WA.TAG WESTERN AUSTRALIAN THERAPEUTIC ADVISORY GROUP

WESTERN AUSTRALIAN
MEDICATION SAFETY GROUP

19 May 2005
The University Club
The University of Western Australia

# Progressing Medication Safety in Western Australian

# Symposium Program

Department of Health
Government of Western Australia

# Welcome

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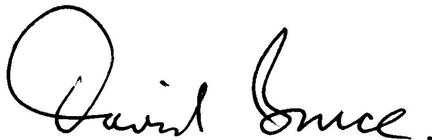
Welcome to the inaugural seminar run by the Western Australian Medication Safety Group. We hope that you enjoy the day and gain useful knowledge to take back to your hospital or organisation. The main purpose of the seminar is to stimulate interest in medication safety and provide you and your colleagues with ideas and practical advice about how to tackle this important topic.

The WA Medication Safety Group is new and has been charged with the task of attempting to improve medication use and reduce adverse drug events in patients in the public hospital system. The group includes a community representative and interested clinicians from multiple disciplines from the metropolitan teaching and non-teaching hospitals, and from the regional health services. We are fortunate to have the services of a full-time coordinator to support the work of the group and Margherita Veroni has proven to be a superb motivator and organiser in this role.

Medication safety is largely about improving our attitudes to patient safety (culture change) and finding ways to reduce the chances of error occurring (system change). The WA Medication Safety Group recognises that the most effective changes will come from staff at the front-line and is seeking ways to promote medication safety within every hospital and clinic. We hope that this seminar will provide opportunities for you to share your ideas and that some of these will lead to practical improvements in patient care.

Once again, may I wish you an enjoyable and stimulating day.

With best wishes,



A/Prof. David Bruce
Chairman
West Australian Medication Safety Group
19 May 2005

**David Bruce**
**Chairman, WAMSG**

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# Program

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|---|---|
| 8:00 am | Registration/ Coffee/Tea |
| 8:30 am | **Welcome**<br>*A/Prof David Bruce Chair, WAMSG* |
| | **Session 1: Medication Safety: New solutions to an old problem**<br>*Chair: David Bruce, Chair WAMSG* |
| 8:45 am | **Medication safety – how big a problem?**<br>*Dr Danielle Stowasser*<br>*Director, Queensland Health Safe Medication Practice Unit* |
| 9:15 am | **Medication safety – it's not rocket science**<br>*Dr Sepehr Shakib*<br>*Director, Clinical Pharmacology, Royal Adelaide Hospital* |
| 9:45 am | **Medication safety – what works what doesn't**<br>*Mr Ian Coombes*<br>*Coordinator Preventing ADE Program, Queensland Health* |
| 10:15 am | **Discussion** |
| 10:30 am | **Morning tea** |
| | **Session 2: Showcasing WA**<br>*Chair: Margherita Veroni, Project Coordinator, WAMSG* |
| 11:00 am | **Medication Management in an Acute Assessment Unit**<br>*James Williamson, Sir Charles Gairdner Hospital* |
| 11:15 am | **Triggers and markers, where they are leading us**<br>*Tandy-Sue Copeland, Kerry Fitzsimons and Liana Johnson Fremantle Hospital* |
| 11:45 am | **Nurse practitioner prescribing**<br>*Susan Hyde, Sir Charles Gairdner Hospital* |
| 12:00 pm | **The effects of an electronic discharge summary**<br>*Stephen Bloomer, Sir Charles Gairdner Hospital* |
| 12:15 pm | **Preventing adverse events and errors - the role of the pharmacy department**<br>*Helen Hunter, Geraldton Regional Hospital* |
| 12:30 pm | **The National Inpatient Medication Chart**<br>*Experience from the WA sites in the National Pilot Project* |
| 1:00 pm | **Lunch** |
| 1:45 pm | **Workshops – Round 1** |
| 2:45 pm | **Workshops – Round 2** |
| 3:45 pm | **Afternoon tea** |
| 4:15 pm | **Session 3: Where to from here** |
| 5:00 pm | **Close** |

# Western Australian Medication Safety Group Members

David Bruce (Chair)
Head of School
School of Medicine and Pharmacology,
University of Western Australia

Marian Balm
Manager, Clinical Governance Unit
Sir Charles Gairdner Hospital

Marie Baxter
Nursing Director, Surgical Division
Royal Perth Hospital

Lewis Bint
Deputy Chief Pharmacist
Women's and Children's Area Health Service

Rowan Davidson
Chief Psychiatrist
WA Dept of Health

Tanya Gawthorne
A/Manager Office of Safety & Quality
WA Dept of Health

Neville Hoffman
Director Clinical Governance
Sir Charles Gairdner Hospital

Neil Keen
Senior Pharmacist
Sir Charles Gairdner Hospital

Helen Lovitt
Senior Pharmacist Dispensing Services
Fremantle Hospital and Health Service

Andrew Marshall
Nursing Co-director Central Clinical Services Unit
Sir Charles Gairdner Hospital

Frazer Moss
Medical Superintendent, Midwest Murchison region
WA Country Health Services

Nancy Pierce
Health Consumer

Chris Swan
Director, Midwest Murchison region
WA Country Health Services

James Williamson
Medical Co-director,
Sir Charles Gairdner Hospital

David Lyon
Executive Officer
Western Australian Therapeutics Advisory Group

Margherita Veroni
Project Coordinator
Western Australian Medication Safety Group

# Western Australian Medication Safety Group
# Terms of Reference

The WA Medication Safety Group (WAMSG or the "Group") is constituted as a subcommittee of the Western Australian Therapeutic Advisory Group (WATAG).

## Mission

To improve medication safety thus reducing actual and potential patient harm caused by the inappropriate use of medications.

## Scope

The WAMSG will have reference to all issues relating to medication safety excluding those relating to workforce planning. The WAMSG will prioritise activities that have the following characteristics:

- National or state priorities;
- Consumer priorities;
- Readily measurable outcomes;
- Evidence for success;
- Increase system capacity to measure medication errors/incidents;
- Promote standardised processes across the health system; and
- Promote a just culture.

## Purpose

1. Coordinate, promote, evaluate and otherwise oversee initiatives to improve medication safety in public health care system in Western Australia.
2. Advocate and seek Executive Support for initiatives to improve medication safety in the public health care system in Western Australia.
3. Provide advice to the Department of Health on medication safety issues.
4. Make recommendations regarding the implementation of statewide directives, policies, guidelines, standards and processes to improve medication safety in the public health care system, and develop these as appropriate.
5. Assess the quality and quantity of available data and information related to medication safety and take appropriate actions to improve data/information sources.
6. Maintain current knowledge of initiatives, priorities and other information relating to improving medication safety arising from local, state or national stakeholders.
7. Develop strategies to promote culture change regarding behaviours inhibiting improving medication safety.

# Invited Speakers

## Danielle Stowasser

Danielle is Director of the Queensland Health Safe Medication Practice Unit. This state-wide program is responsible for implementing a range of initiatives focused on enhancing medication-related services for Queensland Health and improving patient safety.

## Sepehr Shakib

Sepehr is Director of Clinical Pharmacology at the Royal Adelaide Hospital. He was co-chair of the planning group of the National Medication Safety Collaborative, and is the author of Auditmaker, a generic tool for clinical audit. His main ambition is to make hospitals safer, so that he can spend more time playing with his son.

## Ian Coombes

Ian runs the Preventing ADEs program for the Queensland Health Safe Medication Practice Unit. He is also a Clinical Lecturer in the School of Pharmacy at the University of Queensland.

# Poster Presentations

## Keeping our Patients Safe

*St John of God Health Care, Subiaco*

Executive Sponsor: Joan Sheppard
Medical Leader: Dr Rosanna Capolingua
Project Coordinator: Danielle Darragh
Pharmacy Leader: David McKnight
Nursing Leaders: Anne Mahar, Julie Nicholas, Fleur Bushell, Margot Whisson, Ann Tuvik
Consumer Representative- Bruce Campbell

The Subiaco Medication Safety project sponsored by the Safety and Quality Council aimed to reduce to 50% those patients who experience medication related harm during the discharge process. A key desired outcome was to improve the communication regarding medication management between the acute sector and the community.

Interventions such as the provision of medication profiles; comprehensive medication counselling; faxing of the medication profiles to the patients General Practitioner and the use of medication bags to separate discontinued and continued medications resulted in a 60% reduction in harm for our targeted high risk surgical population. Positive feedback was received from patients, staff and General Practitioners.

Medication Safety innovation teams continue to spread and sustain the successful project initiatives as well as focusing on improving medication safety in the areas of admission and prescribing.

Consumer empowerment and participation was an essential component in reducing both actual and potential harm.

## Medication Safety @ SJGHC Murdoch.

*St John of God Health Care Murdoch*

Robyn Sutherland: Director of Nursing
Lachlan Henderson: Director of Medical Services
Helen Rintoul: Manager Orthopaedics
Doris Lombardi: Team Leader
Michael Maher: Chief Pharmacist.

This provides a summation of achievements from the Safety & Quality Council Wave 1 Medication Collaborative which was completed last year.

**Aims**

1.To reduce the number of patients experiencing a high risk ADE to less than 10%
2. Increase the number of medication incidents reported via the incident monitoring system by 40%
3.Reduce the risk of patients that experience a medication order omitted upon admission to 6%
4.To decrease to 8% of patients who experience a near-miss/incident/harm caused by medication not being administered at the prescribed time.

**Achievements** include a 1000% increase in incidents being reported. There has been a reduction to 10% of patients who have medications omitted and prescribing errors have been reduced to 5%. Adverse Drug Reactions have been reduced to below our target of 10%.

**Strategies** included:

1. Improved reporting mechanisms and feedback
2. Monthly audits of medication charts by pharmacist now part of routine practice
3. Red card drug allergy system
4. Dose adjustment table on Gentamicin Toxicology Report from Pathology
5. Anonymous Incident Management slip
6. Withheld chart

## Warfarin administration and prescribing

*St John of God Health Care, Geraldton.*

Executive Sponsor: Rae Peel - Operational Manager/DON SJGHC Geraldton
Nursing Leader : Tammy Batten - Nurse Manager/Quality Coordinator SJGHC Geraldton
Medical Leader : Dr Stuart Adamson - GP
Technical Expert : Fiona Naisbitt - Community Pharmacist

A brief medical record audit undertaken at commencement of the Collaborative highlighted the following issues or potential areas for improvement:

- prescribing processes during stabilisation
- administration omissions due to charting processes
- discharge information

These three items formed the basis of our work

**Aims**

To reduce to 10% the number of patients with an INR > 4 from 46%

To decrease to 10% the number of patients who experience a near-miss/medication incident/harm caused by Warfarin not being administered according to the prescribed time from 29%

To reduce to 5% the number of patients prescribed medications by another doctor when treating doctor is contactable from 17%

**Outcomes**

- A 95% reduction in patients prescribed Warfarin developing an INR > 4
- A 62% reduction in the number of Warfarin related incidents as a result of failure to administer at the prescribed time
- A 100% improvement in contacting the patients own Dr for a Warfarin dose on INR receipt

## Life wasn't meant to be wheezy

*Esperance District Hospital*

Roslyn Wiese (Project Coordinator), Raelene Craft, Graham Jacobs, Annelies Nyssen

The Esperance District Hospital as part of Wave 2 of National Medication Safety Breakthrough Collaborative worked throughout 2004 to improve medication safety in patients/clients having asthma within the Esperance community.

**Goals**

All asthmatics to have a documented asthma action plan

All asthmatics to have received appropriate education on asthma

All asthmatics to have received appropriate education on their asthma medication/s (preventer and relievers)

## Promoting Armadale Warfarin Safety (PAWS).

*Armadale/Kelmscott Health Service*

Donald Coid: Director of Medical Service and Executive Sponsor,
Chris Bone: Director of Nursing,
Debbie Bridgeford: Quality Officer,
Naomi Klopper: Clinical Pharmacist,
Jonathan Liaw: Clinical Pharmacist,
Stephen Lim: Principal Pharmacist and Co-ordinator.

**Achievements**

1. Safe Warfarin prescribing/therapy as laid out in the Warfarin Treatment Kit
2. Achieving therapeutic INR range within 7 days of initiation.
3. Establishing communication with community GP's and improving the continuum of care from the hospital into the community
4. Improving the provision of warfarin information to patients an promoting patient adherence to advice/information given

## Improving Anticoagulation Safety at SCGH

*Sir Charles Gairdner Hospital*

Marian Balm, Tony Dolan, Neil Keen, Andrew Marshall, Kate Overheu, James Williamson

Anticoagulation consistently ranks as a major drug class responsible for causing harm to patients. This is despite the availability of evidence surrounding the most appropriate dose, intensity and administration schedule of warfarin, heparin and low molecular weight heparin. Use of dose adjustment nomograms and clinical guidelines has been clearly shown to improve the quality use of these drugs. Prior to this project SCGH had no published clinical guidelines, or documented policy regarding the use of warfarin and heparin. Our project sought to address these deficiencies and implement initiatives already known to improve safety. Primarily the project involved introducing a single, uniform drug chart for use across the entire hospital for prescription of all types of anticoagulant drugs. The objective of the drug chart was to improve the legibility and clarity of dose orders, provide point of care clinical guidelines, incorporate evidence based safety initiatives and remove the need for drug calculations. Implementation was a major challenge as the chart required consensus from a very large number of stakeholders across many disciplines. The process also highlighted difficulties in generating system change in a large organisation. The chart is now in routine use and is being considered as a template for a larger state based initiative. In addition the project also considered and reformed thromboprophylaxis guidelines, patient education and hospital policy regarding anticoagulant use.

## Improving Medication Safety at Kalgoorlie Regional Hospital

*Kalgoorlie Regional Hospital*

Executive Sponsor/ Medical Leader : Fraser Moss, Director of Medical Services
Project Coordinator/Technical Expert Risk Georgina Trotter
Nursing Leader = Kathy Stein
Technical Expert Pharmacy Frank Andinach

**Aims**

1. To reduce the number of patient harm relating to medication error within the medical ward by 50%.
2. To reduce the number of patients who experience a near-miss/medication incident by a medication not being administered from 27% to 5%.
3. To increase adherence to local prescription and order entry guidelines/protocols from 50% to 70%.

## Kalgoorlie Regional Hospital – Wave 2

*Kalgoorlie Regional Hospital*

### Achievements

An 85% increase in patient's awareness of the dose and frequency of their discharge drugs

A 65% increase in the number of patients who have a record of their discharge medication drugs in their medical record

100% of patients now have completed discharge prescriptions

## Safety Proposal: Medication-Associated Problem Screening (MAPS)

*Julie McMorrow PharmD, Critical Care Pharmacy Specialist, Royal Perth Hospital, page 2678*

The increasing variety and potency of prescribed, "over-the-counter" and "alternative" medicines complicate patient assessment and management. In Western Australia, the reported rate of adverse drug reactions associated with hospitalisations in people aged ≥60 years increased more than five-fold between 1981 and 2002[1]. The prescribing process is often limited to transcription of medication doses from previous records, or as listed by the patient. Pressures to discharge patients quickly discourage detection of medication-associated problems. The updated "Beers' List" (US drugs or drug groups to be avoided or used with caution in the elderly)[2] is of limited usefulness in our practice, as 47/78 (60%) of the agents mentioned in the "potentially inappropriate: independent of diagnoses" table are either unavailable (34) or rarely used (13) in Australia. Medication-Associated Problem Screening (MAPS) is designed to "advertise" medication troubleshooting techniques which, although used routinely by experienced practitioners, are not necessarily obvious to other staff or to our patients. MAPS Guidelines are presented in "prescriber" and "patient-friendly" formats and are intended to facilitate medication review for adults of any age presenting to Australian hospital emergency departments, wards, clinics, general practices and community pharmacies. The MAPS List of fifty medication groups (cross-referenced to individual generic drug and brand names) provides problem-screening and monitoring tips for each group. Australian doctors, pharmacists and nurses can use the MAPS Guidelines and List for training purposes and to identify possible medication-associated problems experienced by their patients. Waiting-room posters or questionnaires may prompt patients to provide more useful feedback to their health care providers. Formal validation by an expert panel of clinicians, followed by "field-testing" and re-evaluation, is needed. MAPS would then be suitable for adoption and promotion Australia-wide by the National Prescribing Service (NPS), or similar body.

**References**

1. Burgess CL, Holman CDJ, Satti AG. Adverse drug reactions in older Australians, 1981-2002. Med J Aust 2005; 182:267-270

2. Fick DM, Cooper JW, Wade WE, Waller JL,Maclean JR, Beers MH. Updating the Beers criteria for potentially inappropriate medication use in older adults. Arch Intern Med 2003; 163:2716-2724

# Session 1: Medication Safety: New solutions to an old problem

Chair: David Bruce, Chair WAMSG

8:45 am **Medication safety – how big a problem?**
Dr Danielle Stowasser
*Director, Queensland Health Safe Medication Practice Unit*

9:15 am **Medication safety - is not rocket science**
Dr Sepehr Shakib
*Director, Clinical Pharmacology, Royal Adelaide Hospital*

Ever watched some NASA footage and been awe inspired? Ever thought how did they ever do that? Well the answers are more simple than you think, in fact, so simple, its not rocket science! This presentation discusses the reasons for the successes and failures of the NASA program in getting man to the moon, and how the same approach can be used for medication safety.

9:45 am **Turning challenges into opportunities**
Mr Ian Coombes
*Coordinator Preventing ADE Program, Queensland Health*

10:15 am **Discussion**

10:30 am **Morning tea**

# Session 2: Showcasing WA

Chair: Margherita Veroni, Project Coordinator, WAMSG

11:00 am **Medication Management in an Acute Assessment Unit**
*James Williamson, Sir Charles Gairdner Hospital*

The Acute Assessment Unit (AAU) at Sir Charles Gairdner Hospital was established in May 2001 to provide for the initial assessment and management of complex medical patients following their admission through the Emergency Department. This is a heterogeneous group of predominantly elderly patients with multiple co-morbidities taking on average 7-8 different medications. The aim of the Unit was to improve the quality of their care and reduce their length of stay in hospital. Approximately 60% of all emergency medical admissions (~4500 per annum) pass through the AAU.

The potential for medication errors to cause harm in this high-risk group of patients was recognised from the outset. A clinical pharmacist is present 7 days per week to supervise pharmaceutical management. An early survey demonstrated that errors were present in at least one third of prescribed admission medications. The reporting of medication incidents was encouraged (the AAU is the biggest single contributor of such incidents to the hospital-wide AIMS database) and a database was established to analyse all incidents (now ~450) following detailed investigation by the clinical pharmacist. Statistical Process Control methods are used and the results of these investigations are "fed back" to staff. Their causes, outcomes and management have been studied and the results have informed changes to clinical practice.

In 2003 the AAU, together with Cardiovascular Medicine and the Clinical Governance Unit, developed an electronic discharge letter, which was shown to improve the quality of medication management at the transition of care. All GPs and patients receive a comprehensive medication list.

Academic detailing of drug rounds was introduced by the clinical pharmacist when it was found that ~50% of incidents were associated with errors during nurse administration. Directly observed error rates fell from 15.5% to 6.7%. A survey of nursing staff showed that their practice and confidence improved. Detailing is now part of continuing education on the AAU and has also been taken up by other wards. Analysis of incidents associated with anticoagulants found that ~70% were drug errors due to physician ordering where "lack of knowledge" was a significant contributory factor. That led to the design and development of an anticoagulation chart with decision support (through NMSBC).

11:15 am **Triggers and markers, where they are leading us**

*Tandy-Sue Copeland, Kerry Fitzsimons and Liana Johnson*
*Fremantle Hospital and Health Service*

Triggers and markers are a reliable and effective method for detecting Adverse Drug Events (ADE). Only 10 to 20% of errors that occur with in the health setting are ever reported through a voluntary reporting and error tracking system
We needed a more effective way to detect events causing harm to patients, to understand the reasons why harm occurs, find trends ,educate and then measure the impact of improvements The trigger tool was developed from literature, adapted to the local setting Federal funding was obtained to fund the project and the triggers were reviewed by the project team
Trigger accuracy of between 57 and 77% was recorded with total Adverse Drug Events (ADE)in the medical ward 9.8% with 4.8% being preventable and the surgical ward 4.46% with 2.1% preventable. In the medical ward 7.5% of ADEs were community originated
The team then developed a number of measures and education to address the trends noted. These require ongoing review and evaluation and expanded to include a number of other projects for example the medication related re admissions and the discharge Liaison Pharmacist

**Medication Related Re-admissions**
Preliminary findings of a study of 119 patients. These patients were general medical patients readmitted within 28 days of discharge from hospital. They were > 65 years of age (>55 years Torres Strait Islanders) in the Fremantle Hospital catchment area discharged to home. Each patient's admissions were assessed using the Trigger Tool. A patient was seen at higher risk of being readmitted if they were taking one or more of the following medications commonly associated with drug-related admissions including: NSAIDS, cardiac medications (ie digoxin, antihypertensive agents, anti-arrhythmic agents etc), anticoagulants, antibiotics, CNS medications (eg antiepileptics), corticosteroids and opiates for chronic pain.
-107 of the 119 patients were discharged on high risk medications
52% of patients had at least one drug related admission (including the first admission)
36% of patients had a Drug Related Re-admission. Another 2.5% had compliance related issues.
Results indicated that there were 54 medication related re-admissions ( 7 patients had 2 medication related re-admissions)
Adverse drug events seen includes hyperkalaemia, hypotension, a decline in renal function, haematemesis, retroperitoneal bleeding, gastritis, G I bleeds, exacerbation of heart failure, falls and confusion.
Medications implemented include ACE inhibitors, anticoagulants, NSAIDs, COX II inhibitors, and benzodiazepines.

**Discharge Liaison Service**
The observation of so many community-originated medication-related problems as observed in the triggers and markers project and as outlined in the readmission study has led to the exploration of and subsequent development of a hospital-based pharmacy discharge liaison service at Fremantle Hospital. The hospital has launched the service this week in association with the Department of Health WA and the University of Western Australia. The service will be trialed over the next 12 months and aims to reduce medication-related utilisation of health services including readmissions to hospital, presentations to the ED and unplanned attendances at GP surgeries. It also aims to improve communication between the hospital and community-based health services through the timely preparation and dissemination of discharge summaries and the provision of a dedicated hospital-based clinical pharmacist to liase with community based health services about medication related issues for patients discharged from hospital. The DLP pharmacist will also conduct home-based medication risk assessments for high-risk patients discharged from hospital to facilitate early intervention for medication related problems.

11:45 am **Nurse practitioner prescribing**

*Susan Hyde, Sir Charles Gairdner Hospital*

**Definition**

"*A nurse practitioner is a registered nurse educated to function in an advanced clinical role. The scope of practice of the nurse practitioner will be determined by the context in which the nurse practitioner is authorised to practice and will include legislative authority not currently within the scope of nursing practice*" (National Nursing Organisations, October 2000).

**Legislation**

The *Nurses Amendment Bill 2000* addressed the legislative changes that were necessary to allow the implementation of the role of the Nurse Practitioner in Western Australia. The Bill required the following acts and regulation to be amended:

- Nurses Act 1992
- Medical Act 1894
- Misuse of Drugs Act 1981
- Pharmacy Act 1964
- Poisons Act 1964
- Poisons Regulations 1965
- Radiation Safety Act 1975
- Road Traffic Act 1974

The Nurse Practitioner will be registered with the nurses Board of Western Australia and will work within specific clinical protocols developed for the designated area that are approved by the Director General of health, Chief Medical officer, Chief Nursing Officer and the Director General of Population Health.

This presentation will describe the clinical protocol that has been approved and will allow the Haematology Nurse Practitioner at Sir Charles Gairdner Hospital prescribe drugs for the management of chemotherapy induced nausea and vomiting.

12:00 pm

## Use of an electronic discharge summary to enhance medication safety

*Stephen Bloomer, Sir Charles Gairdner Hospital*

Sir Charles Gairdner Hospital commenced using an electronic discharge summary, generated from a module in the Clinical Governance Management System (CGMS) in December 2003. Today some 70 – 80% of in-patients at SCGH receive the computer-generated summary.

The electronic discharge summary, can link a specific diagnosis to a best practice guideline (where available) and prompts clinicians to use the guideline. It also produces a 'Discharge medication List' for the patient/carer.

The system realises several safety dividends:

- A typed legible discharge summary – legible to patient/carer, GP and Consultant
- A communication tool between the Secondary and Primary setting.
- Audit of compliance with a best practice guideline is measured and becomes a performance indicator for that department, including appropriate use of medications for that disease type.
- A legible medication list where medications are linked to known patient problems. 'Orphan' medications, with no known problem, are identified. Ceased medications are also listed.
- The medication list has information for the patient on 'Using Medications Safely' and 'Questions You Should Ask'.
- Efficiency in that when a patient returns, the medications and problems recorded in the system can be retrieved.
- Accountability built into the whole process.

The system has demonstrated that a medication list can reduce harm for patients as part of the National Medication Safety Breakthrough Collaborative – Wave 2, with very good results. The system won a High Commendation in the 2004 Premiers Awards, and has been very satisfying for all, users and GP's.

12:15 pm **Preventing adverse events and errors - the role of the pharmacy department**

*Helen Hunter, Geraldton Regional Hospital*

The Pharmacy Department looked at what happens to a patient and their medication during a hospital stay, and where pharmacy staff could play a role in preventing adverse medication events. Times were identified when these could occur, such as medication history taking on admission, writing and interpreting charts, selecting drugs from imprest cupboards and at discharge.

Pharmacy assistants clearly labelled the shelves in the imprest cupboard, highlighting drugs which had different strengths /formulations and similar names.

The Pharmacist takes a medication history from newly admitted patients, checking their own drugs and those the nurses have put in the drawer. The patient is seen daily and assessed for their competency in managing their own medication; the chart is also reviewed for changes in medication and any missed/extra doses.

At discharge a medication profile is prepared for the patient, their discharge scripts checked and the community pharmacist is informed of any changes in Webster packs.

Weekly education sessions, 'Drug of the Week' for the nurses are held at handover. 'Tips for Medication History taking' have been included in the doctor's orientation package. An abbreviated form of the Schedule of Benefits Book has been developed to make it easier for doctors to find quantities, repeats and if authorities are needed.

The outcomes of these initiatives have resulted in the prevention of on average two adverse medication errors/events a day, reduced the number of wrong medications taken from imprest cupboards, doctors writing correct prescriptions and 25% of future adverse medication events being prevented at discharge.

12:30 pm **The National Inpatient Medication Chart**
**Experience from the WA sites in the National Pilot Project**
*Chris Whellum, Helen Barrett: Joondalup Health Campus*
*Roy Finnigan, Kimberley Health Region*

# Workshops

1:45 pm **Round 1**

2:45 pm **Round 2**

**Medication Continuum.**
*Danielle Stowasser*
Seminar Room 1

**Turning challenges into opportunities.**
*Ian Coombes*
Seminar Room 2

**Putting the Awe back into Clinical Audit.**
*Sepehr Shakib*
Seminar Room 3