



Medication safety

How do we measure up?

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The ideal health system

Everyone should have access to the right care delivered in the right way, at the right time, with the best use of available resources.



Where are we in 2008

- We make the wrong plan nearly 50% of the time
- We harm 10% of hospital admissions
- Severe or permanent harm to 2% of admissions. That is 1/300 deaths
- 100,000 preventable deaths since QAHCS in 1995
- Harm cost est. \$1M/hour in Australia



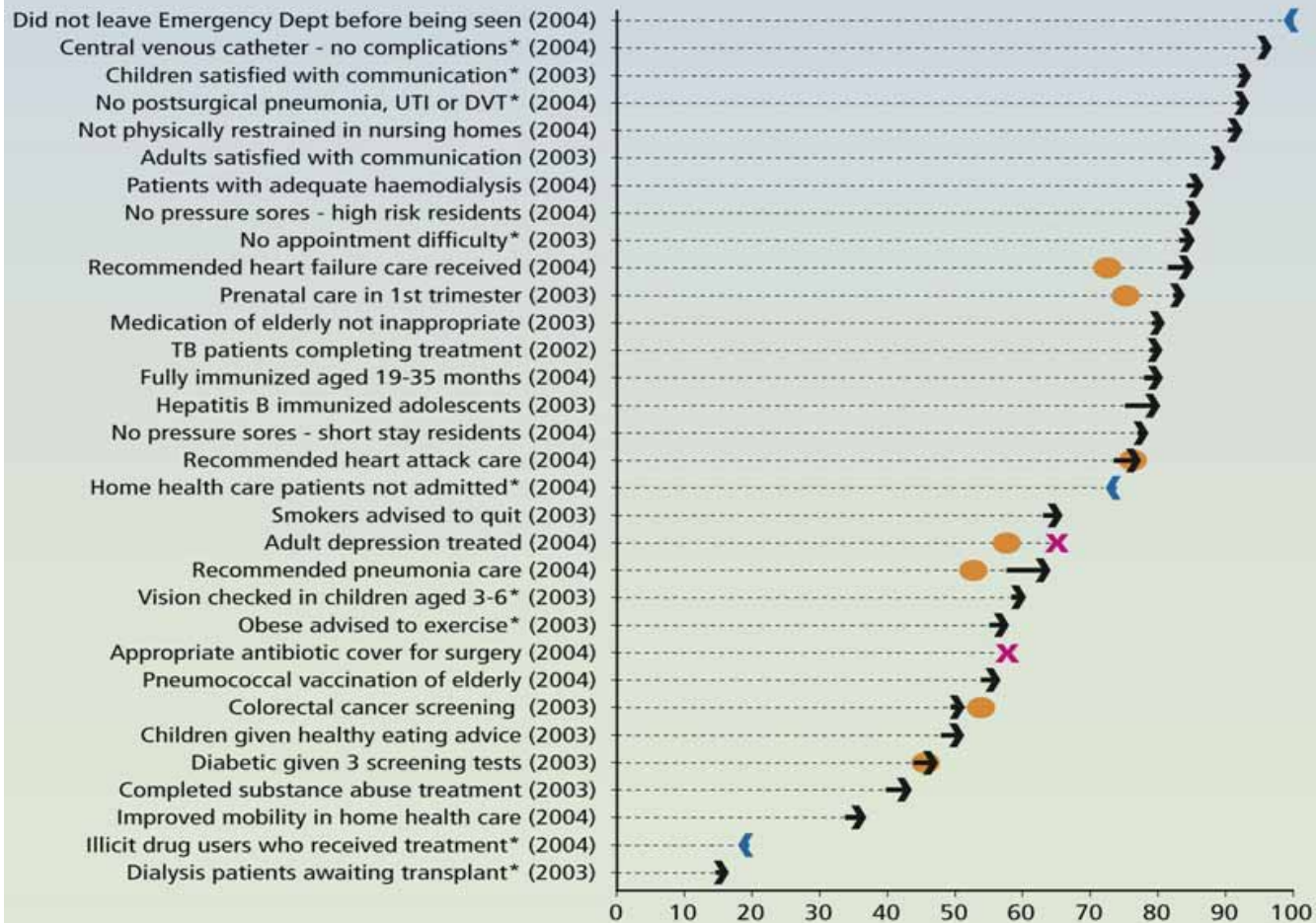
Medication safety

Medical (medication) errors occur when people unintentionally use a wrong plan to achieve an aim, or fail to carry out a planned action as intended.

Runciman WB, Merry AF, Tito F. Error, blame and the law in health care — an antipodean perspective. *Ann Intern Med* 2003; 138: 974-979.

What do we know?

% OF ELIGIBLE PATIENTS WHO RECEIVED RECOMMENDED OR EXPECTED CARE



* denotes change not significant

PERCENTAGE



What do we know?

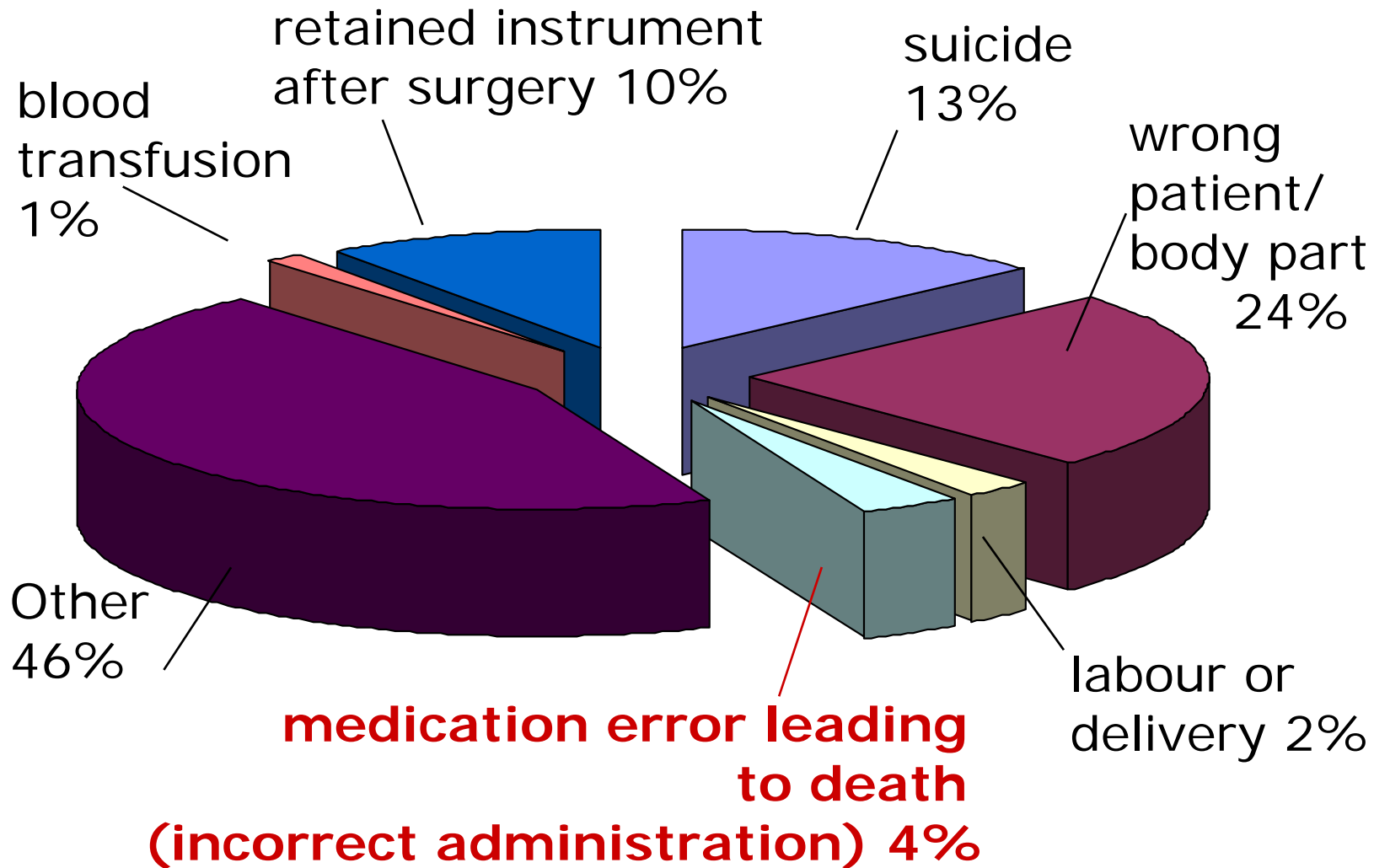
- Medication errors are among the most common incidents reported in public hospitals.
- In NSW public hospitals, the Incident Information Management System (IIMS) report for 2005–2006 included 17,367 medication incidents in which medication error was the primary cause of harm.



What do we know?

- In another 968 incidents, medication error was a secondary cause. Most incidents were notified from the services of general medicine or pharmacy, but all clinical services, including surgery, reported medication errors.
- In the UK 60,000 medication errors were reported to the NPSA since 2005.

What do we know and how do we measure up?

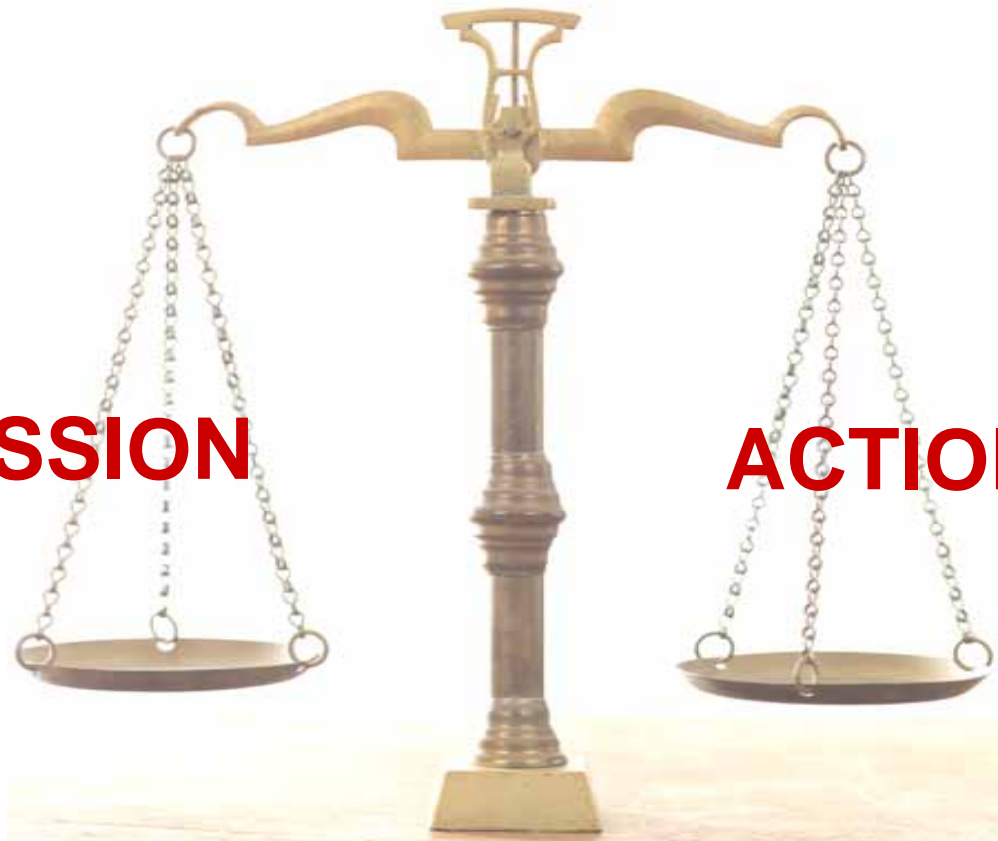


How to think about this question?

MEDICATION SAFETY

OMISSION

ACTION



Thinking further on the question

Knowledge based error	Rule based error
<ul style="list-style-type: none">• Lack of knowledge• Lack of access to knowledge• Competency	<ul style="list-style-type: none">• Lapse of memory• Lack of attention• Error of judgement• Distraction

Thinking of this as a part of a system

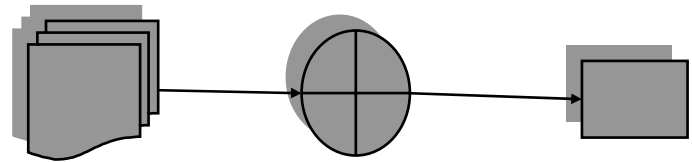
Active failures

- Made by people



Latent failures

- Created by the system





Medication error

Wrong

- dose
- strength
- frequency
- route
- time
- patient
- rate

Omitted

- prescribed not given
- not prescribed

What are we doing in Australia?

National
inpatient
medication
chart

PIMMS

NICS
VET
prophylaxis

NPS
projects

Antibiotic
approval
systems

Medication
Safety
Assessment

Clinicians'
Health
Channel
(Vic)

Electronic
prescribing

Medication
reconciliation



References

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- Runciman WB, Merry AF, Tito F. Error, blame and the law in health care — an antipodean perspective. *Ann Intern Med* 2003; 138: 974-979.