FREQUENTLY ASKED QUESTIONS

Key Element 1

Core Characteristic 1

1&2	**What laboratory tests does this question refer to?** This question refers to laboratory tests done within the hospital and/or tests carried out by external suppliers. Many hospitals have ambulatory areas and the laboratory tests done by the inpatient laboratory or outpatient supplier cannot be accessed. In scoring this question hospitals should consider accessibility to laboratory data from internal and external suppliers.
3	**What does "verified" adverse drug information mean?** If adverse drug information is entered into CLINICAL INFORMATION SYSTEMS by non-registered personnel (e.g. admissions staff, unit secretary) a registered healthcare professional (nurse, pharmacist, or doctor) must verify the information from patient records, patient interview, or other means for accuracy and correct spelling. If applicable, a pharmacist must verify that the adverse drug reactions are correctly entered to allow correct computer screening.
4	**How do I answer this item if adverse drug reaction information is transferred from prior admissions but practitioner verification is only needed for certain medications?** Your answer should not exceed C for this item. The intent of this item is that if your system allows adverse drug information from a patient's prior admission to automatically populate a new patient profile, the information must first be verified before medication orders are processed. ISMP has received error reports when allergies from prior admission populate the pharmacy computer system without further verification, and pharmacists dispense medications assuming that current adverse drug reactions have been entered.
8&9	**What is meant by 'prompt to such information'?** In electronic and paper based systems, adverse drug reactions do not have to be listed on all patient-specific screens or medication chart pages, but an alert to the fact the patient does have adverse drug reactions should be prominently visible (e.g. adverse drug reaction sticker or link to full list of ADRs is visible on the screen). The user should be able to easily access and update the patient's adverse drug reaction information. The Australian Commission on Safety and Quality in Health Care (ACSQHC) has published printing guidelines for the NIMC adverse drug reaction sticker available at http://www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/support-material/nimc-adverse-drug-reaction-alert-sticker/
13	**What three identifiers should be used to verify patient identity during medication administration?** Examples of approved identifiers include the patient name (family/surname and given names), date of birth, gender, address, medical record number or Individual Healthcare Identifier. Identifiers such as room or bed number should not be used, and the patient's family and given names are counted together as a single identifier. All methods of patient identification should utilise three patient identifiers to verify a patient's identity. This includes electronic patient identification systems such as barcoding. Hospitals are required to define 'approved patient identifiers' under Criteria 5.1 of the ACSQHC *National Safety and Quality Health Service Standards*.
15	**What does "available to the pharmacist at the time and place of decision making" mean?** The pharmacy computer system is either populated automatically with information about the patient's comorbid and/or chronic conditions or pharmacists can access this information without exiting the pharmacy dispensing system.
16	**We do not have the capability to automatically display laboratory values. What should we score?** If the laboratory values are not automatically displayed on screens for medications that typically require dose adjustments, score A or B. The Australian Commission on Safety and Quality in Health Care's *Electronic Medication Management Systems: A Guide to Safe Implementation (2nd Edition)* recognises the importance for up-to-date pathology results to be available when making decisions about medication management. It specifies that pathology results should be accessible in the EMM and that results relevant to a medication order being completed, reviewed or administered should be displayed in the EMM to guide decision making.

FREQUENTLY ASKED QUESTIONS

Key Element 1 Continued

Core Characteristic 1

23	**What is meant by a 'tiered severity rating' and who should decide on the severity classification?** Excessive firing of alerts can cause alert fatigue and lead to PRACTITIONERS overlooking serious alerts. For this reason it is recommended that a tiered severity rating system is used, for instance, categorising adverse reactions and allergies as mild, moderate or severe based on the patients reaction to a medicine. The DRUG AND THERAPEUTICS COMMITTEE must decide on the severity classifications that will trigger alerts. In cases where classification based on a patient's reaction is not used, hospitals should not score higher than C.
24	**Does this question imply that the CLINICAL INFORMATION SYSTEM needs to be linked to the information systems of external outpatient service providers?** This question relates to the CLINICAL INFORMATION SYSTEM of the hospital only. For instance if a patient is treated at a hospital's outpatient service and is subsequently admitted as an inpatient, information about the patient collected in both settings should be available. The hospital's CLINICAL INFORMATION SYSTEMS ability to link to health information collected about a patient at an outpatient service unrelated to the hospital should not be considered when scoring this question.
25	**What is the least statutory period for maintaining medical records?** States and Territories of Australia have different requirements about how long medical records must be retained, and this can also differ between public and private hospitals. For more information about retention requirements contact the relevant health authority in your jurisdiction.

FREQUENTLY ASKED QUESTIONS

Key Element 2

Core Characteristic 2

26	**What is a best possible medication history and how should it be obtained?** A best possible medication history is a method for compiling and verifying a medication history for a patient based on a number of sources (e.g. medication containers, community pharmacy list, GP referral letters, and via interviewing the patient/carer) to gain a complete picture about what the patient is taking. This history should be obtained upon admission or as soon as possible. The Australian Commission on Safety and Quality in Health Care has produced a video to describe how to obtain and record a best possible medication history http://www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/taking-a-best-possible-medication-history/. *Note:* Item 26 relates to Indicator 3.1 in the *National Quality Use of Medicines Indicators for Australian Hospitals (2014)* which measures the percentage of patients whose current medicines are documented and reconciled at admission.
30	**Are there other strategies I might implement to ensure HIGH RISK MEDICINES are used safely in our hospital?** Strategies that can be used to improve the management of HIGH RISK MEDICINES in your hospital can be divided into those that focus on improving the system, and those that focus on changing clinical practice. More specifically, the hierarchy of effectiveness ranks interventions from most to least effective in the following way: 1. forcing functions 2. automation and computerisation 3. simplification and standardisation 4. reminders, checklists, double checks 5. rules and policies 6. education and provision of information. This is similar to ISMP's rank order of error reduction strategies. The Institute for Safe Medication Practices provides a list of strategies that might be used to improve safety (https://www.ismp.org/newsletters/acutecare/showarticle.aspx?id=45).
35	**What is meant by 'outpatient care units' in this context?** In the context of this question, outpatient care units refer to those outpatient services co-situated with the hospital and therefore easily accessible by pharmacists employed by the hospital. Examples of such outpatient settings include cardiac rehabilitation clinics, diabetes clinics, oncology centres, diagnostic centres, ambulatory surgical centres, renal clinics, inflammatory bowel clinics and HIV clinics. The emergency department is not an outpatient care unit.
39	**What does 'routinely' mean?** Routinely means a recommended interval as defined by the DRUG AND THERAPEUTICS COMMITTEE (e.g. quarterly).
42	**Does this mean that anyone can screen medication orders in a computer system?** The intent of this item is that all new patient medication orders are entered and screened against the patient's total medication profile in CLINICAL INFORMATION SYSTEM by a pharmacist before the medication is dispensed and administered unless it is an urgent lifesaving situation (e.g. cardiac arrest). In a hospital without 24-hour pharmacy service this process should be performed by a doctor or nurse when a pharmacist is not available.
43	**Should the explanation for overriding an essential alert be viewable to others?** The justification for overriding an essential alert should be viewable to other system users (e.g. nurses and pharmacists) in real-time, and there should be an audit trail for identifying the practitioner who has overridden an essential alert. The use of a hard stop, such as requiring a password to override essential alerts, should be considered. Further information about overriding essential alerts can be found in the Australian Commission on Safety and Quality in Health Care's publication titled *Electronic Medication Management Systems: A Guide to Safe Implementation (2nd Edition)*.

FREQUENTLY ASKED QUESTIONS

Key Element 2 Continued

Core Characteristic 3

44	**What do you mean by a "formal process" of reconciliation?** "Medication reconciliation" is a three step process of verifying medication use, identifying variances, and rectifying medication errors at interfaces of care. Reconciliation is the formal process of double checking the medication history against medications ordered at the following points: a) at admission to hospital; b) at points of transfer within the hospital (e.g. between ICU and wards); and c) on discharge to home and/or another institution. These established formal checking processes can be confirmed by talking with, for example, patients, caregivers, prescribers, and outpatient pharmacies. Some variances are intended therapeutic changes, but other variances are unintended and can be considered medication errors. If these errors have clinical consequences - that is, if they cause harm or have the potential to cause harm - they can be considered actual or potential adverse drug events. The intent of this question is to gauge whether the hospital has an established, formal medication reconciliation process in place for all inpatients.
49	**What are examples of tools available to assist with the conversion of oral, parenteral, and transdermal opioids?** Practitioners should use tools recommended by the DRUG AND THERAPEUTICS COMMITTEE for the conversion of oral, parenteral, and transdermal opioids. There are a number of resources available to assist health professionals with opioid conversion: • The Australian Medicines Handbook publishes a table titled Opioid Comparative Information in the Analgesic section. • The Therapeutic Guidelines: Analgesics, contains a table that provides approximate potencies of various opioids relative to 10mg parenteral morphine. • The Therapeutic Guidelines: Palliative Care, contains a table for dose conversion of transdermal fentanyl patches to morphine. • An online opioid conversion calculator has been developed by eviQ which is available to registered users https://www.eviq.org.au/.
53	**What is meant by the "potential for error" is investigated?** The potential for error in this item refers to a review of external publications (e.g. *ISMP Medication Safety Alert!,* Therapeutic Goods Administration[TGA], Food and Drugs Administration and manufacturer notices) for information on reported errors. Feedback from hospital committee members on any personal experiences with the medication is also obtained and discussion about errors that may be prone to happen due to characteristics of the medication or drug category are reviewed before adding a drug to the formulary.
57	**What does "adequately monitor and manage" mean in this item?** Adequately monitor and manage refers to the ability of the healthcare organisation to provide necessary and current laboratory information, up-to-date drug alerts, and appropriate monitoring equipment in order for practitioners to adjust medication therapy, prevent adverse drug effects (including errors) from occurring or to help mitigate their adverse effects.
58	**What are some examples of medication orders that can be used to test CLINICAL INFORMATION SYSTEMS, in order to verify that the system screens for allergies, contraindications, interactions, and appropriateness?** Examples of medication orders to perform testing on your CLINICAL INFORMATION SYSTEM can be found in the table at the end of this frequently asked questions section. *Note*: it does not an exhaustive list of examples.
59&60	**Explain what is meant by 'off-label uses of medicines' and 'individual patient use of non-formulary medicines'.** Medicines are used 'off-label' when they are prescribed for an indication, population, dose, or route of administration that has not been approved by the Therapeutic Goods Administration. Off-label uses of medicines can be evidence based, and in some cases the standard of care may consist of an off-label use of a medicine. This question refers specifically to off-label uses of medicines which are not routinely prescribed in the hospital. An 'individual patient use of a non-formulary medicine' refers to the hospital providing special access to a particular patient for a medicine that is not on the hospital's formulary. This may include medicines that are used on or off-label, as a hospital's formulary does not necessarily include all products and uses registered with the Therapeutic Goods Administration.

FREQUENTLY ASKED QUESTIONS

Key Element 3

Core Characteristic 4

62	**What do you mean by "pre-printed order forms"?** In high risk situations where hospitals do not have PRESCRIBER ORDER ENTRY SYSTEMS there is a case for having pre-printed forms to guide the use of drugs in accordance with formulary decisions. These may be in the form of standing orders or flow charts. Seek advice about regulatory requirements from your State or Territory health department.
63	**Are there any resources to help us develop a set of standardised terminology, abbreviations and symbols?** The Australian Commission on Safety and Quality in Health Care has published *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines*. This document provides principles for consistent prescribing terminology; acceptable terms and abbreviations to use; as well as error-prone abbreviations, symbols and dose designations to be avoided for all medication orders or prescriptions that are handwritten or pre-printed, and all communications and records concerning medicines. DRUG AND THERAPEUTICS COMMITTEES should use this as the standard.
68	**What is an example of a chemotherapeutic agent used for non-oncologic indications?** Methotrexate used to treat rheumatoid arthritis is an example of a chemotherapeutic agent used for a non-oncologic indication. **Are verbal or telephone order to hold or discontinue chemotherapy acceptable?** Verbal and telephone orders to hold or discontinue chemotherapy are acceptable**.**
73	**What is meant by 'outpatient settings' in this context?** The intention of this item is to ensure that medications administered prior to a patient's admission into the hospital are documented and available. Outpatient settings in this context refer to clinics and laboratories that provide services on behalf of a hospital for non-admitted patients. For instance, lung function laboratory, radiology, endocrine clinic, oncology centres, diagnostic centres and ambulatory care.
75 & 76	**Are there standards for the use of STANDARD ORDER SETS?** There are currently no national standards but each jurisdiction may have their own which should be followed. Refer to the health authority in your jurisdiction for further information. Guidance on constructing STANDARD ORDER SETS is available from ISMP http://www.ismp.org/Tools/guidelines/StandardOrderSets.asp

FREQUENTLY ASKED QUESTIONS

Key Element 4

Core Characteristic 5

80	**What is meant by 'highlighted with appropriate alerts in the pharmacy and ward/imprest areas'?** This includes any strategy that may be used to help differentiate products that may be confused due to similarities in the drug name or packaging. A common risk mitigation strategy is the use of TALL MAN LETTERS on pharmacy and ward/imprest shelf labels.

Core Characteristic 6

90	**Do these labelling requirements refer to inpatient supply or only for discharge?** The intention of this item is to ensure that a medicine is dispensed with appropriate instructions for its safe use. The container must include sufficient identifying information for the person responsible for administering the medicine. When the medicine is administered to a specific patient in hospital by a PRACTITIONER, the medicine name, strength, expiry date, 3 patient identifiers (name, MRN and date of birth) are required. The dose and route of administration may be included, but are not mandatory as these instructions will be included in the patient's medication chart.
95	**Is there any national guidance for the labelling of containers?** The Australian Commission on Safety and Quality in Health Care provides guidance for health professionals to communicate safely the contents of containers and lines used for, and with, injectable medicines and fluids; and the patients for whom the medicines and fluids are intended. The Commission also provides design files for a range of labels. These documents are available through http://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/user-applied-labelling/.
97	**Why is expiry date and time not included in this item?** Anaesthetic labels are used in the closed practice environment of the operating room where patient ID, User ID and details of medicines used including expiry and batch number are noted on the operating room schedule. Therefore, these details do not need to be included on the label. (Examples of anaesthetic labels can be found at http://www.safetyandquality.gov.au/publications/labelling-recommendations-perioperative-labelling-poster/).

FREQUENTLY ASKED QUESTIONS

Key Element 5

Core Characteristic 7

105	**What do you mean by "standard times"?** The National Inpatient Medication Chart (NIMC) provides guidance for recommended administration times. This does not preclude units identifying alternate times for particular patient groups. The important safety principle here is standardisation wherever possible.
106	**Can you give an example of parameters for "dosing windows"?** One example of parameters for dosing windows would be administering the first dose of an antibiotic, which was ordered at 8am, and scheduled for every 8 hours, at 8am and then scheduling the next dose for 2pm if the hospital's standardised schedule for every 8 hours is 6am, 2pm, and 10pm. If the order in this example was written at 12 noon, then the first dose could be administered shortly after the order was received and the next dose would be scheduled to be given at 10pm.
107	**What is meant by "in accordance with established protocols"?** A standardised hospital-wide protocol should be in place. If physicians do no use a common protocol within the one facility you should not score higher than B.
108	**What is meant by "consistent terminology" in this item? What would be an example of a "visual cue" that should be used?** When specifying concentration a consistent set of terms and abbreviations should be used to ensure the safe communication of such information. This should be consistent with the *National Terminology, Abbreviations and Symbols to be Used in the Prescribing and Administering of Medicines in Australian Hospitals* document published by the Australian Commission on Safety and Quality in Health Care. Terminology such as 'double strength' and 'quadruple strength' should not be used. When formally communicating medication orders the concentration must be specified. Visual cues used to distinguish multiple concentrations of the same high-alert infusion may include: using auxiliary labels on the concentrated infusion; and building order entry alerts for verification of the selected concentration.

Core Characteristic 8

110	**What is meant by 'automated delivery'?** Automated delivery of medicines refers to using technology to minimise the need for manual handling of medicines when distributing them to patient care units. For instance, an automated delivery system may consist of pneumatic tubing and robotic delivery. The intention of this question is to ensure that medicines are distributed safely and securely whether via automated systems, and/or managed by trained staff.
112	**What is the appropriate process for removing patient-specific medications?** Discontinued medications should be reviewed at least once daily when a pharmacist is available and should be removed from patient care areas as soon as possible. Permission must be obtained from patients prior to removing any medications brought into the hospital by the patient. A process must be in place to ensure patient consent is obtained prior to their destruction. For discontinued medications that are started in hospital a process should also be in place to ensure their prompt removal.
115	**Are only antidotes and reversal agents for pain/sedating medicines required to be kept?** Where there is a risk of toxicity from using a medicine, antidotes and reversal agents should also be available. Examples include methylene blue to counter methemoglobinemia from oral anaesthetic sprays, flumazenil to counter benxodiazepine toxicity, and lipid emulsions for bupivacaine toxicity.

FREQUENTLY ASKED QUESTIONS

Key Element 5 Continued

Core Characteristic 9

121	**What do we mean by an "official list of HIGH RISK IV solutions (injections and infusions) that are unavailable commercially"?** The hospital should have an official register of IV solutions it deems to be high risk. These should be sourced as commercially premixed IV solutions whenever possible. "HIGH RISK IV SOLUTIONS that are unavailable commercially" refers to those solutions that are NOT available commercially premixed.
123	**What do you mean by "the least number of doses, concentrations, and forms that will meet essential patient needs between replenishment"?** Selection errors can occur if there are multiple forms and strengths available. On the other hand calculation and manipulation errors can occur where the exact dose is not available. Careful consultation needs to occur between nursing and pharmacy staff to ensure an appropriate range of doses, concentrations and forms are available for each medicine. Consideration should be given to staff expertise and familiarity with specific drugs, the risk of error with each drug, and the age and diagnoses of typical patients being treated on the units.
129	**What if my hospital has a policy not covered by options 128A, 128B or 128C?** The main safety principle here is that non pharmacy personnel should be prohibited from entering the pharmacy. If your hospital policy permits non pharmacy personnel to enter the pharmacy then you should choose option 128C and score A or B.
133	**What should be considered when assessing the safety of medicines stored in ward or imprest stock (including automated dispensing cabinets)?** When considering whether a medicine should be stored, the pharmacy and nursing unit manager should consider the needs of each patient care unit, staff expertise and familiarity with specific drugs, the risk of error with each drug, and the age and diagnoses of typical patients being treated on the units.

Core Characteristic 10

147	**What if the manufacturer does not have an expiry date and I repackage the chemical?** If the expiry date is not available from the manufacturer and pharmacy has repackaged the product then the expiration date, according to an established internal policy, should be listed on the container.

FREQUENTLY ASKED QUESTIONS

Key Element 6

Core Characteristic 11

156	**Can all of the components listed in this item (medicine/solution, medication concentration, rate of infusion, patient, channel selection, and line attachment) be independently verified using technology?** No. Currently, the technology does not exist to verify all of these components. A second practitioner would still be required to independently verify some of these components (e.g. verify channel selection, line attachment) depending on the capabilities of the technology available in the hospital.
163	**What do you mean by an administration set that has "integrated free-flow protection"?** The administration set should not be capable of free flow of intravenous fluids in any of the following situations: • when the set is installed in the pump and the pump is not operational • when the set has been removed from the pump • when the set is incorrectly installed in the pump • when the pump door is opened. A roller clamp is not the same as an administration set with integrated free-flow protection.
165	**Does this item infer that all practitioners (nurses, pharmacists, etc.) including agency staff must be educated about medication delivery devices as well as automated equipment used in the pharmacy?** The intent of this item is that practitioners who are required to use the specific equipment are properly educated on its use and competency testing is performed. For example, nurses are competent with the use of monitoring equipment used on their unit, pharmacists are competent with automated compounding equipment used in the pharmacy, and both pharmacists and nurses are competent with the use of automated dispensing cabinets.

FREQUENTLY ASKED QUESTIONS

Key Element 7

Core Characteristic 12

182 183 185	**What noise levels are appropriate?** Studies have shown that people tend to raise their voices when the background noise exceeds 45-50dBA, while casual speech corresponds to 50dBA[1]. This is the noise threshold recommended by ISMP for areas where medications are prepared and selected, or where medication orders are transcribed and/or entered into CLINICAL INFORMATION SYSTEMS.

Core Characteristic 13

189 190 191	**Are there any national standards regarding safe working hours?** Currently there are no national standards or benchmarks for the maximum length of a safe shift or the break required between episodes of work. Some State awards do specify appropriate shift lengths but there are differences between the various practitioners and across States. The Australian Medical Association (AMA) has undertaken a significant amount of research in this area and has developed a *National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors*. This identified that the level of fatigue and the consequent effect on performance are not purely related to the length of shifts but are the product of a range of factors, e.g. number of long and/or night shifts worked per week, minimum periods of rest provided, shift rotations etc. Nevertheless it is generally agreed that hospitals should minimise the number of long shifts (10 or more hours) that practitioners are required to work in a given week. The Code now stands as the accepted standard for safe working hours for hospital doctors in Australia. It contains a Risk Assessment Guide and a Risk Assessment Checklist to help assess the risk level of an individual's working hours. Currently there are no similar codes available for hospital pharmacists and nurses but we would suggest using the AMA National Code of Practice as a guide for these other practitioners. Please contact the AMA for more information or to obtain a copy of the code.
193 194	**How can my organisation measure staff perceptions of staffing patterns and its effect on their ability to perform adequate and safe care?** In order to gain a true perspective from pharmacists, pharmacy technicians, and nurses, regarding the adequacy of staffing patterns within their respective departments, and to select the most accurate choice for each of these items, your organisation may want to consider utilising data obtained from routine, staff surveys conducted within your organisation. Several surveys on patient safety culture (e.g. AHRQ Surveys on Patient Safety Culture) are available that include questions regarding staff perceptions of safe staffing patterns.
195	**Explain the term "minimised" in this item.** The overuse of rotating agency personnel has often been associated with errors. This is usually due to the lack of time for a complete orientation (including competency testing), to the entire hospital. ISMP recommends that the use of agency personnel, unless in special circumstances (e.g. worker strike, severe recruiting difficulties), be kept to less than 5% of the total employee pool for each discipline.

[1] Konkani A, Oakley B. Noise in hospital intensive care units – a critical review of a critical topic. Journal of Critical Care (2012) 27, 522.e1-522.e9.

FREQUENTLY ASKED QUESTIONS

Key Element 8

Core Characteristic 14

206	**What type of training is suggested and are there any online resources to assist with training staff about medication safety principles?** At this time appropriate levels of training are not agreed at either a state or federal level. Examples of appropriate training could include training on prescription writing for doctors and training in the use of electronic resources e.g. eMIMs (all practitioners). Paediatric facilities should include training in the following areas: weight documentation; Body Surface Area (BSA) calculation; dose calculation; calculation of drug displacement for IV solutions; and off-label drug use. Online education modules provided by NPS MedicineWise can assist with training of prescribers, pharmacists and nurses. These include modules about medication safety, national inpatient medication chart, and quality use of medicines. The NPS MedicineWise Learning website is accessible via http://learn.nps.org.au/.

FREQUENTLY ASKED QUESTIONS

Key Element 10

Core Characteristic 17

242	**What is meant by "error rate" in this item?** Many organisations attempt to use the number of voluntary reported errors as a numerator to calculate a medication error rate using a denominator (such as total doses dispensed) to compare the rate of errors in their organisation and for unit specific rates of comparison. These calculations should not be used for internal or external comparison. Some organisations may use a determination of error frequency based on the number of errors detected using valid scientific methodologies such as direct observation (numerator), divided by a volume indicator such as the total number of medication doses that should have been administered, total patient admissions, or number of associated procedures (denominator). Even if these methods are employed they should not be used to compare practitioners or units within the hospital.
246 247	**What is meant by the governing body's "commitment to patient safety" and the "hospital's strategic plans"?** These items relate to the atmosphere (culture) that exists within your organisation. Everyone, including the governing body, must believe and exhibit that patient safety and a non-punitive system based approach to medication error prevention is important. Organisations with open error reporting policies, which are non-punitive and that use results of error analysis to institute system changes that may involve capital investment are, in the ISMP experience, ahead of the curve in safe medication use practices. Answers to these items must be honestly agreed upon between the senior administrator(s) on your assessment team as well as all other members.
248	**What is meant by 'have time dedicated specifically to enhance detection of medication errors' in this item?** The intention of this item is to ensure that there is a suitably qualified employee who has at least part of their time dedicated to the detection and analysis of medication errors and risk mitigation. ISMP recommends 0.5 to 1 full time equivalent qualified PRACTITIONER is employed for this purpose alone.

Core Characteristic 18

265	**How should "NEAR MISSES" and potential errors be analysed?** We recommend extracting data from your incident reporting system in an aggregate way to review higher volume but less serious errors. These can be analysed at a unit and/or facility level.
266	**We have a multidisciplinary team that shares error experiences but we do not routinely convene in person. Could we answer E to this item?** In our experience organisations that have set a routine time to meet to share and analyse external and internal errors are more successful than those organisations that seldom meet or only meet when a sentinel event occurs. If you do not have routine face-to-face meetings your answer should be C or D.
273	**Can you provide examples of indicators or resources that might be used for measurement?** The *National Quality Use of Medicines Indicators for Australian Hospitals (2014)* provide a set of indicators for hospitals to measure their performance and drive improvements in the safe and quality use of medicines. The Australian Commission on Safety and Quality in Health Care also provides resources to hospitals to assist with auditing of the National Inpatient Medication Chart.

FREQUENTLY ASKED QUESTIONS

Key Element 10 Continued

Core Characteristic 19

279	**Do we need to include the mg/kg per dose or mg/m^2 per dose for all paediatric patients?** The intention of this question is to ensure that paediatric patients are given an effective and safe total dose. It is important that facilities have a consistent understanding of when the mg/kg per dose or mg/m^2 per dose needs to be documented. For instance, it may be decided that the mg/kg per dose or mg/m^2 is not necessary in paediatric patients already on an adult dose of a drug, or for children over 40kg. In all cases care should be taken to ensure that the upper dose limit for adults is not exceeded in paediatric patients.
297	**Does this item require every medication order that is entered into the pharmacy computer system to be INDEPENDENTLY DOUBLE CHECKED by a second pharmacist?** No. However, medication orders entered into the pharmacy computer system should be double checked for transcription accuracy either by a pharmacist or another licensed healthcare practitioner, prior to administration of the first dose. This double check should ideally be performed by a practitioner other than the individual who entered the order. This can be accomplished by using a number of different methods (or a combination of these methods), for example: • The order is entered into the pharmacy computer system and a pharmacist compares either the entered order or the label that is generated to the original order; • A pharmacist enters the order into the pharmacy computer system and a nurse compares the electronic medication administration record to the original order. If all medication orders are entered by prescribers into a PRESCRIBER ORDER ENTRY SYSTEM, that is fully integrated or INTERFACED with the pharmacy system, then a double check does not need to occur as no transcription would be required. If the organisation's PRESCRIBER ORDER ENTRY SYSTEM, however, is not fully integrated or INTERFACED with the pharmacy system, and pharmacists are still required to transcribe some or all medication orders into the pharmacy computer system, then the transcription would still need to be INDEPENDENTLY DOUBLE CHECKED.

FREQUENTLY ASKED QUESTIONS

Medication orders to perform testing of CLINICAL INFORMATION SYSTEMS (see item 58 FAQ)

Test Category	Patient Profile	Drug	Dose	Route	Frequency
Allergies and Cross Allergies	Patient with a penicillin allergy.	ticarcillin/clavulanate potassium (TIMENTIN)	3.1 grams	IV	every 4 hours
	Patient with a sulphonamide allergy.	sulfamethoxazole 800mg/ trimETHOPRIM 160mg.	1 tablet	PO	twice a day
Contraindication Based on: Route.	Adult patient	vinCRISTine	2 mg	Intrathecally	now
	Adult patient	cephalexin oral suspension.	250 mg	IV	every 6 hours
Contraindication Based on: Pregnancy/lactation.	Pregnant patient	simvastatin	20 mg	PO	once daily in the evening
	Pregnant patient	ISOtretinoin	40 mg	PO	twice daily
Dose Limit or Contraindication Based on: Patient Diagnosis.	Adult patient with rheumatoid arthritis	methotrexate	10 mg	PO	daily
Dose Limit or Contraindication Based on: Laboratory Results.	Adult patient with a creatinine clearance (CrCl) of less than 30mL/min.	cIPROFLOXAcin	400 mg	IV	every 12 hours
	Adult patient with an INR of 6.	warfarin	5 mg	PO	daily
Dose Limit or Contraindication Based on: Patient Age/Weight	Paediatric patient with a weight of 8kg.	morphine	8 mg	IV	once
	12 year old patient.	clSplatin	204 mg	IV	once
	83 year old patient.	dabigatran	0.5 mg	PO	at bedtime
Single and Cumulative Dose Limits	Adult patient.	warfarin	3 mg	PO	every 1 hour
	Adult patient.	atenolol	100 mg	PO	three times a day
	Opioid-naïve adult patient	HYDROmorphone	4 mg	IV	once
Dose limits for combination products and single products	Adult patient already receiving paracetamol 500mg/codeine 30mg 1 tablet PO every 6 hours	paracetamol	650 mg	PO	every 4 hours
Dose limits for each component of combination products	Adult patient	paracetamol 500mg/ codeine 30mg	2 tablets	PO	every 4 hours
Therapeutic Duplication	Adult patient already receiving enalapril 5mg PO daily.	lisinopril	10 mg	PO	daily
Ability to build corollary orders into the system.	Adult patient without a baseline platelet count.	heparin	5,000 units	Subcutaneously	every 12 hours
	Adult patient without an ordered INR.	warfarin	5 mg	PO	daily