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Australian Safety & Quality Goals for Health Care

The following are my comments of my observations over many years as a **senior clinical hospital pharmacist, patient and carer**:

Goal 1: Safety of Care

Medication Safety

1. Until a standardised **national electronic system** is in place to allow access to patients' clinical information by care providers across the spectrum, I try to educate & provide patients with as much hard copy info as possible to communicate with other practitioners.
    a. Initially, a complete & detailed **medication list**, with instructions that all the patient's health providers should edit the contents as relevant.
    b. Plans to set up a **patient folder** (similar to the Blue Book and the red My Health Record book) for patients to keep all relevant & current info – this is a priority initially for palliative care patients, but is applicable to any chronic disease patient.
    c. The Record would consist of sections for diagnoses, disease contraindications/precautions, recent letters, results, medications, etc and would be tailored to the specific needs of the patient groups
    d. **All GPs, specialists, hospital and community clinicians** should provide **copies of letters for the patients** not just for their referring carers. These need to be more detailed than they currently are, and use more 'plain English" terminology as well as the necessary technical terms, to improve patient understanding. This is vital because over the years a patient will have seen many clinicians for a number of seemingly unrelated issues, and without copies of summary letters, future clinicians and the patient are left in the dark and need to repeat investigations etc. These letters would be kept by the patient in their Record Book
2. Community and private health care strategies should include **residential care and the medical officers associated with these** (ie close co-operation with DGPs and the governing bodies for residential facilities). Patients transferred to residential facilities from hospital can be "lost" to the system and fall through the cracks of safety & QUM measures initiated within the hospital. Having **two different systems** with differing protocols & policies, and which exclude the main medical carer (the GP) places the patient at risk. Hospital clinicians must follow standard protocols of treatment & are monitored via the system. **The GP** who treats nursing home patients does not

seem to be **governed by a protocol** when initiating pain relief with opioids, so may practice outside of the evidence-based/best practice guidelines considered appropriate in hospitals. Is each GP required to practice within a standard set out by DGPs? Are they closely monitored? They do not have in-house pharmacists to set systems for med safety, and they are not obliged to change practice on the recommendation of an HMR pharmacist.

3. There is a need for research on **health literacy**, and to **standardise the wording of medication instructions** on labels based on good evidence. In particular, the sentence structure of pharmacists whose mother tongue is not English, and the semi-technical terms used contribute to medication incidents & poor compliance.
4. There is a need for research to standardise or better guide clinicians in **defining higher risk patients** in terms of medication incidents.
5. There is a need for more **transparency and closer involvement by pharmacists in Morbidity and Mortality committees.** In particular, I feel **palliative care** is a "black whole" when in comes to identifying and ensuring appropriate use of medications. This area of practice has relatively few evidence-based drug usage guidelines relative to their patients' needs. Much treatment occurs outside of manufacturer guidelines, and with less regard for usual pharmacy-monitored issues such as drug interactions and dose adjustment due to renal function. Some units have few standard protocols to follow, and the nature of their patients' illness necessitates practicing outside of these protocols at times. These patients are expected to die. Although the professional clinician will continue to palliate as ethically as possible, we do not know if preventable adverse medication events are contributing to these deaths.

Goal 2: Appropriateness of Care

1. A priority within antibiotic stewardship must be a review of **surgical prophylaxis** and develop evidence-based protocols and restrictions. In particular, the practice of using **chloramphenicol eye ointment** post-operatively for up to a week either to prevent wound infection post procedures such as circumcision & hemorrhoidectomy, or to prevent wound scarring must be reviewed. The risk (although not common) of serious late adverse effects and the possible development in a strong antibiotic useful for serious infections including anthrax, should prompt a review of the drug's recent Poisons List **reschedule to S3**. An assistant at a local chemist offered it to me as a treatment for nasal infection!

Goal 3: Partnering with Patients and Consumers

See Goal 1 point 1, above.

Barriers to Achievement

1. Resources to **purchase** appropriate improvement-related tools from **pharmacy budget**
2. Lack of **pharmacy support staff** to set up and maintain improvement strategies
3. Lack of **pharmacists and pharmacist time to allocate to develop improvements**. (NOTE: the few Garling positions created have not made enough of a difference as not all the positions are

allocated to appropriate tasks **full time** ie **inadequate backfill**, **not enough positions** have been created, general pharmacy **positions remain unfilled**, the **terms of reference** for the Garling positions should be **expanded** to include not just a higher quality of standard clinical pharmacy duties, but also **innovative practice-improvement activities** to increase safety & QUM. Examples are research, projects, more intense mentoring & education of variety of clinicians re med safety, etc. I believe every hospital pharmacist should (could) be trained up to competency level of what is currently termed "clinical pharmacist"; ie why waste Garling funds just on tasks which everyone should be doing anyway? The **Garling positions should allow development of SYSTEMIC clinical practice improvement models** which the generalist pharmacist cannot do.

4. There has been **no increase in the number of technician positions** to allow the required changes.
5. **Higher pharmacy management also desperately needs more support**, both clerical and professional.