Position statement

Medication Safety

Medication safety describes the systems and strategies necessary to ensure health professionals safely prescribe, dispense and administer appropriate medicines to patients and/or carers.\textsuperscript{1,2}

Medication safety systems and strategies aim to ensure medicines are used in a manner which reduces the risk of avoidable adverse health outcomes and enhances positive health outcomes.\textsuperscript{1}

Medication safety principles apply to all parts of, and all people involved in, the medication management pathway: prescribing, storage and distribution, dispensing, administering and monitoring of medicines.\textsuperscript{1}

Position

The Society of Hospital Pharmacists of Australia’s (SHPA) position is that medication safety is a fundamental patient right and is not an optional extra. Every patient has the right to receive effective medicines in the safest possible manner.

Medication safety systems are fundamental to every health organisation’s risk management strategy. Medication safety should be embedded into the culture and integrated into practice. It should not be a concept raised intermittently in projects or through a siloed program.

Medication safety requires the involvement of a multidisciplinary team with leadership, sponsorship and governance from the organisation’s executive. Medical, nursing, pharmacy and other staff, together with patients and carers, should be actively encouraged to participate in targeted medication safety programs.

Ideally medication safety programs, conducted within and external to a hospital pharmacy, should be led by a pharmacist supported by other pharmacists, technicians and other staff within the department and health service organisation.

Health facilities need to assess their ability to comply with Standard 4: Medication Safety of the National Safety and Quality Health Services Standards. In addition hospital pharmacy services need to assess their ability to comply with the SHPA Standards of Practice for Medication Safety.

SHPA emphasises that adequate numbers of pharmacy staff need to be employed to assist organisations to achieve the mandated National Safety and Quality Health Service Standard for Medication Safety and the SHPA Standards of Practice for Medication Safety.

Background

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) recognises medication safety as a priority area. Standard 4: Medication Safety of the National Safety and Quality Health Services Standards require appropriate governance and systems for medication safety. The Standard states that “health service organisations have mechanisms for the safe prescribing, dispensing, supplying, administering, storing, manufacturing, compounding and monitoring of the effects of medicines.”\textsuperscript{2}
The need for a multidisciplinary, systematic, organisation-wide approach is highlighted by the fact that Standard 4 lists five high-level criteria with numerous recommended strategies and actions:

- Governance and systems for medication safety
- Documentation of patient information
- Medication management processes
- Continuity of medication management
- Communicating with patients and carers

The SHPA Standards of Practice for Medication Safety state that the core tasks for pharmacists leading medication safety programs are to ensure systems are in place for:

- Leading the governance of medication safety committees. This includes ensuring medication safety principles are considered in the organisational clinical governance programs.
- Leading the development and implementation of improvement initiatives using change management techniques (e.g. smart pump technology, electronic medication management).
- Promoting a ‘just culture’ and ‘open disclosure’ in highlighting potential risks and hazards and responding to incidents involving medicines.
- Sharing knowledge and skills with other health professionals.
- Leading the development and review of policies to minimise opportunity for errors in medication use.
- Reporting and reviewing errors, near misses and adverse medicines events (AMEs).
- Reporting and monitoring adverse drug reactions (ADRs).
- Monitoring trends and reviewing work practices and systems to identifying risks or gaps in practice (e.g. drug use audit, chart review, medicines labelling) or emerging risks (e.g. look-alike, sound-alike products).
- Introducing evidence-based medication safety initiatives and programs that can be monitored against accreditation standards (e.g. medication reconciliation, procedures for managing high-risk medications, use of standard forms such as the National Inpatient Medication Chart).
- Educating pharmacy and other clinical staff about medication safety.

Every health organisation should undertake regular medication safety self-assessments.

In addition every organisation should have the resources and capacity to monitor and implement identified quality improvement programs to address identified risks and gaps.

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Background information