

# Process of Pharmaceutical Review

Follow-Up Audit 2010

# Objectives



- Understand the background to the process of pharmaceutical review.
- Understand the objective and methodology of the follow-up audit.
- Understand the components of the audit tool.
- Understand how the sections of the audit tool are to be completed to ensure consistency of collected data.

# Background



- A significant number of errors are being made when prescribing, dispensing, documenting and administering drugs.
- It is estimated that:
  - 140,000 hospital admissions each year are associated with medication problems;
  - medication errors account for up to 20% of adverse events in Australian health care; and
  - medication errors cost \$380 million per year in the public hospital system.

# Background



- July 2003 - the Australian Council for Safety and Quality in Health Care established a multidisciplinary working group to look at medication errors.
- April 2004 - Australia's Health Ministers endorsed eight key safety and quality initiatives to reduce the number of adverse events and improve patient safety.
  - One of the eight initiatives was to implement a process of pharmaceutical review in all public hospitals by December 2006.

# WA Pharmaceutical Review Policy

Ensures that:

- Accurate medication histories are recorded on admission to hospital,
- Medication reconciliation, including an accurate medication history, is conducted for all hospital inpatients;
- All inpatient medication charts are reviewed, ideally on a daily basis, by an appropriately credentialed professional, such as a clinical pharmacist.
- Patients are educated about their medications during their stay in hospital and on discharge

# Phase 1 - Policy Development

- Development of the WA Pharmaceutical Review Policy by the Office of Safety and Quality in Healthcare, in consultation with the Expert Advisory Group.
- Policy was released in March 2007.

# Phase 2 - Baseline Audit



- Completion of a baseline audit by WA Health Services to identify their current level of compliance against the five standards of the Pharmaceutical Review Policy.
- Resource gaps identified by the audit will form the basis for a business case submitted to the State Health Executive Forum in December 2007.
- The results of the Pharmaceutical Review Baseline Audit indicated that there is *significant variation between clinical practice in WA hospitals and the standards outlined in the WA Pharmaceutical Review Policy.*

# Phase 2 - Baseline Audit Report



- The audit data confirmed a considerable gaps between policy and practice.
- The identified gaps are the result of a number of factors, including:
  - workforce and resource issues,
  - a lack of knowledge/impetus to conduct certain tasks,
  - a lack of documentation confirming whether the tasks have been performed



# Phase 2 - Baseline Audit Report



- AHS must define which health professionals are 'appropriately credentialed' to undertake the pharmaceutical review process, and invest resources accordingly.
- Implementation of the Pharmaceutical Review Policy is an operational responsibility of hospitals.
- **"Area Health Services should review existing clinical pharmacy resourcing, knowledge and practices within their sites, and implement appropriate human resources, clinical policies and clinical practice improvement strategies to achieve full compliance with the standards of the policy."**

# Phase 3 - Follow-up Audit



## *Objective*

- To measure and compare the current level of compliance by WA Health Services against the five standards of the WA Pharmaceutical Review Policy with the baseline audit.
- The results from this audit and the baseline will be used to
  - inform future policy directions, and
  - provide feedback to Area Health Services.

# Phase 3- Follow-up Audit



## *Audit Period*

- Follow-up audit period will run between Sunday 17<sup>th</sup> October and Sunday 14<sup>th</sup> November 2010 .
- The SAMPLE COLLECTION PERIOD will be between Sunday 17<sup>th</sup> October and Sunday 24<sup>th</sup> October 2010.
- Projects Leads will be required to submit all data back to the Office of Safety and Quality in Healthcare by Tuesday 30<sup>th</sup> November 2010.

# Phase 3- Follow-up Audit



## *Sample Size*

- Ideally, all available patients admitted to hospital between Sunday 17<sup>th</sup> October and Sunday 24<sup>th</sup> October 2010 should have an audit form attached to their file.
- Where time and resources are limited, audit as many patients as viable
  - **Aim is to audit over 50% of all patients.**
  - Balance the need to minimise pressure on staff against the need to capture a comprehensive picture of current activity.
- Each ward should keep a record of:
  - The number of patient's admitted between 17 and 24 October 2010.
  - % of admitted patients who are audited.

# Phase 3 - Follow-up Audit



## *Audit Team*

- A multidisciplinary team approach can be taken to completing the audit.
- All staff involved in the patient's care can participate in the audit
  - Directly - by completing relevant sections of the audit tool.
  - Indirectly - by answering questions about the patient's care and/or documenting aspects of the patient's care in the medical record.
- Audit team members can include:
  - Pharmacists
  - Pharmacy technicians
  - Pharmacy students/interns
  - Medical Officers
  - Nurses
  - Ward Clerks

# Phase 3 - Follow-up Audit



## *Audit Process*

- The audit will be done prospectively i.e. sections of tool can be completed as the activity is done.
- To ensure that accurate data is obtained, it is imperative that audit teams are honest in their responses,
  - do not alter behaviour for patients that are being audited.

# Phase 3- Follow-up Audit



## *Role of the Project Lead*

- Recruit coordinators at a ward level.
- Determine the audit sample size.
- Educate staff about the audit process and the audit tool.
- Collate the audits at the end of the audit period and submit forms to the Office of Safety and Quality in Healthcare.
- Complete the Hospital Demographic Information Collection sheet



## Pharmaceutical Review Baseline Data Collection

Hospital Demographic Information Collection  
One sheet to be completed per hospital.

1. Hospital: \_\_\_\_\_
2. Total number of patients admitted to hospital between 01 July and 08 July 2007: \_\_\_\_\_
3. Total number of patients with Pharmaceutical Review Baseline Audit Tool attached to patient file between 01 July and 08 July 2007: \_\_\_\_\_  
Total number of COMPLETED Pharmaceutical Review Baseline Audit Tools collected at the end of the audit period (this includes patients that weren't discharged, but have the 'Not discharged prior to audit completion date' box ticked): \_\_\_\_\_
5. Total number of INCOMPLETE Pharmaceutical Review Baseline Audit Tools collected at the end of the audit period: \_\_\_\_\_
6. Total number of authorised full-time equivalent (FTE) Pharmacist positions: \_\_\_\_\_
7. Total number of filled full-time equivalent (FTE) Pharmacist positions: \_\_\_\_\_  
Total number of Pharmacists (count the number of Pharmacists including full-time, part-time and casual staff): \_\_\_\_\_
9. Total number of authorised full-time equivalent (FTE) Clinical Pharmacist positions: \_\_\_\_\_
10. Total number of filled full-time equivalent (FTE) Clinical Pharmacist positions: \_\_\_\_\_  
Total number of Clinical Pharmacists (count the number of Clinical Pharmacists including full-time, part-time and casual staff): \_\_\_\_\_
12. Total number of Clinical Technicians (support staff working in a clinical capacity): \_\_\_\_\_
13. Average Clinical Pharmacist to patient ratio during the audit period: \_\_\_\_\_
14. Does the hospital have a committee that is responsible for the oversight and coordination of initiatives relating to the Quality Use of Medicines? YES NO
15. Does the hospital promote participation in Quality Use of Medicine activities? YES NO
16. Does the hospital participate in drug use evaluations? YES NO
17. Does the hospital conduct routine review/audit of charts for features such as legibility, errors on charts, dose administration times and dose omissions? YES NO  
If 'YES' are the above review/audit of charts endorsed by an appropriate QA committee (i.e. audit tools are endorsed and consistent with the aims of the QA committee) YES NO
19. Are hospital staff involved with other hospital and state medication safety working groups and email discussion networks, such as the WA Medication Safety Group? YES NO



# Hospital Demographic Information Collection Sheet

- Only one sheet needs to be completed per site.
- Authorised FTE Positions
  - number of allocated positions.
- Filled FTE Positions
  - how many of the allocated positions have someone working in the position.
- Total number of clinicians
  - count the number of bodies i.e. full-time, part-time and casual.





# COMPLETING THE TOOL

# i. Patient Demographics



- Affix patient ID label.
- Enter ward name/number and date of admission.
- Ward clerks can be involved in completing this section of the audit.

## AFFIX PATIENT IDENTIFICATION LABEL

UR Number:	
Family Name:	
Given Names:	
Address:	
DOB:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F

Ward:	
Date started/date of admission:	
Discharge date: OR Not discharged prior to audit completion date	<input type="checkbox"/>

# i. Patient Demographics (cont.)

- Complete the patient's GP details, and community pharmacist and residential care facility where appropriate.
- These details are included so that the sources can be contacted to confirm discharge summary details.

Patient's GP Name:

GP Contact Number:

Patient's Community Pharmacist Name (if applicable):

Community Pharmacist Contact Number:

Patient's Residential Care Facility Name (if applicable):

Residential Care Facility Contact Number:

# i. Patient Demographics (cont.)

- Indicate if patient is high-risk.
- Ideally high-risk patients are monitored more closely as they have an increased likelihood of the occurrence of an adverse event.

<p>Is this patient a high-risk patient?</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p>Definition of a high-risk patient – A patient who has one or more of the following:</p> <ul style="list-style-type: none"><li>• Currently prescribed five or more medications</li><li>• Multiple co-morbidities</li><li>• Prescribed a medication with a narrow therapeutic index (see guidelines for narrow therapeutic index medications)</li><li>• Therapy with high-risk drugs (see guidelines for high-risk drugs)</li><li>• Symptoms suggestive of a drug related admission</li><li>• Difficulty managing medicines because of literacy, language difficulties, dexterity problems, impaired sight, dementia or other cognitive difficulties.</li></ul>
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## NOTE

the following audit sections do not need to be completed in numerological order

# 1. CHART REVIEW



**“All inpatient medication charts are to be reviewed, ideally on a daily basis, by an appropriately credentialed professional, such as a clinical pharmacist”**

# 1. Chart Review

## 1.1.A.

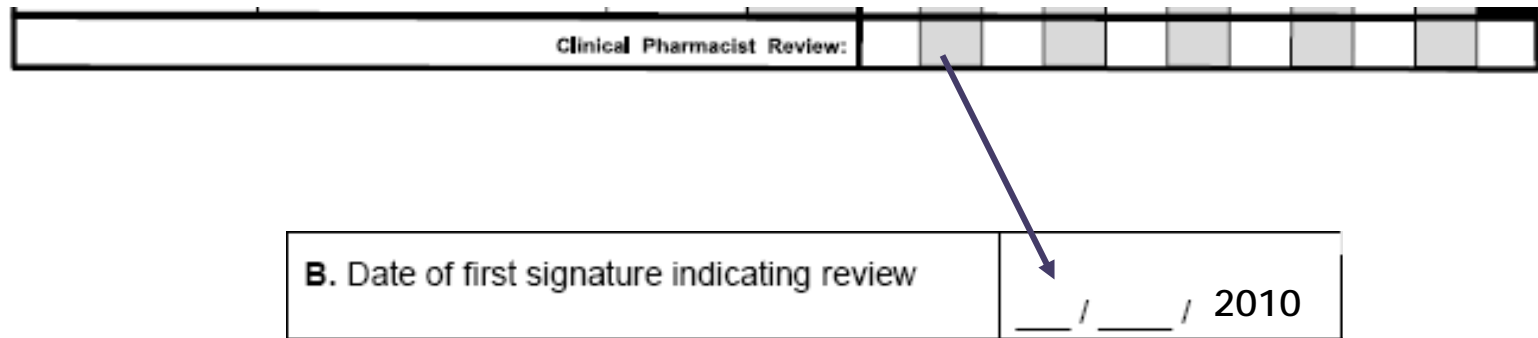
Activity	Yes	No	NA	Unknown/ Not Documented
A. Was a chart review conducted for the patient by an appropriately credentialed professional? If no, continue to section 1.2.				

- For the chart review section to be signed, a comprehensive chart review must be undertaken, including (but not limited to):
  - Noting patient's medication history and clinical condition;
  - Identifying, clarifying and documenting potential ADRs;
  - Changing medication names from trade to generic;
  - Clarifying doses.

# 1. Chart Review

## 1.1.B.

- Document the date on which the first chart review occurred.



The diagram shows a horizontal bar representing a 'Clinical Pharmacist Review' form. The bar is divided into several segments, with the first segment labeled 'Clinical Pharmacist Review:'. A blue arrow points from the first segment of the bar to a callout box below. The callout box contains the text 'B. Date of first signature indicating review' and a date field with the format '\_\_ / \_\_ / 2010'.

- Ideally, high-risk patients should have their chart review within 24 hours of admission.
- Tasks associated with chart review are outlined on page 7 of the Pharmaceutical Review Policy.



# 1. Chart Review

## 1.1.C.



Of the patient's <b>total admission period</b> :	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>C.</b> Indicate the number of each day that passed eg <i>total number of Mondays, Tuesdays etc.</i>							

- Of the patient's total admission, how many days were a Sunday etc.

# 1. Chart Review

## 1.1.D.



• Clinical Pharmacist

<p>D. For each day of the patient's admission, how many of the corresponding 'Clinical Pharmacist Review' boxes had been signed by a:</p> <ul style="list-style-type: none"><li>• Clinical Pharmacist</li><li>OR</li><li>• Other appropriately credentialed professional</li></ul>	<b>Comments:</b>						

• Appropriately Credentialed Professional

- Of the total number of Sundays that the patient was admitted, count how many (if any) of the 'clinical pharmacist review' boxes were signed by a:

# 1. Chart Review

## *Example*

Mr Citizen is admitted on Tuesday 19<sup>th</sup> October at 3pm and discharged on Sunday 31<sup>st</sup> October at 8am. His chart was reviewed and signed by a Clinical Pharmacist every Monday through to Wednesday, reviewed and signed in the relevant section by a doctor on Thursday, but was not reviewed on Fridays, Saturdays and Sundays.

Of the patient's total admission period:	SUN	MON	TUES	WED	THUR	FRI	SAT
C. Indicate the number of each day that passed, eg total number of Mondays, Tuesdays etc.	2	1	2	2	2	2	2
D. For each day of the patient's admission, how many of the corresponding 'Clinical Pharmacist Review' boxes had been signed by a: <ul style="list-style-type: none"> <li>• Clinical Pharmacist</li> <li>OR</li> <li>• Other appropriately credentialled professional</li> </ul>	<b>Comments:</b>						
		1	2	2			
						2	

# 1. Chart Review

## 1.2.

	Yes	No	N/A	
<b>A.</b> Nil known/unknown box ticked If yes, continue to question F. below.				
<b>B.</b> ADR sticker attached for all charts				
<b>C.</b> Drug/allergen documented				
<b>D.</b> Reaction details documented				
<b>E.</b> Initials documented				
<b>F.</b> ADR box signed and dated by clinician				

- ADR should be recorded on the NIMC and all other relevant documents eg. patient's case notes.
- Tick 'yes' if the section was completed on NIMC.
- Tick 'no' if the section was not completed in its entirety on the NIMC.



# 1. Chart Review

## 1.3.

- Two sections - pre and post chart review.
- To be done on one day of the audit period - obtain a snapshot.
- Clinical pharmacist to be involved in auditing the sections marked with an asterisk (\*).



# 1. Chart Review



- **Scenario 1:** A clinical pharmacist reviewed the patient's medication chart on Monday October 18, and made the appropriate changes. The pharmaceutical review audit section was then completed on Thursday October 21. The auditor would document:
  - In the 'POST CHART REVIEW' section all orders that were reviewed on 9 July.
  - In the 'PRE CHART REVIEW' section all orders that were not reviewed (i.e. any orders that were written between 9 July and the review date).
- **Scenario 2:** A clinical pharmacist reviewed the patient's medication chart on Tuesday October 19, and made the appropriate changes. The pharmaceutical review audit section was also completed on Tuesday October 19, after the chart review. The auditor would document:
  - All activity in the 'POST CHART REVIEW' section on the audit tool.
- **Scenario 3:** A clinical pharmacist had not reviewed the patient's medication chart. The auditor would document:
  - All activity in the 'PRE CHART REVIEW' section of the audit tool.



## 2. MEDICATION RECONCILIATION ON ADMISSION

“Medication reconciliation, including an accurate medication history, is to be conducted for all inpatients by an appropriately credentialed professional, ideally within 24 hours of admission for high-risk patients”

# 2. Medication Reconciliation

## 2.1.A. Medication History

Activity	Yes	No	NA	Unknown/ Not Documented
<b>A. Medication history completed.</b> <i>If the medication history is not fully completed, document this in the 'comments' section</i> <b>If no, continue to section 2.2.</b>  <b>If yes:</b> Date: ____ / ____ / 2010 Completed by: <ul style="list-style-type: none"> <li>• Pharmacist</li> <li>OR</li> <li>• Doctor</li> <li>OR</li> <li>• Appropriately credentialed nurse</li> <li>OR</li> <li>• Other (please specify)</li> <li>OR</li> <li>• Not identified</li> </ul>				

• Tick the 'unknown/not documented' box if the date of history and/or whom the history was completed by is unknown

- Indicate if medication history was completed (on the NIMC or separate form), date of completion and who the history was completed by.
- Check NIMC guidelines for requirements where 2 or more charts are used.



# 2. Medication Reconciliation

## 2.1.B. Medication History

**B. Medication history obtained from...** (tick as many boxes as applicable)

- Patient
- Carer
- General practitioner
- Community pharmacist
- Other (please specify)

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

• Tick the unknown/not documented box if source of medication history is unknown

- Consult the patient and/or patient's treating team to determine who the medication history was completed by.

# 2. Medication Reconciliation

## 2.2.

Activity	Yes	No	NA	Unknown/ Not Documented
A. Did patient have, or get given, a Patient's Own medication bag on admission?				
B. Did patient have a current medication profile on admission?				
C. Did patient have a previous hospital discharge summary or nursing home summary on admission?				
D. Did patient have St John Ambulance MedicAlert bracelet or MedicAlert wallet card on admission?				
E. Did patient have a Home Medicines Review report on admission?				

- Consult the patient and/or patient's notes to determine if the activities were undertaken.

# 3. MEDICATION EDUCATION DURING HOSPITALISATION AND ON DISCHARGE



Patients and/or their carers are to be provided with medication education during their hospitalisation to ensure that they have an understanding of their medications, and ideally be given a medication profile on discharge

# 3. Medication Education



## 3.1.A.

Activity	Yes	No	NA	Unknown/ Not Documented
A. Were there any changes (additions, cessations or alterations) made to the patient's medication management?				

- Consult the patient's medication chart - determine if any changes were made.
- This includes drugs being ceased, addition of new medications, change in dosing regimen etc.
- Ideally, the patient should be educated on any changes made.

# 3. Medication Education



## 3.1.B.

**B.** Was the provision of **education** for these changes in medication management documented in the medical record or on the medication chart?

**If yes:**

Medication education was provided by:

- Clinical Pharmacist
- Doctor
- Appropriately Credentialed Nurse
- Other (please specify)

**Note: If you provide the patient with education, document this in the patient's records.**

- If any changes were made to the medication management, was patient education about these changes documented in the patient's notes, and who was the education provided by.

# 3. Medication Education



## 3.1.C/D.

<b>C.</b> Was the provision of a Consumer Medicine Information leaflet (or other appropriate literature) documented in medical record?				
<b>D.</b> Was the provision of a 'Patient First' booklet documented in the medical record?				

- CMI and the Patient First booklet are valuable sources of information and education for the patient.

**Note:** If you provide the patient with a CMI leaflet or 'Patient First' booklet, document this in the patient's records.

# 3. Medication Education

## 3.1.E.

- E. Where the patient was prescribed the following **high-risk** medications, was the provision of education documented in the medical record or on medication chart?
- Anticoagulant(s) eg Warfarin
  - Immunosuppressant(s)
  - Medication with a narrow therapeutic index eg digoxin
  - Other 'high risk' drugs (please specify)

Note: If you provide the patient with education on a high-risk medication, document this in the patient's records.

- If the patient was prescribed a high-risk medication, determine if education was provided, and if the provision of education was documented.

# 3. Medication Education



## 3.1.F.

F. Was the patient provided with a medication profile on discharge?				
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- Check with patient/carer, appropriate clinician and/or medical record to see if the patient was provided with a medication profile on discharge.
- Medication profile may be provided using an electronic system (e.g. TEDS, i.Pharmacy, CGMS, Medic8) or the 'Patient Medication Record Form' in the Patient First Booklet
- Tick 'NA' if patient is not discharged at the completion of the audit period.



# 4. DISCHARGE PROCESS - COMMUNICATION WITH GENERAL PRACTITIONERS AND OTHER HEALTH PROFESSIONALS

“A patient’s medication-related information is to be provided to his or her general practitioner and other health professionals upon discharge”

# 4. Discharge Process

## 4.1.A.

Activity	Yes	No	NA	Unknown/ Not Documented
A. Was a discharge summary prepared for the patient within the one-month audit period? If no, continue to section 5.1.				

- Check the patient's records and/or with the appropriate clinician to see if a discharge summary was prepared before the end of the audit period.

# 4. Discharge Process

## 4.1.A. Discharge Summary

- The discharge summary should include the following information:
  - Admission information:
    - Presenting complaint
    - Diagnosis
    - Progress during treatment
  - Medication list on discharge
  - Follow up



# 4. Discharge Process

## 4.1.B.



B. Were there any discrepancies between:			
<ul style="list-style-type: none"><li>• NIMC and the discharge summary?</li></ul>			
<ul style="list-style-type: none"><li>• Patient's medication profile and discharge summary?</li></ul>			

Compare the medications on the discharge summary with the medications on the NIMC (or relevant chart) for any discrepancies.

Compare the medications on the discharge summary with the medications on the patient's medication profile for any discrepancies. Tick 'NA' if the patient does not have a medication profile.

# 4. Discharge Process

## 4.1.C.



C. Was the involvement of a clinical pharmacist in the medication component of the discharge summary documented in the medical record?				
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- Check the patient's records to see if clinical pharmacist involvement in the discharge summary is recorded.

**Note: If you are involved in the medication component of the discharge summary, document this in the patient's records.**

# 4. Discharge Process



## 4.1.D.

D. Did the patient receive a copy of the discharge summary within audit period?				
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- Consult the patient or patient's record to determine if it is documented that the patient received a copy of their discharge summary by the end of the audit period.

**Note: If you provide the patient with a copy of their discharge summary, document this in the patient's records.**

# 4. Discharge Process



## 4.1.E.

<b>E.</b> Was the patient's general practitioner provided with discharge summary during the audit period?  <b>If yes:</b> Date GP provided with discharge summary:				
	___ / ___ 2010			

- Consult the patient's notes or contact the patient's general practitioner to determine if the general practitioner was provided with a copy of the patient's discharge summary by the end of the audit period.

**Note:** If you provide the patient's GP with a copy of the discharge summary, document this in the patient's records.

# 4. Discharge Process

## 4.1.F.

<b>F. Was the patient's community pharmacist:</b> <ul style="list-style-type: none"><li>• Provided with discharge medication list?</li></ul> AND/OR <ul style="list-style-type: none"><li>• Contacted to discuss patient's medications?</li></ul>				

- Consult the patient's notes or contact the community pharmacist.
- If the patient does not have a community pharmacist, tick 'NA'.

**Note: If you provide the patient's community pharmacist with a copy of the discharge summary, document this in the patient's records.**



# 4. Discharge Process

## 4.1.G.

Activity
<p><b>G.</b> Does the patient reside in a Residential Care Facility?</p> <p><b>If yes:</b></p> <ul style="list-style-type: none"><li>• Was the facility provided with patient's discharge medication list?</li></ul> <p>AND/OR</p> <ul style="list-style-type: none"><li>• Was the facility contacted to discuss patient's medications?</li></ul>

Note: If you provide the patient's residential care facility with a copy of the discharge summary, document this in the patient's records.

- If patient resides in a residential care facility, consult the patient's notes or contact the facility to determine if they were provided with a copy of the patients discharge medication list and/or contact to discuss the patient's medications.

# 4. Discharge Process

## 4.1.H/I.

H. How many medications are listed on the patient's discharge summary?		
I. How many of the medications in the discharge summary had the following documented?		
• Generic drug name (or brand name where relevant)		
• Dose		
• Drug status		
• Rationale for changes		
• Monitoring requirements where relevant e.g. interactions, dose increased		
• Expected outcomes		
• Additional information (please specify)		

Count all medications listed on the discharge summary

Of all the medications listed on the discharge summary, how many had documented:

e.g. ceased, new drug, dose changed



# 5. QUALITY ACTIVITIES PROMOTING MEDICATION SAFETY

“Health services are to be involved in medication-related safety and quality activities.”

# 5. Quality Activities

## 5.1.A.

Activity	Yes	No	NA	Unknown/ Not Documented
A. Did the patient experience any adverse drug reactions (ADR) during this admission?  If yes:				
[Hatched area]				

- Consult the patient's notes and/or appropriate clinician to see if an adverse drug reaction was experienced any time during the admission.

# 5. Quality Activities

## 5.1.B.



<p><b>B. Was the ADR:</b></p> <ul style="list-style-type: none"><li>• Life threatening OR</li><li>• Non life threatening</li></ul>	
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- If an ADR was experienced, was emergency medical attention needed - i.e. was it life-threatening.

# 5. Quality Activities

## 5.1.C.

**C.** Was the reaction documented:

- In the patient's notes?
- On the patient's medication chart?
- In the discharge summary?



- If an ADR was experienced, consult the patient's notes, patient's medication chart and discharge summary, and indicate in which of the records the ADR was documented.

# 5. Quality Activities

## 5.1.D.



<b>D.</b> Is there evidence of the ADR being reported via the hospital's clinical incident management process (AIMS form completed)?				
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- If an ADR was experienced, is there documentation in the patient's notes that the event was reported via the hospital's clinical incident management process - i.e. a statement that the ADR was reported to AIMS or other reporting systems.

# 5. Quality Activities



## 5.1.E.

<b>E.</b> Was the ADR reported to the Adverse Drug Reaction Advisory Committee (ADRAC)?				
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- If an ADR was experienced, is there documentation in the patient's notes that the event was reported to the Adverse Drug Reaction Advisory Committee.



# Audit Completion



- Once a patient is discharged:
  - Check to make sure all sections of the tool are completed.
  - Complete the 'discharge date' on page 2.
  - Forward the audit tool to the site Project Lead.
  - Project Leads are to forward all completed audit tools to the OSQH *by Tuesday 30<sup>th</sup> November 2010.*

# Questions, Queries, Comments

- Any queries about the audit process or the audit tool can be directed to your Project Lead, or the Office of Safety and Quality in Healthcare:
  - Phone: 9222 0246
  - Email: [safetyandquality@health.wa.gov.au](mailto:safetyandquality@health.wa.gov.au)