WHO GLOBAL PATIENT SAFETY CHALLENGE: CONSULTATION DRAFT FEEDBACK FORM

Name:	Dr Carolyn Stapleton
Title:	Manager – Policy and Advocacy
Organisation (if applicable):	Australian College of Nursing (ACN)

In 2017, the third World Health Organization (WHO) Global Patient Safety Challenge – *Medication without harm* (the Challenge) was launched at the Global Ministerial Patient Safety Summit in Bonn, Germany.

Medication errors vary in type, setting and impact. Many errors will be noticed before they reach a patient or have minimal impact to the patient. Others can have devastating consequences.

The WHO goal for the Challenge is to reduce severe, avoidable medication-related harm by 50% in the next five years, globally, specifically by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems. The Challenge aims to make improvements at each stage of the medication process, including prescribing, dispensing, administering, monitoring and use.

The Challenge aims to improve medication safety by strengthening the system for reducing medication errors and avoidable medication related harm. The three flagship areas of the Challenge defined by WHO are:

- Polypharmacy
- High-risk situations
- Transitions of care

SECTION 1 – POLYPHARMACY

Australians are high consumers of medicines. In 2017-18, more than 200 million dispensed, subsidised prescriptions were filled. Australians are also high consumers of complementary and over-the-counter medicines. The polypharmacy definition used in the response is five or more medicines at the same time, including prescriptions, over-the-counter and complementary medicines. The challenge is to monitor and respond to **inappropriate** polypharmacy.

Risks include delirium, increased frailty, co-morbidities, and adverse reaction beyond the risk of individual medicine.

Options for national action	
Feedback Question	**Feedback**
• What is considered best practice now?	ACN considers good national governance, collaboration at all levels of government and within the health and aged care systems and interdisciplinary leadership as essential components for reducing medication error. The Australian Government's National Medicines Policy (2000) was developed to bring about better health outcomes for all Australians, focusing on people's access to, and wise use of, medicines. The Guiding principles for medication management in residential aged care facilities builds on the principles outlined in this National Medicines Policy promoting the Quality Use of Medicines approach to medicines use and medication management in Residential Aged Care Facilities. The Australian Commission on Safety and Quality in Health Care (ACSQHC) have taken a lead role nationally in medication management through initiatives such as provision of a Medication Management Plan. This plan includes resources for matching medicines (promoting medication reconciliation to prevent harm), information for patients and consumers, training and tools for health professionals. The ACSQHC Medication Safety Standard aims to ensure that clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks. Health care organisations are assessed and accredited against the ACSQHC standards. The Australian Pharmaceutical Advisory Council (APAC) provide guiding principles to achieve continuity in medication management. ACN considers medication reconciliation best practice in terms of reducing risks associated with polypharmacy. Medication reconciliation is the formal process of obtaining and verifying a complete and accurate list of each patient's current medicines on admission to a care facility by nursing and or pharmacy staff. Pharmacy staff match the medicines the patient should be prescribed to those they are actually prescribed. The process of medication reconciliation has been shown to reduce errors and adverse events associated with: - Poor quality information at transfer of care; and

	- Inaccurate documentation of medication histories on patient admission to hospital. ACN also considers the following as best practice in reducing polypharmacy: - A multidisciplinary approach to care ensuring effective and timely communication between health care providers across different disciplines (e.g. General Practitioners/GPs; nurses; pharmacists; dietician etc.); - Regular Medication Management Reviews/Home Medicines Reviews (HMRs) by MMR/HMR accredited pharmacists to ensure there is a comprehensive clinical assessment of a patient's medicines. This review is capable of identifying potential and current issues including drug interactions, interactions with herbal medicines, adverse events, side effects, contra-indications; and making recommendations including cessation of therapy, reducing dosage, non-pharmacological approaches, pathology testing and the need for urgent review by the GP. - In the Residential Aged Care Facility (RACF) setting, ACN reinforces that unregulated/unqualified health care workers (also known as assistants in nursing) and regulated nurses (RN) work within their scope of practice. Importantly, ACN advocates that care delivered within a RACF is always provided under the direct supervision of an RN who can manage the intricate interplay between co-morbidities, polypharmacy and complex care. The administration of medicines by unqualified staff presents a significant risk to residents and patients' safety. This is increasingly becoming an issue in aged care due to poor workforce supply in these settings and the reliance on unqualified staff. ACN continues to demand support for a legislated minimum number of RNs in RACFs. In order to reduce harm from high-risk medicines and polypharmacy, an appropriately skilled workforce must be provided across all health care settings, which includes an RN being onsite and available 24/7. - Non-pharmacological therapies as first line approaches. Emedication management systems are being implemented by the State / Territories in Australia. At the same time the Australian Digital Health Agency is leading established a Medicines Safety Program in 2017 acknowledging that good medicines management can help to reduce the likelihood of medication errors and hence patient harm. This Program is designed to improve the access and quality of medicines information through the use of digital health, enabling consumers and healthcare providers to make safe, informed decisions and achieve better health outcomes. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has released a guide for healthcare providers on electronic medication management (EMM) to enable increased sharing of information with consumers, their carers and providers. The safety benefits include fewer prescribing errors, lower dispensing errors, reduced administration errors, less omission and commission errors at transition in care and improved medication adherence.

• What, if anything, should be done more or less of?	The Australian Government's National Medicines Policy was launched in 2000 and should be reviewed to ensure it remains contemporary. ACN believes there should be more of: - Regular review of all older patients' medications and doses (five or more or taking a combination of medicines with higher risk of adverse effects), based on current indication, benefits of treatment and making the regimen as simple as possible. - Review of adherence to medication. Use of dosette pill containers or Webster/blister/dosette packs are recommended in older patients who may have issues with memory or dexterity. These help manage a patients medications by ensuring the right medication is taken at the right time and mitigating the need for use of hands to open bottles, or remove pills out of small blisters from original packaging. - Electronic Medication Management is an emerging field and there is a need to support more research in this area as digital health evolves in the Australian context. We need to continue to build the evidence base. - Ongoing implementation of digital health and emedication management systems nationally - A continued focus on empowering consumers through improving health literacy, providing information and resources and continuing to build on the national clinical record system myhealth record ACN believes there should be less of: - Prescribing of repeats for antibiotics. There are classes of antibiotics that are problematic in terms of drug interactions and this is a greater risk with polypharmacy. Drug metabolism via the cytochrome P450 (CYP450) system is responsible for several drug interactions that can result in drug toxicities, reduced pharmacological effect, and adverse reactions. It is important to note that antibiotics may behave as enzyme substrates, inducers, or inhibitors in the CYP450 system. In order to prevent clinically significant interactions, ACN supports reducing the number of repeats a prescriber is authorised to issue on specific classes of antibiotics. This would prevent unintended long-term use of antibiotics whilst continuing to provide an optimal response with minimal adverse effects.
• What are the current gaps in achieving positive patient outcomes to reduce adverse events from polypharmacy in the future?	ACN notes there are currently gaps in medication reconciliation and multi-disciplinary communication, which transcends health care sectors including the acute, aged-care and community sectors. In the hospital setting, timely discharge notification to healthcare providers is currently an issue. Medication changes need to be more efficiently communicated with the individuals GP in the community setting.
• What indicators should be used to measure progress towards the 50% reduction target?	More medicine does not mean better medicine; healthcare professionals need to consider the out of pocket expenses that impact on access to medications by patients with multiple medications / scripts which may impact on medication adherence. Monitoring side effects to medications which result in withdrawal and ceasing medications. The ACSQHC medication standard has a list of criteria which for assessing organisations during an accreditation review. The criteria have been

	developed with the aim of ensuring clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicines use whilst also ensuring consumers are informed about medicines, and understand their own medicine needs and risks.
• Other feedback?	To promote the awareness that Aboriginal and Maori, Pacific Islander populations use multiple medications at a younger age to Europeans due to earlier onset of chronic diseases in these groups. Waiting time for patients accessing specialist services for advice regarding appropriate medication; specialist services, geriatric specialist.

SECTION 2 – HIGH RISK MEDICINES

High-risk medicines are associated with significant patient harm or death if they are misused or used in error. The response focuses on the prescribing, dispensing, administration and consumption of four high-risk medicines.

The four high-risk medicines are insulin, opioid analgesics, anticoagulants and antipsychotics.

SECTION 2.1 – INSULIN

Options for national action	
Feedback Question	**Feedback**
• What is considered best practice now?	See polypharmacy response regarding national governance, ACSQHC and emedication management. The ACQSHC in the Medication Safety Standard includes a section which aims to minimise medicine related risks by identifying and safely managing processes relating to high risk medicines. Organisations are assessed and accredited against this ACSQHC standard. Insulin therapy is prescribed by a registered medical practitioner or nurse practitioner and managed as part of a diabetic management plan. Insulin doses are adjusted based on the monitoring of blood glucose.
• What, if anything, should be done more or less of?	Discharge planning and communication to the general practitioner or local community – early discharge planning. Timely referral to telehealth services – e.g. diabetes WA. Access to education and psychological support. Self-management and monitoring of insulin therapy.
• What are the current gaps in achieving positive patient outcomes to reduce adverse events from poor	Timely discharge planning and discharge summary with changes to medications to the general practitioner. Accessibility to pump therapy and continuous glucose monitoring.

diabetes and insulin management in the future?	
• What indicators should be used to measure progress towards the 50% reduction target?	Rural and remote diabetic clients receiving support as part of their diabetic management plan with telehealth services and nurse led care coordination. Out of pocket costs. Medication incidents
• Other feedback?	Closing the gap funding for diabetic services into rural and remote communities for HbA1C testing, education (diet and prevention) and a multidisciplinary action with diabetic educators and physiotherapists, podiatrists and renal nurse educators. Cost benefit factors to ensure diabetic self-management.

SECTION 2.2 – OPIOID ANALGESICS

Options for national action	
Feedback Question	**Feedback**
• What is considered best practice now?	See polypharmacy response regarding national governance, ACSQHC and emedication management. The ACQSHC in the Medication Safety Standard includes a section which aims to minimise medicine related risks by identifying and safely managing processes relating to high risk medicines. Organisations are assessed and accredited against this ACSQHC standard. Registered Nurses x 2 to perform within their scope of practice checking to ensure the right patient, right time and frequency of administration, right dose, right route of administration and the right drug is given to ensure a positive reaction of pain relief. Opioid analgesics Endorsed Enrolled Nurses (EENs) have completed further medication endorsement to their training. EEN's, who are authorised, may administer Schedule 2, 3, 4 and 8 medications except intravenous, epidural, intraventricular and intrathecal. Any medication, which requires checking prior to administration, must be checked with a Registered Nurse or Midwife. Provision of opioids on discharge include: - Appropriateness; - Quantity of opioid to be ordered; - Legal requirements of an opioid prescription; - Required patient and carers education, provision of fact sheets; and - Communication to the primary care provider.

• What, if anything, should be done more or less of?	Opioid medications are inclusive of a management plan for chronic and cancer, sickle cell pain management to ensure medications are reviewed for effectiveness. Pain assessment and management in the aged care workforce. Nurses identifying, reporting and escalating care for pain management in aged care.
• What are the current gaps in achieving positive patient outcomes to reduce adverse events from opioid analgesics in the future?	Appropriate pain management in aged care facilities; acute and chronic pain. Recognition of pain with patients that have cognitive decline in aged care facilities.
• What indicators should be used to measure progress towards the 50% reduction target?	Comprehensive pain management training and skills development in the aged care sector. Out of pocket costs.
• Other feedback?	Palliative care opioid medication management policies are established to ensure carers are educated to provide with nursing oversight care at home, end of life care at home which consists of opioids. Consider use of medicinal cannabis for chronic pain and cancer pain when reviewing opioid medication management. It is important to note that ACN continues to acknowledge there are inherent risks associated with cannabinoid use, which may outweigh any potential benefits, particularly around drug interactions, side effects and potential toxicity. In order to strengthen the evidence base, we recommend further clinical trials regarding the use of medicinal cannabis for various conditions and post-marketing surveillance alongside community use of medicinal cannabis. ACN also considers it appropriate for relevant organisations, bodies and stakeholders to engage in discussions concerning the prescribing, supply and use of medicinal cannabis. Some examples include Palliative Care Australia, and the Faculty of Pain Medicine of the Australian and New Zealand College of Anaesthetists (ANZCA), who have expressed caution and concern in the use of medicinal cannabis.

SECTION 2.3 – ANTICOAGULANTS

Options for national action	
Feedback Question	**Feedback**
• What is considered best practice now?	See polypharmacy response regarding national governance, ACSQHC and emedication management. The ACQSHC in the Medication Safety Standard includes a section which aims to minimise medicine related risks by identifying and safely managing processes relating to high risk medicines. Organisations are assessed and accredited against this ACSQHC standard. ACQSHC provides an audit and risk tool for medication safety self-assessment for antithrombotic therapy in Australian Hospitals. Risk mitigation involves addressing anticoagulant prescribing, storage, supply, administration, patient monitoring, pharmaceutical review and patient information and education requirements. Perioperative Management of Anticoagulant and Antiplatelet Agents have been developed to assist clinicians with the inpatient and outpatient management of adult patients undergoing procedures who are taking anticoagulant or antiplatelet therapy. In addition, communication documents assist with communicating the anticoagulant plan with patients and other health care professionals.
• What, if anything, should be done more or less of?	National implementation of the NSW anticoagulation standard implementation checklist to assist hospitals in monitoring risks associated with anticoagulant use.
• What are the current gaps in achieving positive patient outcomes to reduce adverse events from anticoagulants in the future?	Provision of optimal education to patients due to gaps in practice and knowledge of nurses on Atrial Fibrillation and anticoagulation.
• What indicators should be used to measure progress towards the 50% reduction target?	The ACSQHC medication safety self-assessment for antithrombotic therapy in Australian hospitals provides criteria for measuring progress towards reduction of medication errors related to antithrombotic medications. Incidents such as duplication of therapy, failure to adjust an anticoagulant dose according to patient factors, incorrect use of protocol. Anticoagulant guidelines are in place for all facilities administering anticoagulants. Out of pocket costs.

• Other feedback?	It is important that patients on anticoagulant therapy maintain their self-administration skills as inpatients in a hospital setting if appropriate. As this task is often performed for them, there is a risk of “de-skilling”, which could have adverse impacts on the patient’s ability to manage their therapy as an outpatient.

SECTION 2.4 – ANTIPSYCHOTICS

Options for national action	
Feedback Question	**Feedback**
• What is considered best practice now?	See polypharmacy response regarding national governance, ACSQHC and emedication management. The ACQSHC in the Medication Safety Standard includes a section which aims to minimise medicine related risks by identifying and safely managing processes relating to high risk medicines. Organisations are assessed and accredited against this ACSQHC standard. The treatment of behavioural and psychological symptoms of dementia (BPSD) should consider non-pharmacological treatments before drug treatments as BPSD are transient. Antipsychotics should be prescribed for specific problem behaviours and the response to treatment should be closely monitored. If treatment is ineffective the antipsychotic should be withdrawn. Antipsychotics are only indicated as a “last resort” if aggression, agitation or psychotic symptoms cause severe distress or an immediate risk of harm to the patient or others. Even for these indications they are only moderately effective.
• What, if anything, should be done more or less of?	Education of healthcare professionals on medication management, dementia training, picking up signs of pain and unmet needs before behavioural issues escalate. ACN notes it is particularly crucial within BPSD service contexts that registered nursing roles not be substituted by unlicensed/unqualified health workers (also known as assistants in nursing) as occurs throughout general areas of residential aged care. Funding to support continuing professional development (CPD) education for nurse managers, registered nurses (RNs), enrolled nurses (ENs) and assistants in nursing (unlicensed health workers) is essential to the timely identification and appropriate management of residents presenting with severe BPSD. Such funding needs to be acquitted against the employment of skilled nurses rather than be added to the general revenue stream of service providers. Specialist education at a state

	and territory level is necessary to ensure a skilled workforce in the effective management of BPSD residents.
• What are the current gaps in achieving positive patient outcomes to reduce adverse events from antipsychotics in the future?	There are barriers such as limited staff knowledge, processes and commitment to change from utilisation of antipsychotic medications in aged care patients. ACN notes there is a need for 'Specialist Dementia Care Units' (SDCU) for individuals presenting with severe BPSD in aged care facilities. ACN believes effective and high-quality care and management in SDCUs, can positively impact these individuals quality of life and health outcomes. ACN recognises however that federal and state funding as well as effective oversight is lacking in BPSD where specialised care and services are often needed. Aged care facilities are often inadequately resourced in terms of clinical and management skills to meet the complex needs of residents with BPSD, which extend beyond high-level physical care, including lacking access to specialist nursing and medical services. BPSD symptoms are wide-ranging requiring an understanding by service managers that extends beyond lifestyle and basic care considerations.
• What indicators should be used to measure progress towards the 50% reduction target?	Aged care residents - antipsychotics should only be prescribed when all other treatment modalities / medications have failed. ACSQHC national residential medication chart was developed for use in residential aged care facilities. This is a mandatory tool in RACF therefore compliance to the chart should be measured. Medication errors and incorrect packaging of resident's medicines following NRMC introduction. Out of pocket costs.
• Other feedback?	Chemical restraint is defined as the use of any type of medication to restrict an individual's movement or freedom. Chemical restraint may be used to manage agitation or aggression or sedating an individual. The usual medications associated with this are antipsychotics and benzodiazepines. Permission from the family must be given prior to administration of antipsychotics to treat Behavioural Psychological Symptoms of Dementia and they must be used at the lowest dose for the shortest time necessary.

SECTION 3 – TRANSITION OF CARE

Transition of care are recognised as an area of high clinical risk for patients. Passing from one care setting to another, particularly for patients with complex and chronic care needs, opens the potential for mistakes, oversights and misunderstandings and a marked absence of vital information that should flow from the hospital to the receiving carer.

Risks include Medication change, Potentially Inappropriate Medicines (PIMs) at discharge, no separation summary or adverse events

Options for national action	
Feedback Question	**Feedback**
• What is considered best practice now?	See polypharmacy response regarding national governance, ACSQHC and emedication management. The ACQSHC in the Medication Safety Standard outlines the requirements for continuity of medication management and Partnering with Consumers Standard outlines the requirements of health professionals and organisations to partner with consumers/patients in their own care but also with health literacy. Organisations are assessed and accredited against the ACSQHC standard. Other areas of best practice include Medication Issues and Management Plan to identify discrepancy in charting medication orders. Any identified medication management issues and required actions can be documented in the “Identified Medication Management Issues” section on the Management plan. Once the action is completed the date of action and description of the results of the action are documented. On discharge the medications are reconciled with the national inpatient medication chart, prescriptions and discharge summary by the pharmacist and medical officer. Points of transition that require special attention to medication are: - admission to hospital - transfer from the emergency department to other care areas (wards, intensive care, or home) - transfer from the intensive care unit to the ward - from the hospital to home, residential aged care facilities or to another hospital. - The Australian Commission on Safety and Quality in Health Care (ACSQHC) has released a guide for healthcare providers on electronic medication management (EMM) to enable increased sharing of information with consumers, their carers and providers. The safety benefits include fewer prescribing errors, lower dispensing errors, reduced administration errors, less omission and commission errors at transition in care and improved medication adherence. - The Australian Digital Health Agency established a Medicines Safety Program in 2017 acknowledging that good medicines management can help to reduce the likelihood of medication errors and hence patient

	harm. The Program is designed to improve the access and quality of medicines information through the use of digital health, enabling consumers and healthcare providers to make safe, informed decisions and achieve better health outcomes.
• What, if anything, should be done more or less of?	Medication Risk assessment – documentation of the patients: – adherence issues, – ability to administer medications / education required. – Patient understands treatment regimen – involve aboriginal liaison officer / family / carer etc. – Swallowing / education on how they take tablets and oral dosage forms to reduce the number of tablets taken. Emedication management systems are being implemented by the State / Territories in Australia. At the same time the Australian Digital Health Agency established a Medicines Safety Program in 2017 acknowledging that good medicines management can help to reduce the likelihood of medication errors and hence patient harm. This Program is designed to improve the access and quality of medicines information through the use of digital health, enabling consumers and healthcare providers to make safe, informed decisions and achieve better health outcomes.
• What are the current gaps in achieving positive patient outcomes to reduce adverse events from transition of care in the future?	Aged care workforce made up of unregulated workers and Enrolled Nurses. However, any medication, which requires checking prior to administration, must be checked with a Registered Nurse or Midwife. There is not always a registered nurse on shift. Timely discharge summary Medication discrepancies due to lack of medication reconciliation noted on weekends. Discharge planning, planning for discharge without resources in place. Inability for rural and remote patients to follow up with their service provider due to distance, transportation and time of discharge, availability of pharmacy in the communities.
• What indicators should be used to measure progress towards the 50% reduction target?	Primary care physicians need to be contacted at the time of discharge and provided with key elements of the discharge summary, medication changes, significant lab results or pending tests, new treatments, and follow-up plans. Management of the overall post-discharge process for patients with knowledge of what is located in the smaller rural communities prior to discharging patients (pharmacy, transportation).

	A clinical pharmacist should be part of the healthcare team to follow-up with patients within five days after discharge to review medications and assess for potential problems. Medication reconciliation must be done to ensure chronic medications were not stopped and new medications are safe on a 7 day/ week basis – nursing, medical and pharmacy collaboration. Care transition interventions when discharging from hospital to home should be patient-specific, such as goal-oriented patient goals, conducting follow-up phone calls, and linking patients to community resources. Education for patients and their families to assure they understand their diagnosis, changes in medication therapy, follow-up instructions, changes in drug therapy, and who to contact with questions or problems. This should be done prior to discharge and again after discharge once they reach their home or outpatient facility.
• Other feedback?	Health information technology is essential to being able to communicate with and disseminate information to patients, carers and community health teams.