

# ANTICOAGULATION DISCHARGE COMMUNICATION (AC-DC) AUDIT TOOL



Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Data Collector's name: \_\_\_\_\_ Email/phone: \_\_\_\_\_

**Purpose:** To evaluate your facility practices regarding communication of requisite anticoagulation-related elements to subsequent providers upon patient transfer or discharge.

**User instructions:**

- Using the criteria below, audit 5-10 medical records of patients transferred or discharged on any anticoagulant.
- Answer Y, N, or NA (Not Applicable) to the following questions using data found in the patient's discharge instructions, discharge summary or other written communication intended to accompany the patient upon discharge or transfer.
- For questions contact: Anne Myrka, anne.myrka@area-i.hcqis.org.
- For each record reviewed assign a number in the Pt. column heading (e.g. Pt. 1). For patients with more than one anticoagulant, complete an adjacent column for the additional drugs (e.g. Pt. 1 also in column 2). Use additional copies of this form if needed.

**FAX completed form to 518-426-3418 to Anne (main phone:518-426-3300)**

Anticoagulation Discharge Communication Criteria upon Transfer Audit Tool	Pt. ____ Y/N/NA	Pt. ____ Y/N/NA	Pt. ____ Y/N/NA	Pt. ____ Y/N/NA	Pt. ____ Y/N/NA
<b>Name of Anticoagulant Drug:</b>					
Was the primary indication for use of the anticoagulant clearly documented?					
Was an assessment of fall risk clearly documented?					
Did documentation indicate whether the patient was new to anticoagulation therapy or a previous user?					
If new*, was start date of anticoagulation therapy provided?					
Did documentation indicate whether treatment is intended to be acute (short term) or chronic (long term)?					
If acute (short term) was total duration of therapy provided? (was there a stop/end date?)					
Date, time, and strength of last dose given documented? (all must be present for Yes)					
Date, time, and strength of next dose due provided? (all must be present for Yes)					
If on Coumadin (warfarin), was the target INR or INR range documented?					
If on Coumadin (warfarin), were the last 2 INR lab results provided (with dates and results)?					
If on Coumadin (warfarin), was the date provided for when the next INR was due?					
Was the most recent serum creatinine or creatinine clearance evaluation provided* (with date and results)?					
Was the patient provided with educational material?					
Was an assessment of patient/caregiver understanding of the education documented?					
Was documentation of patient/caregiver education and understanding communicated to the next provider setting?					
Was contact information provided for the anticoagulation management prescriber/physician?					
Was patient referred to an anticoagulation management service? (e.g. Coumadin/warfarin clinic)					

\* within the previous 30 days

Anticoagulants: Coumadin (warfarin), Pradaxa (dabigatran), Xarelto (rivaroxaban), Eliquis (apixaban), Savaysa (edoxaban), Lovenox (enoxaparin), Arixtra (fondaparinux), Heparin, Fragmin (dalteparin)