Anticoagulation Discharge Communication Discovery Tool

Facility: _____Date:_____

Data Collector's name: _____Email/phone:_____

Purpose: To determine within your medical record, *the existence* and *location(s) of* salient AC information that should be communicated to the next provider on discharge.

User instructions:

This tool is to be used subsequently to "Anticoagulation Discharge Communication Audit Tool" for any criteria for which a "No" exists in any patient record audited. Answer Y (yes) or N (no) to the following audit criteria questions using data found anywhere in the medical record. If the question(s) do not apply, leave the answer section blank. For questions contact: Anne Myrka, anne.myrka@area-i.hcqis.org

Anticoagulation Discharge Communication Criteria upon Transfer	**Does the data *exist* in the medical record in *any* patient records reviewed? (Y/N)**	**If Yes, in *what location(s)* can it be found?**	**If Yes, is the data *consistently documented across all patient records* reviewed? (Y/N)**	**Comments on how to ensure *criteria is documented consistently in the medical record*** (e.g. specific process changes, IT solutions, staff training, etc.)	**Comments on how to include *criteria into discharge communications*** (e.g. specific process changes, IT solutions, staff training, etc.)
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?)					

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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

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