Reinvigorating the Medication Safety Conversation: Connecting Local Area Leaders with Local Safety and Quality Data

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Background

The National Safety and Quality Health Service Standards for Clinical Governance and Medication Safety[1] require organisations to identify safety and quality measures. Once identified, medication management performance and outcome measures need to be monitored and reported.

We identified that our pharmacy department had unique access and expertise to obtain and analyse medication safety and quality metrics at a local level, particularly since electronic medical record (EMR) implementation in 2020.

Objective

To share local-level medication safety and quality measures by organisational service, clinical unit or ward area to improve transparency of data and promote local improvement activities.

Methods

A suite of medication safety and quality measures were collated by the medication safety pharmacists (see Figure 1). Where needed, Excel databases were established to filter, analyse and present data. A standardised PowerPoint template was also developed (see example slide in Figure 2).

Support was obtained from general managers and medical/nursing directors from each service, along with the quality department, to present the measures on a quarterly basis during existing service-level quality meetings. A senior pharmacist from each service area presented the local data and commentary on trends.

Medication Safety & Quality Measures:

Barcode Scanning for Medication Administration

- Ward-based data from EMR
- % of medications scanned by nursing staff during administration (target 85%)

Medication Reconciliation Rates

- Clinical unit-based data from EMR
- % of patients with medication reconciliation completed by a pharmacist within the episode of care (target 80%)

Venous Thromboembolism (VTE) Risk Assessment

- Clinical unit-based data from EMR
- % of patients admitted for >24 hours who are assessed for VTE risk within 24 hours (target 85%)

Medication Incident Trends

- Ward-based data from the incident reporting system (analysed in Excel)
- Number of reported incidents related to medications/fluids with breakdown by local area, incident severity rating and process type (e.g. prescribing, administration, storage)
- Trends for high risk medicines
- Top 10 medicines involved

Figure 1: Medication safety and quality measures presented

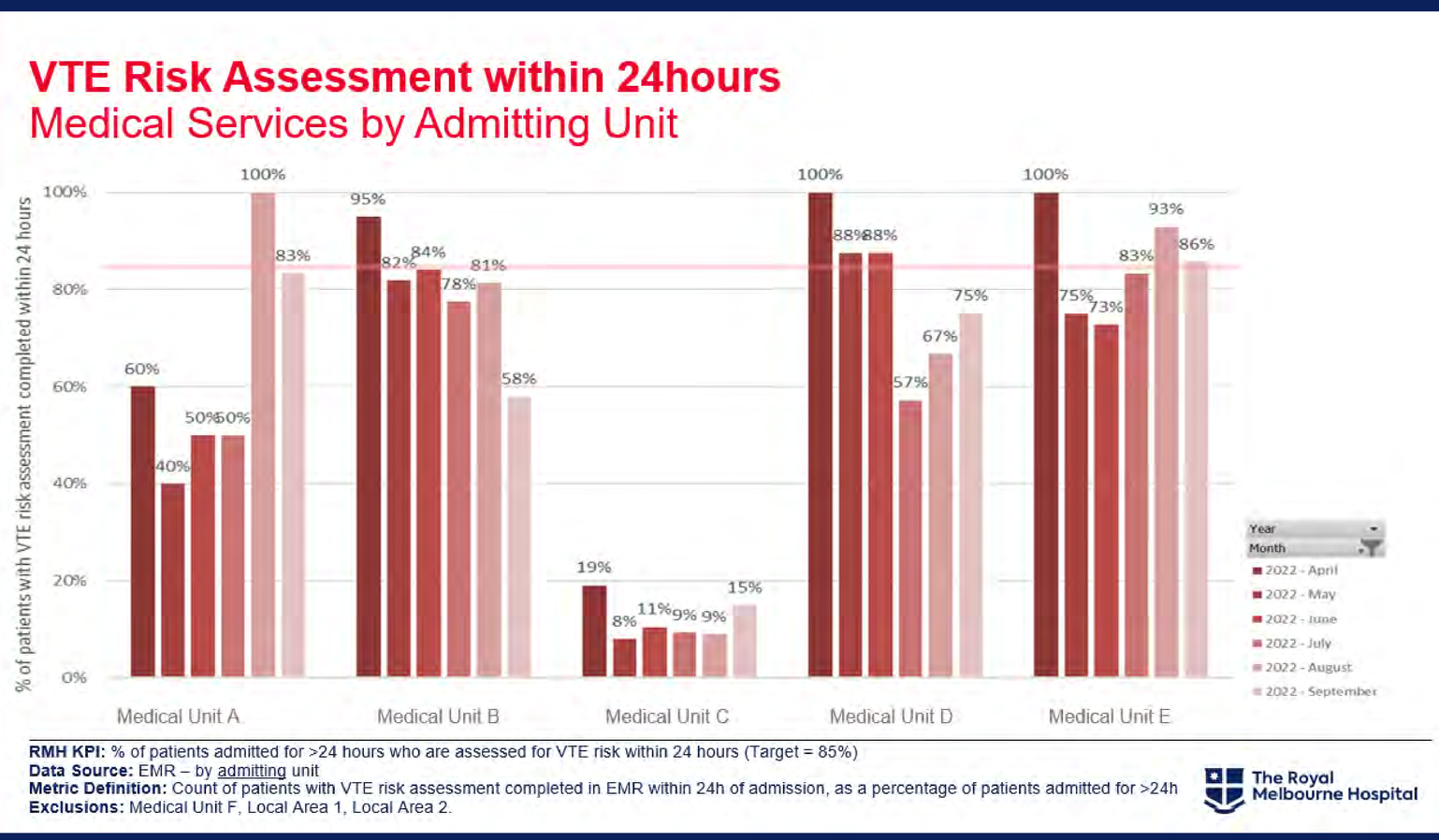

Figure 2: De-identified example of a slide including trended data,, data source, definitions and exclusions

Evaluation

The service-level quality meetings were well attended by the relevant heads of units, nurse unit managers, general managers, medical/nursing service directors and quality consultants.

The information presented was very well-received, particularly the local commentary explaining reasons behind the trends and actions to improve (see example in Figure 3). Attendees had high levels of engagement with the data, with questions and discussion regarding:

- Definitions e.g. if local medication incident data should have a bed-day denominator to account for hospital activity levels.
- Exclusions e.g. VTE risk assessment for hospital in the home patients.
- Targets e.g. rationale for 80% medication reconciliation rates.
- How to access own local data e.g. medication barcode scanning data for individual nurses.

Discussion

Local leaders' high level of engagement in medication safety and quality measures was reflective of their interest in data that had not previously been reported at a service, unit or ward level, along with the informative commentary. This commentary provided the local context to interpret the trends observed (e.g. staffing, workflow differences), and prompted discussions on the impact of existing improvement activities and the identification of areas or workflows requiring improvement.

Presentation of local medication safety and quality measures to service quality meetings has improved transparency of data and promoted local improvement activities. This pharmacy-led reporting process is an effective and sustainable strategy to monitor the effectiveness and performance of medication management within our organisation.

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References

1. Australian Commission on Safety and Quality in Healthcare. National Safety and Quality Health Service Standards - Second edition. May 2021.

- *"Congratulations to Medical Units A, D & E for significant improvement over recent months*
- *Discussions are occurring regarding requirement for Medical Unit C to complete VTE risk assessment*
- *Medical Unit B lower rate in September likely due short staffing affecting admission workflows*
- *Data reviewed monthly by the RMH Anticoagulation Stewardship Committee. They have sent a reminder to all heads of units."*

Figure 3: Example of commentary provided