

Medication Safety initiatives in Australia

**Australian Commission on Safety and Quality in Healthcare
ehealth and Medication Safety team**

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The Australian Commission on Safety and Quality in Healthcare

- The Commission leads and coordinates key improvements in safety and quality in health care across Australia
- In partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system



Introduction

- There are currently 35 individual projects across the E-Health and Medication Safety team
- Projects focus on:
 - Stewardship
 - Review / update
 - Development of new resources



Work streams

- 1. Standardised medicines information**
2. Quality use of medicines
 - High-risk medicines
 - Polypharmacy
3. Digital health
4. Transitions of care



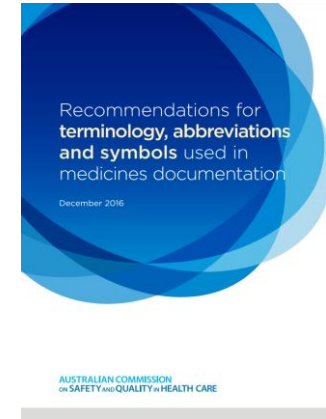
1. Standardised Medicines Information

1. National tall man lettering list
2. *Recommendations for terminology, abbreviations and symbols*
3. *National standard medication charts (inc. audits)*
4. Look-alike, sound-alike
5. *Dispensed labelling standard*
6. *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines*
7. Active ingredient prescribing



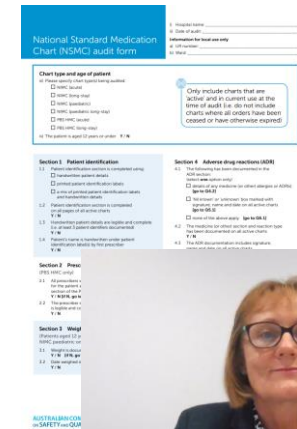
Terminology, abbreviations and symbols used in medicines documentation

- Review to assess the need for updating the **recommendations for terminology, abbreviations and symbols used in medicines documentation**



National Standard Medication Chart audit

- Review of participation in the 2020-21 **National Standard Medication Chart audit** to determine whether future national audits of paper medication charts are required



National Standard for labelling dispensed medicines

- Misunderstanding of how to use medicines can lead to unintentional misuse, which may result in harm or adverse health outcomes, particularly for those on polypharmacy
- Standardised and consistent presentation of medicine-related information on dispensed medicine labels has the potential to improve health outcomes



National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines

- It is reported that nearly 60% of medication errors that result in serious patient harm or death involve injectable medicines
- The Labelling Standard addresses one recognised risk point in the safe administration of injectable medicines by preventing medicine administration errors, such as wrong patient, wrong route, wrong medicine or wrong dose

National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines



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2. Quality use of Medicines

- National action to address agreed safety risks, including the analysis of changes in medication-related harm over the duration of the WHO 3rd Global Patient Safety Challenge – medication without harm
- Phase 1 – baseline report focussed on aged care and issues of polypharmacy, use of antipsychotic medicines and transitions of care.

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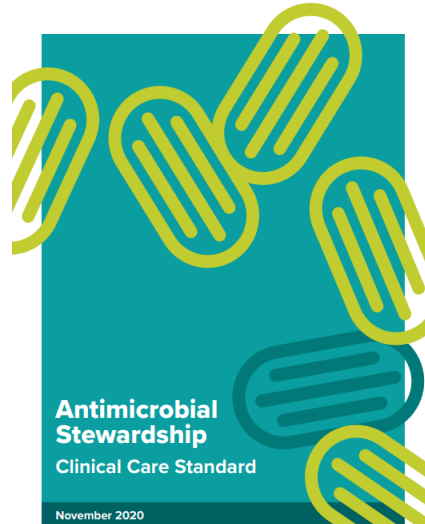
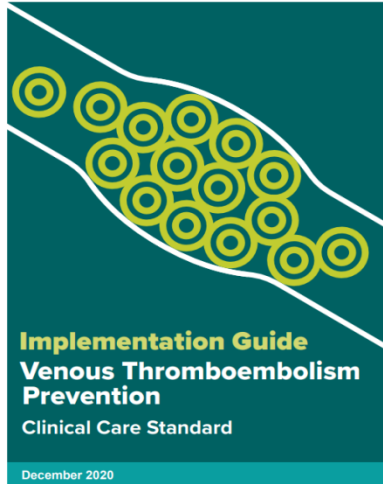
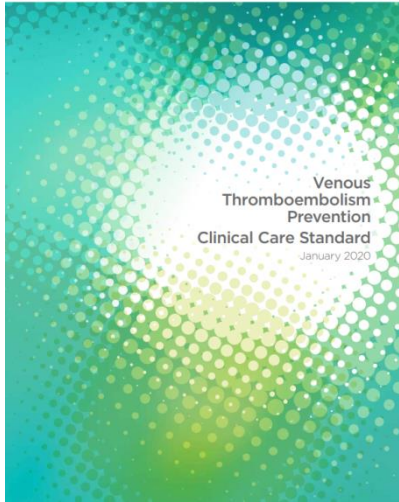


High-risk Medicines



- High-risk medicines are associated with significant patient harm or death if they are misused or used in error.
- The high-risk medicines of focus in Australia are insulin, opioid analgesics, anticoagulants and antipsychotics.





Clinical Care Standards



High-risk medicine courses

- National e-learning courses to improve the safe use of high-risk medicines in hospitals. The current topics available include:
 - An Introduction to High Risk Medicines
 - Insulin
 - Anticoagulants
 - Clozapine
 - Opioids
 - Psychotropic medicines (coming soon)
 - Anticancer medicines (in development)
- The course is intended for all healthcare staff involved in the management of high risk medicines.

The screenshot shows the 'High Risk Medicine Education' website. At the top, there is a navigation bar with the text 'High Risk Medicine Education'. Below this is a large banner image of a hospital hallway with a white overlay box containing the text 'High Risk Medicine courses for Health Professionals' and two green buttons: 'New Registration' and 'Log in'. Underneath the banner is a section titled 'Featured Courses' which displays five course cards. Each card has a small image, a title, and a green 'More info' button. The courses shown are: 'Introduction to High Risk Medicines' (with an image of a pharmacist and a patient), 'Anticoagulants' (with an image of healthcare workers), 'Clozapine' (with an image of a doctor and a patient), 'Insulin' (with an image of insulin vials), and 'Opioid Analgesics in Acute Settings' (with an image of medical supplies).



Polypharmacy

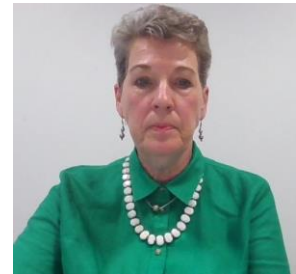


- Polypharmacy – use of *five or more* medicines at the same time, including prescribed, over-the-counter and complementary medicines
- Hyper-polypharmacy - use of *ten or more* medicines at the same time, including prescribed, over-the-counter and complementary medicines



Polypharmacy in Australia

- Up to **91%** of people in Australian residential aged care facilities (RACFs) are prescribed more than five concomitant medicines, and up to **74%** of care recipients take more than nine medicines
- Prevalence of polypharmacy in Australians 70 years and older had increased from **33.2%** in 2006 to **36.2%** in 2017 amongst Pharmaceutical Benefits Scheme (PBS) concession cardholders
- In 2017–18, one in two Australians had one or more of 10 recognised chronic conditions and one in five had two or more of these chronic conditions



ACSQHC Initiatives

- Updating the national Quality Use of Medicine Guiding Principles(July 2022)
- Underpin the National Medicines Policy
- The Guiding Principles are intended to guide healthcare professionals and the individual, their carer and/or family in the quality use of medicines
- They offer a systems approach to the medication management pathway – that is, they advocate consistent and standard practice across all providers of healthcare services.
- A greater focus on
 - Equity
 - Person-centred partnership
 - Collaboration and coordination
 - Digital health



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3. Digital Health

1. *National guidelines for onscreen presentation of discharge summaries*
2. *National guidelines for on-screen display of medicines information*
3. *Electronic National Residential Medication Chart*
4. Classification of EMM incidents
5. Stewardship of EMM SAT
6. Real time prescription monitoring
7. e-Chemotherapy Med. Chart



Updating the National Guidelines for On-screen Presentation of Discharge Summaries

- Supports adoption of minimum safety elements in electronic discharge summaries
- Ensures necessary information about admission and immediate next steps are provided
- For the medical software industry and Health Service Organisations

The image displays a sample discharge summary and the cover of the National Guidelines for On-Screen Presentation of Discharge Summaries. The discharge summary is titled "Discharge Summary" and is divided into sections: Patient details, Hospital details, START OF DOCUMENT, Recipients, Author, Presentation details, Problems and diagnoses, Principal diagnosis, Reason for presentation, and Secondary diagnoses. The National Guidelines cover is titled "National Guidelines for On-Screen Presentation of Discharge Summaries" and is dated September 2017. The Australian Commission on Safety and Quality in Health Care logo is also visible.

Patient details		Hospital details			
Bernice VANK Date of birth: 01 Jan 1951 (65y) Female 276 Flinders Street, Melbourne, Victoria, 3000, Australia Phone: (03) 9288 3467 (home) MRN: 913474 IHI: 1234 7683 9873 2984		Roxboro Hospital, Eastern Health District Miltown, Victoria, 3110, Australia Phone: (03) 9699 3466 (workplace) / (03) 8895 3161 (fax)			
START OF DOCUMENT					
Recipients: Dr Andrew SMITH Joe DOE		Author: Dr Jane McDONALD, (03)			
Presentation details					
Presentation date	Discharge date	Length of stay	Episode type	Clinical unit	Senior
05 Mar 2016 09:00	08 Mar 2016 10:00	3 days	General surgery	Surgical unit	Dr (CO)
Problems and diagnoses					
Principal diagnosis	Acute appendicitis with peritonitis				
Reason for presentation	Abdominal pain following recent travel to South East Asia				
Secondary diagnoses	Digoxin toxicity Hyperkalemia CCF - Congestive cardiac failure				

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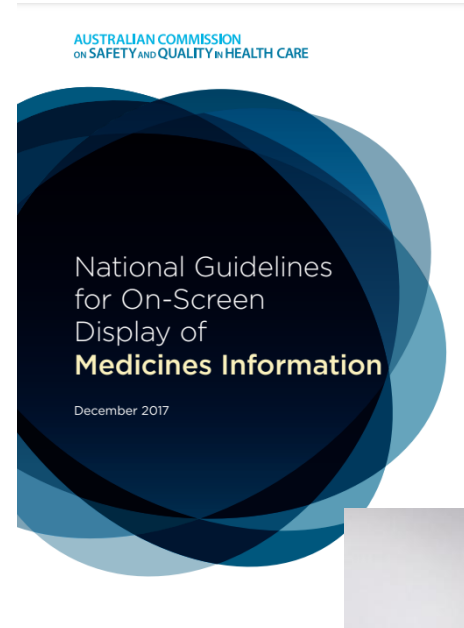
National Guidelines for On-Screen Presentation of Discharge Summaries

September 2017



Updating the National Guidelines for On-screen display of medicines information

- These guidelines provide recommendations to enable standardisation of medicines information in digital health systems, across the healthcare continuum
- Targeted at those involved in developing, assessing, procuring and implementing digital health systems for electronic medication management (eMM).



Electronic National Residential Medication Chart Medication Management Systems

- Outlines advice on transition from a paper-based or hybrid (electronic and paper) medication management system to an eNRMC system
- Provides useful tools and resources to implement an eNRMC system from planning to go-live



Work streams

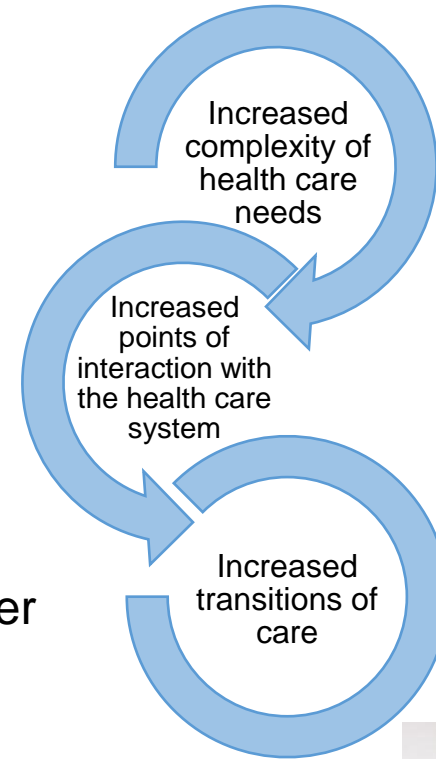
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4. Transitions of care

Safety and Quality Risks

- Most vulnerable are at greatest risk
 - older people
 - people with disability
 - chronic or complex conditions
- Poor transitions of care are associated with higher rates of readmission
- > 50% of medication errors occur when people move between healthcare settings



Transitions of Care

- National approach to transitions of care, including the movement of aged care patients from hospitals to community settings
- Review and development of further action to improve communication across transitions of care, including between acute, community, primary and aged care settings as needed
- Identification of best practice use of national digital health infrastructure and digital health solutions to achieve safer transitions of care



Principles of Safe Transitions of Care

1. Person-centred
2. Central point of care (e.g. GP)
3. Clear accountability and responsibility
4. Information is current, available, and follows the person
5. Enduring comprehensive and secure record system

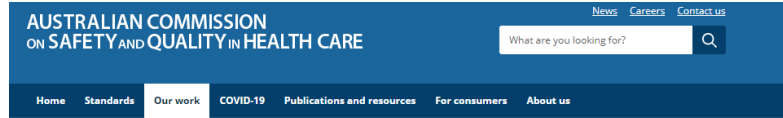


Safer Transitions of Care for Older Australians

- Aims to facilitate expanded use of a national electronic medical record- the My Health Record (MHR) to support residents transitioning between RACFs and hospitals



World Patient Safety Day 2022



[Home](#) > [Our work](#) > [Medication safety](#) > [WHO Global Patient Safety Challenge](#) > WHO Patient Safety Day 2022

WHO World Patient Safety Day 2022

The World Health Organization (WHO) World Patient Safety Day takes place on 17 September every year. The theme for 2022 is Medication Safety. The Commission continues to support WHO in their efforts to increase safe use of medicines.



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- [Overview](#)
- [Initiatives around Australia](#)
- [Testimonial videos](#)
- [Polypharmacy](#)
- [High-risk medicines](#)
- [Transitions of care](#)

Overview

The theme for [World Patient Safety Day](#) 2022 is Medication Safety, building on the WHO Global Patient Safety Challenge - Medication without harm. Health services are encouraged to take action and prioritise medication safety across the WHO's three flagship areas:

1. Monitoring **polypharmacy** and responding to inappropriate polypharmacy
2. Reducing harm from **high-risk medicines**
3. Improving medication safety at **transitions of care**

Our work

- Medication safety**
 - Electronic medication charts
 - Active Ingredient Prescribing
 - Quality use of medicines
 - WHO Global Patient Safety Challenge
 - WHO Patient Safety Day 2022**
 - Initiatives around Australia
 - Position and safety statements
 - High risk medicines



SCAN ME



<https://www.safetyandquality.gov.au/our-work/medication-safety/who-global-patient-safety-challenge-medication-without-harm/who-world-patient-safety-day-2022>

To make contact with members of our team:

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