

#### **FACT SHEET**

## **Medicines in focus**

This fact sheet addresses medication safety and management in relation to the Australian Commission on Safety and Quality in Health Care's (ACSQHC) National Safety and Quality Health Service (NSQHS) Standard4 and the ACSQHCs' Australian Safety and Quality Goals for Health Care 10-12, EQUIP 5 from the Australian Council on Healthcare Standards (ACHS)<sup>6-8</sup>, and the APAC Guiding principles to achieve continuity in medication management<sup>13.</sup>

# **Organisational medication safety** Managing risk – how pharmacists help

Medicines use has been demonstrated many times to be risky and organisations need to have appropriate systems and practices in place to ensure that these risks are managed and minimised. Medication safety systems and strategies aim to reduce the risk of avoidable medication error and enhance outcomes for individual patients and the organisaion as a whole.<sup>2</sup> Medication safety is the responsibility of all healthcare professionals involved in the medication management pathway (Figure 1). Pharmacists have a key role.

## **Effective medication safety** systems and strategies:

- · are critical for patient safety and a fundamental patient right<sup>3</sup>
- · require multidisciplinary involvement, with clinical and executive leadership and support
- · ensure that appropriately skilled staff are working with medicines
- ensure the supply of medicines to patients is safe, effective and efficient
- · are fundamental to an organisation's risk management strategy
- · monitor medicines use and can detect and manage system deficiencies
- · are mandated within Standard 4 of the National Safety and Quality Health Service (NSQHS) Standards<sup>4,5</sup>, and are key to achieving organisational accreditation<sup>6-9</sup>
- reduce healthcare costs
- help to prevent reputational risks from adverse media attention.

### How pharmacists manage and reduce medication risk

Medication safety does not happen by chance; it is the result of sound decisions, systems, policies and processes. Pharmacists are integral in meeting the NSQHS Standard for Medication Safety by identifying risks, implementing processes and strategies to address these risks, and detecting medication errors and preventing associated harm. Their focused education and training in medicines uniquely equips them to lead medication safety strategies in health service organisations.

#### Pharmacists lead medication safety systems and strategies by:

- · leading the governance of medication safety committees
- · assisting with auditing the safety of the organisation's medication management system
- leading development and implementation of evidencebased medication safety initiatives and programs: e.g. recording a best possible medication history; reconciling medications<sup>14</sup>; procedures for safe management of high risk medications; antimicrobial stewardship<sup>15</sup>; electronic decision support for prescribing
- monitoring trends and reviewing work practices and systems to identify risks or gaps in practice e.g. undertaking audits, evaluation and monitoring of the medication management system
- reporting and reviewing errors, near misses and adverse medicines events; and monitoring adverse drug reactions
- · educating staff about medication safety and sharing knowledge with other health professionals
- promoting a no-blame (just) culture and 'open disclosure'.2

#### Woman in hospital for routine knee surgery dies due to clerical error on medical charts.

"The State Coroner heard how it took seven days for bungling hospital staff to discover they had made two separate medication charts for the woman, with paracetamol ordered and administered on both." "A coronial autopsy found the woman died of multiple organ failure due to, or as a consequence of, drug toxicity, predominantly paracetamol," Parliament was told.... the HQCC reported a "concerning pattern of disregard for basic medication safety practices across health professions".

Herald Sun: The Courier-Mail October 12, 2012; on abc. net.au/pm

In 2003, the Australian Council for Safety and Quality in Healthcare released a national Intravenous Potassium Chloride Alert in response to numerous deaths associated with preparation and administration of this medication in Australia and overseas. Cause of errors was availability of concentrated potassium ampoules in wards and patient care areas. Actions from recommendations included removing them from ward stock and replacing with diluted premixed solutions, developing guidelines for use, standardising prescribing, training and education.<sup>20</sup>

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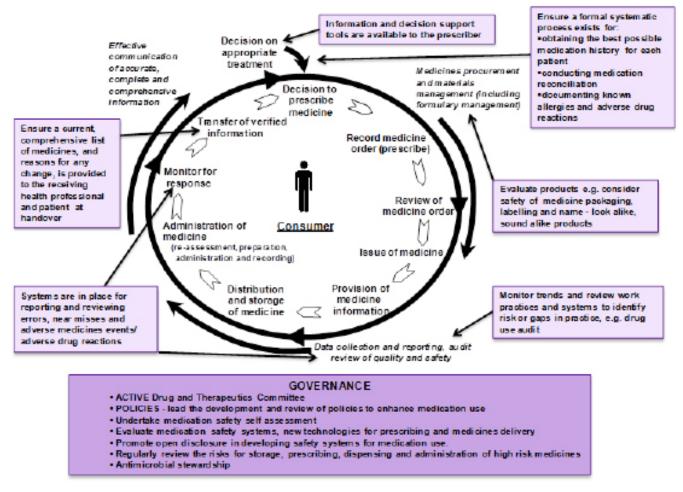


Figure 1: Examples of medication safety strategies/practices/actions along the Medication Management Pathway<sup>13,19</sup>

#### **Executive and Board – Medication safety considerations:**

- Does your organisation support a culture of medication safety? Are medication safety strategies and activities adequately resourced and supported? Is medication safety on your risk register?
- Has your organisation undertaken a Medication Safety Self Assessment<sup>16</sup> to assess the safety of the medication management system? Has your organisation acted to address the issues identified?
- What strategies does your organisation have to meet the ACSQHC's NSQHS Standards<sup>4,5</sup> and Australian Safety and Quality Goals for Healthcare<sup>11-12</sup>, and the APACs *Guiding Principles to Achieve Continuity in Medication Management*<sup>13</sup>?
- · Does your organisation have a pharmacist leading medication safety programs and initiatives?
- Are pharmacists represented on Drug and Therapeutics Committees and Medication Safety Committees or similar?
- Does your organisation assess and review medication safety across all steps of the medication management pathway?
- Does your organisation participate in National medication safety and quality initiatives and programs e.g. antimicrobial stewardship15, the National Inpatient Medication Chart<sup>17</sup>, National Tall Man lettering to reduce risk of drug selection error<sup>18</sup>?

The Society of Hospital Pharmacists of Australia (SHPA) is the professional body which represents over 4,000 pharmacists, pharmacy students, pharmacy technicians and associates practising in all parts of the Australian health system.

#### **SHPA** vision

Excellence in Medicines Management.

## **SHPA** purpose

Deliver value through people, systems and processes and processes for the best patient outcomes