Government of **Western Australia**
Department of **Health**

Medication Safety Strategic Plan for WA Health

2015 - 2020

Quality Improvement and Change Management Unit

health.wa.gov.au

Contents

Executive Summary

The Western Australian Medication Safety Strategic Plan 2015-20 (the Strategic Plan) articulates the vision and system-wide priorities for medication safety and quality improvements in WA Health.

The Strategic Plan focuses on the prevention of adverse medication events by supporting clinicians and empowering patients to achieve best practice in medication management through implementation of proven and sustainable strategies integrated across all health settings. There are multiple factors that result in medication-related incidents, with poor communication (written or oral) a significant contributing cause, as is failure to follow policy. Forcing functions, automation, computerisation simplification and standardisation of systems are important strategies to improve safe use of medications.

The strategies to minimise harm of medication-related incidents and maximise quality use of medications are identified within each of the four principles (consumer and carer centred, driven by information, organised for safety and led for high performance). The development of these strategies has been guided by the Australian Commission on Safety and Quality in Health Care Framework and WA Health stakeholder feedback. Responsibility for each key activity has been assigned to the most appropriate sector. Collaboration between medication safety governance groups will continue to ensure adequate consultation and functionality within the health sector.

Electronic medication management systems (EMMS) have demonstrated reduced medication errors through improved written communication of medication orders including prescription legibility, in-built dose calculation, and clinical decision support, and enable best practice information to be more readily available to prescribers, including antimicrobial stewardship program decisions, and improve linkages between clinical information systems. Benefits also include improved efficiency in the medication management processes, such as providing real-time auditing information on prescribing and administration of medications, mandatory field prompts to ensure completion of all required information and reducing the time required to locate paper medication charts or to supply non-imprest medicines. It is recognised that EMMS would facilitate considerable advances in medication safety and is supported by the Office of Patient Safety and Clinical Quality as a priority for WA Health. It is the only approach to mitigating medication safety incidents that remains to be implemented in WA that has proven efficacy.

WA Medication Safety Strategic Plan

The Western Australian Medication Safety Strategic Plan 2015-20 (the Strategic Plan) articulates the vision and system-wide priorities for medication safety and quality improvements in WA Health in alignment with the Western Australian Strategic Plan for Safety and Quality in Health Care 2013-17[1], the National Safety and Quality Health Service Standards - Medication Safety Standard 4[2] and the Australian Commission on Safety and Quality in Health Care Framework.[3]

It is envisaged that the programme will continue to evolve as models of care further develop in line with the requirements of WA Health.

The inaugural Medication Safety Strategic Plan 2012-15 provided sound foundations on which to build future direction in medication safety, including standardisation of medication charts, a form for documenting medication reconciliation, policy development (high risk medications, clinical alerts and safe use of medication refrigerators), safer systems for administration of medications and auditing tools for benchmarking. The Strategic Plan (2015-20) continues to develop strategies outlined in the inaugural plan and extends to future requirements for WA Health to ensure programme evaluation and implementation of systems for reliable and relevant ongoing monitoring and feedback on medication safety. Both Strategic Plans were developed after consultation with experts in the area of medication safety along with research and planning by the Quality Improvement and Change Management Unit, Patient Safety and Clinical Quality Division at the Department of Health.

A stakeholder workshop was held to determine shared understandings about key strengths and gaps of the current system, and the priorities for future focus for safety and quality for medication management improvements in WA.

The Governance for medication safety in WA is managed by several stakeholders, including the WA Therapeutic Advisory Group (WATAG), the WA Medication Safety Group (WAMSG), the Pharmaceutical Services Branch (PSB), the Quality Improvement and Change Management Unit (QICM) and the Safety and Quality Executive Advisory Committee (SQuEAC) which has area health service representation.

The Strategic Plan focuses on the prevention of adverse medication events by supporting clinicians and empowering patients to achieve best practice in medication management through implementation of proven and sustainable strategies integrated across all health settings.

Background

Medicines are one of the most common causes of harm in health care.

- Medication-related hospital admissions have previously been estimated to comprise 2% to 3% of all Australian hospital admissions, with rising estimates of prevalence when sub-populations are studied. For example, 12% of all medical admissions and 20% to 30% of all admissions in the population aged 65 years and over are estimated to be medication-related.[4]
- There were 9.3 million separations from Australian hospitals in 2011-2012, which would suggest a medication-related hospital admission rate of 230,000 annually. With an average cost per separation in 2011-12 of $5,204, this suggests the annual cost of medication-related admissions is $1.2 billion.[4] 50% of hospital admissions due to medication errors are considered potentially avoidable.[4]
- It is estimated that medication errors in Australia cost over $660 million per year and represent 27% of all clinical incidents occurring in Australian hospitals.[6,7]
- In WA, medication errors account for the second highest proportion (21.4% 2013-15) of SAC-2 and SAC-3 incidents and 4.4% of SAC-1 incidents reported to the Datix Clinical Incident Management System[8] (Datix-CIMS).
- In WA, medication omissions (23.9%) and medication overdoses (23.9%) were the most frequently observed types of medication errors during 2013-14.[8]
- Of the reported medication errors for SAC-3 incidents in WA in 2013-14,
    - Over 40% were caused by a failure to follow policy and procedure (an increase from 28% in 2008/10),
    - 19.8% caused by inadequate knowledge or experience,
    - 19.7% due to communications problems, and
    - 16.2% were caused by a failure to read or misread prescribing information.[8]

Strategic Alignment

The Strategic Plan will align with policies and guidelines arising from a number of key bodies and important strategic directives. It will also incorporate goals from a state and

national levels to ensure initiatives are actioned and provides for ongoing evaluation and development. The Strategic Plan aims to promote better health outcomes through safe and quality use of medicines.

The Strategic Plan aligns with the:

- Western Australian Strategic Plan for Safety and Quality in Health Care 2013-17
- Australian Commission on Safety and Quality in Health Care Framework
- National Safety and Quality Health Service Standards (Medication Safety and medication-related components of other standards)
- National Medicines Policy
- National Strategy for Quality Use of Medicines
- Commonwealth Department of Health and Aging including Therapeutic Goods Administration, NPS MedicineWise and Pharmaceutical Benefits Division
- Australian Pharmaceutical Advisory Council (APAC) Guidelines
- WA Therapeutic Advisory Group Strategic Plan (WATAG)

WA Medication Safety Goals

The primary goals for medication safety are:

- Reduce the number of patients harmed by preventable adverse medication events,
- Prescribe and manage patients' medications based on best practice evidence, and
- Reduce resources wasted through inaccurate, inappropriate and/or inefficient use of medicines.

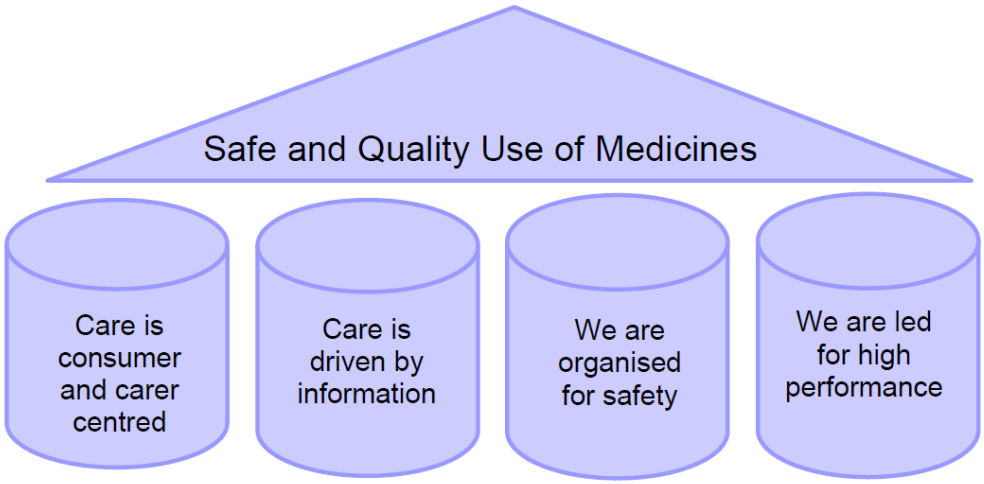
These goals can be reached by:

- Creating, communicating, and demonstrating a **leadership-driven culture of safety** – which is driven by transparent sharing of information and benchmarking
- **Reducing the risk** of medication incidents and errors
- **Improving safe use** of medications
- **Improving the effectiveness** of medicines
- **Enhancing effective communication** to improve the continuity of medication management
- **Integrating technology** to improve safety and efficient medication management
- **Providing timely and cost effective access** to medicines

Actions to improve medication safety should include:

- Encourage safe prescribing and administration of medications by supporting the use of the national inpatient medication chart (NIMC), standardisation of specialised medication charts and medication reconciliation in WA public hospitals; and accelerating implementation of electronic medicines management (EMM) in hospitals.
- Ensure the six rights are adhered to by all health professionals involved in the management of the patient's medication – for prescribing, administration and dispensing of medications. (The Six Rights of Medication Administration include the right patient, the right medication, the right dose, the right time, the right route and the right documentation).
- Ensure processes for documentation of the patient's adverse drug reaction(s) (ADRs) and allergy status are outlined and roles and responsibilities are clear.
- Encourage a culture of reporting and learning from medication incidents.
- Improving the transfer of medication information at transition points of care.
- Reduce harm from high risk medicines and systems by raising awareness and providing strategies for services to implement to minimise harm.
- Developing a measurement and evaluation framework to monitor reductions in medication harm and contributing errors and assess programme effectiveness.
- Encourage a culture of benchmarking and transparent sharing of information in relation to medication issues and incidents to cultivate a system of quality improvement.
- Improve staff awareness, skills and competencies in all aspects of the medicines management cycle
- Ensure the patient, and/or their carer, is educated in the safe and appropriate use of medicines.
- Support research and evaluation of programmes or projects focused on medication safety initiatives.

Key Principles for Safety and Quality Use of Medications



Care is Consumer and Carer Centred

- Active engagement of patients and family caregivers with the care team empowering them to share decision-making about their medicines.
- Empower patients and family caregivers to manage their medications by keeping personal medication lists, bringing their medicines with them to hospital, and informing them about the purpose, effects and side effects of their medications.
- Embed Open Disclosure as an integral component of keeping the patient, their family and carers informed of the rationale for the initiation, ceasing or changing of a patient's medications during each episode of care.
- Provide consumer medication information (CMI) or patient information leaflets which are easy to understand.
- Including carers in the consumer-centred approach to mental health patient's management of medications as part of the patient's overall care-plan.
- Be consumer focused when prescribing medication by being alert to the unintended implications of polypharmacy.

Care is Driven by Information

- Learn from consumers' and carers' experiences.
- Invest in data management and promotion of audit, research, evaluation and benchmarking to review clinical practice for improvement opportunities to communicate safety and quality practice and provide future strategic direction.
- Provide a transparent sharing of information in relation to medication issues and incidents to cultivate a system of quality improvement.
- Ensure effective and efficient access to evidence-based clinical practice guidance and decision support tools.

We are Organised for Safety

- Encourage organisational structures that enable good governance and cooperative partnerships at all levels of the health system to support consumer and workforce safety.
- Maintain clear, consistent safety and quality policies and procedures for safe medication management.
- Ensure activities are consultative, collaborative, and multi-disciplinary.
- Improved communication among doctors, pharmacists, nurses and carers regarding the patient's medication management.
- Apply lessons learned through investigating, managing and responding to identified clinical incidents and complaints.
- Ensure safety and quality processes and controls are built into all new technologies and infrastructure design, development, procurement, deployment and operations.

We are Led for High Performance

- Initiate and support leadership and cultural change throughout the health system.
- Support a culture of continuous improvement.
- Educate and train to enhance capacity and capability in resilience and change management for staff and clinicians.
- Foster a culture of openness, open reporting, transparency and collaboration amongst health care providers and consumers.
- Link performance and funding through activity based management.

Priority areas of WA Medication Safety Strategic Plan

The WA Medication Safety Strategic Plan focuses around FIVE major streams:

- **High Risk Medicines (Organised for Safety)**
  - Promoting safer management of high risk (APINCH) medicines
    - ❖ A Antimicrobials and Antipsychotics
    - ❖ P Potassium and other Concentrated Electrolytes
    - ❖ I Insulins
    - ❖ N Narcotics and sedatives
    - ❖ C Chemotherapy
    - ❖ H Heparin and other anticoagulants

- **High Risk Process and Medicines Use Systems (Organised for Safety)**
  - Ensuring complete and accurate documentation of the patient's medication history, including history of adverse drug reactions (ADRs) and allergies.
  - Supporting safer outcomes through standardisation and best practice in processes for ordering, supplying, storing and administering of medicines.
  - Ensuring quality electronic medicines management (EMM) systems supporting safer medication use.

- **Continuity of care and equity of access (Consumer and Carer centred)**
  - Improving timeliness of communication of medicine use across the continuum between hospital and community care settings, ensuring correct and complete medications lists are communicated in the discharge summary.
  - Promoting equity of access to medicines for all patients.

- **Improving Communication (Driven by Information and Organised for Safety)**
  - Increasing awareness of risks of patient harm in medication management.
  - Improving the development of the medicines management workforce.
  - Improving clinical handover of medication management in line with developments in health care provision.

- **Evaluation and Research (Led for High Performance)**
  - Ensuring programme evaluation and implementation of systems for reliable and relevant ongoing monitoring and feedback on medication safety.
  - Encouraging innovative and targeted research into medication issues and strategies.

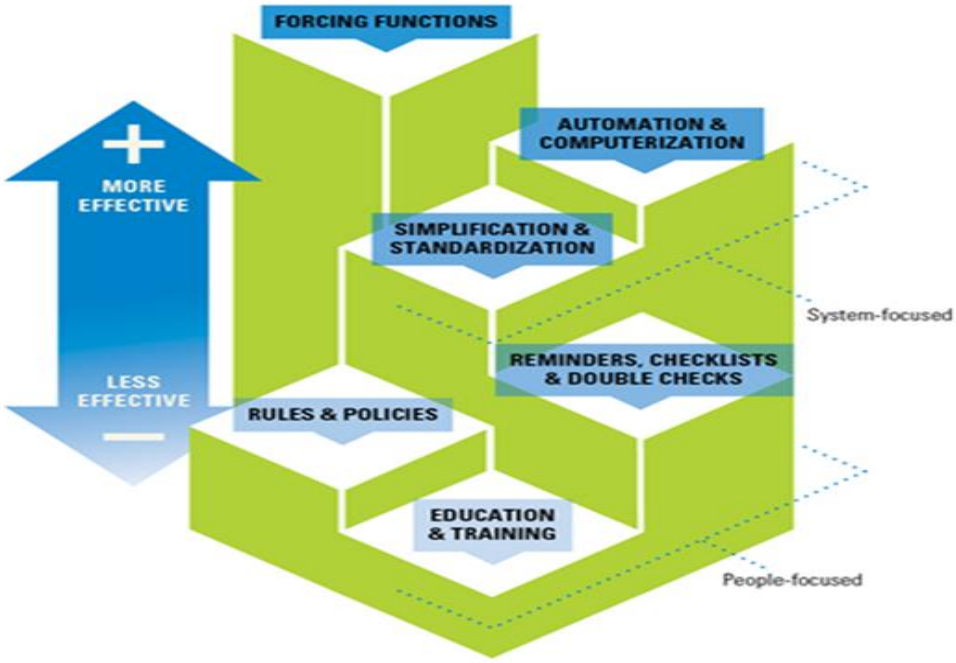
Reducing Medication-related Clinical Incidents

The principles of error reduction which provide the greatest chance of sustainable impact is based on human factor concepts include:

- Automation of processes
- Restricted access or limitation of use - forcing functions and constraints to guide individuals to promote correct actions and avoid errors
- Standardisation which results in simplification and consistency of processes
- Simplification of tasks, reducing reliance on individual performance skills
- Provision of policies, procedures and guidance to ensure a standard of practice is maintained
- Improve access to decision support information
- Creation of strategies to reduce potential for error
- Education and training

The Hierarchy of Intervention Effectiveness[9] (Figure 1) provides a visual representation of the principles of error reduction in relation to their impact on minimising errors and whether the solutions are people focused (based on enhancing individuals' knowledge, providing expectations of performance and check-points to follow) or systems focused (which provide automated or physical barriers to prevent errors or mandate an act or function).

Figure 1: The Hierarchy of Intervention Effectiveness[9]



WA Medication Safety Priorities 2015-2020

Principle 1: Care is consumer and carer centred

Consumers and carers have significant potential to influence service delivery if they are supported to be involved in quality improvement, health service planning, monitoring, delivery and review. Consumers and carers need to be supported to be actively involved in their own health care as well as service delivery across the health care system.

Active consumer participation in their own care leads to improvements in health outcomes. Health services must consider the most vulnerable consumers including, but not limited to, mental health, co-morbidities culturally and linguistically diverse patients, older adults, children and young people.

Key Activity 1.1	**Improve continuity of care for patients on discharge from hospital** • Standardise medication-related information in the discharge summary.	Responsibility Area Health Services
	• Improve clinical handover for medication management for hospital transfer care	WAMSG
	• Provide consumers with medication care plans on transfer home or to other levels of care.	Area Health Services/ QICM/ WAMSG
	• Provide adequate medicines information for patients initiated on high risk medications	WAMSG / Area Health Services
	• Standardise process for clinical handover of medication information at transfer of care (to home, residential aged care facilities, hostels or another hospital).	Area Health Services
Key Activity 1.2	**Improve medication-related information for provision to the consumer** • Provide a Consumer Adverse Drug Reaction Information Leaflet.	QICM
	• Undertake a gap analysis to determine whether consumer information is required to be developed.	WAMSG/QICM
	• Develop medication-class information for provision to consumers.	WAMSG
Key Activity 1.3	**Promoting equity of access to medicines across health services** • Support development of a state medication formulary to provide guidance and governance for availability and restrictions for medication access.	WADEP/OCMO
Key Activity 1.4	**Medication Safety Information and Communication Technology (ICT) Solutions** • Support requirements for purchase and implementation of EMM systems for WA Health to improve patient safety	OCMO/QICM
	• Ensure safety and quality processes and controls are built into all new technologies and infrastructure design, development, procurement, deployment and operations.	OCMO/QICM

Principle 2: Care is driven by information

The process of the collection, analysis and reporting of valid, reliable and timely information is critical for continuous quality improvement. Information needs to be used at all levels of the organisation from the use of data to drive strategic planning to ensure the accessibility of best practice evidence for clinicians.

Key Activity 2.1	**Adverse Drug Event (ADE) Reporting** • Promote reporting of adverse drug events through Clinical Incident Monitoring System (Datix CIMS).	**Responsibility** PSSU
	• Review of clinical incidents to identify, investigate and improve clinical and service outcomes.	QICM
Key Activity 2.2	**Data Management** • Monitor key performance indicators for medication reconciliation to provide strategic direction for improvement	Area Health Services
	• Monitor NIMC Audit results for state-wide progress in medication safety initiatives supported by the NIMC	QICM
	• Initiate an audit tool registry to identify and make accessible audit tools developed for medication safety	QICM
Key Activity 2.3	**Evaluation and Research** • Investigate outcome measure/s for medication safety – identifying method of coding for adverse medication events.	QICM
	• Encourage innovative and targeted research into medication issues and strategies.	QICM
Key Activity 2.4	**Medication Safety Information and Communication Technology (ICT) Solutions** • Support requirements for purchase and implementation of EMM systems for WA Health to improve patient safety and to assist with providing data on prescribing of medications within WA Health	OCMO/QICM

Principle 3: We are organised for safety

The structures within the organisation, processes and overall culture of the organisation support continuous quality improvement and effective health care delivery. This involves:

- quality planning and reporting,
- communicating relevant information within hierarchies and across professional boundaries, and
- sharing commitment, responsibility and involvement with all staff for creating and maintaining structures and processes for high quality care.

In health care new technologies are constantly being developed that have the potential to improve the safety and quality of care. Inversely, safety and quality processes need to be considered across the system including during the development of new technologies, infrastructure and procurement.

Key Activity	**Monitor compliance with NIMC safety features** • WA Health mandatory audit participation biennially	**Responsibility** Area Health Services

3.1	• Biennial provision of a report outlining areas of improvement and areas requiring attention with recommendations	QICM
Key Activity 3.2	**Standardisation of charts across all WA Hospital sites** • Provide governance for existing state charts to ensure the charts are current and support best practice evidence. Issue logs are maintained and issues escalated for consultation as appropriate. Including: - WA National Inpatient Medication Chart (NIMC) (Short stay and Long stay) - WA Paediatric Inpatient Medication Chart - WA Clozapine Initiation and Titration Chart - WA Anticoagulation Medication Chart	QICM
	• Review and support uptake of Subcutaneous Insulin Order and Blood Glucose Monitoring Form (Currently in development phase [ACSQHC])	QICM
	• Standardise an insulin intravenous infusion chart for WA Health	QICM/WAMSG
	• Standardise chemotherapy charting for WA Health	WAMSG
	• Other charts for state-wide development: - Depot medication chart - Agitation and Arousal in mental health patients chart - Pre and post-operative ophthalmic chart - Post-operative nausea and vomiting chart	QICM
Key Activity 3.3	**High Risk Medication OD 0561/14 and Systems** • Promote safer outcomes from high risk medicines - Development of an insulin safety toolkit - Review uptake of clinical indicators for monitoring warfarin including: ▪ 1.1 Percentage of hospitalised adult patients that are assessed for risk of venous thromboembolism ▪ 1.2 Percentage of hospitalised adult patients that receive venous thromboembolism prophylaxis appropriate to their level of risk ▪ 1.3 Percentage of patients prescribed enoxaparin whose dosing schedule is appropriate ▪ 1.4 Warfarin therapy is initiated with a starting dose defined according to the guidelines on the WA Anticoagulation Chart ▪ 1.5 No patient receiving warfarin has a measured INR greater than 4.0 without prompt review and dose adjustment. ▪ 5.4 All patients transferred home on warfarin or New Oral Anticoagulants receive written information prior to transfer	QICM
	• Review and report on antipsychotic polypharmacy	WAPDC Area Health Services
	• Improve safe use of intermittent transdermal medications	QICM Area Health Services

Key Activity 3.4	• **Standardised Abbreviations OD 0184/09** Audit and report on prescribing standards of approved standardised abbreviations across secondary, tertiary and quaternary healthcare	QICM
Key Activity 3.5	**National Recommendations for User-Applied Labelling of Injectable Medicines, Fluids and Lines OD 0385/12** • Review of Operational Directive in alignment with revision of recommendations by ACSQHS (version 3) **National Standard for User Applied Labelling of Injectable Medicines, Fluids and Lines OD 0647/16** • Review of requirements for education and promotion in alignment with National Standard for User Applied Labelling of Injectable Medicines Fluids and Lines by ACSQHS and revised WA Operational Directive • Inclusion of new labels in National Standard for inclusion in state tender	QICM QICM HCN
Key Activity 3.6	**Pharmaceutical Review Policy OD 0039/07** • Review of policy in line with proposed new Safety and Quality Standard – Medication Safety (MS) – Medicine review core action	QICM
	• Develop a risk assessment screening tool to prioritise high risk patients for medication reconciliation on admission and discharge to be integrated into existing assessment documentation or eReferral pathways	QICM
	• Standardise processes in medication management using the WA Medication History and Management Plan	QICM
	• Standardise documentation of counselling of medications.	QICM
	• Review Information and Communication Technology (ICT) platforms for medication management.	QICM
Key Activity 3.7	**Antimicrobial Stewardship Policy (OD 0626/15)** • Support a systematic approach to optimisation of antibiotic utilisation	QICM/WACA
	• Ensure the appropriate use of antibiotics to limit unnecessary antibiotic administration or exposure by - Optimising diagnosis, - Ensuring selecting appropriate antibiotics, and - Optimising dosing, frequency and duration of therapy with executive support and Antimicrobial Stewardship Programs.	Area Health Services
Key Activity 3.8	**VTE Risk Assessment** • Provide a systematic approach to venous thromboembolism risk assessment before initiating pharmacological or mechanical prophylaxis	QICM/Area Health Service
Key Activity 3.9	**Medication Safety Information and Communication Technology (ICT) Solutions** • Support requirements for purchase and implementation of EMM systems for WA Health to improve patient safety	OCMO/QICM

	• Ensure safety and quality processes and controls are built into all new technologies and infrastructure design, development, procurement, deployment and operations.	OCMO/QICM
	• Provide recommendations to procurement regarding requirements of smart infusion pump equipment (including recommendations for smart pump library management)	WAMSG/QICM

Principle 4: We are led for high performance

Cultural change is more likely to occur in organisations where people at all levels are committed to, and involved in, the process. Systemwide improvement, innovation and sustainable changes come from an organisational culture of strong leadership.

This involves educating, empowering and resourcing leaders at all levels of the organisation. A high performing workforce demonstrates high levels of collaboration and innovation and is committed to the vision and values of WA Health.

Key Activity 4.1	**Initiate and support leadership and cultural change throughout the health system** • To improve communication to hospitals on medication safety issues and work in collaboration with the Medication Safety Network to identify risk areas, and develop tools/initiatives to assist in safe medication practices including: - linking individuals and project teams working on medication safety activities - identifying issues and challenges which require state-wide solutions - sharing medication safety learning and resources - building on existing medication safety work - aligning medication safety activities across area health services - promoting medication safety through events such as Medication Safety Week and the Medication Safety Symposium held annually	**Responsibility** QICM/WAMSG

It is acknowledged that there are medication-related issues that occur in the community health sector that have been raised. These include standardised medication charts and electronic medication management systems for community health services. These currently fall out of scope of this Strategic Plan, but have been registered for future action.

Responsibilities have been allocated to the key strategies and are outlined in more detail in the Medication Safety Operational Plan 2015-20 which outlines objectives and deliverables with projected timeline expectations.

Roles and Responsibilities for Medication Safety

Consumers and health care providers in partnership are responsible for:

- Improving medication use by:
    - recognising when and where problems exist,
    - identifying factors that contribute to those problems,
    - initiating interventions to improve medication use, and
    - evaluating outcomes.
- Enhancing understanding of the risk and benefits associated with the use of all medicines;
- Fostering informed debate about the role of medicines in health care; and
- Working in partnership to achieve quality use of medicines (QUM).

Health care consumers are responsible for:

- Asking for and utilising objective information, resources and services to make decisions and take actions that enable medicines, when they are required, to be chosen and used wisely;
- Becoming more aware of the risks and benefits of medicines, the possibility of non-drug options and the importance of a healthy lifestyle;
- Developing skills and confidence to use medicines appropriately and seeking help to solve problems when they arise; and
- Becoming more aware of the place of medicines in the broader context of health services and society.

Health practitioners and educators are responsible for:

- Assisting people in making informed decisions and learning more about health issues and health care through information, education and discussion;
- Becoming more aware of the risks and benefits of medicines, the possibility of non-drug options and the importance of a healthy life-style;
- Utilising objective information, resources and services to make decisions and take actions that enable medicines, when required, to be chosen and used wisely;
- Continually developing knowledge and skills to use medicines appropriately; and
- Becoming more aware of the place of medicines within society.

Health (hospital and community health) and aged care facilities are responsible for:

- Providing facilities, systems, training opportunities and structures that support staff, health practitioners and consumers in using medicines wisely and that avoid medication errors.

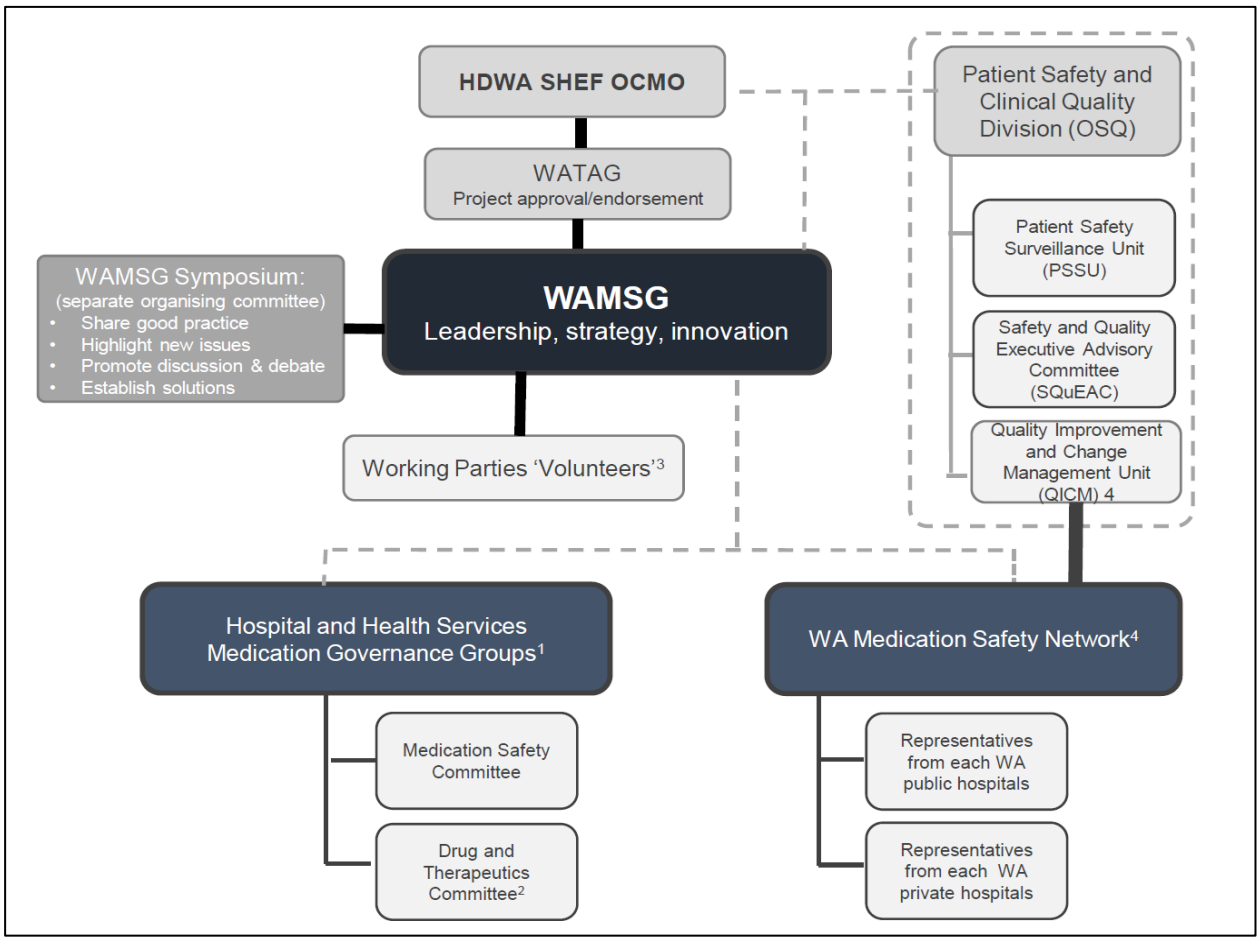
Quality Improvement and Change Management Unit are responsible for:

- Providing governance for standardisation of processes used in the management of medications, including state medication charts and forms.
- Provide structure and support for quality initiatives for safe use of medications.

Appendix I: State-based governance for Medication Safety

Various statewide initiatives have been developed to complement or support the implementation of the National Medicines Policy in WA. Governance for medication safety is outlined in Figure 2.

Figure 2: WA Health governance for medication safety



WA Therapeutic Advisory Group (WATAG) and subcommittees

WATAG is a multidisciplinary clinical expert group that advises on matters related to medicines and therapeutics in WA Health.

WATAG is guided by the principles of:

- Equity: Equity of access to medicines across health services
- Safety: Medicines are used with care to avoid or reduce side-effects or harm
- Quality: The appropriate medicine is used each time.

In addition to supporting the quality use of medicines, WATAG provides independent advice to health professionals, health services and the Department of Health regarding the use of drugs and therapeutics in the public hospital and wider community setting in WA.

Four subcommittees are established under WATAG, namely the Western Australian Psychotropic Drugs Committee (WAPDC), Western Australian Drug Evaluation Panel (WADEP), Western Australian Committee for Antimicrobials (WACA) and the Western Australian Medication Safety Group (WAMSG).

The primary aim of WAMSG is to reduce patient harm associated with medication errors. This sub-committee operates by involving stakeholders and local experts to develop standards that may be uniformly applied throughout the WA Health System.
A number of Working Groups have been established under WAMSG, such as a Continuum of Care Working Group, Analgesic Management Working Group, Anticoagulation Steering Committee and Timely Administration of Medications Working Group which may advise on strategies or initiatives that can be implemented to achieve the standards contained in this policy.

Office of Patient Safety and Clinical Quality

The role of the Office of Patient Safety and Clinical Quality is the establishment of safety and quality standards; the regulation and licensing of non-Government healthcare providers; the purchase of publicly funded health services through business and financial modelling of health needs; specification and contract development services; and reporting and monitoring performance. The Quality Improvement and Change Management Unit, Patient Safety Surveillance Unit, and the Licensing and Accreditation Regulatory Unit within the Office have healthcare safety and quality as their principal focus.

The Quality Improvement and Change Management Unit (QICM) is responsible for planning, developing and promoting clinical governance policies and programs and safety and quality strategies to be implemented across the WA health system, in line with the Strategic Plan. The QICM unit provides governance for medication charts developed for use across WA Health and liaise closely with the Australian Commission for Safety and Quality in Healthcare to govern the WA NIMC suite of charts.

The Patient Safety Surveillance Unit (PSSU) is responsible for the governance of patient safety through the development of policy and system wide reporting in a number of areas including:

- Clinical Incident Management
- WA Audit of Surgical Mortality
- statewide complaints policy and reporting

- statewide Review of Death policy and reporting
- management of the Coronial Liaison Unit and reporting to the Office of The State Coroner.

The Licensing and Accreditation Regulatory Unit (LARU) is responsible for the licensing and monitoring of private hospitals in Western Australia. The LARU is also the regulator of accreditation against the NSQHS Standards which are mandatory for all hospitals and day surgeries, both public and private, in Western Australia.

Health Services have overall responsibility for service provision and implementation of safety and quality policies and standards at the local level.

The Medication Safety Network was established in July 2012 by local pharmacists involved with the SQUIRE Medication Reconciliation Project and is supported by QICM to align medication reconciliation activities across the state. The Network is accountable to the Quality Improvement and Change Management (QICM) Unit, Patient Safety and Clinical Quality Division, Department of Health. The scope of the Network's work is limited to all Medication Safety processes and activities in the public hospital sector.

Activities of the network include:

- Reviewing all relevant Medication Reconciliation tools, processes and policies including
    - Measurement and documentation of process
    - Organisational Supports
    - Education
    - Evaluation, audit and feedback
    - Technological systems and solutions
- Review and exchange information on, current Medication Safety activities across the state and Medication Safety strategies nationally
- Review and advise on the Australian Commission on Safety and Quality in Health Care's (ACSQHC) activities in Medication Safety
- Review any draft Medication Safety strategies developed by QICM Unit, Patient Safety and Clinical Quality Division
- Lead implementation of any endorsed state-wide Medication Safety strategy.
- Aligning Medication Safety activities including the development and implementation of a statewide medication management plan.

References

1. Western Australian Strategic Plan for Safety and Quality in Health Care 2013-17 http://www.safetyandquality.health.wa.gov.au/docs/WASafetyandQualityStrategicPlan2013-2017.pdf
2. Australian Safety and Quality Framework for Health Care http://www.safetyandquality.gov.au/national-priorities/australian-safety-and-quality-framework-for-health-care/
3. National Safety and Quality Health Service Standards- Standard 4 Medication Safety. http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf
4. Roughhead E, Semple S, Ms Ellie Rosefeld Literature Review: Medication in Australia: Australian Commission on Safety and Quality in Health Care August 2013. http://www.safetyandquality.gov.au/wp-content/uploads/2013/08/Literature-Review-Medication-Safety-in-Australia-2013.pdf
5. Ehsani JP, Jackson T, and Duckett SJ, The incidence and cost of adverse events in Victorian hospitals 2003-4. Medical Journal of Australia, 2006. 184(11): p. 551-555
6. Roughhead E, Semple S Medication safety in acute care in Australia: Where are we now? Part 1: A review of the extent and causes of medication problems 2002-2008 ANZ Health Policy 2009;6:18
7. Runciman, W., Roughead, E., Semple, S., & Adams, R. Adverse drug events and medication errors in Australia. International Journal for Quality in Health Care. 2003; 15(suppl 1): i49-i59
8. Patient Safety Surveillance Unit (2014), Your Safety in Our Hands in Hospital. An Integrated Approach to Patient Safety Surveillance in WA Hospitals, Health Services and the Community: 2014. Delivering Safer Care Series Report Number 3. Department of Health: Perth. Version 1. http://www.safetyandquality.health.wa.gov.au/docs/clinical_risk_man/Your_Safety_2014.pdf
9. Joseph A Cafazzo and Oliver St-Cyr. From Discovery to Design: The Evolution of Human Factors in Healthcare Healthcare Quarterly, 15 (Special Issue) April 2012. Doi:10.12927/hcq.2012.22845.

10. Australian Pharmaceutical Advisory Council. Guiding Principles to achieve continuity in medication management. Canberra; Commonwealth of Australia; 2005
11. Department of Health (WA). Pharmaceutical Benefits Scheme (PBS) Reform [online] 2006 [cited 15 Nov 2006]. Available from: URL http://www.health.wa.gov.au/pbsreform/
12. Review of public hospital pharmacy departments in Western Australia by D. Aldous January 2004.

This document can be made available in alternative formats on request for a person with a disability.