



National Prescribing Service Limited

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**Discussion Paper**  
**Medication safety in Australia:**  
**Status at November 2007**

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**National Prescribing Service Ltd (NPS) is an independent, non-profit organisation for Quality Use of Medicines. We provide accurate, balanced, evidence-based information and services to help people choose if, when and how to use medicines to improve their health and wellbeing. We are member-based and work in partnership with health professionals, government, pharmaceutical industry and consumers. NPS is funded by the Australian Government Department of Health and Ageing.**

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## Acronyms

ACSQHC	Australian Commission for Safety and Quality in Health Care
ADR	adverse drug reaction
ADRAC	Adverse Drug Reaction Advisory Committee
AHMAC	Australian Health Ministers Advisory Committee
AIMS	Advanced Incident Monitoring System
AME Line	Adverse Medicines Events Line
APAC	Australian Pharmaceutical Advisory Committee
APSF	Australian Patient Safety Foundation
APS	Australian Pharmaceutical Society
CEC	Clinical Excellence Commission
CHF	Consumers' Health Forum
CMEC	Complementary Medicines Evaluation Committee
CMI	consumer medicines information
COPD	chronic obstructive pulmonary disease
CPAM	Corporate Public Affairs and Marketing
CQUM	Consumer Quality Use of Medicines Program
CREPS	Centre for Research Excellence in Patient Safety
DUE	drug utilisation evaluation
EQAP	Education and Quality Assurance Program
HIREU	Health Informatics Research and Evaluation Unit
IHI	US Institute of Healthcare Improvement
IIMS	Incident Information Monitoring Systems
ISMP	Institute for Safe Medical Practice
NEHTA	National Electronic Health Transition Authority
NHMRC	National Health and Medical Research Council
NICS	National Institute of Clinical Studies
NIMC	National Inpatient Medication Chart
NMSBC	National Medication Safety Breakthrough Collaborative
NPS	National Prescribing Service
NSAID	nonsteroidal anti inflammatory drugs
OACIS	Open Architecture Clinical Information System
PDS	Pharmaceutical Decision Support
PHARM	Pharmaceutical Health and Rational Use of Medicines
PIMS	Performance Indicators in Medication Safety Project
QUM	quality use of medicines

RACGP	Royal Australasian College of General Practitioners
SHPA	Society of Hospital Pharmacists of Australia
SMPU	Safe Medication Practice Unit
SWOT	Strengths, Weaknesses, Opportunities and Threats Analysis
TAG	Therapeutic Advisory Group
TGA	Therapeutic Goods Administration
UMORE	Unit for Medication Outcomes Research and Evaluation
VMAC	Victorian Medicines Advisory Committee

## Purpose of this document

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- To understand what has and is happening with medication safety in Australia and internationally.
- To understand the gaps in providing medication safety.

The work began as a response to recent concerns that there are gaps in the national co-ordination and implementation of medication safety activities. This report summarises the work of a group of health professionals and researchers at the National Prescribing Service (NPS) as they sought to understand the current state of medication safety in Australia, identify any linkages between work on medication safety and quality use of medicines<sup>a</sup> work and identify gaps in that work that NPS may be able to assist with.

## Limitations

This document is based on a review of information during July 2007 from available, relevant current and past documents, websites related to medication safety, discussion with one director of a State-based Therapeutic Advisory Group, a meeting with an ACSQHC staff member and a board member, and presentations given by members of the ACSQHC. Information relating to the ACSQHC One Year Work plan and current activities were updated in November 2007

The document is an amalgamation of information and is not a comprehensive literature review or a definitive review of the current status of medication safety work in Australia.

## Summary

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Medication safety is a significant problem in Australia. It is estimated that last year around 180,000 people experienced an adverse effect from a medicine that required admission to hospital. While in hospital, another 2% of patients experience harm or die as a result of medication errors. Between 30% and 50% of these incidents are preventable.

The **Australian Commission for Safety and Quality in Health Care** (ACSQHC; the Commission) is responsible for providing leadership and facilitation for medication safety and is expected to deliver measurable improvements in safety and quality health care by 2010. Since its establishment in 2006, the Commission has focussed on managing and building on the work of the previous Australian Council of Safety and Quality in Health Care (the Council) and on developing projects that will bring about significant improvements in safety and quality. The work of the Council had previously focussed on medication safety in the public hospital sector. The Commission will now more actively engage with consumer groups, the primary health care sector, State and Territory jurisdictions and the private hospital sector to improve safety and quality in all settings. The Commission is taking a strategic approach, with new work directed at elemental structural changes that will fill gaps and overcome obstacles to safety and quality in health care. For example, it is identifying obstacles to the monitoring of safety and quality, and attempting to work with stakeholders to advance new strategies that provide improved data availability, quality and usefulness for monitoring.

The authors identified 11 areas of responsibility relating to co-ordinating and implementing medication safety initiatives that would represent a comprehensive national approach to managing medication safety. These areas were identified from past and current responsibilities undertaken by a range of national and international medication safety groups. They are:

- providing national leadership and strategic direction on medication safety
- liaising and advocating in Australia for system improvements for medication safety
- identifying medication safety issues

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<sup>a</sup> Quality use of medicines includes the judicious, appropriate, effective and **safe** use of medicines.

- monitoring and reporting on medication errors, complaints and adverse drug events
- developing medication safety information, education and tools for healthcare professionals and consumers
- providing information and advice to consumers and healthcare professionals on adverse effects and drug interactions
- working with stakeholders to develop dissemination strategies for medication safety
- distributing/disseminating medication safety information, education and tools for healthcare professionals and consumers
- improving linkages between medication safety and quality use of medicines (QUM)
- training healthcare professionals to improve medication safety
- promoting research into improving medication safety
- international liaison and advocacy for improvements in medication safety systems

Table 1 presents a snapshot of organisations taking responsibility in these 11 areas and the activities being implemented at a national, State and local level. Additional information about the activities and groups working in medication safety in the various jurisdictions is described in Section 3, and summarised in Table 2.

**Table 1: Snapshot of current responsibilities and activities for medication safety in Australia**

<b>Responsibility/activity</b>	<b>National level</b>	<b>State level</b> (Health departments, TAGs, other bodies)	<b>Local level</b> (Regional health services or hospitals)
<b>Provide leadership and strategic direction on medication safety</b>	Medication safety is a priority area for the ACSQHC, which is focussing on co-ordination and facilitation rather than implementation	Most States and Territories have one or more bodies that oversee and provide direction for State activities. In some case role delineation of these bodies is an issue	Drug and therapeutics / quality and safety / clinical governance committees provide oversight and direction in regional services and individual institutions
<b>Liaise and advocate in Australia for system improvements for medication safety</b>	ACSQHC will provide high-level advocacy and funding to bring about change ACSQHC will influence national groups, e.g. NEHTA, and State health ministers Private Hospital Sector Committee of ACSQHC Joint TAGs	Most States and Territories have at least one body that liaises and advocates for medication safety	Individuals and units from health services and facilities involved in liaison and advocacy
<b>Identify medication safety issues</b>	Part of the remit of the Centre of Research Excellence in Patient Safety (CREPS)	Undertaken in most States through complaints reporting and incident monitoring	Undertaken in many facilities and services through complaints reporting and incident monitoring

<b>Responsibility/activity</b>	<b>National level</b>	<b>State level</b> (Health departments, TAGs, other bodies)	<b>Local level</b> (Regional health services or hospitals)
<b>Monitor and report on sentinel events, medication errors, complaints and adverse drug events</b>	<p>National sentinel event monitoring is in place.</p> <p>No nationally co-ordinated system in place to monitor and report on medication errors and complaints</p> <p>ADRAC receives reports from healthcare professionals about ADRs</p> <p>AME line collects information from consumers on adverse drug events and reports to ADRAC</p> <p>ACSQHC proposes to improve postmarketing surveillance of ADEs using linked data</p> <p>CREPS responsible for developing data tools to monitor safety and quality in healthcare</p>	<p>States have healthcare complaints reporting.</p> <p>NSW, SA, WA and some Vic regional services have incident-monitoring systems in place</p>	<p>Occurring in regions and facilities — data dependent on monitoring activities in place. Most at least have a complaints-reporting mechanism</p>
<b>Develop medication safety information, education and tools for healthcare professionals and consumers</b>	<p>National Inpatient Medication Chart (NIMC) Oversight Committee</p> <p>ACSQHC will investigate the effectiveness of current patient-education programs and recommend any necessary action</p> <p>ACSQHC proposes to investigate how to improve on e-prescribing to inform the setting of national standards for user interface design, charts, alerts and messaging</p> <p>NPS education, quality assurance and consumer programs and activities, including drug utilisation evaluation projects</p>	<p>Occurs in some States (NSW, Qld, Vic, WA) led by safety and quality units or others (e.g. NSW TAG and the CEC have co-ordinated development of self-assessment tools and indicators for QUM in hospitals)</p>	<p>Occurs on ad hoc basis in interested sites</p>
<b>Provide information and advice to consumers and health professionals on adverse effects and drug interactions</b>	<p>NPS Medicines Lines and TAIS lines</p> <p>NPS products such as <i>NPS News</i>, <i>NPS RADAR</i>, <i>Medicines Update</i>, and <i>Medimate</i></p> <p>NPS education and quality assurance and consumer programs</p>	<p>State health call centres</p>	<p>Drug information centres in hospital and health regions</p>
<b>Work with stakeholders to develop dissemination strategies for medication safety</b>	<p>NIMC Oversight Committee</p>	<p>State groups such as TAGs are responsible for building dissemination strategies</p>	
<b>Distribute/disseminate medication safety information, education and tools for healthcare professionals and consumers</b>	<p>Inter-jurisdictional Committee of ACSQHC responsible for implementing quality and safety initiatives in States</p> <p>The Society of Hospital Pharmacists of Australia disseminates Australian safety messages and US safety briefs (from ISMP USA) via the <i>Journal of Pharmacy Practice and Research</i> and via its website</p>	<p>Most States co-ordinate distribution of information, education and tools</p> <p>All States involved in roll-out of NIMC</p> <p>TAG activity in some States via email discussions and activities of medication safety groups</p>	<p>Safety and quality / clinical governance / pharmacy depts. / drug and therapeutics committees responsible for implementing State strategies</p> <p>All hospitals implementing NIMC</p>

<b>Responsibility/activity</b>	<b>National level</b>	<b>State level</b> (Health departments, TAGs, other bodies)	<b>Local level</b> (Regional health services or hospitals)
<b>Improving linkages between medication safety and quality use of medicines (QUM)</b>		Some TAGs and some State health departments integrate QUM and medication safety	Individual clinical governance / pharmacy depts / drug and therapeutics committees will provide these linkages locally
<b>Train healthcare professionals to improve medication safety</b>	ACSQHC involved in accrediting healthcare practitioners and organisations	Some States have co-ordinated quality and safety training activities	Training conducted by safety units / clinical governance units / pharmacy depts
<b>Promote research into improving medication safety</b>	ACSQHC supports CREPS to provide research to promote safety and quality in health care Guild and APS fund individual projects in the community Some universities have medication research centres or programs related to medication safety	States fund research and practice-improvement projects	Some clinical areas conduct local research and practice-improvement projects
<b>International liaison and advocacy for improvements in medication safety system</b>	ACSQHC is a partner in the WHO Patient Safety Alliance — focus is on clinical handover	TAGs and others liaise with the Institutes of Safe Medication Practice and similar international groups	Individuals

## What is missing at a national level for medication safety?

Although the Commission is identified as having responsibility for many of these roles, there appears to be a gap between their remit and current activities. There appears to be limited activity around the design, organisation and funding of national medication safety activities such as:

- co-ordinating input from key stakeholders into medication safety information strategies for health professionals and consumers, for example, national medication safety alerts
- co-ordinating input from key stakeholders in the development of medication safety educational packages and audit tools based on evidence for national distribution
- co-ordinating input from key stakeholders in developing implementation and dissemination strategies and kits for these initiatives
- assisting States and Territories with development and dissemination of medication safety strategies
- national co-ordination of 'bottom up' medication safety activities
- acting as an advocate with other national stakeholders to share information and bring about change
- acting as an advocate with international stakeholders to share information and bring about change.

# 1. Background

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The Australian Commission on Safety and Quality in Health Care (ACSQHC or the Commission) has replaced the Australian Council for Safety and Quality in Health Care (the Council). The Council had a large number of medication safety initiatives underway, a proportion of which may have been unsustainable. Some of the Council's medication safety projects have been dropped from the Commission's new work plan. While the Commission's 5-year work plan defines only two projects or programs directly related to medication safety (the National Inpatient Medication Chart [NIMC] implementation and Pharmaceutical Review), more recently the Commission has proposed a series of additional strategies to improve medication safety in their 1-year work plan. The Commission has approached suitable implementation partners to achieve some progress in this area but most of these negotiations are in the early stages.

## What is medication safety?

There are several definitions for medication safety. The first relates to the outcome of providing safety — 'freedom from unintentional injury during the course of medication use'; the second focusses on what needs to be done to achieve safety — 'activities to avoid, prevent or correct adverse drug events that may result from the use of medications'. Both are valid and relevant to this discussion.

## Why is medication safety important?

Medication safety is a significant problem overseas and in Australia, in both hospital and community settings.

Most of the evidence on problems with medication safety in hospital settings comes from overseas studies. In the US it is estimated that 2% of patients (over 770,000 people) are injured or die each year in hospitals as a result of adverse drug events (ADEs), most of which are due to medication errors during prescribing or administration of medicines.

The Quality in Australian Healthcare study found that around 2% of all hospital admissions are related to problems with medicines. This means that in Australia in 2005/6, 146,000 people experienced an adverse effect from a medicine that required admission to hospital. It is estimated that about 30%-40% of these admissions are preventable. A review of case notes of 1000 'high risk' patients in Australia who received a medication management service in the community found that 90% of participants had medication-related problems. Twenty-seven per cent of these problems were due to inappropriate use of prescribed medicine, 25% required additional medication, and 21% were prescribed an inappropriate dose, frequency or duration for a medication. Other problems included patients needing additional therapy or additional tests, and using unnecessary medicines.

Of the 100 million general practice encounters each year in Australia it has been estimated that about 400,000 involve adverse events associated with medicines. A survey of general practitioners reported that 10.4% of patients had experienced an adverse drug event in the previous 6 months. About 50% of ADEs were classed as mild, 36% were moderate and 10% were severe.

These figures may underestimate the actual harm being caused by medication errors, given that the risk of such errors is rising each year with the increased intensity of medical care, use of more and more complex drug regimens and potent medications, and the increasing age and comorbidities of patients.

## Medication safety and quality use of medicines (QUM)

Quality use of medicines includes the judicious, appropriate, effective and safe use of medicines. Medication safety is one element of QUM. Quality use of medicines spans the spectrum from not using medicines, through using medicines, to using medicines in the optimal manner. For each of these stages there are potential benefits and harms. Medication safety focusses particularly on preventing and minimising harm when medicines are used. This of course is essential, but it is

important to consider a quality use of medicines approach, as not all harms are preventable. Often the clinician must weigh up both the benefits and harms of a medicine to deliver the most appropriate and effective treatment. If medication safety initiatives do not link to a broad quality use of medicines approach, we may also miss opportunities, such as building confidence and expertise in prescribing and managing medicines, which will result in the maximal impact on health outcomes.

## 2. Medication safety: international perspective

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The World Health Organization World Alliance for Patient Safety has been set up to raise awareness and promote political commitment to improve the safety of health care. The body facilitates the development of patient safety policy and practice in all WHO Member States.

Many countries have a national body that co-ordinates medication safety activities. Most notable are the Institutes of Safe Medication Practice (ISMP), which operate in the US, Canada, Spain and Brazil, and the National Patient Safety Agency in the UK. Recently these agencies met and discussed forming an international alliance — the International Network of Safe Medication Practice Centres — to optimise medication safety through addressing common issues experienced worldwide, and to lobby the pharmaceutical industry to address look-alike, sound-alike product presentation and non-friendly product design.

The aims and responsibilities of key international medication safety agencies are outlined below.

### The World Health Organization World Alliance for Patient Safety

The Alliance delivers a range of programs covering systemic and technical aspects to improve patient safety around the world. A core program of the World Alliance for Patient Safety is formulation of the Global Patient Safety Challenges, which focus on topics that cover a major and significant aspect of risk to patients receiving health care and are relevant to all WHO Member States, and which are identified for action over a 2–3-year cycle. The first two Global Challenges focussed on 'Clean care is safer care' and 'Safe surgery saves lives'. Recently, the Alliance has identified nine patient safety solutions; most are directly or indirectly related to medication safety. They are:

1. look-alike, sound-alike medication names
2. patient identification
3. communication during patient hand-overs
4. performance of correct procedure at correct body site
5. control of concentrated electrolyte solutions
6. assuring medication accuracy at transitions in care
7. avoiding catheter and tubing mis-connections
8. single use of injection devices
9. improved hand hygiene to prevent healthcare-associated infection areas

(For more information see: [www.jcipatientsafety.org/24725](http://www.jcipatientsafety.org/24725))

ACSQHC is a partner in the WHO Patient Safety Alliance. Australia is the lead on clinical handover.

### The Institutes for Safe Medication Practices (ISMP)

The US ISMP is a non-profit organisation based in Philadelphia and devoted to medication error prevention and safe medication use. The ISMP:

- collaborates with a wide variety of partners — healthcare practitioners, legislative and regulatory bodies, healthcare institutions, consumers, healthcare professional organisations, regulatory and accrediting agencies, employer and insurer groups and the pharmaceutical industry
- develops and distributes impartial, timely and accurate medication safety information and tools (e.g. *Medication Safety Alert* newsletters) for healthcare professionals and consumers
- uses system-based non-punitive approaches to increase understanding and educate healthcare professionals and others about medication error prevention through educational programs, (e.g. lectures and teleconferences at hospitals or other healthcare settings on current medication use

issues; posters, videos, patient brochures, books and other resources)

- conducts a voluntary practitioner error-reporting program 'USP-ISMP Medication Error Reporting Program (MERP)' to learn about errors happening across the nation, understand their causes, and share lessons learned with the healthcare community
- works with the pharmaceutical industry through Med-E.R.R.S. (Medical Error Recognition and Revision Strategies) to prevent errors that stem from confusing or misleading naming, labelling, packaging, and device design
- provides a consulting service to healthcare providers to proactively evaluate medication systems or analyse medication-related sentinel events
- monitors the impact of their work, especially learnings from the error monitoring system on changes in pharmaceutical labelling and packaging, policy and standards implementation, health system changes and individual practice changes.

(More information on the US ISMP can be found at [www.ismp.org](http://www.ismp.org))

There are also ISMPs in Canada ([www.ismp-canada.org](http://www.ismp-canada.org)) and Spain ([www.ismp-espana.org](http://www.ismp-espana.org))

## **The UK National Patient Safety Agency**

The National Patient Safety Agency (NPSA) is a special health authority created in the UK to learn from patient safety incidents and co-ordinate healthcare efforts to improve patient safety. NPSA:

- maintains and monitors the National Reporting and Learning System, which collects and appraises information on reported patient safety incidents and 'near misses' and other material useful for any purpose connected with the promotion of patient safety
- identifies lessons drawn from error reports and disseminates them back to the health system
- liaises with the Department of Health to develop educational programs and implementation strategies to improve patient safety, including design safety in healthcare.

(More information on the UK NPSA can be found at [www.npsa.nhs.uk](http://www.npsa.nhs.uk))

### 3. Medication safety in Australia

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Medication safety in Australia is part of a broader strategy to improve patient safety and quality of care. The Australian Council on Safety and Quality in Health Care was established in 2000 to provide leadership and co-ordinate safety and quality strategies across the health system. The council worked for 6 years to establish a range of initiatives to improve patient safety. A review of the Council's work found that 'the lack of formal links and partnerships between Council, jurisdictions and other key bodies, have hampered its effectiveness' and recommended 'that the future work of a national body should have a broad quality improvement focus, across a range of healthcare delivery settings, with the aim of achieving care that is safe, effective and responsive to the needs of consumers'. In January 2006, the Australian Commission for Safety and Quality in Health Care replaced the Council as the peak body responsible for improving the safety and quality of health care in Australia.

This section describes the role and activities of these organisations, particularly as they relate to medication safety initiatives.

#### **Australian Council on Safety and Quality in Health Care**

The Council worked in consultation with health professionals, consumers, State and Territory health authorities and other key stakeholders to develop and implement a range of safety and quality strategies. Key action areas for the Council between 2000 and 2005 included:

- building capacity of the health workforce to deliver safer patient outcomes
- improving the use of data and performance information to promote care
- developed a 'measurement for improvement toolkit'
- promoting consumer and community involvement in improvements in care
- leading practice improvement in key areas of harm
- influencing safer design of equipment, processes, environment and improved information technology for health
- building awareness and understanding of safety and quality issues
- increasing effective safety and quality governance and investment
- developing strategic partnerships and future directions.

#### **National Medication Safety Initiatives of the Council**

In 2001, the Medication Safety Task force of the Council was established to reduce patient harm due to medications. Descriptions of the six major projects initiated by the Council that directly relate to medication safety follow.

#### ***National Medication Safety Breakthrough Collaborative (NMSBC)***

The overall aim of the NMSBC was to reduce harm caused by medication use by 50% in participating organisations over the course of the collaborative. One hundred health service teams from metropolitan, regional and rural areas, from both the public and private sectors around Australia, participated in the NMSBC. This collaborative developed a national network and system to sustain and transfer the improvements in medication safety to health services across Australia through communities of care.

**Wave 1:** Forty-seven teams participated. Focus was improving processes associated with medication use, for example, information for consumers, medication appropriateness, prescribing, administration, dispensing, and documentation processes. Specific medications that most commonly result in medication incidents include anticoagulants, antibiotics, corticosteroids, cancer chemotherapy, and medications acting on the central nervous system.

**Wave 2:** Fifty-three teams participated. Focus was on the interface between hospital and the community.

It is difficult to summarise results from the NMSBC across all the facilities, as each facility chose to address different issues, with different strategies and methods of measurement. The collaboratives were well received in facilities and many teams worked together to achieve a 50% reduction in harm in their chosen area, while others focussed their attention on new ways of working together to raise awareness and change systems to improve patient safety. The NMSBC demonstrated that 'significant improvements can be made through effective multidisciplinary collaboration and small-scale testing of changes at the facility, State and national levels'. Improvements made at individual facilities included:

- improved rate of documenting previous adverse event (from 30% to >90%)
- reduced potential for patient harm (from 20% to 0%)
- reduced potential for medication-related harm during the discharge (by 80%)
- an increased proportion of patients with documented medication history within 24 hours of admission (from 40% to 70%).

A summary of the achievements of individual teams can be found at

[www.safetyandquality.org/internet/safety/publishing.nsf/Content/230D531B52042254CA2571C7000A38A5/\\$File/nmsbcshocase.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/230D531B52042254CA2571C7000A38A5/$File/nmsbcshocase.pdf)

and

[www.safetyandquality.org/internet/safety/publishing.nsf/Content/230D531B52042254CA2571C7000A38A5/\\$File/projectchronicl.pdf](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/230D531B52042254CA2571C7000A38A5/$File/projectchronicl.pdf)

**Current status:** Some individual hospitals are continuing their involvement in this initiative but the status of the national network is uncertain.

More information on NMSBC can be found at

[www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-breakthrough](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-breakthrough)

### **High Risk Medication Alerts**

This program aimed to identify and provide information to warn frontline health professionals and administrators about high-risk medications (i.e. those with the potential to cause serious or catastrophic harm to patients) and provide tools to assist health services and clinicians to reduce the hazards at the local level. Two medication alerts were released: *Medication Alert 1 — Concentrated intravenous potassium chloride* in 2003 and *Medication Alert 2 — Vincristine* in 2005.

**Current status:** No further alerts are planned.

(More information on High Risk Medication Alerts can be found at

[www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-potassium-chloride](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-potassium-chloride)

### **Adverse Medicine Events Line (AME Line)**

The AME Line allows the community to report their suspected adverse medicine events, possible errors or 'near misses' with their medicines. It also aimed to identify areas and trends in adverse medicine events to know when, where and how things go wrong; and ultimately integrate such information into health systems to improve their safety and quality.

**Current status:** AME is currently being temporarily funded by the National Prescribing Service.

More information on AME Line can be found at

[www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-phoneline](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/former-pubs-archive-phoneline)

### **National Inpatient Medication Chart (NIMC)**

The National Inpatient Medication Chart (NIMC) was developed through the National Medication Chart Working Group to produce a standard hospital medication chart that would improve medication safety across all Australian hospitals. The chart was scheduled to be implemented across Australian

public hospitals by June 2007.

**Current status:** The Commission has agreed to support this project, and a new NIMC Oversight Committee has been convened to monitor and review the implementation of the standard chart and develop and implement ancillary charts, such as long-stay and paediatric charts.

More information on NIMC can be found at

[www.safetyandquality.org/internet/safety/publishing.nsf/Content/national-inpatient-medication-chart](http://www.safetyandquality.org/internet/safety/publishing.nsf/Content/national-inpatient-medication-chart)

### ***Pharmaceutical Review***

The Taskforce began developmental work to improve safety around medication prescribing, dispensing, administration and documentation in hospitals. The strategies suggested for this included:

- use of computerised prescribing with clinical-decision-support systems
- computerised adverse drug events alerts
- individual patient medication supply in hospitals
- pharmacy services supporting systems to reduce medication incidents, through patient and staff education, monitoring and medication review.
- improved transfer of information between hospitals and community settings
- community-based medication management services and case conferences to assist patients considered at high risk of medication-related problems through review of their prescribed over-the-counter and complementary medicines, and discussion of their overall health care
- discharge medication management services — a range of services for people at risk of medication incidents, including providing discharge medication summaries to patients and healthcare providers.

**Current status:** This project was in the early development stage when the Council was replaced in 2006. In May 2005 the Council had convened a workshop of experts and stakeholders to discuss the definitions, scope and potential models for delivery of pharmaceutical review, but no further co-ordinated activity has occurred since this time. This project is in the current work plan of the Commission. Some States have developed local definitions and have begun work on development of implementation plans for pharmaceutical review, but action has not been progressed in a co-ordinated way.

The 'Patient Medicines Profiling Program', which begins in late 2007 and funded as part of the Fourth Pharmacy Agreement, will provide consumers with a medication profile service through community pharmacies. This program aims to assist people 'to better understand and manage' their prescription, over-the-counter and complementary medicines.

### ***Safer Systems — Saving Lives Program***

Safer Systems — Saving Lives is based on the '100,000 Lives Campaign' of the US Institute for Healthcare Improvement. This campaign aimed to 'avoid 100,000 deaths by June 2006 and every year after' by implementing six interventions to improve patient outcomes. The interventions are evidence based and, when systematically applied across organisations, have been proven to prevent harm to patients.

The Quality and Safety Branch of the Department of Human Services in Victoria provides the organisational lead and overarching project management to the hospitals participating in the project. Projects include preventing surgical site infection, preventing adverse drug events and improving care for acute myocardial infarction. Selected hospitals in New South Wales, Northern Territory, South Australia, Tasmania and Victoria are involved.

Several projects are underway to reduce adverse drug events, including warfarin management in acute stroke, which aims to improve warfarin management, education, safety and compliance in acute stroke patients.

More information on the Adverse Drug Events Project and the tools developed for these projects can be found at [www.health.vic.gov.au/sssl/interventions/adverse.htm](http://www.health.vic.gov.au/sssl/interventions/adverse.htm)

**Current status:** Ongoing. This project is in the work plan of the Commission.

### ***NHMRC Centre of Research Excellence in Patient Safety. (CREPS)***

The Centre was established and funded by the Council through the NHMRC. It aims to design, conduct, promote and promulgate high-quality multicentre research to improve quality, safety, efficiency and effectiveness of health care for Australians.

**Current status:** Ongoing. The Commission now funds the Centre through the NHMRC.

## **Australian Commission for Safety and Quality in Health Care**

The Commission was established in January 2006 and is expected to deliver measurable improvement in safety and quality in health care by 2010. The Commission will provide leadership and co-ordination of improvements in safety and quality in health care in Australia and is also responsible for reporting publicly on the state of safety and quality, including:

- performance against national standards
- recommending national data sets for safety and quality
- providing strategic advice to Health Ministers on 'best practice' thinking to drive quality improvement, including implementation strategies
- recommending nationally agreed standards for safety and quality improvement.

Information about current activities of the Commission can be found on the website via the 2007–08 work plan and the Commission's 2006/7–2010/11 5-year work plan <sup>b</sup>. The work proposed by the Commission relates to managing and building on the work of the previous Council and developing projects that will bring about significant improvements in safety and quality. Of the 183 projects that were in progress when the Commission replaced the Council, about 20 were continued; most were expected to be completed by end of the 2007.

Key areas of the Commission's 5 year Work plan include:

- developing and implementing a National Strategic Framework for Safety and Quality in all healthcare settings, which will be based on mapping current safety and quality activities across Government and non-Government sectors and an analysis of gaps and risk areas in safety and quality
- consulting with relevant professional bodies and consumers to improve consumer pathways and simplify and reduce gaps, particularly those associated with transfer of care
- communicating and disseminating knowledge gained through environmental scanning, international experience and mining of national data sets and monitoring of sentinel events
- examining the usefulness of existing datasets for safety and quality purposes and creation of national safety and quality data sets where needed
- communicating safety and quality messages to healthcare providers and the public
- assisting the development and national roll-out of electronic health records, to ensure incorporation of safety and quality improvements
- accrediting all settings of health care, registering health professionals nationally and credentialing health professionals for high-risk interventions
- managing and building on existing projects.

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<sup>b</sup> [www.health.gov.au/internet/safety/publishing.nsf/Content/whats-new-lp](http://www.health.gov.au/internet/safety/publishing.nsf/Content/whats-new-lp)

ACSQHC is a member of the WHO World Alliance for Patient Safety. It has chosen the area of 'communication during patient hand-overs' as the patient safety solution that it will work on.

We were unable to find information on the ACSQHC website about the key stakeholder committees other than the Chairman and Commission members. In the work plan only one established committee is identified, the Inter-Jurisdictional Committee. No other information about this committee appears on the website. The work plan identifies that a new committee will be established to work formally with the private hospital and health fund sectors to improve safety and quality. A presentation by Diana Horvath notes that stakeholder reference groups would be established, but no details are available about which stakeholders will be involved, whether the reference groups have been established, or their direction.

### Medication safety initiatives of the Commission

Medication safety remains a priority for the Commission (Priority Program 6). Based on a review of the 2007–2008 work plan and the 2006/7 to 2010/11 5-year work plan<sup>c</sup> and discussion with one of the Commission's staff, the areas of the Commission's work that relate to medication safety are presented in the table below.

#### Key medication safety initiatives for 2007–08

Program Name	Strategies	Deliverables	Known current activities
<b>Part A — Nine priority programs</b>			
<b>6. Medication Safety</b>	<p>Feasibility study for postmarketing surveillance of medications</p> <p>Evaluation of MATES program and relevant international experience. (The MATES program uses a variety of interventions, including prescriber and patient feedback, to improve prescribing practice.)</p> <p>Map the processes involved in prescription and potential points of error in a range of e-prescribing implementation scenarios</p> <p>Conduct an extensive consumer consultation process regarding medication education</p>	<p>Potential improvement in the effective and safe use of medication</p> <p>Evaluation of potential for improving professional support for medication prescribing</p> <p>Determination of the future electronic form for the National Inpatient Medication Chart</p> <p>Investigation of the effectiveness of current patient medication education programs</p>	<p>This information would be used to build a business case to improve data access for safety and quality activities (e.g. NPS education activities) and the postmarketing surveillance of adverse events related to new drugs</p> <p>The Commission plans to outsource this consumer consultation process to investigate the effectiveness of current patient education programs for medications and recommend any necessary action</p>
<b>Part B — Legacy programs</b>			
<b>1. Safer Systems — Saving Lives</b>	<p>Department of Human Services Victoria to project manage and co-ordinate collection of data across 40 hospitals nationally under contract with the Commission</p>	<p>Implement Safer Systems — Saving Lives program</p>	

<sup>c</sup> [www.health.gov.au/internet/safety/publishing.nsf/Content/whats-new-lp](http://www.health.gov.au/internet/safety/publishing.nsf/Content/whats-new-lp)

<b>Program Name</b>	<b>Strategies</b>	<b>Deliverables</b>	<b>Known current activities</b>
<b>6. National Inpatient Medication Chart — and further development</b>	<p>Common medication chart to be used in all public and private hospitals</p> <p>To be included in Health Services Accreditation to measure compliance with a single version across the nation</p> <p>Electronic linkage of inpatient and PBS prescription data</p> <p>Implementation of electronic health records and guidelines will incorporate safety and quality components</p>	<p>Develop, maintain and assist national enforcement of a common national inpatient medication chart</p> <p>Remove risks to patient health caused by transcription errors, by ensuring prescription information is automatically registered as both a PBS prescription and an entry on the inpatient medication chart</p> <p>Advocate for the adoption of electronic prescribing with decision support (EPDS) across healthcare settings</p>	<p>An NIMC Oversight Committee meets to monitor and review the implementation of the standard NIMC. Commission will 'work with stakeholders to update as needed and ensure national enforcement of a single version'. Implementation across all public and private sector facilities should be complete by June 2008</p> <p>Commission to advocate jurisdictions, NEHTA, private hospitals, clinicians and pharmacists to implement in association with software vendors</p> <p>The Commission will work with AHMAC, NEHTA, NHIMPC, private sector stakeholders, health professionals and informed consumers</p>
<b>7. Eight uniform national actions to improve patient safety (agreed by Ministers)</b>		<p>Common medication chart</p> <p>Hospital reporting on sentinel events</p> <p>State and Territory reporting on sentinel events</p> <p>Pharmaceutical review</p> <p>Adopting the 'five-rights' protocol (right patient, right drug, right dose, right route, right time)</p> <p>Incident management system</p>	<p>Pharmaceutical review: strategies for managing and implementing this project have not yet been finalised. Some States are advancing work in this area, building on the original work of the Council</p>

### ***Additional medication safety initiatives in the Commission's 5-year plan***

- **Communicate and advocate safety and quality messages to healthcare providers and the public**

This will include formal and informal communications, e.g. about safe medication usage and avoidance of hospital acquired infections. No new medication messages have been developed or released to date.

### ***Communication and dissemination of knowledge***

The Work plan identifies several key areas around communicating and disseminating knowledge about quality and safety. These include:

- collating and assessing knowledge gained through environmental scanning, international experience and mining of national data sets
- extracting useable data for professionals and consumers to inform choices on the basis of quality of care
- supporting high-quality and relevant professional and consumer education.

More information on the Commission can be found at [www.safetyandquality.org](http://www.safetyandquality.org)

### **Centre for Research Excellence in Patient Safety**

The NHMRC Centre of Research Excellence in Patient Safety (CREPS) was established by the Council and is currently funded by the Commission through the NHMRC. It aims to design, conduct, promote and promulgate high-quality multicentre research to improve quality, safety, efficiency and effectiveness of health care for Australians.

Current research focus and projects of the Centre that relate to medication safety include:

- developing and maintaining data and tools to measure health care quality and to facilitate data use and translation into useable information by external and internal stakeholders to inform decision-making and quality-improvement processes. Projects include linking indicators with outcome measures
- health information technology to increase the development, diffusion and adoption of health IT to improve the quality of health care for all Australians. (No projects identified on website)
- care management to promote effective, evidence-based and patient-centred care through research, information, dissemination, tool development and promotion of decision-support processes. Projects include sentinel events, clinical pathways, and warfarin complications in the community
- medication safety to improve health outcomes through the safe and effective use of pharmaceuticals. Projects: medication error in the recovery room.

CREPS regularly releases the *Patient Safety Bulletin* to summarise and interpret results from important papers and other information to ensure clinicians and health service managers are kept up to date with literature on quality and safety issues. For more information see:

[www.crepatientsafety.org.au/news](http://www.crepatientsafety.org.au/news)

More information about the Centre can be found in Appendix 2 and at

[www.crepatientsafety.org.au](http://www.crepatientsafety.org.au)

## Other national organisations involved in medication safety

There are other national organisations involved in medication safety. These include the following professional bodies.

### **Australian Council of Healthcare Standards**

The Australian Council of Healthcare Standards now has standards relating to patient safety and specifically to medication safety.

### **Australian Patient Safety Foundation Inc. (APSF)**

The Australian Patient Safety Foundation is a 'non-profit independent organisation dedicated to the advancement of patient safety'. A subsidiary of APSF, Patient Safety International (PSI), has developed and distributes the Advanced Incident Management System (AIMS) software, which captures information from a wide variety of sources to enable de-construction and classification of incidents from near misses to sentinel events in a consistent way, so that subsequent, detailed analysis is possible. This tool is used to monitor incidents in SA, WA and NSW public hospital systems.

### **Australian Pharmaceutical Advisory Council (APAC)**

The Australian Pharmaceutical Advisory Council is a consultative forum that advises the Australian Government on a wide range of medicines policy issues. The Council includes representatives of peak health professions (pharmacy, medical and nursing), pharmaceutical industry, consumer and media organisations, as well as government members with an interest in implementing Australia's National Medicines Policy.

Publications include:

- *Guidelines for medication management in residential aged care facilities*, supported by Department of Human Services of Victoria toolkit
- *Guiding principles for medication management in the community*, and *Guiding principles to achieve continuity in medication management*.

### **Consumers Health Forum (CHF)**

CHF is an advocacy-based organisation that works on priority consumer health issues, including safety and quality in health care, safe and appropriate use of medicines and effective health care for people with chronic conditions. *The Safety and Quality Project 2007–08: It's all about communication*, a project developed by the CHF in consultation with the ACSQHC, will involve consumer networks in improving safety and quality in health care. The expected outcomes of this project include:

- greater understanding and awareness among health consumer organisations and their networks about safety and quality improvement in health care and the work of the Commission
- better engaging of consumers in implementing improvements in safety and quality in health care
- strategic input on consumer perspectives for safety and quality in health care
- quality information provided for consumers and consumer representatives on improving safety and quality in health care
- increased capacity in the CHF network of consumer organisations to participate in, and respond to, emerging issues in implementing safety and quality improvements in health care.

The NPS in partnership with the CHF is undertaking the *Community Quality Use of Medicines (CQUM) Project 2005–07* to provide consumers with information about how to find independent, credible and reliable sources of information about how to use medicines safely, wisely and appropriately.

More information on CHF and safety can be found at: [www.chf.org.au](http://www.chf.org.au)

### **National Institute of Clinical Studies (NICS)**

The National Institute of Clinical Studies focusses on getting evidence into practice. NICS has conducted gap analysis to identify where evidence is not being implemented in practice then, with key stakeholders, developed initiatives to address these gaps. Medication-related initiatives that are in progress or have been completed include:

- preventing stroke in atrial fibrillations
- use of appropriate medications in heart failure
- antibiotics for bronchitis and colds
- preventing thromboembolism in hospitalised patients
- managing acute and cancer pain
- folic acid supplements
- promoting use of preventers in chronic asthma
- managing acute mild asthma in the emergency department
- vaccinating against influenza
- achieving blood pressure control
- preventing recurrence of osteoporosis-related fractures.

NICS established 'Safer systems saving lives' initiatives with the Council.

More information on NICS initiatives can be found at: [www.nhmrc.gov.au/nics](http://www.nhmrc.gov.au/nics)

### **Australasian Association for Quality in Health Care (AAQHC)**

The AAQHC publishes the *Journal of the Australasian Association for Quality in Health Care*. It also facilitates the networking of groups through conferences and other activities to promote information sharing and practical solutions to medication safety issues. It recognises qualifications and experience through accrediting of quality practices.

### **HealthConnect**

HealthConnect is 'an overarching national change-management strategy to improve safety and quality in health care by establishing and maintaining a range of standardised electronic health information products and services for healthcare providers and consumers.'

Various medication-related projects were started, including:

- e-prescriptions between healthcare provider and community pharmacy
- e-hospital discharge summaries (sent from hospitals to community-based health professionals or aged-care facilities)

### **National Drugs and Poisons Schedule Committee**

This Committee is responsible for scheduling of medicines and chemicals. It is also responsible for labelling and for guidelines for direct-to-consumer advertising of Schedule 3 drugs.

### **National Electronic Health Transition Authority (NEHTA)**

NEHTA is currently working to develop national standards to identify, name and describe medicines, including developing coding that is fundamental to monitoring safety.

### **National Prescribing Service (NPS)**

Many NPS Programs incorporate medication safety messages and/or work towards improving medication safety.

The following NPS programs are either actively involved in a medication safety issue or include safety as one of their messages when the program is delivered:

### ***NPS Health Professional Education and Quality Assurance Program (EQAP)***

Medication safety is incorporated into EQAP programs in two ways.

- As one of the key program messages, when a needs assessment of all the factors in QUM (judicious, appropriate, safe and effective use) finds gaps in safety issues that are a major QUM issue, or when prescribers' response to risk of harms may be a driver for inappropriate drug use or cause unintended consequences that may result in inappropriate use. An example of this is that excessive concern about risk of therapeutic overdose of paracetamol is a barrier to the appropriate regular dosing of paracetamol in chronic pain. Under-use of paracetamol is a factor in overuse of NSAIDs, potentially placing at risk of adverse events people who may have responded to paracetamol.
- Monitoring to ensure safety. NPS clinical audits may require review of monitoring, adverse events, avoidance of drug interactions, dosing changes or switching. For example, monitoring levels of renal impairment is important in patients on metformin.

### ***NPS Community Quality Use of Medicines Program (CQUM)***

CQUM is involved in a range of initiatives in which key messages relate to the safe use of medicines by consumers.

Consumer awareness initiatives, the community antibiotics program and the peer education initiative have the key message 'Know about all your medicines' to promote safe and effective use of medicines among consumers. This key message includes second-level messages about:

- knowing that medicines include prescription medicines, over-the-counter medicines, herbal and natural medicines
- knowing the names of all your medicines, the reason for taking them and how to store them
- keeping an up-to-date list of your medicines with you at all times and having this reviewed regularly by your doctor
- being an active partner in your medicines management
- getting good, reliable information about your medicines.

NPS chronic conditions initiatives promote safety and appropriate use of medicines in people with type 2 diabetes and chronic pain by improving their awareness, knowledge and skills and their access to reliable and independent relevant information; increasing their capacity to be actively involved in making medicines decisions and in appropriate day-to-day self-management; improving concordance with treatment to improve health.

### ***NPS Curriculum and Training Program (CAT)***

CAT has developed and implemented a range of online training modules that incorporate principles to improve medication safety during the medication management process and emphasise providing information to patient and carers about medication use, including:

- online prescribing modules, which encourage attention to safety data for each medication as a criterion for choosing one medication over another. Some modules contain ADR and drug–drug interaction information and they all emphasise providing information to patients and carers about medication use.
- a training module to support the national roll-out of the *National Inpatient Medication Chart*
- the Good Medicines Better Health Project modules, which contain content about the accurate and appropriate recording of medication administration, drug–drug and drug–food interactions.

### **Phone line services**

NPS funds three national phone line services to support consumer and healthcare professionals with decisions and concerns about over-the-counter, prescription and complementary medicines.

- NPS Medicines Line enables consumers to talk to a health professional about how medicines work, how to take medicine, doses, side effects, interactions with other medicines and special precautions.
- NPS Therapeutic Advice and Information Service (TAIS) supports general practitioners, community pharmacists and other health professionals with immediate access to independent drug and therapeutics information such as interactions with other drugs, foods or complementary therapies and how to manage these; side effects, especially unusual ones not included in the product information; safety of drugs in pregnancy and lactation; use of drugs for unlicensed indications and if there is good evidence to support use and information about new drugs.
- Adverse Medicine Event Line (AME). Recently NPS has taken over responsibility for the AME Line, where consumers can report medicine-related problems. Information is passed directly onto the Adverse Drug Reaction Advisory Committee of the Therapeutic Goods Administration.

### **NPS Research Activities related to Medication Safety**

The Pharmaceutical Decision Support Program (PDS) and the Research and Development Program (R&D) at NPS are involved in several projects that will provide valuable information about medication safety in general practice, community pharmacy and hospitals:

- Drug-interaction decision-support evaluation. In this study the PDS team together with an expert panel investigated drug interaction decision support in commonly used prescribing and dispensing software systems.
- Safety, quality and usefulness of GP clinical software. The PDS and R&D Programs teams together with a group of external researchers are currently undertaking a study to identify the most important features of prescribing software systems to enhance patient safety and health outcomes, and which are useful for clinicians and patients, and to test whether they are present in general practice prescribing software.
- The R&D team are involved in two NHMRC projects with the University of Sydney, evaluating the effect of electronic medication management on medication safety during the prescribing and administration processes.

### **Pharmaceutical Health And Rational use of Medicines (PHARM)**

The PHARM Committee is a multidisciplinary Committee that provides expert advice to the Minister for Health and Ageing and the Department of Health and Ageing on the QUM strategy. The QUM strategy is based on a partnership approach between consumers, health professionals, industry and government. The PHARM Committee promotes and reviews the QUM strategy in Australia and oversees its implementation.

Publications include a CMI guide for consumers and health professionals, and a report on consumer perspectives of managing multiple medications.

### **Pharmaceutical Society of Australia (PSA)**

The PSA develops and implements service guidelines and standards for community pharmacists and provides guidelines and tools for promoting safe use of medicines with consumers (for example – using CMI with patients, assessing the use of dose administration aids).

### **Pharmacy Guild of Australia**

Currently the Guild contributes to medication safety in the community by:

- developing accreditation standards and accrediting community pharmacies
- funding research projects that relate to using medicines safely and effectively

- promoting community pharmacy initiatives that relate to using medicines safely and effectively, e.g. Patient Medication Profiling Program, Pharmacy Assistant training, Dose Administration Aids Program and Medicines Information to Consumers Program.

### **Royal Australian College of General Practitioners (RACGP)**

The RACGP has a variety of patient safety resources and initiatives. Some initiatives have been funded through the Office of the Safety and Quality Council in the Australian Government Department of Health and Ageing and include the following, which may incorporate medication safety:

- *Analysing near misses* — a guide to analysing 'near misses' in general practice
- *RACGP standards for general practices* — focus on the structures and processes needed within general practices to provide reliably safe and high-quality care
- *Thinking safety, being safer* — an education module for general practitioners (both those in vocational training, and those who have finished their vocational training), aims to assist a range of professionals in identifying, preventing and managing medical errors
- *Being human, being safer* — an education module for general practitioners (both those in vocational training, and those who have finished their vocational training), a focus on working safely, with a focus on teamwork at the practice level, leadership, and 'human factors' such as creativity and imagination, fatigue and stress
- *Safety every time* — a general practice checklist to assist general practices that perform procedures
- *Open communication in general practice* — dealing with errors in care in general practice.

For more information on RACGP activities see [www.racgp.org.au](http://www.racgp.org.au)

### **Society of Hospital Pharmacists of Australia (SHPA)**

SHPA develops standards for hospital pharmacists and funds research into medication safety.

Medication safety is the content of a series of articles published in the *Journal of Pharmacy Practice and Research*, which provide up-to-date information about medication safety issues and strategies to prevent medication errors. The incidents reported are drawn from Australian experience and from the Institute for Safe Medication Practices (ISMP), USA. March 2007 topics include anticoagulation safety, oral syringes to prepare doses for nebulisation, and medical device issues.

### **Therapeutic Goods Administration (TGA)**

The TGA is responsible for the regulation of therapeutic goods in Australia.

They have developed guidelines for the reporting of adverse drug reactions, postmarketing surveillance, clinical safety information discovered during drug development and best practice guidelines for the labelling of prescription medicines.

Several TGA Committees monitor the safety of medicines, including:

#### ***Australian Drug Evaluation Committee (ADEC)***

ADEC provides advice to the Minister and the Secretary of the Commonwealth Department of Health and Ageing through the Therapeutic Goods Administration, on:

- the quality, risk–benefit, effectiveness and access within a reasonable time of any drug referred to it for evaluation
- medical and scientific evaluations of applications for registration of prescription drugs (e.g. new chemical entities, new forms of previously registered drugs and therapeutic variations to registered drugs).

The Committee also provides services to other Government departments, committees and community-based organisations on a wide variety of regulatory matters related to prescription medicines.

### ***Adverse Drug Reactions Advisory Committee (ADRAC)***

ADRAC reports to ADEC on all matters relating to adverse drug reactions. The committee publishes regular bulletins and contributes to the WHO data bank on adverse drug reaction reports.

### ***Complementary Medicines Evaluation Committee (CMEC)***

CMEC evaluates complementary medicines and/or selected ingredients of complementary medicines, including giving advice to the Minister of their opinion as to the safety, efficacy and quality of a complementary medicine and the short- and long-term risks and claimed benefits of a complementary medicine.

For more information on the TGA and its committees see [www.tga.gov.au](http://www.tga.gov.au)

### **Universities**

Several university groups are involved in medication safety research, including the following.

#### ***Centre for Medication Safety (Monash University)***

The Centre is involved in the following active research projects on medicine use and safety across both community and hospital settings:

- implementation of electronic prescribing and decision-support systems to improve safe and effective use of medicines
- examination of factors that affect medication adherence in patients
- impact of adverse effects of anticancer drugs on quality of life
- factors impacting on the safe and effective use of medicines in paediatric patients
- implementation and evaluation of new professional roles for pharmacists in disease management
- factors affecting the safe and effective use of generic medicines
- collaborative approaches to improve medication safety across hospitals
- safer and more effective use of medicines through understanding clinical pharmacokinetic–pharmacodynamic relationships.

For more information on the Centre see

[www.vcp.monash.edu.au/departments/pharmpract/research/medicineuse.html](http://www.vcp.monash.edu.au/departments/pharmpract/research/medicineuse.html)

#### ***Health Informatics Research and Evaluation Unit (HIREU) (University of Sydney)***

The following medication safety research projects are underway:

- impact of electronic medication administration records on medication administration safety and nurses' work
- safety and effectiveness of hospital e-prescribing systems: a controlled time-series study
- role of clinical communication loads in contributing to medication administration errors and task-scheduling errors.

For more information on HIREU see [www.fhs.usyd.edu.au/hireu/research](http://www.fhs.usyd.edu.au/hireu/research)

#### ***Unit for Medication Outcomes Research and Education (UMORE) — University of Tasmania***

Recent health informatics projects completed or underway to improve medication safety include:

- Medsafety — an innovative e-learning initiative in medication safety for healthcare professionals and students, commercialisation underway with Multi-Ed Medical Limited
- Promise I — Community Pharmacy Medication Incident Reporting and Management System, establishing a national electronic database for medication-related incidents and pharmacists' clinical activities in the community setting. A national electronic database for medication-related incidents and pharmacists' clinical activities in community pharmacy

- Promise II — establishing and economically evaluating a national electronic database for medication-related incidents and pharmacists' clinical activities in the community setting
- Medesupport — a national program to improve communication flow between hospitals and the community setting to reduce adverse outcomes after hospital admission or discharge
- remote monitoring of medication response (home-based self-monitoring by patients taking warfarin).

For more information on UMORE see [www.pharmacy.utas.edu.au/UMORE.htm](http://www.pharmacy.utas.edu.au/UMORE.htm)

## **Quality and safety initiatives of the Australian States**

Most States and Territories have at least three tiers of health infrastructure, with a responsibility to improve quality and safety. Tier 1 is a committee that plays a strategic role and directly advises and reports to the State health minister on quality and safety issues. At the second tier there may be one or more units or organisations, which:

- set standards and regulate activities for improving quality and safety
- disseminate national safety and quality initiatives
- monitor incidents
- manage complaints about care
- evaluate the outcomes of activities.

This second tier oversees and provides direction and advice to the third tier — the local level hospital and health services, which are responsible for implementing activities to monitor and improve safety and quality at the service level. At this third tier, there may be a range of groups that have responsibility for quality and safety, including clinical governance or quality and safety units and co-ordinators in regional or area health services or in individual hospitals. Medication safety is also a responsibility of drug and therapeutics committees and pharmacy services.

Table 2 summarises the key safety organisations in each State, the strategy or framework in place to guide patient safety and quality work, medication safety projects and activities being implemented by the States in key areas that have been endorsed by the Commission or are directed by the peak State safety and quality committee.

See Appendix 3 for more detail about the objectives and work of the quality and safety groups in each State, particularly focussing on medication safety projects and activities.

This analysis is based on discussions with one representative from NSWTAG and information publicly available on websites for State quality and safety organisations.

**Table 2: Medication Safety in the States and Territories**

Broad activity area	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
<b>Provide main leadership and strategic direction on medication safety</b>	Clinical Excellence Commission (CEC) (tier 1) Quality and Safety Branch (NSW Health Dept) NSWTAG (Safer Medicines Group) Pharmaceutical Services Branch	Victorian Quality Council (Tier 1)  Quality and Safety Branch (Vic Dept of Human Services) VMAC VicTAG	Safety and Quality Board  Qld Health Dept Units: Patient Safety Centre Safe Medication Practice Unit	SA Safety and Quality Council (tier 1)  Quality Unit (SA Health Department) SA TAG	WA Council of Safety and Quality in Health Care (tier 1)  Office of Safety and Quality in Health Care (WA Health Dept) WA TAG (Medication Safety Group)	Tasmanian Quality Council	NT Safety and Quality Council	ACT Quality and Safety Forum
<b>Strategies</b>	NSW Medication Safety Strategy	Safety & Quality Improvement Framework for Victoria	Strategic Plan for Safety and Quality 2005–2010	SA Safety and Quality Program 2007–2012	WA Strategic Plan for Safety and Quality in Health Care (2003–2008)			Quality and Safety in the ACT 2004–2008
<b>Current Projects</b>								
NIMC	✓	✓	✓	✓	✓	✓	✓	✓
Pharmaceutical review	✓	✓	✓		✓		✓	✓
Medication reconciliation	✓	✓			✓			
Development of information and education packages	Guidance & Safety alerts	Guidance & Safety alerts	High-risk medicines and processes		Guidance & Safety alerts			
Incorporating quality and safety into healthcare activities	Clinical Service Redesign		Human Error and Patient Safety (HEaPS)					
Safer Systems — Saving Lives (SS-SL)	✓	✓ (lead agency)		✓	✓	✓	✓	
Information transfer between hospital and community sector	✓		✓	✓	✓	✓		
<b>Development of audit tools</b>	Medication Safety Self-Assessment Tools & Indicators for QUM in Aust hospitals (NSWTAG/CEC)		Medication Chart: Documentation Audit Tool					

Broad activity area	NSW	Vic	Qld	SA	WA	Tas	NT	ACT
<b>Activities and programs to monitor and report on medication errors, complaints and adverse drug events</b>	<p>Patient Safety Unit of CEC analyses State-wide data from the IIMS (Incident Information Monitoring System)</p> <p>National Sentinel Events Monitoring</p> <p>NSW Health Care Complaints commissions reports on complaints</p>	<p>Incident Information System Project under development</p> <p>National Sentinel Events Monitoring</p>	<p>PRIME Clinical Incident Monitoring System under development</p> <p>National Sentinel Events Monitoring</p>	<p>Advanced Incident Monitoring System (AIMS) implemented — recent review</p> <p>National Sentinel Events Monitoring</p>	<p>Advanced Incident Monitoring System (AIMS) implemented</p> <p>National Sentinel Events Monitoring</p>		<p>Piloting incident monitoring in remote primary care</p> <p>National Sentinel Events Monitoring</p>	
<b>Identify medication safety issues</b>	<p>Patient Safety Unit of CEC recommends preventive actions based on incident-monitoring data</p>	<p>Strategic approaches under development as part of Incident-monitoring project</p>	<p>Strategic approaches under development as part of Incident-monitoring project</p>					
<b>Undergraduate and postgraduate curriculum/training in patient safety</b>	✓		Skills Development Centre	✓				
<b>Technology solutions for safety and quality</b>	<p>e-Medical Record build</p> <p>e-Discharge Referral System</p>		Electronic Medicines Management Strategy	Developing decision support in OACIS hospital clinical information system. Working with GPs for better IT solutions		HealthConnect Tasmania — pilot of Patient Discharge Medication Record	e-prescribing pilot at Royal Darwin Hospital	

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## **Appendix 1. Centre for Research Excellence in Patient Safety**

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The **objectives** of the centre are to promote and develop resources to improve patient safety through:

- better identification of factors that affect patient safety in clinical situations
- a better understanding of the role of human performance factors, organisational factors, and system deficiencies in the generation of clinical errors
- more effective use of registry data to identify variations in performance, and the development of research models to investigate them
- a better understanding of the role of patients and carers in working with staff to identify and support innovation
- an understanding of error management in other industrial settings and its potential application to health care
- the use of clinical simulation to provide a realistic and safe environment for research, training, and education in the recognition and management of error-prone situations
- the development of mechanisms for ensuring the uptake and application of research outcomes.

The **current research focus** of the Centre includes:

- improving communication by identifying barriers to effective transfer of information between healthcare workers across care boundaries and to implement and evaluate strategies to promote effective handover and referral. Projects focus on clinical handover.
- developing and maintaining data and tools to measure health care quality and to facilitate data use and translation into useable information by external and internal stakeholders to inform decision making and quality improvement processes. Projects include: quality indicators in trauma, legal and ethical implications of performance reporting, linking indicators with outcome measures.
- education to foster the growth, dissemination and translation of patient safety and health service research. Project: Assessment and prediction of performance by junior medical staff.
- health information technology to increase the development, diffusion and adoption of health IT to improve the quality of health care for all Australians. No projects identified on website.
- care management to promote effective, evidenced-based and patient-centred care through research, information, dissemination, tool development and promotion of decision-support processes. Projects include sentinel events, clinical pathways, warfarin complications in the community.
- medication safety to improve health outcomes through the safe and effective use of pharmaceuticals. Projects: medication error in the recovery room, warfarin complications in the community.

More info at [www.crepatientsafety.org.au/about](http://www.crepatientsafety.org.au/about)

## Appendix 2. More information on State and Territory quality and safety groups and activities

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### ACT

The quality and safety agenda in the ACT is underpinned by the **ACT Health Quality and Safety Plan 2004–2008** and the **ACT Health Clinical Governance Framework**. The plan identifies five priority areas:

- consumer-centric health care
- clinical health improvement
- clinical audit
- clinical risk management
- accreditation.

The Framework provides explicit lines of accountability within a clearly defined management structure and allows facilitation, co-ordination, monitoring and evaluation of, and feedback on, the services provided.

**ACT Quality and Safety Forum** provides leadership in fostering better quality health services in the ACT, with a focus on implementing the Quality and Safety Plan. The Forum:

- provides strategic advice to the Chief Executive and Clinical Council on priority areas and strategies for improvement in quality and safety in health care
- draws on national activity and local issues to identify emerging safety and quality needs for the ACT
- facilitates the introduction and maintenance of ACT-wide clinical practice improvement projects, programs and policies
- identifies and evaluates learning and development needs to achieve improvements in the quality and safety of service delivery.

ACT Health has established a reference group for its **quality use of medicines** priority area. This Reference Group provides leadership on medication management within the ACT, facilitates the application of guiding principles to achieve the quality use of medicines across the medication management continuum. The implementation of the National Inpatient Medication Chart is a key medication safety initiative in the ACT.

### New South Wales

In NSW, there are five organisations involved in quality and safety:

- NSW Clinical Excellence Commission (Tier 1)
- Quality and Safety Branch of the NSW Health Department
- NSW Therapeutic Advisory Group
- Health Care Complaints Commission
- Pharmaceutical Services of the NSW Health Department (are responsible for issuing the policy directives about handling of medicines in hospitals, so they do have a role in defining/promoting safe practices).

#### **NSW Clinical Excellence Commission (CEC)**

CEC was launched on August 24 2004, as part of the NSW Patient Safety and Clinical Quality Program. It replaces the Institute for Clinical Excellence. The CEC is a board-governed statutory

health corporation with the CEO reporting directly to the NSW Minister for Health. Its mission is 'to build confidence in healthcare in NSW, by making it demonstrably better and safer for patients and a more rewarding workplace.' The strategic directions of the CEC include to:

- provide assurance through credible public reporting, identify areas to address and ultimately demonstrate improvements
- facilitate the uptake of clinical improvement programs
- implement a system of quality assessments
- develop and manage information and reporting systems
- build leadership capacity
- influence culture through communication and advocacy.

More information on the NSW Clinical Excellence Commission at [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au)

### **Quality and Safety Branch — NSW Health Department**

The Branch is responsible for:

- setting standards for Area Health Service quality systems
- developing policies on quality and safety for State-wide implementation
- developing and reporting on system wide quality indicators
- monitoring and analysing serious clinical incidents, and taking appropriate action such as advice and warnings to the health system
- overseeing State-wide clinical governance issues
- overseeing consistent implementation of the NSW Patient Safety and Clinical Quality Program.

### **NSW Medication Safety Strategy**

The NSW Strategy brings together a range of activities that focus on all stages in the medication management pathway to minimise the level of adverse outcomes. The Strategy is based on the guiding principles of the Australian Pharmaceutical Advisory Council (APAC) to achieve the quality use of medicines across the medication management process. It promotes three initiatives:

1. Implementation of the National Inpatient Medication Chart (NIMC)
2. Pharmaceutical Review
3. Medication Reconciliation.

### **NSW Therapeutic Advisory Group Inc (NSW TAG)**

NSW TAG is an independent, not-for-profit association that aims 'to promote quality use of medicines by sharing unbiased, evidence-based information about drug therapy'. NSW TAG receives funding from the NSW Department of Health. Its members include clinical pharmacologists, pharmacists and other clinicians from hospitals in NSW and affiliated academic units. The objectives of the NSW TAG are:

- to investigate and evaluate new initiatives in therapeutics
- to support drug and therapeutics committees
- to promote rational, high-quality, safe and cost-effective use of medicines in public hospitals and the wider community.

NSW TAG uses the following strategies to achieve these objectives:

- develop consensus statements for the rational use of specific drugs and drug groups
- collect and analyse quantitative and qualitative drug usage data

- develop and utilise specific strategies to influence prescribing behaviour and provide a counter-balance to industry promotion
- describe and monitor the activities and decision making of drug committees to improve equity, to increase transparency and to promote peer review/support
- assess the impact of new pharmaceuticals on quality of patient care in the hospital system
- disseminate information to stakeholders and educate identified target groups
- provide advice on therapeutic matters to NSW Health
- undertake projects on behalf of NSW Health according to availability of resources
- conduct and facilitate research pertinent to quality use of medicines
- facilitate provision of economic analyses and critical appraisal of pharmaco-economic studies.

### **Performance indicators and medication safety**

The NSW TAG and the Clinical Excellence Commission have collaboratively developed two sets of tools to improve medication systems and monitor performance in QUM in Australian hospitals.

Phase 1 involved adaptation for Australian use of the *ISMP Medication Safety Self Assessment* and the *Medication Safety Self Assessment for Antithrombotic Therapy* to help hospitals take a proactive and system-based approach to medication safety. The tools allow self-assessment of the medication safety practices within a hospital, identification of improvement opportunities and comparison with the aggregate experience of similar hospitals.

Phase 2 involved the revision of the 1998 *NSW TAG Manual of Indicators for Drug Use in Australian Hospitals* and the *NSW TAG Performance Indicators for Drug and Therapeutics Committees*.

The **Safer Medicines Group** of NSW TAG has undertaken the following activities:

- publishing guidance on the use of terminology, abbreviations and symbols used in prescribing and administration of medicines
- developing a safety alert for analgesic skin patches
- co-ordinating information sharing about policies on the use of intravenous potassium chloride.

More information at [www.nswtag.org.au](http://www.nswtag.org.au)

### **Previous NSW projects**

#### **National Medication Safety Breakthrough Collaborative**

**Venous Thromboembolism Prevention Program.** The program was developed by the National Institute of Clinical Studies and aims to improve the assessment of all patients at risk, improve the use of preventive measures and integrate effective thromboprophylaxis systems into the core business of Australian hospitals.

### **Northern Territory**

**NT Safety and Quality Council** was established in 2003 to 'promote a culture of safety and quality and continuous improvement for health services throughout the Northern Territory'. It reports through its Chair to the CEO of Department of Health and Community Services. The work of the Council builds on pre-existing work done by the Acute Care Quality Committee.

Current activities that relate to medication safety include: piloting incident monitoring systems in remote primary care and the electronic prescribing trial at Darwin Hospital.

## Queensland

### Queensland Health Patient Safety Centre (PSC)

The Queensland Health Patient Safety Centre (PSC) was formed in early 2005 to take a lead role in planning, implementing, managing and evaluating patient safety initiatives and programs as part of the broader system to prevent and address patient harm. The PSC works in partnership with health service providers at a local, area and State-wide level to co-ordinate and support State-wide and local patient safety programs.

The PSC is committed to reducing preventable patient harm by:

- raising risk awareness and promoting a culture of safety at all levels with Queensland Health
- building local district capacity for identifying vulnerabilities and implementing solutions using human factors approach
- building a central resource centre that adds value by providing training, support, data and trend analysis, and works with local areas to develop solutions for State-wide implementation
- developing and implementing comprehensive and integrated clinical incident management systems focussed on learning and improvement rather than individual blame
- developing patient safety tools for consistent use across the State
- creating and supporting networks for discussion and shared learning
- involving consumers in system re-design and safety improvement.

For more information on the Patient Safety Centre [www.health.qld.gov.au/patientsafety](http://www.health.qld.gov.au/patientsafety)

### Safe Medication Practice Unit

The Safe Medication Practice Unit is a unit of the Patient Safety Centre and is responsible for developing and implementing medication safety initiatives throughout Queensland Health, to prevent and address adverse drug events that result in patient harm. It is working to improve practice in four main areas:

- high-risk medicines and processes
- medication continuum — transfer of accurate comprehensive, complete and standardised information relating to medications on admission and discharge from Queensland Health facilities
- medication review — reviewing of therapy decisions to ensure safe effective medication treatment
- Electronic Medicines Management Strategy — a strategy for the implementation of electronic solutions and standards to address medication safety issues.

Contact: Christine McLean

### Health Quality and Complaints Commission (HQCC)

The HQCC is responsible for the oversight of quality activities in all public and private health services in Queensland. It is also responsible for addressing complaints from any person associated with health service delivery and setting standards for hospitals, which will include some standards relevant to quality and safety in medicines management. More info at: [www.hqcc.qld.gov.au](http://www.hqcc.qld.gov.au)

## South Australia

### SA Safety and Quality Council (Tier 1)

#### *The Safety and Quality Unit*

This Unit of the SA Health Department works in partnership with health services to improve patient safety and quality of care. It is guided by the South Australian Safety and Quality Program 2007–2011. The Program is based on the previous South Australian patient safety framework, a review

of the literature and hundreds of meetings with consumers and people working in the health sector. It covers all sectors of the health system.

Medication safety priority areas and selected strategies in the Program include:

- safe use of medications through implementing a standard medication chart nationally, continuing pharmaceutical reform, improving the management of anticoagulation in hospitalised patients and improving the use of renally cleared medications
- falls prevention through developing a vitamin D and calcium program for aged care
- ICT solutions to improve safety through:
  - implementing incident monitoring and management systems
  - developing and implementing a pharmacy order and review within decision support
  - developing an electronic medication chart that would be available across the whole health sector
  - developing an electronic health record initially focussing on hospital discharge.

Contact: Naomi Burgess

[www.safetyandquality.sa.gov.au](http://www.safetyandquality.sa.gov.au)

### **South Australian Therapeutics Advisory Group**

Contact: Lloyd Sanson

## **Tasmania**

The role of the Tasmanian Department of Health and Human Services **Quality Council** is to:

- foster learning regarding the various approaches to quality across the agency
- articulate national quality agendas and relevant initiatives of other jurisdictions into the strategies and actions at a State level
- develop, monitor and continue to revise an overarching strategic plan for quality in health and human services in Tasmania
- develop a monitoring framework that ensures utilisation of well recognised quality tools across the agency, and that action is considered to address issues raised by the collection and analysis of information
- develop greater consumer feedback and involvement in service quality and delivery
- foster the continued uptake of an evidence basis to service planning and delivery.

Key Initiatives related to medication safety are implementing the *National In-patient Medication Chart* at Launceston General Hospital, and improving infection control at the North West Regional Hospital.

Tasmania has a state-wide Therapeutics Drug Committee.

## **Victoria**

### **Victorian Quality Council (VQC)**

The Victorian Quality Council (VQC) was established in 2001 as an expert strategic advisory group to lead the safety and quality agenda for Victorian healthcare services. VQC consults widely with a range of recognised experts when developing projects and tools to assist health services implement quality and safety initiatives. VQC has:

- developed and disseminated a safety and quality improvement framework for Victoria
- undertaken two State-wide *Pressure Ulcer Point Prevalence Surveys*

- compiled a guide for consumers and carers
- produced guidelines for minimising the risk of falls and falls-related injuries.

More information at [www.health.vic.gov.au/qualitycouncil](http://www.health.vic.gov.au/qualitycouncil)

The **Quality and Safety Branch** of the Department of Human Services in Victoria provides the organisational lead and overarching project management to the hospitals participating in the Safer Systems — Saving Lives Initiative. They are also involved in the following medication safety activities:

- National Inpatient Medication Chart
- pharmaceutical review
- medication reconciliation
- developing guidance and safety alerts.

More information at [www.dhs.vic.gov.au/rrhacs/qualitybranch.htm](http://www.dhs.vic.gov.au/rrhacs/qualitybranch.htm)

### **Victorian Therapeutics Advisory Group**

The Victorian Therapeutics Advisory Group (VicTAG) comprises directors of pharmacy, clinical pharmacologists and other clinicians from Victorian hospitals who meet regularly to discuss a range of medication-related issues such as:

- hospitals' drug and therapeutics committees decisions
- the access to and funding of pharmaceuticals
- the rational use of medicines
- drug policies at local, State and national levels
- medication safety
- drug usage data.

They also lobby to improve medicine use at an institutional and government level.

More information at [www.victag.org.au](http://www.victag.org.au)

### **Victorian Medicines Advisory Committee**

The Victorian Medicines Advisory Committee (VMAC) is the expert group advising the Victorian Department of Human Services, through the Quality and Safety Branch, on strategic direction and policy development with respect to the application of the National Medicines Policy and the National Strategy for Quality Use of Medicines in Victorian hospitals and at the interface with primary care settings.

VMAC activities related to medication management include development and implementation activities related to:

- National Inpatient Medication Chart
- pharmaceutical review
- strategies for safe use of high risk medication
- identifying and implementing guidelines for best practice in safe and effective prescribing, administration and supply of medicines throughout the continuum of care.

More information at [www.health.vic.gov.au/vmac](http://www.health.vic.gov.au/vmac)

## **Western Australia**

### **WA Council of Safety and Quality of Health Care**

The WA Council was set up in 2002 to provide high-level strategic advice to the Director General of Health and the Minister for Health on system-wide safety and quality issues and to provide strategic direction and leadership for quality improvement in WA. In this role the Council works conjointly with the Office of Safety and Quality in Health Care. The Council has developed a strategic plan that provides a strategic framework to further promote the delivery of consumer-focussed, safe quality healthcare in Western Australia for 2003–2008.

More information at [www.wacsqhc.health.wa.gov.au](http://www.wacsqhc.health.wa.gov.au)

### **Office of Safety and Quality in Health Care (OSQH)**

The OSQH was established in 2001 to provide strategic advice on safety and quality issues to the Minister for Health and the Department of Health. The Office is responsible for the development of policies, programs and standards to support the establishment of effective systems and processes that will foster a culture of continuous improvement, and ensure individual and organisational accountability for the provision of safe high-quality health care. Monitoring of patient safety outcomes at a system level is also a key role of the Office.

A key priority of the Office of Safety and Quality in Health Care is to work, in partnership with clinicians and consumers, to ensure that consistent policies and standards are developed to ensure the effective implementation and co-ordination of clinical governance across the WA health system.

Medication-safety-related activities include:

- implementing the National Inpatient Medication Chart
- pharmaceutical review
- Safety and Quality Investment for Reform Medication Safety — Medication Reconciliation Project
- incident monitoring and reporting using the Advanced Incident Monitoring System

Contact: Tanya Gawthorne

[www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au)

### **Western Australian Therapeutics Advisory Group (WATAG)**

WATAG was established in 1997 to promote rational therapeutic drug use in Western Australia. The Committee is convened and funded by the WA Department of Health. It aims to provide independent advice to health service professionals and the Department of Health on issues relating to the use of drugs and therapeutics in Western Australia. The TAG also oversees the development and implementation of best practice standards and guidelines for drug use in Western Australian hospitals.

Contact: David Lyon

Further information about the work of the Western Australian Therapeutic Advisory Group and its publications are available from: [www.watag.org.au](http://www.watag.org.au)

### **WA Medication Safety Group (WAMSG)**

WAMSG is an expert group of WATAG and aims to minimise patient harm due to drug errors. It was established to co-ordinate communication and activities in WA public hospitals and the wider community. The initial focus of WAMSG has been on public hospitals. WAMSG involves stakeholders and local experts to develop standards that may be uniformly applied throughout the WA health system. Working groups have been established to review and prepare State wide policies for potassium chloride, anticoagulants, cytotoxics, medication history, antibiotics and consumer representation in medication safety.

Contact: Marguerite Veroni

More information at: [www.watag.org.au/wamsg](http://www.watag.org.au/wamsg)