STANDARD 4: Medication Safety

CRITERION: Clinical governance and quality improvement to support medication management (Actions 4.1, 4.2, 4.3, 4.4)

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

Provide a summary of the processes that are in place to meet this criterion.

Reporting to the Safe Care Committee, the Western Health (WH) Medication Safety Committee has overarching authority for the implementation and review of medication safety at WH. Consumer representation on this Committee assists with implementation of systems for Medication Management with a 'Patient First' perspective for patient care.

Reporting directly to the Medication Safety Committee are the Drugs and Therapeutic Committee and the Adverse Drug Reaction Committee.

Pharmacy and operational management committees also support medication safety management within WH.

Policies and Procedures (PPGs) for the safe supply, storage, dispensing, prescribing and administration of all medications are endorsed by the Medication Safety Committee or the Drug and Therapeutic Committee and are aligned to the Australian Regulatory Guidelines for Prescription Medicines.

The WH Pharmacy Service provides a comprehensive, professional pharmacy service to the wards and departments of Western Health.

Professional governance of medical practitioners for the purposes of prescribing medications is administered through AHPRA, the authoritative body for limiting a practitioner's prescribing practice, with limitations monitored through the WH Cgov credentialing system.

New graduate nursing staff, midwives and newly graduated enrolled nurses with medication endorsement are required to complete medication competency assessment, including drug calculations, prior to commencing work at WH. Nursing staff also complete the National Prescribing Service Medicine Wise - Medication Safety Training (7 Modules) and supervised medication rounds.

An information card with commonly utilised medication calculations for easy referral is provided for attachment to staff IDs.

A bi-monthly 'Western Medication Updates Newsletter' relays important medication information to all clinicians throughout WH, including notification of medication changes that may impact on practice.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

Medication incidents and near misses, as well as investigation results are entered into the Incident Management System (RiskMan). Recommendations and actions arising from incident investigations are implemented and monitored to ensure medication safety improvements. Monthly medication incident reports, including specific high-risk drugs (i.e. APINCH), are developed for reporting at the ward level, division level, and through the Medication Safety Committee and Best Care Committee Structure. Incident data is also utilised for benchmarking purposes.

Operational risks relating to Medication Safety are monitored through the Medication Safety Committee and escalated to the Safe Care Committee as required.

Audits are undertaken to monitor compliance with medication management process and are reported through operational and Medication Safety Committee lines.

The Victorian Health Experience Survey (VHES) includes a question on patient satisfaction with medication information. VHES data is reported quarterly to the Medication Safety Committee.

Have improvements been implemented?

The introduction of electronic medication prescribing and administration, as well as electronic support for the tracking and management of medication safety processes has been made possible through the introduction of the Electronic Medical Record (EMR). WH's 'Live EMR' microsite supports staff use of the medication functionalities of the EMR which are continually being enhanced, for example by the introduction of the 'Medication Administration Wizard' (MAW).

WH has implemented quality improvements as a result of recommendations from clinical incident investigations. An example is introduction of red plunger syringes for administration of neuromuscular blocking agents (NMBA) and "ENFit®" syringes for administration of oral/enteral medications to align with ISO 80369-3 standard.

Optimisation of Insulin Prescribing Ordersets in the EMR triggered by a clinical incident and prescriber feedback further illustrates how continuous improvements are being implemented for patient safety.

Supporting incident review and medication management training is the introduction of a medication reflection tool to support nursing staff review and improve medication administration practice following a medication error.

Provide examples of outcomes since the previous onsite assessment

The introduction of the EMR has enhanced processes for safe use of medications. For example, EMR functionality and staff education on safe insulin prescribing and administration has supported a 5.1% decrease in reported medication incidents that resulted in minor, moderate or severe harm during 2018/19 when compared with 2017/18.

Apart from a spike in documentation errors during the five weeks of EMR implementation, APINCH medication incidents overall have steadily declined over the past 18 months. This has been supported by improved information dissemination and communication, education and use of equipment and tools supporting safe medication prescribing, administration and storage.

CRITERION: Documentation of patient information (Action 4.5, 4.6, 4.7, 4.8, 4.9)

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Provide a summary of the processes that are in place to meet this criterion.

The design in the EMR ensures that a primary medication history is taken upon admission by the prescriber. A clinical pharmacist subsequently completes best possible medication history which includes completion of a Medication Management Plan (MMP) and admission medication reconciliation.

The Clinical Pharmacy Standard Operating Procedure details the process of how to obtain a best possible medication history and reconciliation.

The MMP and admission reconciliation documented by the clinical pharmacists has components that demonstrate processes to partner with patients by ensuring that:

- A best possible medication history is obtained
- Patients history of allergies and adverse drug reactions are documented
- Any issues that may potentially affect the ability to manage their medications such as living at home alone, adherence to medications, Webster pack management is also documented to assist with developing a plan for management prior to discharge.

The WH Adverse Drug Reaction Recording and Reporting Procedure outlines the requirements for documenting patients' known medication allergies and Adverse Drug Reactions (ADRs) during the admission process.

The requirement for clinicians to record new ADRs experienced during an episode of care, reporting and data collection is also included in this procedure.

The workflow in the EMR also enables documentation and risk rating of ADRs upon admission. The banner and alerts in the EMR informs clinicians during the process of prescribing and administration of medicines.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

As part of the WH Medication Safety auditing program, Pharmacist admission medication reconciliation activity is reviewed quarterly.

In addition, admission note completion data is drawn from the EMR into a Power BI dashboard that is refreshed every 15 minutes to support day-to-day activity and monitoring of documentation of patient information.

Data can also be accessed from the EMR to monitor compliance with documenting a patient's known medicine allergies and ADRs during the admission process.

New allergies and ADRs are reported through the incident management system (RiskMan) to enable the management of ADRs including reporting to TGA (Therapeutic Goods Administration) by the ADR Committee.

The ADR Committee reviews all newly reported medicine allergies and ADRs and advises patients and their general practitioners.

The ADR Committee reports quarterly to the Medication Safety Committee on compliance with reporting and follow up of patients with a suspected ADR.

Medication incidents and near misses, as well as investigation results are entered onto RiskMan. Recommendations and actions arising from incident investigations are implemented and monitored to ensure medication safety improvements.

Monthly medication incident reports, including specific high-risk drugs, are developed for reporting at the ward level, division level, and through the Medication Safety Committee and Best Care Committee Structure. Incident data is also utilised for benchmarking purposes.

Operational risks relating to Medication Safety are monitored through the Medication Safety Committee and escalated to the Safe Care Committee as required.

Have improvements been implemented?

Support for the documentation, monitoring and review of patient medications has been made possible through the introduction of the Electronic Medical Record. EMR workflow supports recording of the best possible mediation history and reconciliation, as well as documentation and risk rating of ADRs.

WH has implemented quality improvements as a result of the review of patient medications documentation activity. For example, a decrease in MMP KPI and pharmaceutical review has led to an appointment of an additional 3.7 FTE clinical pharmacists to improve timely medication reconciliations. The timeframe for commencement of these roles is February - April 2020.

The ADR committee have also streamlined processes of recording an ADR which has been updated in the Adverse Drug Reactions procedure.

Additionally, Pharmacy input was sought in the development of the new Joan Kirner Women's and Children's building, with pharmacists appointed to support service provision.

Provide examples of outcomes since the previous onsite assessment:

The introduction of the EMR has enhanced processes for documenting, accessing and reviewing activity on recording best possible medication history and reconciliation.

The EMR has also supported requirements for documenting and accessing patients' known medication allergies and ADRs, with streamlined practices supporting timely communication on allergies with patients and general practitioners.

In addition, with suitable Pharmacy input, there was no interruption in pharmacy cover experienced with the opening of the new Joan Kirner Women's and Children's building.

CRITERION: Continuity of medication management 4.10, 4.11, 4.12

A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Provide a summary of the processes that are in place across the health service to meet this criterion.

The WH Medication Use and Management Policy defines the roles, responsibilities and accountabilities of the clinical workforce in informing patients and carers about their individual medicine needs and risks.

WH Medication Policies and Procedures (PPGs), as well as Pharmacy Operating Procedures outline requirements for undertaking, prioritising and documenting medication reviews, as well as generation and distribution of medicine lists. Lists support safe handover of care and are also provided at discharge. PPGs are also focused on engagement of patients and carers in these processes, both from an information and shared decision perspective.

Staff medication related resources to facilitate adequate information provision for patients include access to eMIMs (online Australian drug database) and access to the 'Clinicians Health Channel' which includes resources for making decisions regarding treatment options.

In addition, a drug information pharmacist is available five days a week to respond to requests by staff or patients seeking information on medications.

The WH library maintains resources for clinicians seeking further information on specific medicine regimes.

The WH drug formulary contains a list of all current medications able to be prescribed at WH. Drugs not contained within the drug formulary require approval by the Drugs and Therapeutic Committee.

Medication lists provided to patients on discharge outline the type of medication, ceased medications, new medications and any special instructions for patients discharging home. The pharmacy discharge note on the EMR outlines any medication changes and if Webster packs are required for ongoing management, and if home medicines review is required.

The community pharmacy is followed up for organising Webster packs. Patients discharging to a residential care facility are provided with an interim medication chart for dosing at the nursing home before the facility doctor reviews and writes up the medication chart at the residential care facility.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

Discharge Counselling and completion of Pharmaceutical Review data is presented and discussed at the Pharmacy Management Committee meetings on a quarterly basis, with divisional reporting via service reports.

The Victorian Health Experience Survey (VHES) includes a question on patient satisfaction on receiving information about medications given in hospital. VHES data is reported quarterly to the Medication Safety Committee.

Medication incidents and near misses, as well as investigation results are entered into the Incident Management System (RiskMan). Recommendations and actions arising from incident investigations are implemented and monitored to ensure medication safety improvements.

Monthly medication incident reports, including specific high-risk drugs (i.e. APINCH), are developed for reporting at the ward level, division level, and through the Medication Safety Committee and Best Care Committee Structure. Incident data is also utilised for benchmarking purposes.

Operational risks relating to Medication Safety are monitored through the Medication Safety Committee and escalated to the Safe Care Committee as required.

Have improvements been implemented?

Support for the documentation, monitoring and review of patient medications has been made possible through the introduction of the EMR.

Following introduction of the EMR, clinical handover is undertaken in front of a computer to enable a patient's current medicine regime to be reviewed as part of the handover. Clinicians can also request a referral to the clinical pharmacist for a review if patients are at high risk eg being managed for delirium or on restricted antimicrobials.

Pharmacy staff have received education on how to access consumer leaflets on specific medication products via Lexicomp®. A Pharmacy newsletter article on how to access the leaflets in various languages was also published in December 2019 for circulation to all medical, nursing and pharmacy staff.

Work has been undertaken in collaboration with the VicTAG Quality Use of Medicines (QUM) group to generate 5 generalised patient information leaflets into 10 languages that WH can use. Feedback from consumers across VicTAG hospitals been collated and submitted to the VicTAG executive committee for endorsement. Publication of the final leaflets on the VicTAG website is anticipated by the end of March 2020.

Provide examples of outcomes since the previous onsite assessment:

The introduction of the EMR has enhanced processes for review of patient medications and handover of medication information.

The VHES patient satisfaction rating on receiving information about medications given in hospital has remained consistently around 70%, similar to peer hospitals on comparative review.

An increased focus on patient and carer engagement in medication management is reflected in education and improvement activity to access patient information.

CRITERION: Medication management processes 4.13, 4.14, 4.15

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Provide a summary of the processes that are in place to meet this criterion.

WH utilises a variety of methods to inform clinicians of evidence-based medication information to support safe supply, use and storage of medicines.

Pharmacy Procurement has a robust system for approving the non-registered compounded products from an external provider as outlined in the Pharmacy standard operating procedure.

Education is provided to clinicians at orientation and during EMR training to support informed decision making and facilitate the safe and effective management of medications. Clinicians have access to online resources such as eMIMs (online drug formulary) and the Clinicians Health Channel.

A drug information pharmacist is available five days a week to provide up-to-date information on new medicines, while the Western Health library service disseminates a quarterly newsletter to clinicians including new medication related evidence-based articles and updated guidelines.

The Pharmacy Department publishes newsletters once every two months to inform clinicians on various medication related health topics, medication safety and formulary updates and the Director of Pharmacy also disseminates any medication alerts or notifications. The Medication Safety Committee is also responsible for informing staff of changes relating to medication safety.

A poster on high risk medicines (APINCH) is available in all clinical areas to inform clinicians of medications falling under this group. High risk medicines have a shelf alert on the wards and in the pharmacy, and specialised order sets and alerts in the dispensing systems to reduce the risk of inadvertent prescribing, administration and dispensing. Barcodes also have TALLman lettering to distinguish between drug names that look alike.

The WH Medication prescription, supply and administration procedure outlines requirements for the safe storage and distribution of medicines including schedule 8 medicines, temperature sensitive medicines and cold-chain medicines. This procedure also outlines the correct method for disposal of unwanted, expired and unused medicines.

The Medication Refrigeration procedure outlines the requirements for monitoring and recording of cold chain items and processes on the management of items that have undertaken temperature excursion.

Every medication storage area that stores drugs of restrictions and misuse potential (S8/S11) has video surveillance equipment.

How does the health service monitor the requirements of this criterion are being met and where is the information reported?

Intervention forms are completed by pharmacists following the identification of prescribing issues on the EMR with clinically significant incidents entered into the Incident Management System (RiskMan). The intervention forms are sent to the responsible prescriber on EMR and the pharmacist also contacts prescribers to discuss identified issues.

Medication incident reporting includes specific reporting of all APINCH high risk medicines.

KPI reports presented at Divisional Quality and Safety meetings and the Medication Safety Committee specifically monitor high risk medications with trended data being analysed to identify areas of concern and inform improvement initiatives. Incident data is also utilised for benchmarking purposes.

Annual medication safety initiative and security audits are undertaken to monitor compliance with safe storage, distribution and disposal of all medicines including a patient's own medicines.

Drugs with misuse potential not accounted for in checks performed during each shift are reported, as with legislation, as a Police matter. These are collated and themed, and reported quarterly to the Medication Safety Committee.

High risk medications need a review by the quality use of medicines pharmacist for product packaging as part of application to the DTC for addition to the formulary. An example is the application of high dose Insulin Glargine (Toujeo®).

Operational risks relating to Medication Safety are monitored through the Medication Safety Committee and escalated to the Safe Care Committee as required.

Have improvements been implemented?

Support for the safe use of medications has been made possible through the introduction of the EMR. WH recently implemented the EMR Medication Administration Wizard (MAW). The MAW is now being used to scan the patient wristband to ensure Positive Patient Identification (PPID), which ensures that the right patient receives medication at the right time, decreasing the potential rate of medication error and ADRs.

Order sets through the EMR have also been introduced to enhance safe management of high-risk medications such as insulin. A Neuromuscular Blocking Agents (NMBA) advisory tool was also piloted early in April 2019 to provide feedback to VicTAG on its useability. This tool has been developed to assess against best practice standards.

Learning from the EMR implementation experiences of other health services, WH had Pharmacist representation on the EMR team and a patient safety team supporting live reporting and review of medication errors during the five weeks of EMR implementation. While there was an anticipated spike in medication documentation errors as staff first used the EMR in a live environment, no medication errors reached the patient during ERM roll-out.

Recommendations arising from medication incident reporting has led to Schedule 8 drug registers being pre-labelled to prevent documentation errors.

Recommendations have also resulted in video cameras installed above the drug storage locations of all drugs with misuse potential at WH. A Drug Discrepancy investigation process has been developed to assist with reporting discrepancies.

Provide examples of outcomes since the previous onsite assessment:

The introduction of the EMR has enhanced processes for safe use of medications. For example, EMR functionality and staff education on safe insulin prescribing and administration has supported a 5.1% decrease in reported medication incidents that resulted in minor, moderate or severe harm during 2018/19 when compared with 2017/18.

Apart from a spike in documentation errors during the five weeks of EMR implementation, APINCH medication incidents have steadily declined over the past 18 months.

The security of medications has been enhanced through increased physical surveillance and development of discrepancy investigation processes. This is reflected in strong audit results on the security of medications.