WAMSG
Medication Safety Symposium 2012

Program

Tuesday May 29, 2012
8:30 –16:00

Medication Safety: Making a difference
Program

Theatrette, Department of Health

189 Royal St, EAST PERTH
Western Australian Medication Safety Group

Helen Lovitt (Chairman)
Senior Pharmacist
Fremantle Hospital

A/Prof Christopher Beer
Geriatrician and Clinical Pharmacologist
Royal Perth Hospital and UWA

Katherine Birkett
Senior Project Officer
Clinical Services Redesign
Royal Perth Hospital

Prof David Bruce
Head, Community and Geriatric Medicine
Fremantle Hospital and UWA

Máire Connolly
Clinical Practice Improvement Coordinator
Safety Quality and Performance Unit
Sir Charles Gairdner Hospital

Dr Rowan Davidson
Chief Psychiatrist
WA Department of Health

Kerry Fitzsimons
Medication Safety Pharmacist
Fremantle Hospital and Quality Improvement Directorate

Leanne Gough
Clinical Practice Improvement Coordinator
Safety Quality & Performance
Princess Margaret Hospital

Violet Ford
Senior Pharmacist
Princess Margaret Hospital

Dr Stephen Lim
Chief Pharmacist
Armadale Health Service

Wendy McIntosh
Program Manager, Clinical Quality
WA Country Health Service

David McKnight
Deputy Chief Pharmacist
St John of God Subiaco Hospital

Dr Mark Newman
Clinical Director
Safety Quality and Performance Unit
Sir Charles Gairdner Hospital

Barbara O’Callaghan
Clinical Nurse Consultant
Haematology & Oncology
Fremantle hospital

Nancy Pierce
Consumer Advocate

David Lyon
Executive Officer
Western Australian Therapeutics Advisory Group

Dr Margherita Veroni
Project Coordinator
Western Australian Medication Safety Group
# Program

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Registration/Coffee/Tea</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Medication Safety: A primary care perspective.</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Dr Pradeep Jayasuriya</td>
<td></td>
</tr>
<tr>
<td>9:15</td>
<td>Medication Safety—Are you up to standard?</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Margaret Duguid</td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Meeting the national standard for medication management and EQUIP V5 mandatory requirements.</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Sally Winfield¹ and Christine Phillips²</td>
<td></td>
</tr>
<tr>
<td></td>
<td>¹Clinical Nurse Specialist, Bethesda Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>²Manager, Safety and Quality, Bethesda Hospital</td>
<td></td>
</tr>
<tr>
<td>10:15</td>
<td>Who gets an intervention? An examination of high risk indicators in a regional hospital.</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Meeghan Clay</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acting Chief Pharmacist, WACHS - Great Southern</td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>Morning tea</td>
<td></td>
</tr>
<tr>
<td>11:00</td>
<td>The 6 rights by everyone—every time: A lean action challenge.</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Gillian Charlwood, Coordinator Enrolled Nurse Education, Princess Margaret Hospital</td>
<td></td>
</tr>
<tr>
<td>11:15</td>
<td>Nurses wearing Medibibs to reduce drug errors.</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Dr Vickey Brown, Clinical Nurse Manager, Surgical Services (Orthopaedics ), Fremantle Hospital &amp; Health Service</td>
<td></td>
</tr>
<tr>
<td>11:30</td>
<td>Eliminate medication omissions in the Low Level and High Level care units by Dec 2011.</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Sipelile Chakaingesu</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical Nurse Specialist, Merredin Hospital</td>
<td></td>
</tr>
<tr>
<td>11:45</td>
<td>Reflections from the frontline: A participatory action research project investigating the clinical education of third year nursing students and medication administration scope of practice. Janie Brown, Director of Teaching and Learning, School of Nursing and Midwifery, Curtin University</td>
<td>15</td>
</tr>
</tbody>
</table>
Proffered papers (continued)

12:00  Making a difference: The OZ born way.  
Karen Chapman  
Senior Pharmacist, Osborne Park Hospital  
Page 16

12:15  “Cleaning up” intravenous paracetamol usage at Armadale Health Service.  
Yang Liu  
Senior Pharmacist, Armadale Health Service  
Page 17

12:30  Non-luer enteral feeding systems- A WA Health procurement strategy aimed at improving medication safety and delivery.  
Jane Fellman  
Corporate Nursing, Sir Charles Gairdner Hospital  
Page 18

12:45  Sticking to your guns to solve a problem: Our oxycodone story.  
Meeghan Clay  
Acting Chief Pharmacist, WACHS - Great Southern  
Page 19

13:00  Lunch

    Forum: Putting the patient at the centre  
    Facilitators: Marie Connolly and Barbara O’Callaghan  
    Page 20

14:00  Learning from experience—Consumer Stories

14:30  Improving the patient journey by engaging the consumer

16:00  Close
Invited speakers

Dr Pradeep Jayasuriya

Pradeep is the principal of a small independent general practice in the Perth metropolitan area for the last 20 years. A graduate from UWA he has advocated for primary care in various capacities representing professional bodies. When he was Director of research for the RACGP in WA, he passionately supported the development of research capacity to lead the development of general practice as well as undertaking a wide range of research projects. He has contributed to guideline initiatives including those for chronic disease self management and preventive activities in general practice. He has lectured in the area of international health at Curtin University and currently teaches casually at the department of pharmacy at UWA. He is member of the Health Decision Support Advisory Group for the National Prescribing Service and a member of the advisory board for the Veteran Mates project co-ordinated by the University of South Australia. He is involved in various community committees and would like to see a primary care centred health system where the generalist health professionals are valued and patients firmly at the centre of practice.

Margaret Duguid

Margaret is the Pharmaceutical Advisor at the Australian Commission on Safety and Quality in Health Care where she is involved in leading and coordinating improvements in the safe and quality use of medicines nationally.

A graduate of Otago University in New Zealand, Margaret commenced her career in hospital pharmacy in New Zealand before moving to Australia to work in the pharmaceutical industry. She then spent some time in community pharmacy in Australia and Scotland before returning to Australia and hospital practice where she worked as a pharmacy manager for 25 years, most recently as Director of Pharmacy at Royal North Shore Hospital, NSW.

Margaret has been an active member of the Society of Hospital Pharmacists of Australia (SHPA) for over 30 years. She has served as a Federal Councillor, Federal President, and Chair of the SHPA Research and Development Grants Advisory Committee. Margaret has been an examiner for the former NSW Pharmacy Board and has served on the former Australian Pharmaceutical Advisory Committee. (cont..)
(Margaret Duguid cont.) In 1995 Margaret was awarded the Merck Sharp Dohme (Australia) Medal for Pharmacy Practice and in 2005 received the Fred J Boyd award from the Society of Hospital Pharmacists for meritorious service to hospital pharmacy.

Margaret has a keen interest in patient safety and the quality and safe use of medicines. Her particular interests are the continuity of medication management, medication reconciliation, standardisation and systems improvement and antimicrobial stewardship.

**Joseph Cuthbertson**

Executive Manager Clinical Governance, St John Ambulance (WA)

**Dr Stephen Lim**

Stephen is Chief Pharmacist at Armadale Health Service where the Pharmacy Department actively promotes medication safety. The department has participated in many safety programs including PAWS (Promoting Armadale Warfarin Safety) program, SOAP (Safe Oxycodone Administration Promotion), ADR documentation and WHO (World Health Organisation) High 5s medication reconciliation project. Stephen is also a member of WAMSG and conducts lots of audits and research in many areas of pharmacy.

**Sandy McKiernan**

As Director of Cancer Information and Support Services at Cancer Council WA (CCWA), Sandy oversees the strategic and operational direction of all cancer services provided by CCWA to people affected by cancer as well as health professional education related to supportive and palliative care. Sandy has over 20 years’ experience as a Cancer Nurse in the public and not for profit sector in WA and completed her Masters of Public Health in 2004. Sandy has played an active role in the Cancer Nurses Society of Australia since 2003 and is currently President Elect taking up the Presidency in January 2013.

**Adina Quattrini**

Adina is the Chronic Conditions Self-Management Coordinator for the South Metropolitan Area Health Services. Adina trained as an Occupational Therapist and has worked across the continuum of care in various hospital and community positions. She has also been a lecturer and clinical coordinator/educator of student training at the School of Occupational Therapy at Curtin University.
Deirdre Criddle

Deirdre has had a varied career in pharmacy. Her experience includes practicing as a clinical pharmacist, working as a drug information pharmacist in the pharmaceutical industry and as an academic detailer for several GP Networks through the National Prescribing Service Educational Visiting Program. Currently Deirdre occupies herself at Sir Charles Gairdner Hospital in the area of Drug and Therapeutics and teaching in the University of Western Australia Department of Pharmacy. Accredited since 2003, Deirdre is passionate about Medication Review in the community, and is looking forward to seeing this area of clinical pharmacy develop into a true career pathway for pharmacists.

Margaret Ryan

Margaret first became a health consumer around 1995 with her late husband’s health problems. Seeing the things that could go wrong with her late husband’s treatment, things that happened to parents, step-parents, siblings and friends and, not being afraid to speak out she decided that the only way to help to improve was to be involved.

Brian Stafford

Brian first became a health consumer with an unwanted lived experience of substandard health delivery back in 1995. It started with a hospital error. At the time he failed to recognise the significance of the events that had taken place.

Nancy Pierce

Nancy has been interested in QUM since 1996 when she participated in the National Polypharmacy in the Elderly Project. Since then she has represented the consumer voice in QUM at a number of levels including the WAMSG.

Iren Hunyadi

Iren is a Registered nurse with 40 years experience in the health system. She has been a Health Consumer Advocate since 1996.
Medication safety is an important issue that concerns all health professionals. Despite the various activities to address the problem, the prevalence of medication errors is unacceptably high. Errors can arise in any part of the medication process but are particularly a problem at the point where patients’ care is transferred from one sector to another. Medication safety thereby becomes a problem for all sectors of the healthcare system and to maximise benefit from interventions it is necessary and imperative that issues are approached collaboratively. At a primary care level, the research is less well established but the prevalence of errors is common. Improving medication management in primary care provides unique challenges. In contrast to the tertiary setting, there is fragmentation of information among different health professionals and the role of the patient is different as they are actively engaged in all steps of medication management. Despite these challenges, analysis of the activities show some significant gains, particularly through multifaceted interventions that have demonstrated positive outcomes for patients. e-health also has the potential for delivering positive outcomes. Though the evidence for benefit is patchy, analysis of these initiatives provides guidance for the development of innovative solutions. A key challenge in the future is the rapidly escalating cohort of older patients with chronic and complex disease that are already known to be at high risk. To make gains in medication safety, it is necessary to have a robust research base upon which, collaborative activities where the needs of patients are central are developed and constantly appraised as the healthcare environment changes.
Medication safety – are you up to standard?
Margaret Duguid, Pharmaceutical Advisor, Australian Commission on Safety and Quality in Health Care

The process of accreditation is an important mechanism for driving improvements in safety and quality in health services. From January 2013 all hospitals seeking accreditation in Australia will be assessed against the National Safety and Quality Health Service Standards 2011. There are 10 standards. Standard 4 is Medication Safety and requires “Clinical leaders and senior managers of a health service organisation implement systems to reduce the occurrence of medication incidents and improve the safety and quality of medicines use. Clinicians and other staff implement medication safety systems”. The intention of this Standard is to ensure competent clinicians safely prescribe, dispense and administer appropriate medicines to informed patients and carers.

The Medication Safety Standard contains five criteria:
1. Systems and Governance for medication safety
2. Documentation of patient information
3. Medication management processes
4. Continuity of medication management
5. Provision of medicines information to patients

Medication safety also features in other standards including Standards 1 - Governance for Safety and Quality in Health Service Organisations; 2 - Partnering with consumers; 3 - Preventing and Controlling Healthcare Associated Infection; 5 - Patient identification and procedure matching; 6 - Clinical Handover and 10 - Preventing Falls and Harm from Falls.

Resources to assist hospitals demonstrate they meet the standards will be discussed including materials produced by Australian Commission on Safety and Quality in Health Care.
Meeting the national standard for medication management and EQUIP v5 mandatory requirements.

Sally Winfield, Christine Phillips and Joan Sheppard, Bethesda Hospital

The Australian Commission on Safety and Quality in Health Care (ACS&QHC) identified medication safety and reducing harm from medicines through safe use as key to improving health. Bethesda Hospital, aligned its goals with the Commission to improve the quality of health care for patients.

With changes in the Australian Council for Healthcare Standards (EQuIP) accreditation to include Medication Management (criteria 1.5.1) as mandatory and the introduction of National Safety and Quality Health Service Standards (NSQHS), Bethesda Hospital allocated resources to review management, identify gaps and work towards system and process improvements.

The Clinical Excellence Commissions’ Medication Safety Self Assessment for Australian Hospitals (MSSA) was used to provide a comprehensive action plan, supported by gap analysis completed on the draft criterion for EQuIPV5 and the draft NSQHS standard 4.

Our review validated most systems and processes were in place, they focussed on:

- Patient information, education and involvement in care
- Drug information, labelling, packaging and nomenclature
- Environmental factors, workflow and staffing patterns
- Staff competency and education
- Quality and risk management

Key outcomes:

- A medication governance framework, providing a reporting structure, controls and KPI to measure and monitor trends for improvement.
- Staff knowledge and education with orientation, developed competencies, high risk and high use drug awareness, monthly education sessions and auditing. Outcomes include reduced error in administration, improved knowledge of drug interaction and adverse events and improved use of tools and process.
- Enhanced patient information developing resources with consumers for content and health literacy comprehension.
Who gets an intervention? An examination of high risk indicators in a regional hospital.
Meeghan Clay1, Greg Kyle2 and Lisa Nissen3
1Albany Hospital, 2University of Canberra, 3University of Queensland

Background: Pharmaceutical review policy high risk indicators are used to determine which patients are most likely to experience a drug related problem and benefit from pharmacist intervention. Current indicators have been developed over many years by panel consensus. Such high risk indicators are used in the pharmaceutical review policy in WA.

Aim: To explore the frequency of current indicators designating a patient as “high risk” and the ability of these indicators to predict a drug related problem.

Method: Data were collected for all charts reviewed by a pharmacist during normal ward rounds over a 2 month period. A tool was developed to collect demographic data, medication specific data, patient specific data and information about interventions.

Results: Interventions occurred in 27% of patients where charts were examined. The high risk indicators of multiple co-morbidities, five or more medications, narrow therapeutic index drugs and high risk medications were associated with more interventions. Five or more medications were prescribed for 91% of all patients. Only 5% of charts examined did not have at least 1 high risk indicator.

Conclusion: A review of current indicators is warranted, especially as multimodal prescribing has increased the normal number of medications charted. Larger scale research in this area is needed.
The 6 rights by everyone—every time: A lean action challenge.
Pam O’Nions¹, Gillian Chartwood² and Nicola Phillip²
¹Lean HealthCare Consultants, Melbourne
²Princess Margaret Hospital for Children

Introduction: The 6 Rights of medication administration is a process to decrease the areas errors occur. Medications are administered by nurses in hospitals hundreds of times each day; yet, many disregard the 6 Rights.

Aim: To apply lean thinking strategies to reduce the wastes associated with medication administration thus increase compliance with the 6 Rights.

Method: Lean thinking begins with driving out waste so that all work adds value. Value-added and non-value-added steps in the process of medication administration were identified. Using Lean principles data was collected by WORMPIT analysis, observation audit, and construction of value stream maps for single and double check S4/S8 medications to identify wastes. Nurses and pharmacy were consulted regarding the content layout in the medication room.

Results: The WORMPIT analysis and observational audit found that a significant amount of nursing time was spent searching: looking for another nurse, the chart and keys. The medication room was small, cluttered and disorganised, and the location resulted in many interruptions. Patient verification was inconsistent. Almost half of medication administrations required the nurse to go back to get a drink for the patient to take the medication.

Conclusion: Working together with the nurses in the clinical area to generate solutions resulted in the project gaining momentum and being locally led. The results to date have shown a change in practice and compliance with the 6 Rights of medication checking, thereby improving patient safety.
Nurses wearing Medibibs to reduce drug errors.
Vickey Brown, Fremantle Hospital

Medication safety is of critical importance to all medication competent nurses and others who work in the health care system. Nurses are acutely aware of the legal requirements of drug administration and on any work day can administer numerous medicines to patients who have a great deal of trust in the nurse to give them the right drugs. However, there are too many day-to-day distractions in clinical settings that interrupt the administrator's focus which can lead to drug errors. This paper looks at the introduction of nursing staff wearing a disposable "bib" in an effort to reduce the overall number of drug errors on a surgical ward. Data will be presented providing evidence of the impact of the introduction along with suggestions to further increase medication safety.
Eliminate medication omissions in the Low Level and High Level care units by Dec 2011.
Sipelile Chakaingesu, Anne Stones, Sheila Bartlett, Alois Mpisa and Sue Ellen Mitchell, Merredin Hospital

Background: At Merredin hospital, in the Low level care (LLC) and high level care (HLC), medications are administered from Webster packs and there are different signing sheets. The Webster pack process can be frustrating as it not streamlined. Staff giving medications is also allocated to work in other departments and tend to be in a hurry when giving medications. While giving medications they have to attend to residents causing interruptions. Medications out of regular times are not signed for as they no reminders. Medications are not signed even if they have been given. Staff spend time walking from one department to the next.

Objective: Eliminate medication omissions in the LLC and HLC units. By December 2011

Method: This was undertaken as The 100 day Lean Action Challenge, while SC was under going Emerging Leaders Program for 2011- learning about leading for improvement. We used LEAN thinking principles which focus on, Quality, Speed, Cost and People. We focused on Quality, eliminating errors by using small changes which lead to huge gains, adding value to processes and removing waste, using visual controls. We audited signature omission for the month of July on regular medication charts. 47 omissions were picked up. The Webster pack process was streamlined, staff retrained in the Webster pack process. The medication apron was introduced as well as visual controls for medications out of regular times. A poster on the 6 rights of medication was created and posted in all medication rooms. A new medication file was created and medications were moved into medication draws by the pt’ bedside. Weekly audits were done up to the second week of November. A nurse was rostered to work in HLC unit who is medication competent.

Conclusion: Medication omissions were reduced by 93% on the regular medication signing sheet.
Reflections from the frontline: A participatory action research project investigating the clinical education of third year nursing students and medication administration scope of practice.

Janie Brown1, Louise Ward2 and Paulettia Irwin3

1Curtin University, 2Griffith University, 3Southern Cross University

Medication safety is a key strategic goal for the Australian Commission on Safety and Quality in Health Care. In line with associated state and national policies, the Australian Nursing and Midwives accreditation body have stipulations that require institutions to provide evidence of the teaching and assessment of nursing students’ medication administration across the curricula including education in pharmacology, numeracy and clinical skills and reasoning (Australian Nursing and Midwifery Accreditation Council Limited (ANMAC), 2006).

Nursing students are not permitted to administer medication without the direct supervision of a Registered Nurse. Nursing students are given clear instructions about their scope of practice during clinical. Despite this students continue to be involved in medication errors and near misses.

Inadequate supervision of the student nurse during medication administration increases the risk of a medication error occurring. This research examined why supervision is, on occasion, found to be lacking and explores these reasons from the perspective of clinical faculty. Previous research has reported the student perspective.

Data from this national research project reveals the types of breaches in student scope of practice that are occurring, the supervising clinical faculty’s understanding of their role and responsibilities, and the cultural environment associated with medication administration.

This presentation proposes a number of teaching and learning practices that can be implemented to ensure that patient safety is prioritised. Whilst individual accountability is expected, there needs to be greater emphasis on learning from the mistakes both from an educational institution perspective and also in the clinical setting.
Making a difference: The OZ born way.
Karen Chapman, Tatjana Jovanovska and Richard Cordell
Osborne Park Hospital

Osborne Park Hospital believes in a multidisciplinary team approach to patient treatment. Our pharmacy department, with the help of management, senior medical consultants and nursing staff, have, over the past few years, implemented strategies to improve medication safety within our hospital.

Using NIMC (National Inpatient Medication Chart) guidelines and recurrent auditing, we have established that education needs to start before a medication chart is written. Our audit of 30 patients’ medication charts reflected 956 discrepancies from NIMC guidelines pre-education and 393 discrepancies post education. Our focus has, therefore, been directed towards junior doctors and registrars. We target medication documentation throughout a patient’s stay, beginning with an accurate medication reconciliation on admission, monitoring of compliance with the NIMC guidelines on admission and throughout a patient’s stay and correct documentation at the time of discharge.

We established our top 10 medication chart discrepancies and these are addressed in our education sessions. Pharmacists have extended this medication chart education towards nursing staff to empower them to approach doctors regarding safe and acceptable NIMC orders.

Pharmacists are involved in the reconciliation and facilitation of discharge medications. We review the doctor generated medication summary and follow up on any discrepancies between the medication chart, discharge prescription and our electronic discharge summary - CGMS (Clinical Governance Management System).

It has been found that the medication chart and discharge summary are at high risk of medication errors. Through education, we have reduced errors and by a team approach, have improved medication safety.
“Cleaning up” intravenous paracetamol usage at Armadale Health Service.
Yang Liu, Stephen Lim, Armadale Health Service

IV Paracetamol usage should be restricted due to significant cost differences between oral/rectal/IV preparations. Fasting state, nil by mouth and treating fever are not the criteria to prescribe IV paracetamol. Potentially greater risk for overdose exists if multiple forms of paracetamol are given and each route of administration should be written as a separate order.

Aim: To promote medication safety via the correct use of IV paracetamol.

Method: Analysis of 23 case notes for inpatients who were given IV Paracetamol during their stay in AHS (November 2011 to March 2012).

Results and Discussion: All theatre patients given IV paracetamol were for pain relief. 53.8% of ED patients were incorrectly use for fever.
- 30% of ED and 100% of theatre patients were given opioids concurrently with IV paracetamol.
- 61% had multiple routes IV/Oral/PR paracetamol written in the NIMC (not as a separate order) resulting in confusion on the type of paracetamol administered (one had 13 doses of paracetamol administered but unsure how many were given as IV dose).
- 70% had oral paracetamol given concurrently with IV paracetamol and this practice should be discouraged.
- The reasons to used IV paracetamol were: patients can’t tolerate oral solid, can’t swallow due to tonsillitis, mouth bleed and ulceration, appendicitis, hyperemesis, and nil by mouth. These patients should be offered rectal paracetamol.

Conclusion: IV paracetamol was inappropriately used in this hospital.
Non-luer enteral feeding systems- A WA Health procurement strategy aimed at improving medication safety and delivery.
Jane Fellman on behalf of the Client Reference Group for HCNS 108808
Enteral Feeding Systems

Utilising Procurement strategies to improve upon Patient Safety and Quality is not a new concept. WA Health has endeavoured to increase the level of clinical participation in health procurement by incorporating clinical product advisor (CPA) specialist knowledge in the procurement process. This strategy assists by ensuring that clinical experts in the field of the procurement are involved appropriately. Use of WA health clinical consumables contracts is mandatory, thus offering Health a safety strategy where, after product evaluation, selection and placement onto a contract, the best value, fit for purpose product is chosen and used. In 2009, a new procurement process for Enteral Feeding systems was commenced, facilitated by the Department of Finance and Health Corporate Network. The two CPA’s involved, having researched the concept of non-luer enteral feeding systems and the potential for improving safety and clinical practice around enteral feeding and medication safety, saw an opportunity to influence the procurement of these products and gain a major safety innovation by transitioning from enteral sets with luer fittings to non-luer, colour coded enteral feeding systems. Included were feeding sets, oral medication dispensers, feeding tubes and connectors. With potentially deadly medication errors associated with enteral feeding and intravenous medication occurring persistently, the new systems, which are not only recognised by their distinctive colour coding, but have better marking, and comply to the relevant Australian Standards, ensure that clinical staff and patients are protected from these adverse events.
Sticking to your guns to solve a problem: Our oxycodone story.
Meeghan Clay, Albany Hospital

Look alike sound alike drugs present constant risk of confusion and incorrect dosing. After a cluster of incidents at the hospital involving oxycontin/oxynorm a risk treatment action plan was developed.

Aim: to prevent administration of the incorrect dose formulation of oxycodone. First intervention involved trying labels on the boxes to prompt but this was not sustained by the pharmacy department. Intervention 2 was education sessions on the wards and information available in the safe to remind nursing about the different formulations. Both interventions were unsuccessful. Intervention 3 introduced an adhesive sticker into the front of the schedule 8 register which tidies the index page and prompts the formulation type for oxycodone. The sticker introduced on the surgical ward in February 2011 with the aim to prevent further incidents.

Result: no new incidents in wards which have introduced to index stickers.

Conclusion: constant re-evaluation of risk allowed new ideas to be tried until a successful intervention was found.
Forum
Putting the patient at the centre
Facilitators: Máire Connolly and Barbara O’Callaghan
Panel
Margaret Duguid, Pharmaceutical advisor ACSQHC
Dr Pradeep Jaysuria, General Practitioner
Dr Vickey Brown, Clinical Nurse manager
Janie Brown, School of Nursing and Midwifery, Curtin University
Helen Lovitt, Senior Pharmacist
A/Prof Christopher Beer, Medicine & Pharmacology, UWA and RPH
Consumer advocate (TBA)

Learning from experience—Consumer Stories
Margaret Ryan 21
Brian Stafford
Nancy Pierce
Iren Hunyadi

Improving the patient journey by engaging the consumer

Pre-hospital care and medication safety.
Joseph Cuthbertson 22

Partnering with patients to reduce medication errors and adverse drug events.
Dr Stephen Lim 23

Exploring patient centred care in the cancer context.
Sandy McKiernan 24

Using a Self-Management Lens to support medication safety.
Adina Quattrini 25

HMR - don't leave hospital without one.
Deirdre Criddle and Dr Pradeep Jayasuriya 26
Learning from experience—Consumer Stories

Margaret Ryan
My message is not to be afraid of listening to the consumer as it is their body, they know it the best and do not be afraid of querying something that another health professional has prescribed. Your query may in the end stop an error from happening. Encourage consumers that are in your care to ask questions knowing that the question they ask may not only prevent an error happening to them but, it may in fact highlight a glitch in the system and therefore prevent errors happening to other patients. Whilst things have improved, there is still a lot of resistance in all areas of health to hearing the consumer voice and a lot of consumers who fear speaking out in case their health care is affected.

Brian Stafford
As a member of the general public with little experience of doctors, hospitals or the health system in general I suddenly knew what it is like to be one of the many who experience iatrogenic harm. Systems were in place to prevent and to protect the patient. Our problem was the system was not adhered too. As uninformed members of the general public we knew no better. My family and I accepted what was done until another doctor ordered a re-admittance back to the same hospital.

Nancy Pierce
The discharge process has improved a great deal over the past ten years. But this talk will illustrate, that health professionals must not assume that patients that present at discharge with apparently all their faculties are necessarily competent to take in all the instructions they have been given. Problems do occur in a busy hospital, and I propose that there be an avenue for patients to get a prompt response, to any issues or concerns they have about the safe use of their medicines following hospital discharge.

Iren Hunyadi
My story is about issues around the prescribing of metformin in the presence of liver disease and ultimately about the misdiagnosis of an adverse drug event for memory loss and the need for placement in care. The situation evolved from the medical staff not reading each other’s notes and not taking my concerns seriously.
Pre-hospital care and medication safety
Joseph Cuthbertson

Notes
Partnering with patients to reduce medication errors and adverse drug events.
Stephen Lim, Tiing Chih, Evonne Fong and Dale Mitchell
Armadale Health Service

OBJECTIVE
An inaccurate/incomplete medication history on admission to hospital can lead to adverse drug events (ADEs) if unresolved. Partnership with patients to elicit an accurate Best Possible Medication History (BPMH) during their admission into the hospital has reduced medication errors, reducing ADEs and improving safety. Our KPI (Key Performance Indicator), MR (Medication Reconciliation Measures) and EA (Event Analysis) during this partnership have allowed us to measure the effectiveness in the continuous reduction of ADEs and actual drug errors. EA identifies the potential reasons and causes of ADEs from untimely partnership (medication reconciliation activities for a BPMH) allowing us to learn and to reduce future ADEs and raise staff awareness to prevent future medication errors.

METHOD
Analysis of the monthly KPI, MR and EA to quantify the ADEs in our medication reconciliation (partnership) program

RESULTS
• The monthly KPI showed an average of 60 medication errors (range from 40 to 80) per 100 patients admitted to Armadale Health Service prior to medication reconciliation on admission (0.6 drug errors per patient admission).
• Most medication errors from unreconciled medications were wrong doses (26.7%), wrong drugs prescribed (4.3%) multiple drug omissions (60.4%), non ADR (Adverse Drug Reaction) documentation (3.3%) and commission errors (5.3%) where medications which were non current were prescribed.
• Sources of information for the BPMH (patient interview, patient’s own medication/list, community pharmacy and GP) were often incomplete and had some inaccuracies. Hence, health care professionals should use at least two sources to form a good BPMH during this partnership.
• MR confirmed the accuracy of the BPMH collected during this partnership (confirmed by an independent auditor).
• EA, similar to Root Cause Analysis, provided the tools to prevent future ADEs. EA have also resulted in the reduction of ADEs.

CONCLUSION
KPI, MR and EA have provided measurements (and tools) to detect, quantify and rectify drug errors, resulting in a reduction in ADEs and improvement in the patients’ safety in their journey into the hospital. This partnership should be a mandatory process in all hospital.
Exploring patient centred care in the cancer context.
Sandy McKiernan, Cancer Council WA

Notes
Using a Self-Management Lens to support medication safety.
Adina Quattrini, South Metropolitan Public Health Unit

Notes
HMR - don’t leave hospital without one.
Deirdre Criddle and Pradeep Jayasuriya

Background:
Improving medication management across the continuum continues to be one of the greatest challenges in modern health care. In an era of complex healthcare needs, patients present to hospital with several co-morbidities, taking multiple medications, often prescribed from a variety of doctors and specialists. At discharge the likelihood of medication and medical errors is between 110 and 200 per cent. The problem, accentuated by the need to discharge patients early can result in inadequate information being provided on discharge – especially those relating to medication changes. Analysis of the reasons for errors when patients care is transferred consistently report lack of communication and inadequate systems as the major contributors to the problem.

Numerous strategies have tried to address the issue of medication safety at the transfer of care but the results are largely disappointing. Home Medicines Review (HMR) is an initiative that has an emerging evidence base to support its implementation to address many of the issues identified. Placing skilled, experienced, accredited or clinical pharmacists across the continuum of care for a patient cohort who has been clearly identified as being at high risk of medication misadventure to identify and resolve medication related problems is appealing as a way of filling a gap in the discharge and transfer process.

A successful HMR requires the selection of a pharmacist with appropriate skills. These pharmacists should have the ability to collaborate retrospectively (with the hospital team) and prospectively (with the General Practitioner and Community Pharmacist). The benefit of a successful HMR has the potential to transcend the episode of care to act as change agent to develop medications safety as priority concern across all health sectors.


NOTES

WA Medication Safety Group
http://www.watag.org.au/wams