Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medicines use. The workforce uses these systems.

On this page:

Intention of this standard

The Medication Safety Standard aims to ensure that clinicians safely prescribe, dispense and administer appropriate medicines, and monitor medicine use. It also aims to ensure that consumers are informed about medicines, and understand their own medicine needs and risks.

Criteria

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

Integrating clinical governance

Action 4.01

Applying quality improvement systems

Action 4.02

Partnering with consumers

Action 4.03

Medicines scope of clinical practice

Action 4.04

Documentation of patient information

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Medication reconciliation

Action 4.05

Action 4.06

Adverse drug reactions

Action 4.07

Action 4.08

Action 4.09

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

Medication review

Action 4.10

Information for patients

Action 4.11

Provision of a medicines list

Action 4.12

Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Information and decision support tools for medicines

Action 4.13

Safe and secure storage and distribution of medicines

Action 4.14

High-risk medicines

Action 4.15

Background to this standard

Medicines are the most common treatment used in health care. Although appropriate use of medicines contributes to substantial improvements in health, medicines can also be associated with harm.[1] Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. Some of these events are costly, in terms of morbidity, mortality and resources. Up to 50% are potentially avoidable.[2]

Scope of this standard

The Medication Safety Standard addresses areas of medication management that have a known risk of error, often as a result of unsafe processes and variation in clinician practices.

The Medication Safety Standard requires health service organisations to assess medication management and implement processes and practices that:

- Provide for sound governance for the safe and quality use of medicines
- Minimise the occurrence of medicine-related incidents and the potential for patient harm from medicines
- Ensure that competent clinicians safely prescribe, dispense and administer medicines, and monitor their effects

- Inform patients about their medicines and involve them in decision-making.

Key links with other standards

The Medication Safety Standard should be applied in conjunction with other NSQHS Standards, including the Clinical Governance Standard and the Partnering with Consumers Standard.

Synergies with other NSQHS Standards will also need to be identified. This will ensure that medication safety and quality systems, and policies and processes for medication management are integrated, to reduce duplication of effort.

Medication management pathway

Medication management involves prescribing, dispensing, administering and monitoring medicines. Medication management is complex and involves several different clinicians. Often referred to as the medication management pathway, it comprises multiple activities and three system processes to manage the safe and effective use of medicines for patients at each episode of care.[3,4]

Safe processes and practices are required for all activities in the medication management pathway. These activities include procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

The consumer is the central focus of the medication management pathway. Health service organisations should apply the principles of partnering with consumers, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway.

The pathway provides a framework for:

- Identifying when there is potential for errors or risk of harm
- Responding with strategies to reduce the opportunity for error.

To ensure safe and effective use of medicines within the health service organisation, identify opportunities for patient harm and implement strategies to prevent medicine-related errors. Steps taken early in the medication management pathway can prevent adverse events occurring later in the pathway.

References

1. Roughead EE, Semple SJ, Rosenfeld E. Literature review: medication safety in Australia. Sydney: Australian Commission on Safety and Quality in Health Care; 2013. (accessed Sep 2017).

2. Roughead E, Semple S. Medication safety in acute care in Australia: where are we now? Part 1: a review of the extent and causes of medication problems 2002–2008. Aust New Zealand Health Policy 2009;6(1):18.
3. Stowasser D, Allinson YM, O'Leary K. Understanding the medicines management pathway. J Pharm Pract Res 2004;34(4):293–6.
4. Australian Pharmaceutical Advisory Council. Guiding principles to achieve continuity in medication management. Canberra: APAC; 2005.