3, added:***
  - If a registered nurse or pharmacist contacts the physician for clarification of a dangerous abbreviation prior to giving the medication, the order should be counted as INCORRECT.”
  - Do include orders for intravenous fluids for hydration or nutrition.
  - Do include orders for separate or “IV piggy-back” medication.
  - Orders with a dosage range, such as “Oxycodone 5-10 mg” or sliding scale insulin count as one order. In this situation, you should count this order as 1 towards your 300-order minimum, and then count each use of one of the 9 JCAHO dangerous abbreviations in your numerator and denominator.
  - In a list of pre-printed orders where only some of the orders are checked, the non-checked orders do not count.

- **Appendix F – ICD9 Codes for Measures #1 and 2 - Removed the following codes:**
  - 03.90 – 03.99 Other operations on spinal cord
  - 30.3 Complete laryngectomy
  - 31.1 Temporary tracheostomy
  - 31.29 Permanent tracheostomy
  - 31.42 Laryngoscopy / tracheoscopy
  - 31.74 Revision of tracheostomy
  - 31.99.1 Other tracheostomy operations
  - 34.91 Thoracentesis
  - 38.91 Arterial catheter insertion
  - 39.50 – 39.59 Other repair of vessels
  - 41.02-41.04 Bone Marrow Transplant
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<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.31</td>
<td>Bone Marrow biopsy</td>
</tr>
<tr>
<td>86.06</td>
<td>Insertion of infusion pump</td>
</tr>
<tr>
<td>86.22</td>
<td>Excise debridement of wound</td>
</tr>
</tbody>
</table>
The error prevention measures included in the CheckPoint quality public reporting program reflect a sub-set of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goals. This document includes a brief overview of each goal, as well as the measure specifications that the Wisconsin Hospital Association (WHA) will be using to measure progress towards the JCAHO goals selected for public reporting. WHA makes no claim to be the authority on the JCAHO national patient safety goals. To obtain additional information regarding the purpose and specific requirements of the JCAHO national patient safety goals, please refer to the JCAHO website, www.jcaho.org or contact your JCAHO representative.

**Scoring**

The score for each measure will consist of one component, the demonstrated success rate (DSR) worth a maximum of 100 points.

<table>
<thead>
<tr>
<th>Components</th>
<th>Response Options</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR): varies by measure</td>
<td>Collected Rate</td>
<td>0-100</td>
</tr>
</tbody>
</table>
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**Data Collection and Reporting**

The following pages contain general information about each error prevention measure, as well as detailed instructions on how to collect the Demonstrated Success Rate. In addition, data collection worksheets are provided in Appendix B, C and E to assist in recording your information.

Your hospital’s data will be collected through the CheckPoint Hospital Administration site provided by WHA. If you do not have security access to this site, please contact Brian Competente at 608-274-1820 or bcompetente@wha.org. The error prevention measures data entry portion of the CheckPoint Hospital Administration site has a format similar to the data collection worksheet included in this document. Therefore, if you use the data collection worksheet to record your information as you gather it, entering the data into the CheckPoint Hospital Administration site should require minimal additional time.

**Data Due Date**

All data should be collected and entered into the CheckPoint Hospital Administration site by August 29, 2008.

**Auditing and Record Retention Requirements**

Participating hospitals are randomly selected every 6 months for the CheckPoint error prevention audit. If your hospital is selected, you will be contacted by WHA.

The purpose of the audit is to assess your hospital’s compliance to the CheckPoint Error Prevention Measurement Methodology and will focus on the verification of the demonstrated success rates for each measure. **For audit purposes, it is important you retain a list (audit trail) of the cases or medication orders used for the calculation of each measure’s demonstrated success rates for 1 year after the reporting period end date.**

**Questions and Comments**

Questions or comments regarding this publication may be directed to Bob Beaverson, Director of Quality, WHA, at 608-274-1820 or mailto:Bbeaverson@wha.org.

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CheckPoint Error Prevention Measurement Methodology

ERROR PREVENTION MEASURE #1: IMPLEMENT A PROCESS TO MARK THE SURGICAL OR INVASIVE PROCEDURE SITE AND INVOLVE THE PATIENT IN THE MARKING PROCESS

General Information

Marking the site is required for operative and invasive procedures involving right/left distinction, multiple structures (i.e. fingers), or levels (i.e. spinal procedures). Site marking is not required for other procedures, including but not limited to, midline sternotomy, cesarean section, laparotomy and laparoscopy, cardiac catheterization and other procedures where the site is not predetermined. The surgical site will be marked for laparoscopic cases that involve operating on organs with laterality. The marking must be done near the proposed site or near the proposed incision/insertion site and will indicate the correct side. Procedures done through or immediately adjacent to a natural body orifice (i.e. dental or GI procedures) or situations in which marking the site would be technically impractical are exempt.

For surgeries where interoperative imaging is used, the surgical site will be marked for those cases involving organs or structures with laterality. For spinal surgeries, a two step process is required. Preoperatively, the skin is marked at the level of the procedure (e.g. cervical, thoracic, or lumbar) and the skin mark indicates anterior vs. posterior and left vs. right. Intraoperatively, intraoperative x-rays with immovable marker(s) will be used to determine the exact location and level of surgery.

The JCAHO goal for this measure does not specify who should mark the site, but does require that the patient be involved in this process. This implies that there is a process in place to educate the patient (written or verbal) regarding their role in marking the site. Furthermore, site marking should occur before the patient is significantly sedated. In cases of non-speaking, comatose or incompetent patients, or minor children, the person who has the authority to provide informed consent should be educated and participate in marking the site.

When marking the site, only the operative site should be marked. Marking the non-operative site is not allowed. The site should be marked in a manner where the intent is clear. It is recommended that a line indicating the intended site of incision, the surgeon’s initials, or the word “yes” be used. Please refer to the JCAHO Universal Protocol For Preventing Wrong Site Surgery (Appendix D) for additional details on how to implement this goal.

Demonstrated Success Rate (DSR) Collection Process

The demonstrated success rate for this measure can be obtained through retrospective case review or concurrent observation.

Note: You may use the same cases to collect the data for measures #1 and 2 to reduce the burden of data collection. It should be noted that the JCAHO requirement related to measure #2 includes more cases than those being used for this data collection.
CheckPoint Error Prevention Measurement Methodology

Numerator: Number of surgical and invasive procedures where the surgical site was marked prior to incision and the patient was involved in the marking

Denominator: Total number of surgical and invasive procedures reviewed/observed

X 100

Specifications

- This measure applies to all surgical and invasive procedures that meet the JCAHO requirement for site marking as defined by the Universal Protocol For Preventing Wrong Site Surgery. For the purpose of this data collection, you should include surgical and invasive procedures from the following patient care areas as they apply to your organization.
  - Inpatient surgery
  - Ambulatory/same day surgery
  - Observation patients
  - Outpatient surgery and procedures performed in the hospital setting

You should not include surgical and invasive procedures performed in a clinic setting or other units that are not managed within your hospital’s organizational structure.

- The minimum number of cases that should be included in this sample is 75.
  - If a case includes more than one procedure that meets the requirement for site marking, each procedure may be counted separately towards the 75 case minimum.
  - Hospitals that have more than 75 cases, whether you are sampling or not, must submit at least 75 cases. You may choose to use a larger sample size than is required. If you do so, you must report on all cases in your sample.
  - Hospitals that do not have 75 cases in 6 months, may submit data as long as you have at least 30 cases. In this situation, you should submit all cases that meet the criteria.
  - Hospitals that do not have at least 30 cases in the six-month data collection period, should not report results to CheckPoint for that six-month period.

- Cases used for this measure include procedures with ICD-9-CM Procedure listed in Appendix F or CPT codes listed in Appendix G.

- The case has the ICD-9 or CPT code listed as either a principal or secondary procedure.

- Cases should be identified from discharges that occurred between 01/01/2008 and 06/30/2008.
CheckPoint Error Prevention Measurement Methodology

Data Collection

Retrospective Review

Retrospective case review includes data that is documented in the patient record, internal use form(s), or databases, and reviewed at a later date. The distinguishing characteristic of retrospective case review is that the information is documented at the time of the site marking and reviewed at a later date.

If you have at least 75 cases, but less than 149 cases: Take the total number of cases and subtract 75. This will give you the number of cases that can be removed from your population. Divide the total number of cases in your population by the number of cases that can be removed from your population. Round down to the nearest whole number to identify the \( n \)th patient. Remove every \( n \)th patient from your population.

Example: Total number of cases = 90 cases

Step 1: 90 cases –75 case minimum =15 additional cases
Step 2: 90 cases / 15 additional cases = 6 (round down if needed)
Step 3: Remove every 6th case from your population to create your sample

If you have at least 150 cases: Take the total number of cases in your population and divide by 75. Round down to the nearest whole number to identify the \( n \)th patient. Select every \( n \)th patient for inclusion in your population.

Example: Total number of cases = 359

Step 1: 359 cases /75 case minimum = 4.79 (Round down to 4)
Step 2: Select every 4th case from your population to create your sample

Concurrent Observation or Collection

If your hospital does not have a process to document site marking in the patient record or chooses to do concurrent data collection, you will need a process to determine if the surgical site was marked with the patient’s input prior to the start of the procedure. To do this, you should identify a consistent time in the surgical process and a consistent staff role to conduct the review and document the results.

You will need to estimate the number of cases you expect to have in six months based on previous average caseload per month. Refer to procedures with ICD-9-CM procedure codes listed in Appendix F or the CPT codes listed in Appendix G.
ERROR PREVENTION MEASURE #2: PRIOR TO THE START OF ANY SURGICAL OR INVASIVE PROCEDURE, CONDUCT A FINAL VERIFICATION PROCESS TO CONFIRM THE CORRECT PATIENT, PROCEDURE(S), SITE(S), POSITION, AND EQUIPMENT USING ACTIVE COMMUNICATION TECHNIQUES

General Information

The object of this JCAHO goal is to engage all members of the surgical team in the identification of the patient, the intended procedure(s), the site(s) of the procedure(s), the correct position(s) and ensuring the availability of correct implants and any special equipment or special requirements. “Active” communication is an affirmation that the patient, procedure(s), site(s), and position are all correct, and ensuring the availability of correct implants and any special equipment or special requirements. It is not expected that the patient will participate in this verification process since the patient may be sedated or under anesthesia. Please refer to the JCAHO Universal Protocol For Preventing Wrong Site Surgery (Appendix D) for additional details on how to implement this goal.

Demonstrated Success Rate (DSR) Collection Process

The demonstrated success rate for this measure can be obtained through retrospective case review or concurrent observation.

Note: You may use the same cases to collect the data for measures #1 and 2 to reduce the burden of data collection. It should be noted that the JCAHO requirement related to measure #2 includes more cases than those being used for this data collection.

Numerator = Number of procedures where a verification process occurred to confirm the correct patient, procedure(s), site(s), position and availability of equipment

Denominator = Total number of surgical and invasive procedure reviewed/observed

Specifications

- This measure applies to all surgical and invasive procedures that meet the JCAHO requirement for a verification process as defined by the Universal Protocol For Preventing Wrong Site Surgery. For the purpose of this data collection, you should include surgical and invasive procedures from the following patient care areas as they apply to your organization.
  - Inpatient surgery
  - Ambulatory/same day surgery
  - Observation patients
  - Outpatient surgery and procedures performed in the hospital setting
CheckPoint Error Prevention Measurement Methodology

You should not include surgical and invasive procedures performed in a clinic setting or other units that are not managed within your hospital’s organizational structure.

- The minimum number of cases that should be included in this sample is 75.
  - Hospitals that have more than 75 cases, whether you are sampling or not, must submit at least 75 cases. You may choose to use a larger sample size than is required. If you do so, you must report on all cases in your sample.
  - Hospitals that do not have 75 cases in 6 months, may submit data as long as you have at least 30 cases. In this situation, you should submit all cases that meet the criteria.
  - Hospitals that do not have at least 30 cases in the six-month data collection period, should not report results to CheckPoint for that six-month period.

- Cases used for this measure include procedures with ICD-9-CM procedure codes listed in Appendix F or CPT codes listed in Appendix G.

- The case has the ICD-9 or CPT code listed as either a principal or secondary procedure.

- Cases should be identified from discharges that occurred between 01/01/2008 and 06/30/2008.

Data Collection

Retrospective Review

Retrospective case review includes data that is documented in the patient record, internal use form(s), or databases, and reviewed at a later date. The distinguishing characteristic of retrospective case review is that the information is documented at the time the verification process occurs and is reviewed at a later date.

If you have at least 75 cases, but less than 149 cases: Take the total number of cases and subtract 75. This will give you the number of cases that can be removed from your population. Divide the total number of cases in your population by the number of cases that can be removed from your population. Round down to the nearest whole number to identify the nth patient. Remove every nth patient from your population.

Example: Total number of cases = 90 cases

Step 1: 90 cases – 75 case minimum = 15 additional cases
Step 2: 90 cases / 15 additional cases = 6 (round down if needed)
Step 3: Remove every 6th case from your population to create your sample

If you have at least 150 cases: Take the total number of cases in your population and divide by 75. Round down to the nearest whole number to identify the nth patient. Select every nth patient for inclusion in your population.

Example: Total number of cases = 359
Step 1:  359 cases / 75 case minimum = 4.79 (Round down to 4)
Step 2:  Select every 4th case from your population to create your sample

**Concurrent Observation or Collection**

If your hospital does not have a process to document the verification process or prefer to do concurrent data collection, you will need a process to determine if a complete verification process occurred. To do this, you should identify a consistent time in the surgical process and a consistent staff role to conduct the review and document the results.

You will need to estimate the number of cases you expect to have in six months based on previous average caseload per month. Refer to procedures with ICD-9-CM procedures listed in Appendix F or CPT codes listed in Appendix G, both available as separate documents.
CheckPoint Error Prevention Measurement Methodology

ERROR PREVENTION MEASURE #3: STANDARDIZE THE ABBREVIATIONS, ACRONYMS AND SYMBOLS USED THROUGHOUT THE ORGANIZATION, INCLUDING A LIST OF ABBREVIATIONS, ACRONYMS AND SYMBOLS NOT TO USE

General Information

The objective of this JCAHO goal is to eliminate ambiguous or otherwise dangerous forms of notation from all health care documentation. This implies standardization of all abbreviations, acronyms and symbols including a “do not use” list. To focus data collection and reporting for this survey, we will be targeting communication about medications only. The scope of review for this survey includes the minimum list of nine dangerous abbreviations, acronyms and symbols required by JCAHO beginning January 1, 2004 (Appendix A).

Demonstrated Success Rate (DSR) Collection Process

The demonstrated success rate for this measure is derived through a review of medication orders. For the purpose of this measure, evaluation is limited to the 9 JCAHO dangerous medication abbreviations, acronyms and symbols, including unacceptable methods of expressing dosage, route, frequency and time.

Numerator: Number of times one of the 9 JCAHO dangerous abbreviations is written correctly within the medication orders reviewed

\[ \times 100 \]

Denominator: Total number of times one of the 9 JCAHO dangerous abbreviations is written correctly and incorrectly within the medication orders reviewed

Specifications

- The medication orders to be reviewed for this goal may be obtained from the patient record after discharge or collected at the time of service.

- The sample period is chosen by the hospital and is defined as a consecutive 24-hour period between 01/01/2008 and 06/30/2008.

- The orders used for this data collection includes all medication orders in a designated 24 hour period. You will need to choose the 24-hour period for data collection.

- Medication orders including herbals, nutritional supplements, homeopathic remedies etc. if your hospital has a policy to count these as medication orders.
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- The minimum number of medication orders in the sample is 300 orders. If less than 300 orders are received in the designated 24 hour period, the review should continue for consecutive 24 hour periods until a total of 300 medication orders are collected and reviewed. If you believe that you will not have 300 medication orders in a 24 hour period, be sure that you select a 24 hour period from within the six month data collection timeframe that will allow you to carry the data collection over for an additional 24 hour period(s).

- All medication orders count towards the 300-order minimum, not just those orders that include one or more of the 9 JCAHO dangerous abbreviations.

- Not all medication orders that are reviewed will include one of the 9 JCAHO dangerous abbreviations. In this situation, you may count this medication order towards your 300-order minimum, but will not include this order in the numerator or denominator.

- Some medication orders will contain more than one of the 9 JCAHO dangerous abbreviations. In this situation, you should count this order as 1 towards your 300-order minimum, and then count each use of one of the 9 JCAHO dangerous abbreviations in your numerator and denominator.

- Computerized, pre-printed and handwritten medication orders should be included in the sample.

- If a registered nurse or pharmacist contacts the physician for clarification of a dangerous abbreviation prior to giving the medication, the order should be counted as incorrect.

- Do include orders for intravenous fluids for hydration or nutrition.

- Do include orders for separate or “IV piggy-back” medication.

- Orders with a dosage range, such as “Oxycodone 5-10 mg” or sliding scale insulin count as one order.

**Counting Instructions**

As a general rule, count all instances in the numerator and denominator, number and word abbreviations being used and count all correct instances of number and word abbreviations in the numerator only. Simple rules of thumb for counting these abbreviations:

- Count all abbreviations, even if the same abbreviation is used multiple times in the same order, such as a sliding scale insulin order;
- Remember to count number abbreviations used correctly;
- Don’t count more than the 9 JCAHO dangerous abbreviations.
Specific Counting Instructions:

For all numbers used in dosages, count 1 in the numerator and the denominator:
- Lack of trailing 0’s after the decimal point (X.0mg)
- Use of a leading 0 before a decimal point (0.X mg)

Do not include other fractions that have trailing 0’s not immediately following the decimal point:
- Do not count other fractions which would not have a trailing 0 i.e. 2.5, 3.25 etc.

Count 1 in the numerator and the denominator all instances of proper abbreviations for daily - “Q”:
- Count 1 in the numerator and the denominator all correct abbreviations for daily or once daily including Q Day, Q Daily, Q 24 hours, Q every other day, word “daily” used as an adjective i.e. daily supplement
- Do not count Q am, Q pm in the numerator or the denominator. These are not on the dangerous abbreviations list.

Count all correct abbreviations used in sliding scale orders:
- Count in the numerator and the denominator all instances of the 9 dangerous abbreviations being used correctly including numbers and “units” being spelled out properly.

Don’t count abbreviations above and beyond the 9 dangerous abbreviations:
- Don’t count other abbreviations your hospital decided to add to the list above and beyond the 9 JCAHO dangerous abbreviations specified in the CheckPoint Error Prevention Methodology

Preprinted order sheets with selections:
- Only count the orders that have been selected if the form allows for selection.
- Count 1 in the numerator and the denominator all instances of dangerous abbreviations being used correctly

Counting Examples

Insulin – S Scale

<table>
<thead>
<tr>
<th>Range</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 120 mg/dl</td>
<td>0 units</td>
</tr>
<tr>
<td>121 – 150</td>
<td>2 “”</td>
</tr>
<tr>
<td>151 – 200</td>
<td>4 “”</td>
</tr>
<tr>
<td>201 – 250</td>
<td>6 “”</td>
</tr>
<tr>
<td>301 – 350</td>
<td>8 “”</td>
</tr>
<tr>
<td>351 – 400</td>
<td>10 “”</td>
</tr>
<tr>
<td>&gt; 401</td>
<td>call</td>
</tr>
</tbody>
</table>
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Count 1 order.
Count 6 correct instances of whole numbers not followed by trailing 0’s in the numerator and the denominator. 0 was counted for simplicity and ease of application despite the fact a trailing 0 would not normally be used when 0 is used. Lab values are excluded from counting as they can contain trailing 0’s after the decimal point to indicate precision.
Count 1 instance of “units” being written out correctly in the numerator and the denominator.

Carvedilol 6.25 Mg Oral Tablet

- Count 1 order
- No dangerous abbreviations used

Coumadin 2.5 mg po daily

- Count 1 order
- Count 1 in the numerator and the denominator the instance of correct daily abbreviation (daily written out) being used

Azithromycin 500 mg PO q 24 hours

- Count 1 order
- Count 1 in the numerator and the denominator the instance of a whole number (500) not followed by a trailing 0 and 1 in the numerator and the denominator the correct use of acceptable daily abbreviation

Prenatal vitamins 1 tablet PO daily supplement

- Count 1 order
- Count 1 in the numerator and the denominator the correct use of daily
- Count 1 in the numerator and the denominator the correct use of a number not followed by a lagging 0

Wellbutrin XL Q AM

- Count 1 order
- No dangerous abbreviations used

Thiamine 10 mg Q day

- Count 1 order
- Count 1 in the numerator and the denominator the instance of a whole number (10) not followed by a trailing 0 and 1 in the numerator and the denominator the correct use of acceptable daily abbreviation (Q day)
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Data Collection

- Designate a 24-hour period between 01/01/2008 and 06/30/2008.
- Collect all medication orders written in the designated 24-hour period.
- Review all medication orders received during the designated 24-hour period.
- If less than 300 orders are received in the designated 24 hour period, the review should continue for consecutive 24 hour periods until a total of 300 medication orders are reviewed.
- Document your results using the Dangerous Abbreviation Data Collection Tool (Appendix C).
CheckPoint Error Prevention Measurement Methodology

ERROR PREVENTION MEASURE #4: REMOVE CONCENTRATED ELECTOLYTES (POTASSIUM CHLORIDE, POTASSIUM PHOSPHATE, SODIUM CHLORIDE>0.9%) FROM PATIENT CARE UNITS

General Information

This measure relates to the JCAHO goal to remove “high alert” medications, including but not limited to concentrated electrolytes from patient care units. Although JCAHO allows each hospital to determine which “high alert” medications should be removed, for the purpose of this data collection, you should limit your review and data collection to concentrated potassium chloride, potassium phosphate and sodium chloride >0.9% only.

On patient care areas where it is clinically indicated to use any of these three concentrated electrolyte preparations or multiple concentrations of a drug are necessary, access to these solutions should be strictly controlled with appropriate precautions in place to avoid its being mistaken for other similar packaged solutions. Examples of appropriate precautions include: 1) a requirement that high alert medications are not removed from floor stock or automated dispensing cabinets before a pharmacist reviews the specific patient order and screens the order for safety or 2) that medications stocked in patient care units are in ready-to-use unit dose form (no bulk supplies).

Demonstrated Success Rate (DSR) Collection Process

The demonstrated success rate for this measure is created based on your hospitals organizational structure using the following formula.

\[
\text{Numer} \quad \frac{\text{Number of units that do not have potassium chloride, potassium phosphate and sodium chloride >0.9% in stock plus the number of units that have appropriate safeguards in place}}{\text{Denominator} \quad \text{Total number of patient care units}} \times 100
\]

Specifications

- Count all individual patient care units within your hospital. This number will be your denominator. You should include all patient care areas that are included in your organizational structure that provide continuous, as well as episodic care. This may include the following:
  - Inpatient units – count separately each intensive care unit, step down unit, medical/surgical unit and rehabilitation unit.
  - Operating suite – count separately a pre-operative care unit, surgical unit and post-anesthesia unit.
  - Emergency care unit.
CheckPoint Error Prevention Measurement Methodology

- Ambulatory/day surgery unit if managed under the hospital’s organizational structure.
- Dialysis unit if managed under the hospital’s organizational structure.
- Outpatient procedure units if managed under the hospital’s organizational structure.

Do not include clinic sites or other units that are not managed within your hospital’s organizational structure.

- Observe or obtain information on whether each unit included in the denominator currently stocks concentrated potassium chloride, potassium phosphate, sodium chloride > 0.9%. Include in your numerator:
  - All units that do not have concentrated potassium chloride, potassium phosphate, sodium chloride > 0.9% in their floor stock.

  Plus

  - All units where concentrated potassium chloride, potassium phosphate, sodium chloride > 0.9% are clinically necessary and access is strictly controlled through a defined process to avoid errors (i.e. operating suite, pediatric unit, dialysis unit, etc.).
CheckPoint Error Prevention Measurement Methodology

ERROR PREVENTION MEASURE #6: MEDICATION RECONCILIATION UPON ADMISSION

General Information

Medication reconciliation is a formal process of obtaining a complete list of each patient’s current home medications including name, dosage, frequency and route, and comparing the physician’s admission, transfer and discharge orders to that list. Discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders. Any resulting changes in orders are documented. This process involves three steps:

- Verification (collecting the medication history);
- Clarification (ensuring that the medications and doses are appropriate); and
- Reconciliation (documenting changes in the orders).

Demonstrated Success Rate (DSR) Collection Process

The demonstrated success rate for this measure is derived through case review. For the purpose of this measure, we will only collect data about the medication reconciliation process on admission. JCAHO requires that medications be reconciled on admission, at all transfer points in a hospitalization, and upon discharge.

Numerator Number of cases that have a complete medication reconciliation form in their medical record within 48 hours of admission

Denominator Total number of cases reviewed

Specifications

- The medication reconciliation form may be one or more forms that document your hospital’s medication reconciliation process in either a paper or electronic format.

- A medication reconciliation form is complete when:
  - All data elements required by your policy are completed on the form. (record on Medication Reconciliation Data Collection Form, column D)
    - The following data elements should be included for each medication. If after reasonable effort has been made you are not able to accurately collect the top four elements (name, dose, frequency, and route) of a medication for the medication history, you can consider this medication reconciled if the corresponding order contains all data elements or the medication is addressed through other documentation.
      - Name
      - Dose
**CheckPoint Error Prevention Measurement Methodology**

- Frequency
- Route
- Indicator of reconciliation status (many organizations break this indicator down into options like ordered, held, discontinued, etc. to enhance communication to the care team)

- If you have fields on your medication reconciliation form that are not required by your policy and are not completed, you can count this form as having all required fields completed.

  - All medications are reconciled with a medication order or there is documentation that the medication was addressed. For example, documentation that a medication was addressed would be a hold or discontinuation statement in the provider notes. *(record on Medication Reconciliation Data Collection Form, column E)*
  - One signature is present indicating that the reconciliation process is complete *(record on Medication Reconciliation Data Collection Form, column F)*. This signature can be from any discipline (i.e. nurse, physician, pharmacist, etc.).

- All medications listed on the patient’s current home medication record should be reconciled

  - This includes but is not limited to prescription, over-the-counter, and homeopathic medications, as well as vitamins, herbal supplements, and medications taken on an “as needed” (PRN) basis.
  - If your organization has a policy that excludes over-the-counter medications, homeopathic medications, vitamins, herbal or nutritional supplements from the medication reconciliation process, you may consider these medications reconciled for the purpose of this data collection.

- If no medications have been prescribed for the patient prior to admission and the patient is not on any medications as defined by the hospital’s policy, you should count the home medication record as reconciled for this data collection.

- If a medication is listed on the patient’s current home medication record but no inpatient medication order is written for this medication, you should count this order as reconciled if there is documentation in the patient’s record that the medication was addressed.

- If a medication is listed on the patient’s current home medication record and no inpatient medication order or documentation exists, but the medication is contraindicated for the patient’s admitting condition(s), you can consider that medication reconciled. For example, a patient is admitted for bleeding associated with anticoagulation. Warfarin is not ordered on admission. Since the reason the medication is not ordered is clinically obvious, you can assume that it was intentionally discontinued and consider this medication reconciled.

- If the physician’s admitting order indicates that the patient is NPO and no medications are ordered, all medications listed on the patients current home medication record should be considered reconciled for this data collection.
CheckPoint Error Prevention Measurement Methodology

Note: These medications should be reconciled when the patient is no longer NPO.

Data Collection

- The minimum number of cases that should be included in this sample is 75.
  - Hospitals that have more than 75 cases, whether you are sampling or not, must submit at least 75 cases. You may choose to use a larger sample size than is required. If you do so, you must report on all cases that you include in your sample.
  - Hospitals that do not have 75 cases in 6 months, may submit data as long as you have at least 30 cases. In this situation, you should submit all cases that meet the criteria.
  - Hospitals that do not have at least 30 cases in the six-month data collection period, should not report results to CheckPoint for that six-month period.

- Use inpatient admission date and time to determine the 48-hour window.

- **Inclusion criteria** - All patients admitted for inpatient services that receive medications during this hospitalization should be include in this data collection. This includes patients admitted through your emergency room, as well as patients that are admitted directly to your hospital.

- **Exclusion criteria**
  - Patients with an inpatient length of stay based on admit date and time of < 48 hours
  - Patients that are unresponsive on admission or shortly thereafter, where you cannot obtain a medication history from another competent source (i.e. family, long term care facility, home health agency, etc.)
  - Newborn born during that admission

- Cases should be identified from discharges that occurred between 01/01/2008 and 06/30/2008.

Retrospective Review

**If you have at least 75 cases, but less than 149 cases:** Take the total number of cases and subtract 75. This will give you the number of cases that can be removed from your population. Divide the total number of cases in your population by the number of cases that can be removed from your population. Round down to the nearest whole number to identify the $\text{nth}$ patient. Remove every $\text{nth}$ patient from your population.

Example: Total number of cases = 90 cases

Step 1: 90 cases – 75 case minimum = 15 additional cases
Step 2: 90 cases / 15 additional cases = 6 (round down if needed)
Step 3: Remove every 6th case from your population to create your sample
CheckPoint Error Prevention Measurement Methodology

**If you have at least 150 cases:** Take the total number of cases in your population and divide by 75. Round down to the nearest whole number to identify the $nth$ patient. Select every $nth$ patient for inclusion in your population.

Example: Total number of cases = 359

Step 1: 359 cases /75 case minimum = 4.79 (Round down to 4)
Step 2: Select every 4$^{th}$ case from your population to create your sample

**Concurrent Observation or Collection**

If your hospital chooses to do concurrent data collection, you will need a process to determine if the medication process was completed within 48 hours of admission. You will also need to estimate the number of cases you expect to have in six months based on previous average caseload per month.
**Checkpoint Error Prevention Measurement Methodology**

**ADDITIONAL DATA COLLECTION: PATIENT INITIATION OF THE MEDICATION RECONCILIATION PROCESS**

Wisconsin has several initiatives including Safe Care Wisconsin, the Madison Patient Safety Collaborative and the Milwaukee Patient Safety Collaborative that are implementing tools to help consumers track and communicate their medications to health care providers. Your organization may be doing something similar. Consumer tools include things like a bag to keep medications in, a wallet card or other lists that track medications, etc. We have been asked to measure Wisconsin’s progress with these efforts. **This data collection is optional, but your participation is needed so that we have enough information to track improvement in the state.**

This data will not be reported on the CheckPoint public Web site. The information will be shared using regional and state aggregates only.

The data will answer the question “Did the patient bring their medication information to the hospital when they were admitted?” and create a percentile rate as follows:

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Number of patients that brought medication information to the hospital when they were admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X 100</td>
</tr>
</tbody>
</table>

**Denominator**

- Total number of cases reviewed

**Specifications**

Medication information may be in any format and will include, but is not limited to, pill containers, a paper list, a fax from the clinic or a care facility. If the patient can verbally state all of their medications including name, dose, frequency and route, this should be included as well. You should include information provided by the patient, family members or other caretakers, as well as information provided by other health care organizations. The key is that the medication information must be provided by the patient or other sources, not tracked down by hospital staff.

**Data Collection**

- You may use the cases included in the Medication Reconciliation Upon Admission measure to collect this information, you do not need to review additional cases. For convenience, you might want to add a column to the Medication Reconciliation Data Collection Form in the back of this document if you are using that form for data collection.

- WHA will create two data entry fields (numerator and denominator) for this data within the CheckPoint Hospital Administration Web site so that you can enter this data at the same time you enter your other CheckPoint Error Prevention data.
# Appendix A – JCAHO Required Dangerous Abbreviations

<table>
<thead>
<tr>
<th>Item</th>
<th>Abbreviation</th>
<th>Potential Problem</th>
<th>Preferred Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>U (for unit)</td>
<td>Mistaken as zero, four or cc</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>2.</td>
<td>IU (for international unit)</td>
<td>Mistaken as IV (intravenous) or 10 (ten)</td>
<td>Write &quot;international unit&quot;</td>
</tr>
<tr>
<td>3.</td>
<td>Q.D. (Latin abbreviation for once daily) Q.O.D. (Latin abbreviation for every other day)</td>
<td>Mistaken for each other. The period after the Q can be mistaken for an &quot;I&quot; and the &quot;O&quot; can be mistaken for &quot;I&quot;</td>
<td>Write &quot;daily&quot; and &quot;every other day&quot;</td>
</tr>
<tr>
<td>5.</td>
<td>Trailing zero (X.0 mg)</td>
<td>Decimal point is missed</td>
<td>Never write a zero by itself after a decimal point (X mg), and always use a zero before a decimal point (0.X mg)</td>
</tr>
<tr>
<td>6.</td>
<td>Lack of leading zero (.X mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>MS</td>
<td>Confused for one another. Can mean morphine sulfate or magnesium sulfate</td>
<td>Write &quot;morphine sulfate&quot; or &quot;magnesium sulfate&quot;</td>
</tr>
<tr>
<td>8.</td>
<td>MSO₄</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>MgSO₄</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CheckPoint Error Prevention Measurement Methodology

Appendix B – Data Collection Worksheet

ERROR PREVENTION MEASURE #1: IMPLEMENT A PROCESS TO MARK THE SURGICAL SITE AND INVOLVE THE PATIENT IN THE MARKING PROCESS

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR)</td>
<td>Numerator</td>
</tr>
<tr>
<td></td>
<td>Denominator</td>
</tr>
<tr>
<td></td>
<td>Rate (Num./Den. X 100)</td>
</tr>
</tbody>
</table>

This DSR was collected using: Retrospective case review _____ Concurrent observation _____

ERROR PREVENTION MEASURE #2: PRIOR TO THE START OF ANY SURGICAL OR INVASIVE PROCEDURE, CONDUCT A FINAL VERIFICATION PROCESS TO CONFIRM THE CORRECT PATIENT, PROCEDURE(S) AND SITE(S) USING ACTIVE COMMUNICATION TECHNIQUES

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR)</td>
<td>Numerator</td>
</tr>
<tr>
<td></td>
<td>Denominator</td>
</tr>
<tr>
<td></td>
<td>Rate (Num./Den. X 100)</td>
</tr>
</tbody>
</table>

The DSR was collected using: Retrospective case review _____ Concurrent observation _____

ERROR PREVENTION MEASURE #3: STANDARDIZE THE ABBREVIATIONS, ACRONYMS AND SYMBOLS USED THROUGHOUT THE ORGANIZATION, INCLUDING A LIST OF ABBREVIATIONS, ACRONYMS AND SYMBOLS NOT TO USE

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrated Success Rate (DSR)</td>
<td>Numerator</td>
</tr>
<tr>
<td></td>
<td>Denominator</td>
</tr>
<tr>
<td></td>
<td>Rate (Num./Den. X 100)</td>
</tr>
</tbody>
</table>

See Appendix C for Data Collection Form
CheckPoint Error Prevention Measurement Methodology

ERROR PREVENTION MEASURE #4: REMOVE CONCENTRATED ELECTROLYTES (POTASSIUM CHLORIDE, POTASSIUM PHOSPHATE, SODIUM CHLORIDE>0.9%) FROM PATIENT CARE UNITS

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
</table>
| 1. Demonstrated Success Rate (DSR) | Numerator  
Denominator  
Rate (Num./Den. X 100) |

ERROR PREVENTION MEASURE #6: MEDICATION RECONCILIATION UPON ADMISSION

<table>
<thead>
<tr>
<th>Component</th>
<th>Response</th>
</tr>
</thead>
</table>
| 1. Demonstrated Success Rate (DSR) | Numerator  
*See Appendix E for data collection form*  
Denominator  
Rate (Num./Den. X 100) |

OPTIONAL DATA COLLECTION: PATIENT INITIATION OF THE MEDICATION RECONCILIATION PROCESS

Numerator  
Denominator  
Rate (Num./Den. X 100)
## Appendix C – Dangerous Abbreviations Data Collection Form

Data Collection Time Period: __________________________

<table>
<thead>
<tr>
<th>Item</th>
<th>Abbreviation</th>
<th>Preferred Term</th>
<th>Number of Abbreviations Written Correctly</th>
<th>Number of Abbreviations Written Incorrectly</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>U (for unit)</td>
<td>Write “unit”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>IU (for international unit)</td>
<td>Write “International Unit”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Q.D.</td>
<td>Write “daily” or “every day”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Q.O.D.</td>
<td>Write “every other day”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Trailing zero after the decimal point (X.0mg)</td>
<td>DO NOT USE terminal zeros for doses expressed in whole numbers (X mg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Lack of leading zero before decimal point (.Xmg)</td>
<td>Always use a zero before a decimal point when the dose is less than a whole unit. (0.Xmg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>MS</td>
<td>Write “morphine sulfate”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>MSO₄</td>
<td>Write “morphine sulfate”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>MgSO₄</td>
<td>Write “magnesium sulfate”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Totals:**

*Note: Some abbreviations may not be observed in your sample of medication orders*

Numerator: Total in column D ________________

Denominator: Total in column D + Total in column E ________________
Wrong site, wrong procedure, wrong person surgery can be prevented. This universal protocol is intended to achieve that goal. It is based on the consensus of experts from the relevant clinical specialties and professional disciplines and is endorsed by more than 40 professional medical associations and organizations.

In developing this protocol, consensus was reached on the following principles:

- Wrong site, wrong procedure, wrong person surgery can and must be prevented.
- A robust approach—using multiple, complementary strategies—is necessary to achieve the goal of eliminating wrong site, wrong procedure, wrong person surgery.
- Active involvement and effective communication among all members of the surgical team is important for success.
- To the extent possible, the patient (or legally designated representative) should be involved in the process.
- Consistent implementation of a standardized approach using a universal, consensus-based protocol will be most effective.
- The protocol should be flexible enough to allow for implementation with appropriate adaptation when required to meet specific patient needs.
- A requirement for site marking should focus on cases involving right/left distinction, multiple structures (fingers, toes), or levels (spine).
- The universal protocol should be applicable or adaptable to all operative and other invasive procedures that expose patients to harm, including procedures done in settings other than the operating room.

In concert with these principles, the following steps, taken together, comprise the Universal Protocol for eliminating wrong site, wrong procedure, and wrong person surgery:

- **Pre-operative verification process**
  - **Purpose:** To ensure that all of the relevant documents and studies are available prior to the start of the procedure and that they have been reviewed and are consistent with each other and with the patient’s expectations and with the team’s understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information or discrepancies must be addressed before starting the procedure.
  - **Process:** An ongoing process of information gathering and verification, beginning with the determination to do the procedure, continuing through all settings and interventions involved in the preoperative preparation of the patient, up to and including the “time out” just before the start of the procedure.

- **Marking the operative site**
  - **Purpose:** To identify unambiguously the intended site of incision or insertion.
  - **Process:** For procedures involving right/left distinction, multiple structures (such as fingers and toes), or multiple levels (as in spinal procedures), the intended site must be marked such that the mark will be visible after the patient has been prepped and draped.

- **“Time out” immediately before starting the procedure**
  - **Purpose:** To conduct a final verification of the correct patient, procedure, site and, as applicable, implants.
  - **Process:** Active communication among all members of the surgical/procedure team, consistently initiated by a designated member of the team, conducted in a “fail-safe” mode, i.e., the procedure is not started until any questions or concerns are resolved.
## Appendix – E Medication Reconciliation Data Collection Form

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart Review</td>
<td>Medical Record Number</td>
<td>Is a medication reconciliation form on the chart? (Y/N)</td>
<td>Are all required fields on form(s) completed? (Y/N)</td>
<td>Are all medications reconciled? (Y/N)</td>
<td>Required signature? (Y/N)</td>
<td>Is the medication reconciliation form(s) complete? (Column D, E &amp; F must be &quot;yes&quot;) (Y/N)</td>
<td>Notes on Discrepancies</td>
<td>Reviewer's Initials</td>
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<tr>
<td>1</td>
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<td></td>
</tr>
</tbody>
</table>
# Appendix – E Medication Reconciliation Data Collection Form

<table>
<thead>
<tr>
<th>Chart Review</th>
<th>Medical Record Number</th>
<th>Is a medication reconciliation form on the chart?</th>
<th>Are all required fields on form(s) completed?</th>
<th>Are all medications reconciled?</th>
<th>Required signature?</th>
<th>Is the medication reconciliation form(s) complete? (Column D, E &amp; F must be &quot;yes&quot;)</th>
<th>Notes on Discrepancies</th>
<th>Reviewer's Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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## Appendix – E Medication Reconciliation Data Collection Form

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<th>Required signature?</th>
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Appendix – E Medication Reconciliation Data Collection Form

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Extend to 75 records or more
DSR numerator = The number of patients with a complete medication reconciliation form in their medical record is equal to the number in Column G "Is the medication reconciliation form Complete?"
DSR denominator = Total number of cases reviewed.