Medication Safety

Self Assessment®

CLINICAL EXCELLENCE COMMISSION

For Australian Hospitals

Released 2015

NSW tag New South Wales Therapeutic Advisory Group Inc.

ISMP INSTITUTE FOR SAFE MEDICATION PRACTICES

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FOREWORD

Medication Safety plays a key role in hospital care and focussing on improvement in this area is an important part of wider quality and safety improvement programs.

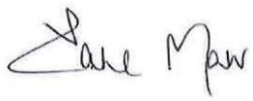
We know medication errors can impact patient outcomes, therefore safe and appropriate use of medicines is an important part of patient safety in hospitals. Fortunately, there is increasing knowledge on how to improve medication practices and it is important for hospitals to be aware of these measures so they can avoid medication errors. This knowledge provides the basis for the *Medication Safety Self Assessment® for Australian Hospitals (2015).*

Hospitals that use this comprehensive resource will be able to assess the safety of medication practices in their facility, identify opportunities for improvement, and take concrete actions to enhance their medication safety systems. Those that utilise the online database will be able to visualise their results, and compare their results against demographically similar hospitals in a de-identified way.

This revised self-assessment is the result of extensive review and consultation, and builds on the previous 2007 Australian self-assessment and the *ISMP 2011 Medication Safety Self Assessment® for Hospitals.* A range of health professionals from around Australia provided input into the development and review of the tool to ensure it remains relevant and useful in the Australian context.

I urge all Australian hospitals to participate in this program to enhance the safety and quality of care for patients. The Clinical Excellence Commission encourages feedback and comments to improve the program and resources available.

If you have a comment or suggestion, please email us cec-mssa@health.nsw.gov.au.



Carrie Marr

Chief Executive
Clinical Excellence Commission

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ABOUT US

Clinical Excellence Commission

The Clinical Excellence Commission (CEC) is responsible for leading safety and quality improvement in the NSW public health system. It was established in 2004 to promote and support improved clinical care, safety and quality across NSW. The CEC is guided by NSW Health values of Collaboration, Openness, Respect and Empowerment.

Our programs, projects and initiatives address quality and safety issues identified in the NSW health system. Areas of focus include engaging patients and consumers in care, improving clinical practice, building capacity in health care and using data to drive change.

The Clinical Excellence Commission is a board-governed statutory health corporation established under the Health Services Act 1997.

Institute for Safe Medication Practices

The Institute for Safe Medication Practices (ISMP) is the only non-profit, charitable organisation devoted entirely to medication error prevention and safe medication use in the United States. ISMP is known and respected worldwide as the leading resource for independent and effective medication safety recommendations.

The Institute's strategies are based on up-to-the minute information gained from analysis of reports to the national, voluntary ISMP Medication Errors Reporting Program, onsite visits to individual healthcare organisations, and advice from outside advisory experts.

ISMP's highly effective initiatives, which are built upon system-based solutions, include: four medication safety newsletters for healthcare professionals and consumers that reach more than three million total readers; educational programs, including conferences on medication use issues; confidential consultation services to healthcare systems to proactively evaluate medication systems or analyse medication related sentinel events; advocacy for the adoption of safe medication standards by accrediting bodies, manufacturers, policy makers, and regulatory agencies; independent research to identify and describe evidence-based safe medication practices; and a consumer website (www.consumermedsafety.org) that provides patients with access to free medication safety information and alerts.

ISMP works with healthcare practitioners and institutions, regulatory and accrediting agencies, consumers, professional organisations, the pharmaceutical industry, and others to accomplish its mission. It is a federally certified patient safety organisation (PSO), providing legal protection and confidentiality for patient safety data and error reports it receives.

As an independent non-profit organisation, ISMP receives no advertising revenue and depends entirely on charitable donations, educational grants, newsletter subscriptions, and volunteer efforts to pursue its lifesaving work. For more information that will make a difference to patient safety, please visit ISMP online at: www.ismp.org.

NSW Therapeutic Advisory Group

The New South Wales Therapeutic Advisory Group Inc. (NSW TAG) is an independent, not-for-profit, member-based association representing the Drug and Therapeutics Committees in NSW public hospitals. Its members include clinical pharmacologists, pharmacists, nurses and clinicians committed to promoting quality use of medicines in NSW public hospitals and the wider community.

NSW TAG has been supporting its members and providing advice and resources for the quality use of medicines for over 25 years. It aims to provide consumers of pharmaceutical health care in NSW with the most suitable medicines in the most appropriate manner whilst ensuring that the limited resources of the health care budget devoted to medicines are used according to sound economic principles. In pursuing this goal, NSW TAG focuses on providing information, advice and support to decision-makers in NSW public hospitals, the NSW Ministry of Health, the Clinical Excellence Commission and other relevant organisations.

ACKNOWLEDGEMENTS

The Clinical Excellence Commission acknowledges all of those who provided input into the revision of the Medication Safety Self Assessment® for Australian Hospitals, and the Australian Commission on Safety and Quality in Health Care for their financial support. In particular the Clinical Excellence Commission thanks the following individuals who contributed to the review at some stage during development: Tristen Pogue, Tracey Moore, Toni Howell, Rachel Taylor, Pamela Schubert, Kerry Fitzsimons, Jan de Clifford, Emma Coyle, Cathie Richards, Carolyn Fields, Christopher Giles, Kate Richardson, Rosemary Burke, Jennifer MacDonald, Gabrielle Couch, Yvonne Koh, Madlen Gazarian, Paula Doherty, and Pauline Dobson.

In addition expert advice on specific aspects of the self-assessment was provided by HealthShare NSW, the Agency for Clinical Innovation, the Pharmacy Board of Australia, the Pharmaceutical Services Unit at the NSW Ministry of Health, and Health Shared Services Victoria. The final version of the self-assessment was reviewed and approved by ISMP.

The Clinical Excellence Commission would like to thank the steering group for providing oversight during the project. The steering group consisted of the following individuals:

- Harvey Lander/Peter Kennedy*, Director/Deputy Chief Executive, Clinical Excellence Commission
- David Hutton, Director of Clinical Governance, Northern NSW Local Health District
- Kate Oliver/ Margaret Duguid*, Senior Project Officer/ Pharmaceutical Advisor, Australian Commission on Safety and Quality in Health Care
- Sasha Bennett, Executive Officer, NSW Therapeutic Advisory Group
- Melita Van De Vreede, Associate Director of Pharmacy (QUM), Eastern Health
- Nina Muscillo/Daniel Lalor*, Medication Safety Manager, Clinical Excellence Commission

The CEC and NSW TAG gratefully acknowledge the expertise and contribution of the individuals, organisations and hospitals, who provided direction for the initial Australian adapted version of the ISMP Medication Safety Self Assessment ® for Hospitals. This second version of MSSA is based on their advisory, review and field testing work.

(* this position was filled by different individuals during the duration of the project. Their affiliation is true to what it was at the time of membership on the Steering Group).

ABOUT THE 2015 MEDICATION SAFETY SELF ASSESSMENT®

The self-assessment is divided into ten key elements that significantly influence safe medication use. Each element is defined by one or more core characteristics that further define a safe medication system. Each core characteristic contains individual self-assessment items to help you evaluate your success with achieving each core characteristic.

ISMP and the Clinical Excellence Commission are not standard setting organisations. The self-assessment items in this document are not purported to represent a minimum standard of practice and should not be considered as such. In fact, some of the self-assessment items represent innovative practices and system enhancements that are not widely implemented in most hospitals today. However, their value in reducing errors is grounded in scientific research and/or expert analysis of medication errors and their causes.

Findings from the Medication Safety Self Assessment® for Australian Hospitals are intended for internal use and become even more useful as repeat assessments are performed to see where you have improved over time. The aggregate results of this assessment will be used for research and educational purposes only.

INSTRUCTIONS

It is important that each hospital in a multihospital system completes the self-assessment individually, and follows the following steps as closely as possible to maximise the quality of results.

1. Establish a multidisciplinary team to complete the self-assessment.

The team should at a minimum consist of appropriate representatives from medical, pharmacy and nursing professions. Ideally the following personnel should be included:

- Director of pharmacy
- Patient safety officer
- IT representative/patient information service representative
- At least two staff nurses from different specialty areas
- At least two staff pharmacists
- At least two active staff doctors from different specialty areas
- Senior hospital administrator

Your team should appoint a team leader who will be responsible for coordinating self-assessment team activities.

The team should be provided with sufficient time to complete the self-assessment and be charged with responsibility to evaluate, accurately and honestly, the current status of medication practices in your facility. Because medication use is a complex, multidisciplinary process, the value and accuracy of the self-assessment is significantly reduced if it is completed by a single discipline. We anticipate that it will take four team meetings of approximately 1 to 2 hours each to complete this self-assessment.

2. Read and review the self-assessment document.

Each team member should read and review the self-assessment in its entirety before the assessment process begins. Items with FAQs that provide additional clarifying information are highlighted. The copyright allows you to make copies of the self-assessment for internal use.

3. Verify your demographic information.

The team leader should review and verify the responses in this section with the hospital's administration. If you are completing the assessment as part of a collaborative that plans to aggregate the group's results please contact cec-mssa@health.nsw.gov.au for further information.

4. Convene the team

During the evaluation process, ensure that each team member can view either a hardcopy or electronic version of the self-assessment during the meeting. A hardcopy of the self-assessment can be completed and transcribed into the online database, or results can be completed directly online with results saved between meetings.

5. Discuss each core characteristic and evaluate the hospital's success with implementing the self-assessment items.

As necessary, investigate and verify the level of implementation with other healthcare practitioners outside your team. When a consensus on the level of implementation for each self-assessment item has been reached, select the appropriate column (A through E, or Not Applicable), using the following scoring key and guidelines:

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Organisations may want to consider assigning an individual to record any discussion generated around each self-assessment item and the rationale behind the selected choice. This information, meant for internal use only, can assist the team when reviewing scores for individual items or reassessing your organisation at a later date. This will provide insight into why the choice selected for each self-assessment item had been chosen at that point in time.

Important Choice Selection Guidelines

For all self-assessment items: Unless otherwise stated, self-assessment items refer to medications prescribed, dispensed, and administered to all inpatients and outpatients typically seen in most hospitals, including patients admitted to the emergency department and ambulatory surgery/procedure units.

For self-assessment items with multiple components: Full implementation (choice of D or E) is evidenced only if all components are present in some or all areas of the organisation. If only one or some of the components have been partially or fully implemented in some or all areas of the organisation, self-assessment choices should not exceed Level C.

For self-assessment items with two or three distinct components, each separated with the word "OR," and labelled (a) and (b), or (a), (b), and (c): Choose the one component within the item that is most relevant to your hospital, and select your choice (A through E, or Not Applicable) for only that one element.

For self-assessment items with an option of "Not Applicable": Select "Not Applicable" only if the item does not correspond to any services you provide in your hospital, either to inpatients or outpatients. Where relevant follow the scoring guideline provided for the item.

6. Repeat the process outlined in Step 5 for all self-assessment items.

7. If you wish to utilise the online database to assist with analysing your results, apply for an account at cec-mssa@health.nsw.gov.au with the following information: person responsible for the account; official hospital name; and physical address of the facility.

Once you have an account you can enter your data by logging in at: https://mssa2.cec.health.nsw.gov.au/. The online database allows you analyse and visualise your results. More information about utilising the database is available from: www.cec.health.nsw.gov.au/programs/mssa.

GENERAL QUESTIONS

I want to do the self-assessment for my health service, but it contains multiple hospitals. What should I do?

The MSSA is designed to be used by individual hospitals. If you wish to conduct a single self-assessment for a group of hospitals you are able to do so, however you will not be able to enter the data into the online database in this format. Accounts in the database are only created for individual hospitals. This is to preserve the integrity and comparability of data in the system.

Collaborative accounts that allows you to see data from multiple facilities is available. For more information email cec-mssa@health.nsw.gov.au.

What benefits does the online database provide?

The online database provides users with automated calculation of weighted scores, and graphical visualisation of results. You are also able to compare your hospital against groups of hospitals that meet criteria you specify (in a deidentified way), or compare your own results over time. More information about accessing and using the database is available through the MSSA webpage.

What if a specific item does not apply in my hospital and there is no 'Not Applicable' option?

You should score no higher than B.

Our hospital does not have a formulary. What should we score for items that refer to a formulary?

Small public hospitals and private hospitals may not have their own formulary. If your facility does not have access to a process for assessing drugs for inclusion in a formulary do not score higher than B.

DEFINITIONS

Below is a list of terms used in the self-assessment that have specific meanings. Where used these terms are capitalised. If using the online database, scroll over the word to see its definition.

Definition Descriptions	
AT-RISK BEHAVIOUR	A BEHAVIOURAL CHOICE that increases risk where risk is not recognized or is mistakenly believed to be justified. Examples of common AT-RISK BEHAVIOURS include: bypassing a duplicate therapy alert during order entry without due consideration; technology work-around; removing more than one patient's medications from an automated dispensing cabinet prior to administration; written orders or documentation that include ERROR-PRONE ABBREVIATIONS.
BEHAVIOURAL CHOICES	Refers to intentional acts that are undertaken by the free exercise of one's judgment. Unlike HUMAN ERROR, which is unintentional behaviour, BEHAVIOURAL CHOICE represents the purposeful behaviour we intentionally employ while engaging in our day-to-day activities.
CLINICAL INFORMATION SYSTEM	Refers to any computer system into which medication information is entered and accessed by PRACTITIONERS. This includes systems into which pharmacy staff enter or validate medication orders and prescribers order entry systems into which medical staff enter medication orders.
CLINICAL PHARMACY SERVICE	A team of pharmacists that provide services aimed at minimising the inherent risks associated with the use of medicines, increasing patient safety at all steps in the medicines management pathway and optimising health outcomes. These activities include: medication reconciliation; assessment of current medication management; clinical review, therapeutic drug monitoring and adverse drug reaction management; contributing to the Medication Management Plan; providing medicines information; facilitating continuity of medication management on discharge or transfer; participating in interdisciplinary ward rounds and meetings; training and education; participating in research; quality improvement activities and peer review. (*SHPA Standards of Practice for Clinical Pharmacy Services* http://jppr.shpa.org.au/Current-issue/JPPR-2013/JPPR-June-2013/N)
CLOSE CALLS	An error that took place but was captured before reaching the patient. For example, penicillin was ordered for a patient allergic to the drug; however, the pharmacist was alerted to the allergy during computer order entry, the prescriber was called, and the penicillin was not dispensed or administered to the patient. Or the wrong drug was dispensed by pharmacy, and a nurse caught the error before it was administered to the patient.
COACH	A supportive discussion among staff (peer-to-peer or manager-to-workers) intended to: 1) help staff see the risks associated with their BEHAVIOURAL CHOICES that were not seen or were misread as being insignificant or justifiable, 2) learn the incentives that encourage these AT-RISK BEHAVIOURS, and 3) help staff make safer BEHAVIOURAL CHOICES in the future.
DEEP SEDATION	An induced state of sedation characterized by depressed consciousness such that the patient is unable to continuously and independently maintain a patent airway and respiratory rate, and experiences a partial loss of protective reflexes and ability to respond to verbal commands or physical stimulation.
DRUG AND THERAPEUTICS COMMITTEE	A multidisciplinary committee with a commitment to the overall governance of the medicines management system in their health service organisation to ensure the judicious, appropriate, safe, effective and cost-effective use of medicines. For additional information on DRUG AND THERAPEUTICS COMMITTEES and their role in medicines governance please refer to CATAG's *Achieving Effective Medicines Governance: Guiding Principles for the Roles and Responsibilities of Drug and Therapeutics Committees in Australian Public Hospitals* (www.catag.org.au/resources).

DEFINITIONS

Continued

Definition Descriptions	
ERROR-PRONE ABBREVIATIONS	Certain medical abbreviations, symbols, and dose designations that are considered dangerous and have often contributed to serious medication errors. The Australian Commission on Safety and Quality in Health Care published the *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines* which contains a list of error-prone abbreviations that should be avoided.
FAILURE MODE AND EFFECTS ANALYSIS	A proactive risk assessment method based on the simultaneous analysis of possible failure modes, their consequences, and associated risk factors. Also referred to as Failure Mode Effects and Criticality Analysis (FMECA) and Healthcare Failure Mode and Effects Analysis (HFMEA).
HIGH RISK MEDICINES/ HIGH RISK IV SOLUTIONS/ HIGH RISK INFUSIONS	Medications that bear a heightened risk of causing significant patient harm when they are used in error. Although mistakes may or may not be more common with these drugs, the consequences of an error are more devastating to patients. Examples of HIGH RISK MEDICINES include heparin, warfarin, insulin, chemotherapy, concentrated electrolytes, opioids, neuromuscular blocking agents, antithrombotic agents, and adrenergic agonists. (ISMP provides a list of high-alert medicines at: www.ismp.org/Tools/highalertmedications.pdf and the Australian Commission on Safety and Quality in Health Care has a webpage dedicated to HIGH RISK MEDICINES http://www.safetyandquality.gov.au/our-work/medication-safety/medication-alerts/).
HUMAN ERRORS	Inadvertently doing other than what should have been done; a mental slip, lapse, or mistake such as miscalculating a dose, forgetting to dilute a medication, or transposing the doses of two antibiotics while prescribing the medications. HUMAN ERRORS are unintentional acts, not a BEHAVIOURAL CHOICE.
HUMAN FACTORS	The study of the interrelationships between humans, the tools they use, and the environment in which they work.
INDEPENDENT DOUBLE CHECK	A procedure in which two individuals, preferably two registered practitioners, separately check each component of the work process. An example would be one person calculating a medication dose for a specific patient and a second individual independently performing the same calculation (not just verifying the calculation) and matching the results. This would involve for example, checking the accuracy of the dose/kg and the weight being used in the calculation. In the case of receiving a telephone order an INDEPENDENT DOUBLE CHECK means that the order must be read back to the prescriber (in figures and words –e.g. 50mg: fifty milligrams, five 0 mg). As a further check, the prescriber should repeat the order to a second person.
INTERFACE	A direct link between two information systems such that the information from one system is immediately available to the user of the second system and integrated into the system in a way that supports clinical decision making (e.g., INTERFACING the laboratory and pharmacy computer systems would immediately provide corresponding laboratory data to the pharmacist while he/she is entering or reviewing a specific medication order). This may or may not include a bi-directional INTERFACE of the two systems to allow communication in both directions.
JUST CULTURE	Refers to a safety-supportive model of shared accountability where healthcare institutions are accountable for the systems they design, for supporting the safe behaviour choices of patients, visitors, and staff, and for responding to staff behaviours in a fair and just manner. In turn, staff are accountable for the quality of their BEHAVIOURAL CHOICES (HUMAN ERROR is not a BEHAVIOURAL CHOICE) and for reporting their errors and system vulnerabilities.

DEFINITIONS

Continued

Definition Descriptions	
MACHINE-READABLE CODING	An encoded identifying mark or electronic tag (e.g. bar code) representing data that can be read with a computerised reading device, such as a scanner or imager.
MAXIMUM DOSE	The dose of a medication that represents the upper limit that is normally found in the literature and/or manufacturer recommendations. Maximum doses may vary according to age, weight, or diagnosis.
MEDICATION DEVICES	Equipment such as infusion pumps, implantable pumps, syringes, pen devices that contain medication (e.g., adrenaline, insulin), tubing, patient-controlled analgesia pumps, automated compounding devices, robotics, and other related devices that are used for medication preparation, dispensing, and administration.
MODERATE SEDATION	An induced state of sedation characterized by a minimally depressed consciousness such that the patient is able to continuously and independently maintain a patent airway and respiratory rate and rhythm, retain protective reflexes, and remain responsive to verbal commands and physical stimulation.
NEAR MISSES	Refer to definition for CLOSE CALLS.
PATIENT-SPECIFIC DOSE/MEDICATION	A ready-to-administer patient-specific dose of medication that exactly matches the dose ordered by the prescriber. This may or may not correspond to the manufacturer unit-dose package. (See UNIT-DOSE).
PHARMACEUTICAL REVIEW	PHARMACEUTICAL REVIEW is a minimum standard of systematic appraisal of all aspects of patients' medication management within an institution conducted or supervised by a qualified and suitably trained health professional (ideally a pharmacist) acting as part of a multidisciplinary team. It includes objective review of medication prescribing, dispensing, distribution, administration, monitoring of outcomes and documentation of medication related information in order to optimise Quality Use of Medicines.
PRACTITIONER	A registered healthcare professional who is authorised within the hospital to prescribe, dispense, or administer medications (such as a doctor, nurse or pharmacist).
PRESCRIBER ORDER ENTRY SYSTEM	A computerised system into which prescribers can directly enter medication orders. Also known as "e-prescribing".
RECKLESS BEHAVIOURS	A BEHAVIOURAL CHOICE to consciously disregard a substantial and unjustifiable risk. The person engaging in RECKLESS BEHAVIOUR: 1) always perceives the risk he/she is taking, 2) understands that the risk is substantial, 3) does not mistakenly believe the risk is justified, 4) behaves intentionally, 5) knows others are not engaging in the same behaviour, and 6) is unable to justify his/her behaviour through an objective risk-benefit analysis. Examples include: reusing a dropped surgical instrument knowing that the action could result in a serious hospital-acquired infection, and working while under the influence of alcohol.
ROOT CAUSE ANALYSIS	A retrospective process for identifying the most basic or causal factor(s) that underlies the occurrence or possible occurrence of an adverse event. The hospital governing body or executive should regularly monitor safety and quality data, as well as take action to improve the safety and quality of patient care (refer to Criterion 1.2 from the ACSQHC *National Safety and Quality Health Service Standards*). The governing body or executive should endeavour to put the findings of ROOT CAUSE ANALYSIS into action.

DEFINITIONS

Continued

Definition Descriptions	
SMART PUMP TECHNOLOGY/ SMART INFUSION PUMP	An infusion pump with computer software that is capable of alerting the user to unsafe dose limits and programming errors if standard concentrations and dose limits have been programmed into the pump's library.
STANDARD ORDER SET	A pre-populated order for multiple medications for a particular treatment regime against which the prescriber may include additional particulars, such as dosage calculations. Includes digital forms created in an electronic medication management system and hard copy forms, including those that combine a medication chart format with non-handwritten hard copy orders or prescriptions.
STAT	In the context of medication administration "stat" is used as an abbreviation to mean "give as a single dose immediately". The expected time of administration should be specified whenever a stat dose is prescribed.
SYSTEM DESIGN	Refers to the design/redesign of processes, procedures, equipment, INTERFACES, overall structure, and the environment or conditions under which staff work, for the purpose of satisfying specific requirements, such as patient safety. The design of a system dictates how reliable it is in terms of satisfying specific requirements.
TALL-MAN LETTERS	TALL-MAN LETTERING is a method for differentiating between drug names that look similar and may be confused. It involves the use of lower and upper case letters to help make medication names more easily distinguishable (e.g. fluoxetine and fluVOXAMine). The Australian Commission on Safety and Quality in Health Care has compiled a *National Tall Man Lettering List* comprising of look-alike, sound-alike names predicted to pose the greatest risk. The national list is available from http://www.safetyandquality.gov.au/our-work/medication-safety/safer-naming-labelling-and-packaging-of-medicines/national-tall-man-lettering/.
UNIT-DOSE	UNIT-DOSE is a system of packaging whereby each dosage unit is separately packed in a protectively sealed unit and labelled with the name of the medicine, strength, dose contained within the pack, batch number and expiry date. The presentation should minimise or eliminate the preparation required for the medicine to be administered. UNIT-DOSE packaging should be consistent with requirements of the Society of Hospitals Pharmacists of *Australia Drug Design and Presentation Guidelines*. The advantage of a unit dose system is that each dosage unit is identifiable up to the point of administration. Dosage integrity minimises wastage as unused doses may be reissued. (For more information, refer to the Society of Hospital Pharmacists of Australia *Standards of Practice for the Distribution of Medicines in Australian Hospitals*. June 2006. J Pharm Pract Res 2006; 36(2): 143-9).
UNIT-OF-USE	This distribution system is based on dispensing individual patient supplies for a short period in a presentation that minimises or eliminates the preparation required for the medicine to be administered. Medicines are usually dispensed in UNIT-DOSE packs or in individually labelled containers. The amount of medicine dispensed should be determined by hospital policy; three to seven days is commonly used in acute care facilities. For more information refer to the Society of Hospital Pharmacists of Australia *Standards of Practice for the Distribution of Medicines in Australian Hospitals*. June 2006, J Pharm Pract Res 2006; 36(2): 143-9).

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

1. PATIENT INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 1

Essential patient information is obtained, readily available in a useful form and considered when prescribing, dispensing and administering medicines.

		A	B	C	D	E
FAQ 1	Prescribers and nurses can easily and electronically access laboratory values for both inpatients and outpatients while working in their respective inpatient and outpatient locations.					
FAQ 2	Pharmacists can easily and electronically access laboratory values for both inpatients and outpatients while working in their respective inpatient and outpatient locations.					
FAQ 3	A nurse, pharmacist, or prescriber verifies that any patient information about previous adverse drug reaction(s) entered into the CLINICAL INFORMATION SYSTEM is accurate, and that the names of implicated agent(s) are spelled correctly and properly coded to allow for computer screening. Absence of a known adverse drug reaction must also be documented.					
FAQ 4	Adverse drug reaction information from a prior admission is readily available for pharmacists to review (e.g. pop-up screens during entry of the first set of orders) when a patient is readmitted. There is a mechanism for ensuring that adverse drug reaction information has been reviewed by a PRACTITIONER and is verified as current and complete.					
5	Orders cannot be entered into the pharmacy computer system until the patient's adverse drug reaction status (including absence of known adverse drug reactions) has been properly entered and coded (adverse drug reactions is a required field).					
6	The PRESCRIBER ORDER ENTRY SYSTEM automatically screens and detects medicines to which patients may be allergic (including cross allergies) and/or have had a previous adverse drug reaction and provides a clear warning to staff during order entry/review.					
7	The pharmacy computer system automatically screens and detects medicines to which patients may be allergic (including cross allergies) and/or have had a previous adverse drug reaction and provides a clear warning to staff during order entry/review.					

1. PATIENT INFORMATION

Continued

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

		A	B	C	D	E
FAQ 8	All paper based medication charts and prescription forms list a patient's adverse drug reactions or have a prominently visible prompt to such information on all pages.					
FAQ 9	Where patient information is electronically available, adverse drug reaction information or a prompt to such information is prominently visible on each patient-specific screen. *Scoring guideline: if patient information is not electronically available, score A or B.*					
10	The level of sedation and the respiratory rate are monitored at least every two hours for patients receiving patient-controlled analgesia, or other infusions to treat pain. Patients with additional risk factors such as obesity, sleep apnoea or asthma are assessed for additional monitoring requirements (e.g. with capnography or sleep apnoea alarms).					
11	All patients undergoing procedural sedation are monitored continuously with pulse oximetry, and the patient's pulse rate, oxygen saturation and blood pressure are regularly recorded. The depth of sedation is monitored routinely, typically by assessing the patient's response to verbal commands or stimulation.					
12	Patient selection criteria have been established for using patient-controlled analgesia, which exclude patients who will not be able to deliver the medicine themselves due to their level of consciousness, physiological condition, or limited intellectual, developmental or psychological capacity. *Scoring guideline: Choose NOT APPLICABLE if you do not offer patient-controlled analgesia in your hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A
FAQ 13A	MACHINE-READABLE CODING (e.g., bar-coding) is used to verify patient identity during medication administration **OR**					
FAQ 13B	Three patient identifiers from the medication chart or electronic medication administration record are manually verified against the patient identification bracelet and/or when possible, with the patient, before medicines are administered.					
14	Basic information (e.g., patient name, patient unique identification number, hospital unit location, birth date, doctor, weight) is clear and easily visible on orders transmitted to the pharmacy whether handwritten or via addressograph imprints, stickers on hard copy or facsimile, or sent electronically.					

1. PATIENT INFORMATION

Continued

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

		A	B	C	D	E
FAQ 15	Information about the patient's comorbid and/or chronic conditions (e.g. hypertension, diabetes, renal or liver impairment, pregnancy, lactation) is available to the pharmacist at the time and place of decision making.					
FAQ 16	Recent inpatient and outpatient laboratory values are automatically displayed on CLINICAL INFORMATION SYSTEM screens for medications that typically require dose adjustments based on pending laboratory results (e.g. if warfarin is ordered, the most recent INR is displayed).					
17	Only trained healthcare workers (not parents or other care providers) administer oral sedatives to children in preparation for a procedure (e.g. Magnetic Resonance Imaging), after the child has arrived at the facility to ensure proper monitoring of neurological and respiratory status, and availability of resuscitation equipment in the event of respiratory depression. *Scoring guideline: Choose NOT APPLICABLE if care is not provided to paediatric patients, even in the emergency department, outpatient surgery, or outpatient diagnostics.*					
		If "NOT APPLICABLE", tick here >>				N/A
18	An active surveillance system is used to monitor available data sources to optimise therapy and identify patients at risk of harm related to medication therapy, and to notify PRACTITIONERS of intervention opportunities in real time as soon as the information is available.					
19	There is a defined process that specifies how to modify patient allergies and reactions in the medical record and who is permitted to make such changes.					
20	The hospital utilises a surgical safety checklist prior to surgical procedures to verify patient identity, allergies, thromboprophylaxis, and preoperative antibiotics (when required).					
21	All documented weights and heights in written and electronic systems are designated as actual, estimated by PRACTITIONERS, or stated by patients.					
22	Medicines requiring dose calculation by weight cannot be ordered on the CLINICAL INFORMATION SYSTEM until the patient's weight has been entered.					

1. PATIENT INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
FAQ 23	CLINICAL INFORMATION SYSTEMS have a tiered severity rating for categorising allergies and adverse drug reactions, which is based on the patient's reaction to the medicine. The tiered severity rating is used to limit alert fatigue by not triggering alerts for allergies and adverse drug reactions with low severity ratings (e.g. medicine intolerances that are not true allergies).					
FAQ 24	The CLINICAL INFORMATION SYSTEM used for outpatients and inpatients are linked so that comprehensive patient information is available to PRACTITIONERS wherever the patient receives care in the hospital system.					
FAQ 25	The CLINICAL INFORMATION SYSTEM maintains (for at least the statutory period) ongoing patient profiles with basic demographic information (including adverse drug reactions) and medication therapy records for each episode of care, which are readily accessible to all PRACTITIONERS when a patient is readmitted. *Scoring guideline: Do not choose level D or E if information is deleted more frequently than every five years.*					

For FAQs, please refer to the FAQ section of this manual

2. MEDICATION INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 2

Essential medication information is readily available in a useful form and is considered when prescribing, dispensing, and administering medications, and when monitoring the effects of medicines.

		A	B	C	D	E
FAQ 26	A complete medication history (i.e. best possible medication history), including prescription and over-the-counter medicines, vitamins, herbal products, and recreational drugs is obtained on every inpatient and outpatient upon admission or initial encounter (including during the pre-admission process).					
27	All patient care areas where medicines are administered have available updated medication reference texts, either current hard copy or electronically. These references include special dosing references (e.g. for paediatrics, geriatrics) and information on herbal and alternative medicines. All outdated hard copy texts are removed from use (texts are outdated after one year of publication or whenever the next edition is available).					
28	Pharmacists and pharmacy technicians have easy access (e.g. on each computer terminal or on electronic hand-held devices) in the pharmacies to user- friendly, up-to-date, computerised medication information systems (e.g. Australian Medicines Handbook, Therapeutic Guidelines, MicroMedex), which include information on over-the-counter, herbal and alternative medicines.					
29	Prescribers and other non-pharmacy PRACTITIONERS have easy access (e.g. on each computer terminal or on electronic hand-held devices) in all patient care areas to user-friendly, up-to-date, computerised medication information systems (e.g. Australian Medicines Handbook, Therapeutic Guidelines, MicroMedex), which include information on over-the-counter, herbal and alternative medicines.					
FAQ 30	HIGH RISK MEDICINES used within the organisation have been defined, identified, and communicated to all PRACTITIONERS who prescribe, dispense, and administer the products.					
31	Current protocols, guidelines, dosing scales, and/or checklists for HIGH RISK MEDICINES (e.g. chemotherapy, anticoagulants, opioids, insulin, electrolyte replenishment with potassium, magnesium, sodium, and phosphate) are readily accessible to prescribers, pharmacists, and nurses, and used when HIGH RISK MEDICINES are prescribed, dispensed, and administered.					

2. MEDICATION INFORMATION

Continued

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

		A	B	C	D	E
32	MAXIMUM DOSES for HIGH RISK MEDICINES such as chemotherapy, electrolytes, and opioids have been established and disseminated and/or included on prescribing guidelines as a reference for prescribers, pharmacists, pharmacy technicians and nurses.					
33	All internally developed medication information tools (e.g. pocket references, medication information cards, pre-printed order forms, protocols or checklists, patient medication education materials, compounding formulae) undergo a formal approval process before use, which includes at a minimum, review by a pharmacist and those who will be using the tool.					
34	Pharmacists regularly work directly in inpatient care units performing clinical activities such as reviewing patient records and medication orders, attending multidisciplinary rounds, providing input into the selection and administration of medicines, educating patients, and monitoring the effects of medicines on patients.					
FAQ 35	Pharmacists regularly work directly in outpatient care units performing clinical activities such as reviewing patient records and medication orders, providing input into the selection and administration of medicines, educating patients, and monitoring the effects of medicines on patients. *Scoring guideline: Choose NOT APPLICABLE if your hospital does not have outpatient care units.*					
36	Pharmacists regularly work directly in emergency departments performing clinical activities such as reviewing patient records and medication orders, attending multidisciplinary rounds, providing input into the selection and administration of medicines, and monitoring the effects of medicines on patients.					
37	There is a process of PHARMACEUTICAL REVIEW within 24 hours of admission for all inpatients.					
38	The CLINICAL INFORMATION SYSTEM displays alerts when a medication order contains dosages that are outside the defined range for the patient or medicine, notes the appropriate dose, and prompts review of the order.					

2. MEDICATION INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
FAQ 39	Appropriately skilled staff routinely test the CLINICAL INFORMATION SYSTEM to assure that MAXIMUM DOSE alerts are present for HIGH RISK medicines and to flag alerts that are not present so that they can be built.					
40	Data generated by the CLINICAL INFORMATION SYSTEM regarding the handling of alerts (e.g. viewed, ignored or 'skipped', overridden, accepted) is regularly reviewed to provide insight into the effectiveness, currency and appropriateness of individual alerts and guide the refinement of individual alerts.					
41	Medication information updates for CLINICAL INFORMATION SYSTEMS are uploaded as soon as practical once received from a database vendor and no later than within 3 months of receipt. If updates are released by software vendors more frequently, steps are in place to ensure each update is uploaded before the subsequent update. A concerted effort is made to ensure the CLINICAL INFORMATION SYSTEM is using the most current medication information.					
FAQ 42	Except in urgent lifesaving situations, all inpatient and outpatient medication orders are entered into a CLINICAL INFORMATION SYSTEM and screened electronically against the patient's current clinical profile for allergies, contraindications, interactions, and appropriateness of doses before medicines are administered.					
FAQ 43	The CLINICAL INFORMATION SYSTEM requires PRACTITIONERS to enter an explanation upon overriding an essential alert (e.g. exceeding a MAXIMUM DOSE for a HIGH RISK MEDICINE, a serious medication interaction, an allergy).					
FAQ 44	There is a formal process used to verify (reconcile) the medicines that the patient had been taking at home before admission and compare them to the medications prescribed upon admission and discharge, and any discrepancies identified are resolved.					
45	Where a pharmacist intervenes to resolve a potentially harmful medication order, the nature of the intervention is immediately communicated to nurses as well as to prescribers, to reduce frustrations with delays and halt the potential administration of the medicine from ward or imprest stock while awaiting clarification of the order					

2. MEDICATION INFORMATION

Continued

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

		A	B	C	D	E
46	Minimum and MAXIMUM DOSE limits have been established for parenteral medicines titrated to effect, which when approached require notification of the prescriber for further instructions regarding the dose or possible discontinuation of the medicine.					
47	A standardised pre- and post-procedure protocol for patients who require contrast media is used to screen patients for allergies, renal dysfunction, and contraindicated medications (e.g., metformin-containing products, medications that must be avoided for several days before the procedure) before and after the procedure is performed, and appropriate measures (e.g., hydration with IV saline, postponement of procedure, use of non-ionic contrast media, resumption of contraindicated medications after verification of normal renal function after procedure) are taken to reduce the risk of radiocontrast-induced nephrotoxicity or allergic response.					
48	Standardised, organisation approved emergency medication dosing guidelines are available on adult and paediatric emergency trolleys, and the information provided corresponds to the dosage forms and concentrations of medicines available in the emergency trolleys.					
FAQ 49	Tools to assist with the conversion of oral, parenteral, and transdermal opioids have been established and are easily accessible to all PRACTITIONERS when prescribing, dispensing, and administering opioids.					
50	Standard practices have been established and are followed for the appropriate use of postoperative IV solutions used to hydrate paediatric patients, along with protocols to identify, treat, and monitor paediatric patients with hyponatremia, water intoxication, and/or syndrome of inappropriate antidiuretic hormone secretion. *Scoring guideline: Choose NOT APPLICABLE if postoperative care is not provided to paediatric patients.*					
		If "NOT APPLICABLE", tick here >>				N/A

For FAQs, please refer to the FAQ section of this manual

2. MEDICATION INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 3

A controlled medication formulary is established to limit choice to essential medicines, minimise the number of medicines with which PRACTITIONERS must be familiar, and provide adequate time for designing safe processes for the use of new medicines added to the formulary.

		A	B	C	D	E
51	The hospital formulary contains almost no duplication of generic equivalents.					
52	The hospital formulary contains minimal duplication of therapeutically equivalent products.					
FAQ 53	Before a decision is made to add a medicine to the formulary, the potential for error with that medicine is investigated in the literature, documented in the medication monograph, submitted to the DRUG AND THERAPEUTICS COMMITTEE (or a similar governing body) and addressed.					
54	When medicines with heightened error potential are identified during the formulary addition process, safety enhancements such as standardised order forms, prescribing guidelines, check systems, reminders, and/or limitations on use, administration, and storage of medicines are established before initial use.					
55	For medicines which have been on the market for less than one year, formulary approval is conditional on a six month review of published literature and local reporting systems. This is continued for at least 12 months after initial formulary approval. If errors and adverse drug reactions occur, safety enhancements are established as necessary or the medicine is removed from the formulary.					
56	A drug use evaluation is initiated after introducing a medicine for hospital use that has been identified as having heightened error potential to monitor compliance and success with established safeguards.					
FAQ 57	The hospital's ability to adequately monitor and manage the anticipated adverse effects of a medicine is investigated, documented, considered by the DRUG AND THERAPEUTICS COMMITTIEE (or other multidisciplinary team), and addressed before adding the medicine to the formulary.					

2. MEDICATION INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
FAQ 58	The CLINICAL INFORMATION SYSTEM is tested after adding a new medicine to verify that important clinical warnings (e.g. serious medication interactions, allergies, cross allergy alerts, MAXIMUM DOSE limits) are functional; and if a serious alert is not yet functional through the medication information system vendor, a temporary free text alert is added so that it appears on the screen during order entry.					
FAQ 59	In non-urgent situations, there are formal evaluation processes undertaken by the DRUG AND THERAPEUTICS COMMITTEE, to assess the appropriateness of: • off-label uses of medicines (including use for unregistered indication, age, gender, dose or route) when that off-label use is not routinely used in the organisation; and • individual patient use of non-formulary medicines, before prescribing these medicines.					
FAQ 60	In urgent situations, the DRUG AND THERAPEUTICS COMMITTEE has a process in place to facilitate the rapid assessment of: • off-label uses of medicines (including use for unregistered indication, age, gender, dose or route) when that off-label use is not routinely used in the organisation; and • individual patient use of non-formulary medicines.					

For FAQs, please refer to the FAQ section of this manual

3. COMMUNICATION OF MEDICATION ORDERS AND OTHER MEDICATION INFORMATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 4

Methods of communicating medication orders and other medication information are standardised and automated to minimise the risk of error.

		A	B	C	D	E
61	The CLINICAL INFORMATION SYSTEM allows prescribed medicines to be dispensed without the need for transcribing between systems. *Scoring guideline: Do not choose D or E if prescribers enter orders into a computer system that is not directly INTERFACED or integrated with the pharmacy computer system.*					
62A	**In hospitals <u>WITH</u> PRESCRIBER ORDER ENTRY SYSTEMS:** The system warns prescribers about unsafe orders (e.g. adverse drug reactions including allergies, MAXIMUM DOSES, interactions) during input and guides the use of formulary medicines and established protocols/clinical pathways. **OR**					
FAQ 62B	**In hospitals <u>WITHOUT</u> PRESCRIBER ORDER ENTRY SYSTEMS:** Pre-printed order forms that have been approved by your hospital's DRUG AND THERAPEUTICS COMMITTEE are used to guide prescribing of medications in high risk situations.					
FAQ 63	A set of standardised terminology, abbreviations and symbols for communicating medicine information or orders (including all paper medication charts and computer screens) is established and communicated/ readily available to PRACTITIONERS. Medication names must not be abbreviated. Any variance from the standard set is carefully considered by the DRUG AND THERAPEUTICS COMMITTEE.					
64	Compliance with safe methods of communicating the medication name, dose, route, and frequency (e.g. on handwritten medication charts, order entry screens, computer-generated medication labels, medication storage bin labels) is monitored through quality improvement efforts.					
65	Upon admission to the hospital or transfer to a different level of care within the hospital, prescribers write (or electronically enter) complete orders for all medication therapy. Orders to "resume the same medications" or to "take medications from home" are not accepted.					

3. COMMUNICATION OF MEDICATION ORDERS AND OTHER MEDICATION INFORMATION

Continued

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

		A	B	C	D	E
66	Verbal (face-to-face) orders from prescribers that are onsite in the hospital are used only in emergencies or during sterile procedures where ungloving would be impractical.					
67	Telephone orders from prescribers that are onsite in the hospital are used only in emergencies.					
FAQ 68	Verbal or telephone orders are <u>never</u> accepted for oral or parenteral chemotherapy (including chemotherapeutic agents used for non-oncologic indications). *Scoring guideline: Score NOT APPLICABLE if you do not offer chemotherapy (including oral agents) to patients.*					If "NOT APPLICABLE", tick here >> N/A
69	When verbal or telephone orders must be taken, the nurse or pharmacist receiving the order <u>immediately</u> writes it down and reads it back to the prescriber for verification and there is a system of INDEPENDENT DOUBLE CHECKING.					
70	Electronic administration records that are generated directly from the PRESCRIBER ORDER ENTRY SYSTEM are used to guide and document medication administration.					
71	Medication charts, including electronic medication administration records, are taken to the patient's bedside for reference during medication administration.					
72	A policy is in place for a process that can be followed by nurses and pharmacists to resolve conflict when prescribers do not agree with their expressed concerns about the safety of an order. The agreed process has been developed in consultation with all three disciplines.					
FAQ 73	Upon inpatient admission to the hospital, all medications administered in the emergency department or outpatient settings are documented in a manner that facilitates comprehensive review for duplicate therapy or medication interactions when subsequent medicines are prescribed.					
74	Where a medicine is prescribed on certain days of the week, the actual day/s are stated in the order (e.g. methotrexate on Wednesday only). The days when the medicine is not to be administered must be crossed out in the administration section of the medication chart.					

3. COMMUNICATION OF MEDICATION ORDERS AND OTHER MEDICATION INFORMATION

Continued

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

		A	B	C	D	E
FAQ 75	STANDARD ORDER SETS (electronic or pre-printed) express IV and epidural infusion/medication doses in the standard concentration(s) used in the organisation and in a manner and sequence that matches the entries on electronic medication administration records and programming choices on infusion pumps.					
FAQ 76	STANDARD ORDER SETS (electronic or pre-printed) sets for complex, compounded products list additives in the same sequence, dosing units, and concentrations as in the pharmacy order entry system and automated compounder order entry system.					
77	PRACTITIONERS utilise a formal standardised process (e.g. SBAR [situation, background, assessment, recommendation]) when reporting clinical information about a patient's condition to other PRACTITIONERS during hand overs, patient transfers, critical conversations, and telephone calls.					

For FAQs, please refer to the FAQ section of this manual

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4. MEDICATION LABELLING, PACKAGING AND NOMENCLATURE

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 5

Strategies are undertaken to minimise the possibility of errors with medication products that have similar or confusing manufacturer labelling/packaging and/or medication names that look and/or sound alike

		A	B	C	D	E
78	The *ISMP Medication Safety Alert!* and/or other current literature such as the Society of Hospital Pharmacists of Australia website on medication safety are regularly reviewed to identify medication labelling, packaging, and nomenclature problems and action is taken to prevent errors with these medicines.					
79	The package and label of new medicines that are being considered for formulary addition are examined to identify any potential for confusion.					
FAQ 80	Products with look-alike medication names and packaging that are known by the hospital staff to be problematic are stored separately and/or are highlighted with appropriate alerts in the pharmacy and ward/imprest areas.					
81	Computer mnemonics are arranged to prevent look-alike medication names from appearing on the same computer screen; or look-alike medication names are clearly distinguished in a way that differentiates them (e.g. use of TALL-MAN LETTERS) if they appear sequentially on the same computer screen.					
82	Different manufacturers are sought for products with labelling/packaging that look like other products to help differentiate the labels/packages.					
83	Alerts are built into the CLINICAL INFORMATION SYSTEM to remind PRACTITIONERS about problematic medication names (including medicines with multiple suffixes such as XL, SR, ER, CD, LA), packaging, or labelling.					
84	Auxiliary warnings or other label enhancements (e.g. TALL-MAN LETTERS to accentuate differences in look-alike medication name pairs) are used on packages and storage bins of medicines with problematic names, packages, and labels.					
85	Prescribers include the clinical indication for all outpatient and inpatient medication prescriptions including "prn" medication orders.					

4. MEDICATION LABELLING, PACKAGING AND NOMENCLATURE

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
86	All clinical staff involved in medication use, particularly frontline nurses, pharmacists, prescribers, and pharmacy technicians, are made aware of the organisation's list of look – and/or sound-alike products, how the medication names were selected, how the list is updated, what it means, why it is important to patient safety, and the interventions required to reduce mix-ups.					
87	Medicines requiring child resistant packaging are highlighted in pharmacy dispensing systems.					

For FAQs, please refer to the FAQ section of this manual

4. MEDICATION LABELLING, PACKAGING AND NOMENCLATURE

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 6

Readable labels that clearly identify medicines are on all medication containers and medicines remain labelled up to the point of actual medication administration.

		A	B	C	D	E
88	Pharmacy computer systems produce clear and distinctive labels free of ERROR-PRONE ABBREVIATIONS and nonessential information (e.g. computer mnemonics and other pharmacy codes).					
89	Policy and practice assures that each injectable medicine drawn up in a bag or syringe is prepared and labelled using the correct specified label according to national guidance provided by the Australian Commission on Safety and Quality in Health Care regarding user-applied labelling of injectable medicines, fluids and lines. Labels applied to prepared injectable bags or syringes include all patient and medication details outlined in this guidance.					
FAQ 90	The containers of medicines dispensed from the pharmacy for specific patients are labelled with the medication name, strength, dose, route of administration, form, expiry date, patient name and location.					
91	Labels affixed to commercially available IV infusion containers are correctly positioned to allow observation of the manufacturer's label, which identifies the base solution and the total amount and concentration of any additives.					
92	Labels affixed to pharmacy-prepared IV admixture containers identify the total volume of solution in the container, the base solution and the concentration or total amount of each medication additive in the container.					
93	All medicines are dispensed to patient care units (including neonatal, paediatric, and critical care units) in labelled, ready- to-use UNIT-DOSES, or in labelled, UNIT-OF-USE containers (excluding topical preparations and antacids).					
94	Oral medications remain in the manufacturer's (or pharmacy's) packaging up to the point of actual medication administration at the bedside so a final check of the medicine against the medication chart can be accomplished.					

4. MEDICATION LABELLING, PACKAGING AND NOMENCLATURE

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
FAQ 95	All medications, medication containers (including syringe basins, or other vessels used to store drugs), and other solutions on and off the sterile field in perioperative and other procedural settings are labelled even when just one product/solution is present. The pre-printed labels or markers used to label containers should be sterile and opened onto the sterile field					
96	Medicines brought into the health facility by a patient or family member are not administered to the patient until an authorised prescriber has approved their use and a pharmacist (or other qualified PRACTITIONER when a pharmacist is unavailable) has visually inspected the medicines and containers to verify the medicines' identity and proper labelling and packaging to guide safe medication administration.					
FAQ 97	Syringes of medications prepared for use during anaesthesia are labelled with the medication name and strength/concentration.					
98	Solid dosage forms supplied by pharmacy should minimise the level of manipulation required at ward level.					
99	The medication name on the pharmacy and manufacturer labels can be matched with the corresponding medication name on the medication chart.					
100	There is a standard process to identify which compounded IV solutions (e.g. chemotherapy, paediatric infusions) with overfill must include the amount of overfill in the total volume expressed on the pharmacy label. *Scoring Guideline: Choose NOT APPLICABLE if no compounded products contain overfill.*					
		If "NOT APPLICABLE", tick here >>				N/A

For FAQs, please refer to the FAQ section of this manual

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 7

IV solutions, medication concentrations, doses and administration times are standardised whenever possible.

		A	B	C	D	E
101	Concentrations for infusions of HIGH RISK MEDICINES such as morphine, heparin, insulin, and inotropes used for adult patients are standardised to a single concentration that is used in at least 90% of the cases. *Scoring guideline: Score NOT APPLICABLE if you do not treat any adult patients (including in the emergency department).*					
		If "NOT APPLICABLE", tick here >>				N/A
102	Concentrations for infusions of HIGH RISK MEDICINES such as morphine, heparin, insulin, and inotropes used for paediatric patients are standardised to a single concentration that is used in at least 90% of cases.(Specific needs for neonates may be considered separately.) *Scoring guideline: Score NOT APPLICABLE if you do not treat any paediatric patients (including in the emergency department).*					
		If "NOT APPLICABLE", tick here >>				N/A
103	Commercially prepared, premixed IV solutions are used whenever they are available on the market					
104	Manufacturer's prefilled syringes, rather than vials or ampoules, are used for at least 90% of the injectable products that are commercially available in such packaging.					
FAQ 105	Standard times for scheduled medication administration have been established as per the National Inpatient Medication Chart and are consistently used on each unit throughout the organisation.					
FAQ 106	Parameters (e.g. dosing windows) have been established, disseminated, and enforced to help nurses safely administer most medicines at established standard times even if the initial dose was administered at a nonstandard time.					
FAQ 107	Sliding scale insulin is not used to treat patients with hyperglycaemia. Regular antihyperglycaemia therapy is prescribed to treat diabetics, with supplemental insulin only added to treat hyperglycaemia as necessary in accordance with established protocols.					

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
FAQ 108	When more than one standardised concentration is needed for HIGH RISK INFUSIONS (for adults or paediatrics), the organisation uses consistent terminology and visual cues to identify and distinguish between the concentrations when communicating medication information. For the formal communication of medication orders the concentration is written as unit per volume (e.g. on labels, hand written or pre-printed orders, electronic administration records, chart notations, and electronic formats, including computer screens).					
109	STANDARD ORDER SETS (electronic or pre-printed) are developed by gaining consensus among all prescribers who treat each condition/targeted patient population regarding the evidence-based clinical management to create a single order set for each condition/targeted patient population. (PRACTITIONER specific or single-group-specific order sets are allowed if only one PRACTITIONER/group provides care to patients with the specified condition.)					

For FAQs, please refer to the FAQ section of this manual

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 8

Medicines are provided to patient care units in a safe and secure manner and available for administration within a timeframe that meets essential patient needs.

		A	B	C	D	E
FAQ 110	The system used to physically deliver medicines from the pharmacy to patient care units is directly controlled by the pharmacy using trained staff and/or automated delivery.					
111	Nurses are notified whenever medicines are delivered to the unit.					
FAQ 112	Discontinued PATIENT-SPECIFIC MEDICATIONS are removed from patient supplies in a timely manner (e.g. upon the patient's discharge, discontinuation of the medicine, or during the next scheduled pharmacy rounds to patient care units) to prevent accidental administration or borrowing of the medication for another patient.					
113	An appropriately secured area in medication rooms has been established for placing discontinued medicines (and medicines from discharged patients, or removed from automated dispensing cabinets) until pharmacy pick-up, and borrowing these medicines for other patients is prohibited.					
114	Whenever a STAT order is prescribed the time for administration is specified on the medication chart or the prescription and this information is immediately communicated to nursing and midwifery staff.					
FAQ 115	Antidotes for MODERATE SEDATION and patient-controlled analgesia/other IV infusion to treat pain and accompanying guidelines for emergency use are readily available near the point of use.					
116	Guidelines for alerting PRACTITIONERS to medication shortages, selecting and using alternative products and doses, and educating PRACTITIONERS about their safe use (including warnings about potential adverse events) have been established and implemented.					
117	A list of antidotes and other medicines, typical doses, and directions for preparation and administration has been established in anticipation of potential disasters and a reliable plan for obtaining these products and associated supplies has been established and is tested at least annually.					

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
118	Sufficient numbers of automated dispensing cabinets, depending on their intended use (e.g. limited narcotic and unit stock versus total medication distribution), are installed in areas that are easily accessible to staff and in close proximity to patients to ensure access without unreasonable wait times and to reduce workarounds. *Scoring Guideline: Choose NOT APPLICABLE if your organisation does not use automated dispensing cabinets.*					
		If "NOT APPLICABLE", tick here >>				N/A
119	Electronic systems that document temperature ranges and provide immediate problem notification to an area staffed around the clock are used for refrigerators that store critical, temperature-sensitive medicines (e.g., frozen vaccines, investigational medicines), and written procedures regarding how to handle any breach of a safe temperature range have been developed and are followed.					
120	Turnaround times for order verification and/or medication delivery from the pharmacy is consistent with the time frames established by the hospital for immediate, urgent, and routine medicines.					

For FAQs, please refer to the FAQ section of this manual

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 9

Unit-based ward or imprest stock is restricted.

		A	B	C	D	E
FAQ 121	The facility has an official list of HIGH RISK IV SOLUTIONS (injections and infusions) that are unavailable commercially. These solutions are prepared in the pharmacy unless needed in urgent lifesaving situations.					
122	Unit stock is reviewed regularly (at least annually) to determine low usage medications that may be eligible for removal from inventory.					
FAQ 123	Medicines stocked in patient care units are available in the least number of doses, concentrations, and forms that will meet essential patient needs between replenishment.					
124	First doses of HIGH RISK MEDICINES are not removed from the imprest or ward stock and/or automated dispensing cabinets before a pharmacist reviews the specific patient order and screens the order for safety. Exception: urgent lifesaving situations and periods when a pharmacist is not on the premises					
125	Medicines are not removed from inpatient and emergency departments (including post-anaesthesia care unit) unit stock (including automated dispensing cabinets) before a pharmacist reviews the specific patient order and screens the order for safety. Exception: urgent lifesaving situations where a delay would harm the patient.					
126	Pharmaceutical vendors and prescribers are prohibited from distributing medication samples in inpatient and outpatient areas (and also in clinics, emergency departments, ambulatory surgery/procedure units, and radiology) and the use of samples is prohibited for inpatients and outpatients.					
127	Pharmaceutical representatives are clearly instructed on the rules governing medication samples; they are required to sign an agreement to abide by the rules; and disciplinary action is taken for intentional rule violation.					

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
128A	Neuromuscular blocking agents are not available as ward or imprest stock and/or in automated dispensing cabinets (except in operating room/anaesthesia stock). **OR**					
128B	If available in critical care units and/or the emergency department, neuromuscular blocking agents are sequestered from other ward or imprest stock medicines (including those stocked in automated dispensing cabinets) and labelled with auxiliary warnings to clearly identify the medicines as respiratory paralysing agents that require mechanical ventilation when used.					
FAQ 129A	At least one pharmacist is physically present onsite 24 hours a day, 7 days a week. **OR**					
FAQ 129B	An after-hours cabinet with a restricted formulary has been established for when the pharmacy is closed, and a pharmacist is on-call for questions and to come into the hospital if needed and non-pharmacy personnel are prohibited from entering the pharmacy when it is closed. **OR**					
FAQ 129C	An- after-hours cabinet with a restricted formulary has been established for when the pharmacy is closed, but a pharmacist at a remote location is available for questions and to enter and screen medication orders before the medicines are removed from the cabinet. Exceptions: urgent lifesaving situations.					
130	A pharmacist or pharmacy technician (or where there is no pharmacist or pharmacy technician an authorised health professional) regularly inspects designated medication storage areas on patient care units to assure that: • no unapproved medicines are stocked; • minimal quantities of approved medicines are stocked, and • all stocked medicines are in-date (have not expired).					

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
131A	Vials of concentrated forms of electrolytes (e.g. potassium chloride, potassium phosphate) that require dilution before IV use are not available as unit stock (including in automated dispensing cabinets) on any patient care units (including in operating room/anaesthesia stock). **OR**					
131B	Vials of concentrated electrolytes (e.g. 23.4% sodium chloride used to decrease intracranial pressure, potassium chloride used to stop the heart in cardiac surgery) are restricted to approved patient care units, stocked in limited quantities, segregated from other medicines in secure storage areas, and accompanied by protocols for use and other safeguards (e.g. warning labels).					
132	Medicines stored in clinical areas are clearly laid out in a systematic sequence which is clearly labelled and uniformly applied throughout the hospital.					
FAQ 133	The range and quantity of medicines stored in ward or imprest stock (including automated dispensing cabinets) in each clinical area are reviewed at least annually through liaison between the pharmacy and nursing unit manager with a view to economy and safety but retention of appropriate stock levels.					
134	Items for ward or imprest stock (including automated dispensing cabinets) are supplied in minimum size original packs, or pharmacy pre-packs if small packs are not commercially available. Packs are end-labelled if storage necessitates visibility of pack end only. Tamper-proof seals and expiry dating is clearly evident.					
135	Heavy items (>10kg) are not stored above 1 metre or lower than 0.3 metre from the floor.					
136	Temperature controls are in place for all medication storage areas and limits are maintained 24 hours per day, 7 days per week. This applies to room temperature (<25 degrees), refrigerated (2-8 degrees) and frozen storage (<0 degrees). Temperature control is audited regularly. All items requiring specific temperature controls are also secured in clinical areas according to legislative requirements.					
137	Light sensitive medicines are always clearly labelled and appropriate packaging and storage conditions are made available to maintain light protection.					

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
138	Only one storage location is provided in each clinical area for each medication item. Exception: emergency trolley supplies.					
139	There is an audited policy to ensure that unit-packed oral medication dose platforms held in stock are not removed from their original containers or cut up into units prior to administration.					
140	Access of personnel to clinical medication storage areas is limited to authorised staff only, according to local legislative requirements (measures must not limit rapid entry for urgent needs). A system is in place to ensure presence of two authorised staff members when accountable medicines are accessed. There is no storage of non-medicine related items such as valuables, food, etc in medication storage areas which would create a demand for non-authorised entry. However, if space is available, medication administration equipment may be co-located.					
141	PATIENT-SPECIFIC DOSES are dispensed for at least 90% of all injectable products (including saline and heparin flushes) for adult, paediatric, and neonatal patients.					
142	All oral solid medications are dispensed to patient care units in labelled, ready-to-use UNIT DOSES.					
143	All oral liquid medications are dispensed to patient care units (including neonatal, paediatric, and critical care units) in labelled, ready-to-use PATIENT-SPECIFIC DOSES.					
144	If automated dispensing cabinets are used, override reports are routinely reviewed for those cabinets that are profiled, and a process (e.g. adjust stock, educate staff) is in place to decrease the frequency of inappropriate overrides. *Scoring Guideline: Chose NOT APPLICABLE if your organisation does not use any automated dispensing cabinets or any profiled automated dispensing cabinets.*					
		If "NOT APPLICABLE", tick here >>				N/A
145	All large-volume bags and bottles (manufacturer and pharmacy-prepared) of irrigation solutions, organ storage solution, and sterile water (e.g. for inhalation, irrigation) are packaged, stored, and labelled in a way that clearly differentiates them from solutions that may be administered parenterally.					

For FAQs, please refer to the FAQ section of this manual

5. MEDICATION STANDARDISATION, STORAGE AND DISTRIBUTION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 10

Hazardous chemicals are safely sequestered from patients and not accessible in medication preparation areas.

		A	B	C	D	E
146	Bulk chemicals in the pharmacy (for compounding) are routinely assessed and those that are not regularly used or that are considered dangerous are eliminated from stock.					
FAQ 147	Bulk chemicals used in the pharmacy (for compounding) are labelled with contents, the date the product was first opened, and the manufacturer's expiration date (if an expiration date is available from the manufacturer).					
148	Pharmacy does not store or distribute formalin.					
149	Throughout the hospital, all liquid chemicals, including cleaning compounds, are clearly labelled as to their contents.					
150	Containers of reagents used to test for faecal blood (e.g. Hemoccult, Seracult) are not present in medication storage or preparations areas, patient rooms, or patient's bathrooms.					
151	All tissue preservatives or fixatives, caustics, and other non-medicine substances used in operating rooms and other patient care areas are clearly labelled and stored separate from medications and other patient supplies.					
152	Hazardous chemicals used in the pharmacy are stored on low shelves, rather than high shelves, to prevent accidental spillage on staff during retrieval.					

For FAQs, please refer to the FAQ section of this manual

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6. MEDICATION DEVICE ACQUISITION, USE AND MONITORING

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 11

The potential for human error is mitigated through careful procurement, maintenance, use and standardisation of devices used to prepare and deliver medicines.

		A	B	C	D	E
153	At a minimum, risk management staff, pharmacists and nurses are actively involved in all MEDICATION DEVICE purchasing and replacement decisions.					
154	Error potential for all new MEDICATION DEVICES is identified through a literature search and a FAILURE MODE AND EFFECTS ANALYSIS (FMEA); and potentially harmful error potential is documented and addressed before a decision is made to purchase and use the device.					
155	All tubing for administration lines (including intravenous, central venous, arterial, epidural, enteral tubing and tubing for bladder instillations) is clearly and boldly labelled adjacent to the injection port(s) to designate the target tissue being treated and the product being administered.					
FAQ 156	With each new bag/bottle, or change in the rate of infusion, of selected HIGH RISK MEDICINES and paediatric/neonatal parenteral solutions, one PRACTITIONER prepares the solution for administration and a second PRACTITIONER independently verifies that the correct medicine, medication concentration, rate of infusion, patient, channel selection (for multiple channel pumps) and line attachment have been selected before starting the infusion.					
157	Specially designed oral syringes, which cannot be connected to IV tubing, are used for dispensing/administering oral liquid solutions.					
158	The types of general purpose infusion pumps used in the hospital are limited to two or less to maximise competence with their use.					
159	The types of syringe pumps used in the hospital are limited to two or less to maximise competency with their use. *Scoring guideline: Choose NOT APPLICABLE if you do not use syringe pumps in your hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A

6. MEDICATION DEVICE ACQUISITION, USE AND MONITORING

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
160	The types of enteral infusion pumps used in the hospital are limited to two or less (adult and paediatric/neonatal pumps) and are different from other infusion devices used in the organisation.					
161	The types of patient-controlled analgesia (PCA) pumps used in the hospital are limited to two or less to maximise competence with their use. *Scoring guideline: Choose NOT APPLICABLE if you do not offer patient-controlled analgesia in your hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A
162	All electronic infusion control devices undergo inspection and testing at least annually to ensure proper mechanical function.					
FAQ 163	All solution administration sets used with infusion pumps have integrated free-flow protection to prevent inadvertent free-flow of solutions if the IV tubing and/or the cassette are removed from the pump.					
164	Criteria have been established to determine which patient populations, specific medicines and rates of infusion require delivery of solutions via an infusion control pump.					
FAQ 165	PRACTITIONERS, including agency staff, are educated about MEDICATION DEVICES (e.g. infusion pumps, automated compounding equipment) and associated protocols/guidelines; and competency with their use is verified before they are permitted to operate a device.					
166	General infusion pumps with SMART PUMP TECHNOLOGY are in use with full functionality employed to intercept and prevent wrong dose/wrong infusion rate errors due to misprogramming the pump, miscalculation, or an inaccurately prescribed dose or infusion rate.					
167	Conduits (including administration lines, catheters and invasive monitoring lines) are labelled according to national guidance provided by the Australian Commission on Safety and Quality in Health Care regarding user-applied labelling of injectable medicines, fluids and lines. Where conduits have an injection port, labels are placed near the port on the patient side.					

6. MEDICATION DEVICE ACQUISITION, USE AND MONITORING

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
168	Burettes are labelled according to national guidance provided by the Australian Commission on Safety and Quality in Health Care regarding user-applied labelling of injectable medicines, fluids and lines. A new label is applied for each medicine administration and is removed on completion. Labels are placed so the text is upright and gradations are not obscured on the burette.					
169	An initial risk assessment has been performed to determine the various types of medical tubing, catheters, and fittings in use, to identify the possibility for misconnections, assess the potential severity of misconnections, and address process changes that need to be made, and this assessment is updated prior to the purchase of any new medical tubing, catheters, and fittings.					
170	Enteral feeding tubes have ports that only connect to oral syringes and catheter tip connectors; they do not have female Leur connectors. Exception: A Luer connector may be used for the inflation balloon that anchors some long-term use feeding devices.					
171	Only one type of epidural infusion pump is used and is different from general infusion devices used in the organisation.					
172	The administration set used for epidural infusion pumps does not contain any access ports (Y connectors), can be distinguished from all other administration sets and medical tubing (e.g. a yellow stripe running the length of the tubing), and is not used for anything other than epidural infusions.					
173	IV bolus doses of medicines are not administered via a maintenance IV solution. Exception: An IV bolus dose may be delivered via a SMART INFUSION PUMP that allows programming of both the bolus dose and continuous infusion rate with separate dose limits for each configured as "hard stops", and then automatically switches to the continuous infusion rate once the bolus dose has been delivered.					

6. MEDICATION DEVICE ACQUISITION, USE AND MONITORING

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
174	Patient-controlled analgesia and syringe infusion pumps with SMART PUMP TECHNOLOGY with full functionality employed to intercept and prevent wrong dose/wrong infusion rate errors due to misprogramming the pump, miscalculation, or an inaccurately prescribed dose or infusion rate are in use in all hospital areas (including the emergency department, paediatrics, oncology, operating room). *Scoring guideline: Choose NOT APPLICABLE if your organisation does not have patient-controlled analgesia and syringe infusion pumps.*					
		If "NOT APPLICABLE", tick here >>				N/A
175	If SMART PUMP TECHNOLOGY is used, the percent of infusions with medicines that are administered using full functionality of the safety software (i.e. medication library and dose-checking software) is monitored, and the findings are used to increase compliance. *Scoring guideline: Choose NOT APPLICABLE if your organisation does not have SMART PUMP TECHNOLOGY.*					
		If "NOT APPLICABLE", tick here >>				N/A
176	If SMART PUMP TECHNOLOGY is used, an interdisciplinary team, which includes pharmacists, nurses, and prescriber representatives, reviews data for soft and hard doses, and volume limits that have been bypassed, and the findings are used to take action to reduce the number of bypassed clinically significant warnings to modify dosing limits when necessary. *Scoring guideline: Choose NOT APPLICABLE if your organisation does not have SMART PUMP TECHNOLOGY.*					
		If "NOT APPLICABLE", tick here >>				N/A
177	If SMART PUMP TECHNOLOGY is used, an interdisciplinary team, which includes pharmacists, nurses, and prescriber representatives, develops and tests the medication library, and reviews and updates the library at least quarterly. *Scoring guideline: Choose NOT APPLICABLE if your organisation does not have SMART PUMP TECHNOLOGY.*					
		If "NOT APPLICABLE", tick here >>				N/A
178	If SMART PUMP TECHNOLOGY is used, the medication library is updated via wireless technology. *Scoring guideline: Choose NOT APPLICABLE if your organisation does not have SMART PUMP TECHNOLOGY.*					
		If "NOT APPLICABLE", tick here >>				N/A

For FAQs, please refer to the FAQ section of this manual

7. ENVIRONMENTAL FACTORS, WORKFLOW AND STAFFING PATTERNS

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 12

Medicines are prescribed, transcribed, prepared, dispensed and administered within an efficient and safe workflow and in a physical environment that offers adequate space and lighting and allows PRACTITIONERS to remain focused on medication use without distractions.

		A	B	C	D	E
179	Lighting is adequate to clearly read labels and other important medication information in pharmacies, patient unit medication rooms, and at automated dispensing cabinets.					
180	Workspaces where medications are prepared are orderly and free of clutter.					
181	Pharmacies and patient unit medication rooms (or areas) have adequate space for storage of medicines, IV solutions, and medication supplies.					
FAQ 182	Medication preparation areas in the pharmacy and on patient care units are isolated and relatively free of distractions, interruptions, and noise.					
FAQ 183	Areas where medication orders are transcribed and/or entered into CLINICAL INFORMATION SYSTEMS are isolated and relatively free of distractions, interruptions and noise.					
184	Medication refrigerators in patient care areas are of sufficient size to allow admixtures that require refrigeration to be stored in an organised manner.					
FAQ 185	Nurses select medications for administration in medication rooms, at automated dispensing cabinets, or in other areas that are isolated and relatively free of distractions, interruptions and noise.					
186	Nurses and medical staff (including anaesthetists) prepare and/or select one patient's medicine at a time, immediately before administering the medicine.					
187	When new construction or renovation of an existing area where medicines will be prescribed, dispensed, stored, or administered is planned, an interdisciplinary group of practicing staff involved in medication use is included in the decision-making process of the design of the area. *Scoring guideline: Choose NOT APPLICABLE if your organisation has not built new space or renovated within the past 3 years*					
		If "NOT APPLICABLE", tick here >>				N/A

7. ENVIRONMENTAL FACTORS, WORKFLOW AND STAFFING PATTERNS

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
188	All phone calls to the pharmacy are triaged and forwarded to medication preparation and order entry areas only when necessary.					

For FAQs, please refer to the FAQ section of this manual

7. ENVIRONMENTAL FACTORS, WORKFLOW AND STAFFING PATTERNS

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 13

The complement of qualified, well-rested PRACTITIONERS matches the clinical workload without compromising patient safety.

		A	B	C	D	E
FAQ 189	PRACTITIONERS involved in medication use (including medical students) work no more than 10 consecutive hours. Exception: Isolated emergency situations outside of usual operations.					
FAQ 190	PRACTITIONERS involved in the medication process have at least 10 hours of rest between shifts worked. Exception: Isolated emergency situations outside of usual operations.					
FAQ 191	Schedules and workload permit PRACTITIONERS involved in the medication process to take at least one 15-minute break and one 30-minute break (for a meal) per 8 hours of work each day. Exception: Isolated emergency situations outside of usual operations.					
192	An effective back-up plan has been established for days when staffing is short due to illness, vacation, educational absences, and fluctuations in patient acuity and workload.					
FAQ 193	Pharmacists believe that staffing patterns in their department are adequate to provide safe pharmaceutical care on most days.					
FAQ 194	Nurses believe that staffing patterns on their units are adequate to provide safe patient care on most days.					
FAQ 195	The use of nursing and pharmacy agency staff is minimised. Exception: Long-term agency staff (e.g. travelling nurses) who have been fully oriented to the hospital and medication use processes before working independently.					
196	Hospital or health-system plans for new and/or expanded clinical programs are well communicated to all affected PRACTITIONERS and appropriate consideration of resources is addressed prior to implementation so that the additional work volume will be met without compromising patient safety.					

7. ENVIRONMENTAL FACTORS, WORKFLOW AND STAFFING PATTERNS

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
197	The pharmacy department has an adequate complement of trained and dedicated personnel to meet the medication-related technology requirements (e.g. PRESCRIBER ORDER ENTRY SYSTEMS, automated dispensing cabinets, SMART INFUSION PUMPS, robotics, automated compounders, and point-of-care bar-coding technology) of the department and organisation.					
198	The organisation has an adequate complement of well-qualified and trained pharmacists to work in specialty areas or provide services to specialty populations (e.g. critical care, paediatric, neonatal, and oncology patients) that represents a substantial portion of the organisation's patient population.					

For FAQs, please refer to the FAQ section of this manual

8. STAFF COMPETENCY AND EDUCATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 14

PRACTITIONERS receive sufficient orientation to medication use and undergo baseline and annual competency evaluation of knowledge and skills related to safe medication practices.

		A	B	C	D	E
199	During orientation and on a routine basis, PRACTITIONERS receive information about the hospital's actual error experiences as well as published errors that have occurred in other facilities; and they are educated about system-based strategies to reduce the risk of such errors					
200	During orientation, pharmacists spend time in patient care units to become familiar with medication prescribing practices, ward or imprest stock storage conditions, administration procedures and patient education processes.					
201	Pharmacists actively participate in the orientation process for all new medical students and medical staff (including attending medical staff).					
202	All prescribers, pharmacists, and nurses who work in specialty areas (e.g. critical care, paediatrics, and oncology) undergo extensive training and/or obtain certification if available in that specialty before working independently.					
203	Nurses and pharmacists are not pulled from their typically assigned work areas to help in other areas without thorough orientation and ongoing training to maintain their skills and knowledge. Exception: Isolated emergency situations outside of usual operations.					
204	Those who train new staff have a reduced workload to accomplish the goals of orientation safely and thoroughly.					
205	The length of time for orientating new nurses and pharmacists is individualised and based on an ongoing assessment of their needs.					
FAQ 206	During orientation, prescribers, pharmacists and nurses receive training in medication safety principles and are assessed for competency in safe medication practices (including documentation, dose calculation and checking procedures).					

8. STAFF COMPETENCY AND EDUCATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
207	The hospital information technology department includes personnel with specialty training in clinical informatics (not just general computing support for hardware and software) who are knowledgeable about applications in medication systems, and who are readily available for assistance in the development, application and troubleshooting of these systems.					
208	A defined time period for orientation and training of agency staff is required before they can work independently.					
209	The hospital only allows PRACTITIONERS who are trained in the use of medicines causing DEEP SEDATION, qualified to rescue patients from general anaesthesia or severe respiratory depression, and not simultaneously involved in a procedure, to administer medications which could lead to DEEP SEDATION (e.g. propofol, ketamine, etomidate) of non-ventilated patients. (Advanced cardiac life support certification alone is not sufficient).					
210	A registered nurse, midwife or medical officer accompanies patients to radiology or other diagnostic departments if they have a hospital-defined HIGH RISK MEDICINE infusing intravenously or by the epidural route of administration, and a defined hand over process, including verbal communication and verification of the infusing HIGH RISK MEDICINE, occurs between the accompanying PRACTITIONER and the qualified receiving staff member.					
211	The organisation provides formal teamwork training (e.g. TeamSTEPPS) to all staff that incorporates elements of information sharing, conflict resolution, communication and teamwork skills, and clarification of team roles and responsibilities.					

For FAQs, please refer to the FAQ section of this manual

8. STAFF COMPETENCY AND EDUCATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 15

PRACTITIONERS involved in medication use are provided with ongoing education about medication error prevention and the safe use of medicines that have the greatest potential to cause harm if misused.

		A	B	C	D	E
212	PRACTITIONERS are educated about new medicines added to the formulary and associated protocols/guidelines and restrictions before the medicines are used in the hospital.					
213	Pharmacists routinely provide nurses with important information about non-formulary medicines before dispensing the products to patient care areas for administration.					
214	PRACTITIONERS receive ongoing information about medication errors occurring within the organisation, error-prone conditions, errors occurring in other healthcare facilities, and strategies to prevent such errors.					
215	PRACTITIONERS are provided with the necessary support and time to attend internal and external education programs related to medication use.					
216	PRACTITIONERS are trained in the clinical and administrative procedures for responding to a serious medication error.					
217	When errors occur, educational efforts are widespread among all PRACTITIONERS who may make a similar error, rather than remedial and directed at only those PRACTITIONERS who were involved in an error.					
218	Nurses, pharmacists and prescribers are provided with education programs on important medication safety issues at least 4 times a year.					
219	Simulations of error-prone conditions (e.g. problematic medication packages and labels, mock transcription/order entry of problematic orders) and/or role-playing (e.g. to teach effective communication skills, inquiry skills, conflict resolution) are used as methodologies to orientate and educate PRACTITIONERS and other staff about medication/patient safety.					
220	HUMAN FACTORS and the principles of error reduction (e.g. standardisation, use of constraints, and redundancy for critical functions) are introduced during PRACTITIONER orientation, and used as the foundation for an annual mandatory educational program for all PRACTITIONERS involved in the medication use process.					

8. STAFF COMPETENCY AND EDUCATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
221	Facilities that serve as clinical sites for medical, pharmacy, nursing, and other professional students, meet with students prior to each rotation and/or supervisors at the beginning of each rotation period to review key medication-related procedures, specific error-prone conditions that may exist during the rotation, and the organisation's list of HIGH RISK medicines and associated error-reduction strategies. *Scoring guidelines: Choose NOT APPLICABLE, if your organisation does not serve as a clinical site for healthcare professionals.*					
		If "NOT APPLICABLE", tick here >>				N/A
222	Senior leaders, management, and frontline staff receive formal training in identifying risk within the system and incorporating high-leverage error-reduction strategies to help eliminate the risk.					

For FAQs, please refer to the FAQ section of this manual

9. PATIENT EDUCATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

SELF ASSESSMENT ITEMS

Core Characteristic 16

Patients and/or their parents/carers are included as active partners in their care through education about their medicines and ways to avert errors.

		A	B	C	D	E
223	Patients are educated routinely upon admission to assist healthcare professionals with proper identification by showing staff their identification bracelet (or other form of identification) and stating their names clearly before medications (and other treatments) are administered.					
224	Patients and/or carers are provided with up-to-date, written information about medicines that are prescribed at discharge. Where possible this should be in the form of a Consumer Medicines Information leaflet. Where Consumer Medicines Information isn't appropriate for a particular patient/condition patients and/or carers are provided with locally developed material or referred to high quality online resources (e.g. the NPS Medicine Wise website).					
225	Prescribers routinely educate patients and/ or carers about recommended medication therapy before the patient receives an initial dose.					
226	During each medication administration, nurses routinely provide patients and/or families with information about the brand and generic name of the medicine, the general purpose of the medicine, the prescribed dose and during initial drug administration, nurses also provide information on important side effects.					
227	Patients and/or their carers are encouraged to ask questions about the medications they are receiving.					
228	PRACTITIONERS fully investigate and resolve all patient/family concerns or questions about a medication prior to prescribing, dispensing and/or administering it.					
229	Criteria have been established (e.g. selected HIGH RISK MEDICINES, high risk patient populations, or patients discharged on five or more medications) to trigger an automatic consultation with a pharmacist for patient education.					

9. PATIENT EDUCATION

A. No activity to implement
B. Considered, but not implemented
C. Partially implemented in some or all areas
D. Fully implemented in some areas
E. Fully implemented throughout

Continued

		A	B	C	D	E
230	Pharmacists or prescribers design medication administration schedules that consider the patient's lifestyle and minimise the number of times per day that medications must be taken for patients at high risk for non-adherence with medicines prescribed at discharge.					
231	Patients are informed about the potential for error with medicines that have been known to be problematic (e.g. methotrexate prescribed weekly for arthritis, frequently changing warfarin doses) and are provided with strategies to help prevent such an occurrence after discharge.					
232	Patients are instructed on when and whom to call for concerns or questions about their medication therapy after discharge.					
233A	Written materials for patients about HIGH RISK MEDICINES prescribed at discharge are available in the primary languages spoken in the nearby community.					
	OR					
233B	An appropriately trained translator is available before the patient is discharged to write down important information about HIGH RISK MEDICINES for patients for whom written materials are not available in their primary language.					
234	Parents and carers of young children and other patients are shown how to accurately measure and administer medicines to recipients in their care. Where required, an accurate measuring device is supplied on discharge.					
235	In hospitals with a rapid-response team, patients/family members are encouraged to summon the team to the bedside for a full evaluation when they fear that something is seriously wrong with the patient and have expressed their concerns without an adequate response. *Scoring guideline: Choose NOT APPLICABLE if your hospital does not have a rapid-response team.*					
		If "NOT APPLICABLE", tick here >>				N/A
236	Patients are educated about the importance of keeping an up-to-date list of all medicines they take at home, to carry the list with them at all times, and to show the list to healthcare PRACTITIONERS during each medical encounter.					

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10. QUALITY PROCESSES AND RISK MANAGEMENT

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SELF ASSESSMENT ITEMS

Core Characteristic 17

A safety-supportive JUST CULTURE and model of shared accountability for safe SYSTEM DESIGN and safe clinical practices is in place and supported by management, senior administration, and the Governing Body.

		A	B	C	D	E
237	Error prevention strategies focus on system enhancements, not individual PRACTITIONERS.					
238	PRACTITIONERS and other staff report and openly discuss errors without embarrassment or fear of reprisal from the hospital/organisation. *Scoring guideline: If possible, choose score based on staff surveys as noted in item 244.*					
239	All known medication errors that reach the patient, regardless of the level of harm that results, are honestly disclosed to patients/families in a timely manner.					
240	Disciplinary action is not taken in the post-incident process against PRACTITIONERS who have made an error, other than in the case of the following: • Malicious or illegal behaviour • Medication diversion or medication misappropriation • Professional negligence or incompetence • Intentional breach of confidentiality/privacy.					
241	PRACTITIONERS do not accumulate demerits or points for making a medication error; and data related to medication errors are not used as a measure of employee competence or vigilance during performance evaluations.					
FAQ 242	Error rates are not determined or calculated from PRACTITIONER error reports and are not used for internal (unit- to-unit) and/or external (hospital-to-hospital) comparison.					
243	Hospital administration and management encourage an environment where incident notification is fostered.					
244	PRACTITIONERS are periodically and anonymously surveyed to determine their level of anxiety and fear with making and reporting errors.					

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		A	B	C	D	E
245	PRACTITIONERS and other staff involved in serious errors that cause patient harm are emotionally supported by leadership and their colleagues and provided with ongoing support through an employee assistance program or other crisis intervention strategies.					
FAQ 246	The Governing Body actively demonstrates its commitment to patient safety (and safe medication practices) by approving a safety plan, rewarding PRACTITIONER error reporting, and approving system enhancements, including technology, that are likely to reduce errors.					
FAQ 247	Specific medication safety objectives (e.g. reduce the risk of errors with HIGH RISK MEDICINES; improve medication error detection, reporting, and use of the information) are included in the hospital's strategic plans, directly communicated to all staff, and celebrated (acknowledged in a positive manner) when met.					
FAQ 248	One or more trained PRACTITIONERS have time dedicated specifically to enhance detection of medication errors, oversee analysis of their causes, and coordinate an effective error reduction plan.					
249	Patient safety is articulated in the organisation's mission and/or vision statements.					
250	Senior leaders (administrative staff, board members when possible) participate in frequent, structured visits (e.g. WALKROUNDS™) to patient care units, the pharmacy, and laboratories to talk to front-line staff about safety and quality issues, learn first-hand about day-to-day challenges that staff face when providing care and services, and show their support for staff-reported errors.					
251	Mid-level managers receive formal training on ways to effectively evaluate PRACTITIONER competency and performance, supervise and mentor PRACTITIONER's clinical skills, COACH AT-RISK BEHAVIOURS and handle difficult PRACTITIONER behaviour without allowing the presence or absence of medical errors to be a factor.					
252	Hospital leaders and managers have received formal education on establishing and/or maintaining a fair and just safety culture (e.g. JUST CULTURE).					

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		A	B	C	D	E
253	The organisation anticipates AT-RISK BEHAVIOURS and proactively takes steps to encourage safe BEHAVIOURAL CHOICES and discourage AT-RISK BEHAVIOURS.					
254	Hospital leaders and managers COACH staff who engage in AT-RISK BEHAVIOURS involving patient safety to assist them in making safer BEHAVIOURAL CHOICES in the future.					
255	Organisational actions toward staff involved in HUMAN ERRORS, AT-RISK BEHAVIOURS, or RECKLESS BEHAVIOURS are consistent, irrespective of the severity of harm that occurs (including no harm).					
256	Hospital staff (including administrative staff) job descriptions and performance evaluations, hospital position statements, and medical staff bylaws include specific accountability standards related to patient/medication safety (e.g. accountability for BEHAVIOURAL CHOICES in response to the risks they see; willingness to speak up about safety issues and ask for help when needed; ability to work well within teams; to follow the safety literature) that do not include the absence of errors or a numeric error threshold; and these standards are supported by the senior leaders and human resources staff.					
257	Units with a strong incident reporting culture are recognised and acknowledged.					
258	There is a visible commitment to patient safety within the organisation that is evident in the behaviours of hospital leaders and managers.					
259	Clinical leaders who exhibit patient safety behaviours serve as models throughout the organisation at the patient care, department, and administrative levels to encourage peer-to-peer role modelling and mentorship of patient safety behaviours.					

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SELF ASSESSMENT ITEMS

Core Characteristic 18

PRACTITIONERS are stimulated to detect and report adverse events, errors (including NEAR MISSES), hazards, and observed at-risk clinical practices, and interdisciplinary teams regularly analyse these reports as well as reports of errors that have occurred in other organizations to mitigate future risks.

		A	B	C	D	E
260	A clear definition and examples of medication errors and hazardous situations that should be reported have been established and disseminated to PRACTITIONERS.					
261	Reportable events include both hazardous situations that could lead to an error and actual errors including those that have been detected and corrected before they reach a patient.					
262	There is a process to facilitate periodic, "off the record" discussions with front-line PRACTITIONERS to learn about perceived problems with the medication use system.					
263	A convened multidisciplinary team, which includes at a minimum, risk management/quality improvement professionals, pharmacists, nurses, prescribers, clinical information technology staff and hospital leadership, reviews medication error reports and other medication safety data to identify the system-based causes of error and facilitate implementation of system enhancements that make it difficult or impossible for PRACTITIONERS to err.					
264	PRACTITIONERS who are directly involved in a serious medication error are interviewed as part of the ROOT CAUSE ANALYSIS process, and encouraged to provide input into the development of system enhancements to reduce the potential for future errors.					
FAQ 265	"NEAR MISSES" and hazardous situations that have the potential to cause patient harm (but score low on a patient outcome severity scale) are given the same high priority for analysis and error prevention strategies as errors that actually cause patient harm.					
FAQ 266	A convened multidisciplinary team routinely analyses and uses published error experiences from other organisations to assess the vulnerability to similar errors and proactively target improvements in the medication use process.					

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		A	B	C	D	E
267	In addition to incident reporting systems, other strategies are used to enhance detection of potential medication errors, adverse events, and system issues, such strategies include the use of computer markers or triggers for selected medicine orders (such as antidotes), or laboratory test results that may indicate the presence of adverse drug events (such as INR > 5).					
268	Drug selection, preparation, and labelling errors identified during routine checking processes are reported and collected for the purpose of identifying SYSTEM DESIGN issues and developing error prevention strategies.					
269	Prescribing errors that are detected by pharmacists and nurses are recorded, analysed, and used in conjunction with medical staff quality improvement activities for system redesign (e.g. establishing medicine/dosing protocols, standardised ordering, pharmacy dose consultation, prescriber awareness, and education).					
270	Prescribers, pharmacists, and nurses are provided with regular feedback about reported errors, hazardous situations and error reduction strategies that are being implemented.					
271	A convened multidisciplinary team routinely evaluates the literature for new technologies and successful evidence-based practices that have been effective in reducing error in other organisations to determine if it can improve its own medication management system.					
272	Patient representatives from the community are invited to participate in patient safety committees or informal ad-hoc meetings to solicit regular input on medication safety issues and expand the community's awareness of the culture of safety in the organisation.					
FAQ 273	The effectiveness of risk reduction strategies are measured using a variety of means such as observational studies, chart review, and trigger tools to help demonstrate improvements. Incident reporting rates are not used for this purpose.					

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		A	B	C	D	E
274	Hospital management has strategies in place to allow for all staff regardless of position or rank to be able to raise concerns related to medication safety without fear of intimidation.					
275	During event investigation (e.g. ROOT CAUSE ANALYSIS), once risks have been identified, the focus of the initial analysis of the event is widened to analyse the same or similar risks throughout the organisation and among other care processes, and interventions extend beyond addressing the immediate risks involved in the event.					
276	When an event involves staff who cut corners, breached a policy, and/or did not follow a procedure, the conditions that led to these AT-RISK BEHAVIOURS are investigated to uncover system-based incentives that encourage the behaviour and/or system-based disincentives that discourage safe behaviours.					
277	When an event involves HUMAN ERRORS, an investigation is undertaken to uncover any pre-existing performance shaping factors (e.g. task complexity, workflow, time availability/urgency, experience, training, fatigue, stress) and other environmental conditions, SYSTEM DESIGN attributes, BEHAVIOURAL CHOICES, or equipment design flaws that allowed the error to happen and reach the patient.					
278	Work systems and processes are designed or redesigned to reduce safety risks in response to reported hazards, CLOSE CALLS, or errors that reach the patient but do not cause harm, without waiting for a significant event or patient harm.					

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SELF ASSESSMENT ITEMS

Core Characteristic 19

Redundancies that support a system of INDEPENDENT DOUBLE CHECKS or an automated verification process are used for vulnerable parts of the medication system to detect and correct serious errors before they reach patients.

		A	B	C	D	E
FAQ 279	Prescribers include the mg/kg per dose or mg/m^2 per dose for paediatric patients along with the PATIENT-SPECIFIC DOSE for medicines that have a published paediatric mg/kg dosing guideline. *Scoring guideline: Choose NOT APPLICABLE if care is not provided to paediatric patients, even in the emergency department.*					
		If "NOT APPLICABLE", tick here >>				N/A
280	Prescribing parameters for paediatric patients are periodically reviewed (on at least a weekly basis) for prolonged hospital admissions, as current weight/ Body Surface Area may differ from admission measurements. *Scoring guideline: Choose NOT APPLICABLE if care is not provided to paediatric patients, even in the emergency department.*					
		If "NOT APPLICABLE", tick here >>				N/A
281	Prescribers include the mg/m^2 dose or area under the curve dose or mg/kg dose with all chemotherapy medication orders. Parameters are periodically reviewed (on at least a weekly basis) for prolonged hospital admissions, as current weight/Body Surface Area may differ from admission measurements. *Scoring guideline: Choose NOT APPLICABLE if chemotherapy is never prescribed in the hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A
282	If an mg/kg dose is listed in a medication order for a paediatric patient, a pharmacist verifies that it is correct and documents (e.g. with initials or electronically) a double check of the prescriber's calculated dose (or it is performed electronically) before preparing and dispensing the medicine. *Scoring guideline: Choose NOT APPLICABLE if care is not provided to paediatric patients, even in the emergency department.*					
		If "NOT APPLICABLE", tick here >>				N/A
283	A pharmacist verifies that the mg/m^2 dose, or area under the curve dose, listed with a chemotherapy order is correct, and conducts and documents (e.g. with initials or electronically) a double check of the prescriber's calculated dose (or it is performed electronically) before preparing and dispensing the medicine. *Scoring guideline: Choose NOT APPLICABLE if chemotherapy is never prescribed in the hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A

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Continued

		A	B	C	D	E
284	Nurses document (e.g. with initials or electronically) an INDEPENDENT DOUBLE CHECK of the prescriber's calculated dose for paediatric medication orders before administering the medicine. *Scoring guideline: Choose NOT APPLICABLE if care is not provided to paediatric patients, even in the emergency department.*					
		If "NOT APPLICABLE", tick here >>				N/A
285	Nurses document (e.g. with initials or electronically) an INDEPENDENT DOUBLE CHECK of the prescriber's calculated dose for chemotherapy before administering the medicine. *Scoring guideline: Choose NOT APPLICABLE if chemotherapy is never prescribed in the hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A
286	The base solution and all additives (including the drug, dose, volume drawn into each syringe, diluents, actual drug containers) for paediatric/neonatal parenteral admixtures are INDEPENDENTLY DOUBLE CHECKED by a pharmacist or a nurse (even if initially prepared by a pharmacist) and documented (e.g. with initials or electronically) before they are added to the final product. *Scoring guideline: Choose NOT APPLICABLE if care is not provided to paediatric patients, including in the emergency department.*					
		If "NOT APPLICABLE", tick here >>				N/A
287	The base solution and all additives (including the drug, dose, volume drawn into each syringe, diluents, actual drug containers) for chemotherapy admixtures or compounded oral solutions are INDEPENDENTLY DOUBLE CHECKED by a pharmacist or a nurse (even if initially prepared by a pharmacist) and documented (e.g. with initials or electronically) before they are added to the final product. *Scoring guideline: Choose NOT APPLICABLE if chemotherapy is never prescribed.*					
		If "NOT APPLICABLE", tick here >>				N/A
288	Medication orders are checked by a pharmacist and dispensing is checked and documented (e.g. with initials or electronically) by at least a pharmacist and one other person before being released from the pharmacy.					
289	Selected HIGH RISK MEDICINES (as defined by the hospital) that are selected for use from ward or imprest stock are INDEPENDENTLY DOUBLE CHECKED by another PRACTITIONER and documented before administration.					

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		A	B	C	D	E
290A	Some form of end product testing (e.g. refractometer, weighing, laboratory confirmation) of complex intravenous admixtures (e.g. Total Parenteral Nutrition, cardioplegic solutions) is used to check the contents before the pharmacy releases the solution. **OR**					
290B	All complex solutions are outsourced to a company that provides documentation of end product testing.					
291	MACHINE-READABLE CODING (e.g. bar coding) is used to verify medication selection prior to dispensing medicines (includes robotic dispensing).					
292A	**In hospitals <u>WITH</u> automated compounders:** MACHINE-READABLE CODING (e.g. bar coding) is used to verify all base solutions and additives attached to automated IV admixture compounders. **OR**					
292B	**In hospitals <u>WITHOUT</u> automated compounders <u>OR WITHOUT</u> MACHINE-READABLE CODING for automated compounders:** At least a pharmacist and one other person verify and document all base solutions and additives used in compounding all Total Parenteral Nutrition and/or cardioplegic solutions. *Scoring guideline: Choose NOT APPLICABLE if neither Total Parenteral Nutrition nor cardioplegic solutions are compounded in your hospital.*					
		If "NOT APPLICABLE", tick here >>				N/A
293	MACHINE-READABLE CODING (e.g. bar coding) is used at the point of care to verify medication selection prior to administering medicines					
294A	**In hospitals <u>WITHOUT</u> PRESCRIBER ORDER ENTRY SYSTEMS**: Medicines are dispensed directly from the medication chart or prescription <u>together with</u> the computer-generated medication label and the pharmacist compares the label with the original order copy before medicines are dispensed. **OR**					
294B	**In hospitals <u>WITH</u> PRESCRIBER ORDER ENTRY SYSTEMS**: A pharmacist reviews the order in the computer before generating a label from which the medication order is filled.					

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		A	B	C	D	E
295	If bar-coding at the point-of-care is used for medication administration, an interdisciplinary team reviews metrics from the system, including the percent of medicines with a readable barcode, scanning compliance rates, and bypassed or acknowledged alerts, and any barriers associated with using the technology are addressed to maximise the safe use of the system. *Scoring guideline: Choose NOT APPLICABLE if your organisation does not use bar-coding at the point-of-care for medication administration.*					
		If "NOT APPLICABLE", tick here >>				N/A
296	The organisation has an effective, interdisciplinary rapid-response team so that any healthcare worker can summon the team to a patient's bedside for a full evaluation when established rapid-response team activation criteria have been met and/or he or she fears that something is seriously wrong with the patient.					
FAQ 297	Medication orders entered into the pharmacy system are INDEPENDENTLY DOUBLE CHECKED for transcription accuracy before the medication is administered. *Scoring guideline: Choose NOT APPLICABLE if no transcription is required because all orders are entered by prescribers into a PRESCRIBER ORDER ENTRY SYSTEM that is fully integrated or INTERFACED with the pharmacy system.*					
		If "NOT APPLICABLE", tick here >>				N/A

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SELF ASSESSMENT ITEMS

Core Characteristic 20

Proven infection control practices are followed when storing, preparing and administering medications.

		A	B	C	D	E
298	Pharmacy staff prepares IV admixtures in an appropriate class of clean room in compliance with Australian Standards and utilising aseptic techniques. *Scoring guideline: Select NOT APPLICABLE if your pharmacy does not prepare any IV admixtures.*					
		If "NOT APPLICABLE", tick here >>				N/A
299	Staff members use appropriate hand hygiene procedures and standardised aseptic techniques prior to preparing any injectable product (e.g.IM, IV bolus, IV admixture).					
300	In patient care areas, multiple-dose vials are not used. Exception: Insulin penfills/vials, provided they are reserved for use in a single patient and labelled accordingly.					
301	Containers of eye drops are not used for more than one patient.					
302	A single syringe is never used for multiple patients, even if the needle is changed between patients.					

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