

WA Paediatric Inpatient Medication Chart & Paediatric Long-Stay Medication Chart

Introduction and Rationale

Safer prescribing, dispensing and administration of medicines to minimise patient harm





Objectives

The objectives of this session is to provide you with an understanding of:

- why a standardised chart is needed;
- the benefits of a standardised chart;
- the main features of the chart.



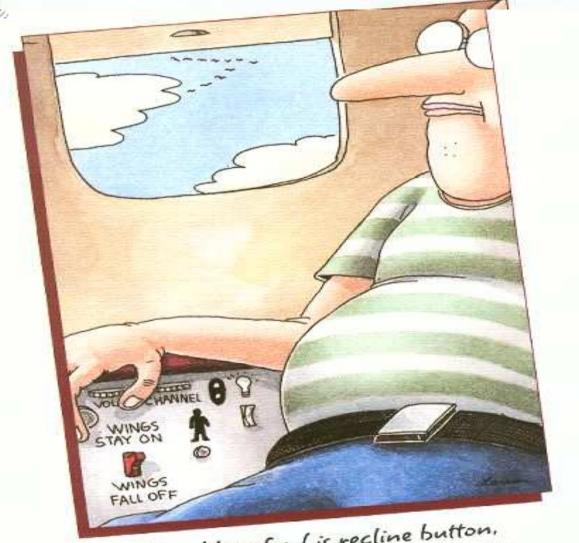
Principles

We all make errors

"all human beings without exception whatsoever, make errors..... And such errors are a completely normal part of human cognitive function"

Allnutt M.F. Human factors in accidents. Br J Anaesth. Jul 59(7):856-64, 1987.





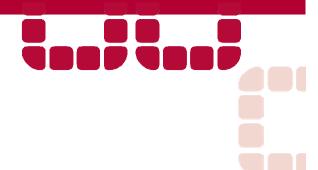


Fumbling for his recline button.

Ted unwittingly instigates a disaster.



Government of **Western Australia** Department of **Health**



Fact:

We are making a significant number of errors when prescribing, dispensing, documenting and administering drugs

The Washington Post

Donald M. Berwick

Invisible Injuries

We need a better system for tracking and preventing medical errors.

The Institute of Medicine, our nation's most respected adviser on medical science, says that at least 100 patients will die in hospitals in the United States today because of injuries from their care, not from their diseases.

How many will die tomorrow?

Tom Nolan, one of the leading quality-improvement scholars of our time, identifies three essential preconditions for improvement of anything: will, ideas and execution. When it comes to reducing medical errors. America's will and ideas are increasing steadily now, following the Institute of Medicine's lead.

And yet, so far I see no evidence that healt care in the United States is becoming safer. T ingredient we seem to be missing most is the third one on Nolan's list: execution. Who will change the care? And when? At least four major roadblocks appear to lie between will and ideas, on the one hand, and execution, on the other,

First, in local hospital settings, our health care workforce largely remains blind to the enemypatient injury. People who work in hospitals and clinics cannot easily see, day by day, the errors and injuries that large-scale research studies have

A simple calculation shows why: If 100 patients die from injuries in U.S hospitals each day and there are 5,000 hospitals, that is very roughly one death per hospital every two months. From the doing what other competent, caring people would viewpoint of individual doctors and nurses, this is do. an unobservably low rate, even if every death They believe that analyzing errors will allow from the case.

a death

Of course, nonlethal injuries to patients are far They believe that adding complexity improves tems and patterns of activity. Dozens of habitual

A simple calculation shows why: If 100 patients die from injuries in U.S. hospitals each day and there are 5,000 hospitals, that is very roughly one death per hospital every two months. From the viewpoint of individual doctors and nurses, this is an unobservably low rate, even if every death caused by error is known to be so, which is far

caused by error is known to be so, which is far them to find a single root cause, even though in fact the very idea of a "root cause" is misleading. It's like most public health burdens. About Most system failures come from complex inter-43,000 Americans die every year in automobile ac- actions between latent failures (the little things cidents, but most of us never actually witness such that go wrong all the time) and specific actions. Saying that one factor is a "root cause" is usually an illusion created by hindsight bias. It is Monday morning quarterbacking.

tant hope for long-term returns or vague calculations about how much patient injuries are costing today don't often seem to carry the day in hospitals and clinics facing large and immediate financial losses.

Finally, improving safety is hard, not easy. A hospital that wants to make patients truly safer has to involve almost all departments, support sys-



More deaths blamed on medical error

Health Editor

More than one death a week deaths in Victoria were reported identify structural issues that Victorian hospitals may be due to ing about 1000 from hospitals. medical mistakes, according to a new investigative unit based at to the Coroner cases that involve eliminate mistakes. the Coroner's office.

year, the Victorian Institute of unexplained death. "We know Forensic Medicine identified there is a level of underabout 30 cases in which medical reporting to the Coroner as errors may have caused or contributed to the patient's death, said the unit's acting director, David Ranson.

from hospitals. Of those we two a week that need in-depth said. analysis," Dr Ranson said.

The Age revealed yesterday that the state's hospitals reported second year hospitals have been required to report such inci-near the start of the process."

Almost a dozen other people suffered injury due to medical staff treating the wrong patient or body part, instruments being left behind after surgery and neurological damage.

A range of errors led to the deaths, including three cases in which patients, including a child. were given the wrong medication. Medical experts regard the 16 reported deaths as only a small proportion of the actual

Dr Ranson said about 4000

reported to the Coroner by to the Coroner each year, includ-

trauma, accident, people in care, In the first six months of this a sudden natural death or an well," Dr Ranson said.

The investigations by the he 60," he said. clinical liaison unit - set up late last year - were independent of "About 20 cases a week come the Health Department and would reinforce confidence in would probably pick up one or the Coroner's office, Dr Ranson

He said the unit's weekly examination of cases would counter criticism that suspected to the Health Department 16 medical error cases were slow to deaths due to medical mistakes be investigated. "Instead of for the year to June 30, 2003, the being looked at the end of the process, they are being looked at

The six-member unit, which nurses, advised which medical specialists should be consulted and help police investigators ask the right questions from the beginning." If medical error was suspected, an inquest would

Dr Ranson said that in most medical error cases, individual doctors or nurses could not be blamed. "The reality is most of the issues are system issues," he

A key aim of the unit was to

would prevent incidents recurring, and provide hospitals with By law, hospitals must report research findings to help them

He said if the unit used broader guidelines to determine whether a medical error possibly contributed to a death, it could investigate 150 deaths a year, "If you take a middle view it might

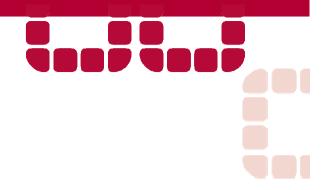
Australian Medical Association federal vice-president Mukesh Haikerwal said that the deaths reported by hospitals in 2002-03 needed to be put in the context of more than one million people seeking hospital treatment in the same period.

"We are at the safest time in history to be in hospital and have procedures done, but there's always room for improvement," he said. "One death is one too many, and 16 is 16 too many."

Dr Haikerwal said the State includes two doctors and two Government needed to ensure that medical equipment in hospitals was at a high standard to for expert advice. "They go out help prevent medical mistakes. "A lot of things need refurbishing and replacing," he said.

> The Government said yesterday it would not release information on which hospitals were involved in medical errors as it did not want to encourage a safety "league table"

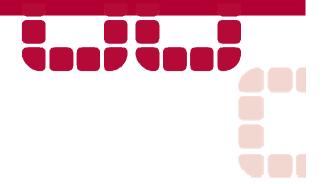
> "The emphasis of the program is to identify systems shortcomings and issues - not to



The Age Newspaper 12 August 2003



Government of Western Australia Department of **Health**



Estimated that:

- 140,000 hospital admissions each year are associated with medication problems.
- medication errors account for up to 20% of adverse events in Australian health care and
- medication errors cost \$380 million per year in the public hospital system.

Australian Council for Safety & Quality in Health Care, "Second National Report on Medication Safety", 2002, Commonwealth Dept of Health, Canberra





Principles

We need to design systems to reduce the potential for error

"Human beings make mistakes because the systems, tasks and processes they work in are poorly designed"

Prof. Lucian Leape, Harvard School of Public Health

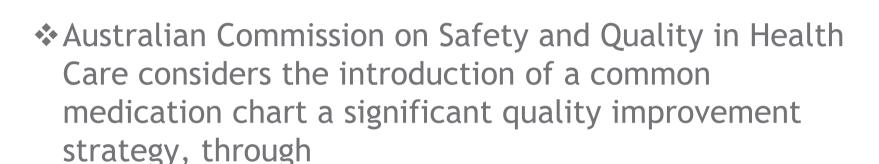


So what are we doing to reduce medication errors?

- Establishment of WA Medication Safety Group
- Distributed alerts on high risk medications eg. KCl (2005), Vincristine (2006)
- Implemented WA Pharmaceutical Review Policy (2007)
- Implementation of a national standardised Adult inpatient medication chart (2006)
- Implementation of Medication reconciliation program in SQuIRe program (2006)
- Implementation of a Paediatric Inpatient Medication Chart and Paediatric Long-Stay Medication Chart in WA Hospitals (2009)



Standardised Paediatric Medication Charts



- standardising processes of communication
- optimising workflow patterns
- introducing functions to improve safe use of medicines



Background to the Paediatre Inpatient Medication Chart

- July 2003, Australian Council for Safety and Quality in Health Care established a multidisciplinary working group to look at medication errors
- April 2004, Australian Health Ministers' Conference agreed that a common medication chart be in use in all public hospitals by June 2006
- ❖ December 2008, Australian Health Ministers' Conference endorsed National Paediatric Medication Chart and National Paediatric Long-Stay Chart for use in public general hospitals in Australia whenever paediatric patients are treated

Government of Western Australia

Department of Health

Timelines for Implementation of the Paediatric Inpatient Medication Chart

- Jan March 2009, WA Paediatric Medication Chart and Paediatric Long-Stay Chart developed
- Stakeholder consultation April 2009
- Implementation of Paediatric Medication Chart at PMH July 2009
- State rollout of Paediatric Medication Chart and Paediatric Long-Stay Chart - commence August 2009
- Complete implementation of the Paediatric Medication Chart and Paediatric Long-Stay Chart in WA public hospitals - December 2009
 Government of Western Australia

Department of Health

The WA Paediatric Inpatient (Short-Stay) Medication Chart - front and back pages

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Hospital Prescription

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Hospital Prescription

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The WA Paediatric Long-Stay Medication Chart – front and back pages

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Hospital Prescription

MEDICINES

Attach ADR Sticker

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Drug (or other)	Reaction/Type/Date	Initials	Given Names: IDENTIFIERS PRESENT
			D.O.B.: Sex: □ M □ F
			1st Prescriber to print patient name & check label correct:
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Complete hosp	ital ADR and alert requir	ements	Weight (kg) Height (cm)
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The WA Paediatric Long-Stay Medication Chart – middle pages

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Paediatric Inpatient Medication Chart

- ❖ Paediatric Inpatient Medication Chart and Paediatric Long-Stay Medication Chart are to be used for all paediatric Inpatients
- ❖ Paediatric Inpatient Medication Chart and Paediatric Long-Stay Medication Chart do not replace specialised medication charts but should be used in conjunction with them
 - ❖ E.g. Chemotherapy, insulin, IV Fluid





What safety features have been added to the Paediatric Inpatient Medication charts?

- ❖ Patient Identification eg UMR Number, Patient Name, Date of Birth and gender to be written on all Paediatric Charts OR use Patient Identification sticker
- Initial clinician (doctor/nurse) needs to print the patient's name under their ID label
- Staff need to record patient height, weight, BSA Index and age
- Discharge Medication panels added
- Staff signature/initial panel added to front page
- ❖ Added 'Calculation of Dose' cell to differentiate from 'Dose' box





NIMC - what it can do

Significantly reduce the types of errors we have identified





NIMC - what it can't do

Eliminate these errors





Success is dependent on

Clinicians recognising the importance of good communication through the medication chart





Where do I find more information?

www.safetyandquality.health.wa.gov.au/medication/index.cfm

