Medication Safety Strategic and Operational Plan for WA Health

Office of Safety and Quality in Healthcare

2012 - 2015
The WA Medication Safety Strategic Plan incorporates the National Safety and Quality Health Service Medication Safety Standard 4 and quality related initiatives to be undertaken including those for which it will have direct oversight and those on which it advises and provides input or has a watching brief. It is envisaged that the programme will continue to evolve as models of care further develop in line with the requirements of WA Health.

Background:

- Medicines are one of the most common causes of harm in health care.
- 2-3% of Australian hospital admissions are medication related.\(^1\)
- This represents an estimated 190,000 medication related hospital admissions per year in Australia.\(^2\)
- Up to 30% of unplanned geriatric admissions are associated with adverse medicines events.\(^1\)
- 50% of hospital admissions due to medication errors are considered potentially avoidable.\(^1\)
- It is estimated that medication errors in Australia cost over $680 million per year.\(^2\)
- In WA, medication incidents account for the highest proportion (23.4% 2008-09 and 23.2% in 2009-10) of incidents reported to AIMS.\(^3\)
- In WA, medication omissions (34%) and medication overdoses (18%) were the most frequently observed types of medication errors during 2008-10.\(^3\)
- Over 33% of reported medication errors in WA in 2009/10 were caused by a failure to follow policy and procedure (an increase from 28% in 2008/10) and 25.7% were caused by a failure to read or misread prescribing information (as compared with 30.3% in 2008/09).\(^3\)

The WA Medication Safety Strategic Plan is consistent with state, national and international standards and goals; ensures initiatives are actioned and provides for ongoing evaluation and development of strategies promoting better health outcomes through safe and quality use of medicines. It is expected that health services will be measured against the Medication Safety Standard 4 of the National Safety and Quality Health Service Standards commencing from 1 January 2013.

The principles of error reduction which provide the greatest chance of sustainable impact include:
- Standardisation
- Simplification
- Restricted Access or Limitation of Use
- Improve Access to Information
- Automation of Processes
- Create Fail-Safe Scenarios
WA Medication Safety initiatives:

- **Reducing risk** of medication incidents and errors,
- **Improving safety** of the medication use processes,
- **Improving the effectiveness** of medicines use, and
- **Improving continuity and efficiency** of medication management

Taking action to improve medication safety

1. Increase reporting and learning from medication incidents
2. Implement safe medication practice recommendations
3. Improve staff skills and competences
4. Minimise dosing errors
5. Ensure medicines are not omitted
6. Ensure the correct medicines are given to the correct patients
7. Document patients’ medicine allergy status
8. Ensure the patient is educated in the safe and appropriate use of medicines.

Strategic Alignment:

The strategic plan will align with policies and guidelines arising from a number of key bodies and important strategic directives and goals from a state and national level including:

- National Safety and Quality Health Service Medication Safety Standard 4
- National Medicines Policy
- National Strategy for Quality Use of Medicines
- Commonwealth Department of Health and Aging including TGA, NPS and Pharmaceutical Benefits Division
- National Safety and Quality Health Standards
- Australian Pharmaceutical Advisory Council (APAC) Guidelines
- Australian Commission on Safety and Quality in Health Care (ACSQH) policies and guidelines
- WA Health
- WA Therapeutic Advisory Group (WATAG)
- WA Medication Safety Group (WAMSG)
- WA Drug Evaluation Panel (WADEP)
- WA Strategic Plan for Safety & Quality in HealthCare
WA Medication Safety Strategic Plan

The WA Medication Safety Strategic Plan focuses around FIVE major streams:

- **High Risk Medicines**
  - Promoting safer outcomes from high risk medicines
    - Anticoagulants
    - Insulins
    - Narcotics
    - Chemotherapy
    - Potassium / Electrolytes
    - Psychotropic Agents

- **High Risk Process and Medicines Use Systems**
  - Supporting safer outcomes through standardisation and best practice in processes for ordering, supplying, storing and administering of medicines
  - Ensuring quality electronic medicines management systems supporting safer medication use.

- **Continuity of care and equity of access**
  - Improving medicine use across the continuum between hospital and community and within care settings; and promoting equity to medicines for all patients.

- **Medication Management Workforce**
  - Increasing awareness of risks of patient harm in medication management.
  - Improving the development of the medicines management workforce
  - Optimising models of medication management in line with developments in health care provision.

- **Evaluation and Research**
  - Ensuring programme evaluation and implementation of systems for reliable and relevant ongoing monitoring and feedback on medication safety
  - Encouraging innovative and targeted research into medication issues and strategies.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Objective</th>
<th>Deliverables</th>
<th>Actioned By</th>
<th>Proposed Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving safety through standardisation of medication management</td>
<td>Consolidate implementation and monitor compliance with NIMC</td>
<td>Audit compliance NIMC</td>
<td>AHS</td>
<td>August-September 2012</td>
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<tr>
<td></td>
<td>Standardisation of charts across all WA Hospital sites</td>
<td>Paediatric NIMC</td>
<td>AHS</td>
<td>June 2012</td>
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<tr>
<td></td>
<td></td>
<td>- Chart should be implemented to all WA Health sites that provide paediatric services</td>
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<td>Neonatal NIMC</td>
<td>AHS</td>
<td>June 2013</td>
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<tr>
<td></td>
<td></td>
<td>- Encourage sites that provide maternity services to implement KEMH neonatal chart</td>
<td></td>
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<td></td>
<td>Clozapine Chart</td>
<td>Chart developed through consultation with Chief Psychiatrist, Alma St Medical Director and Graylands Hospital medical and pharmacy staff. RPH and WACHS also for consultation</td>
<td>OSQH, Graylands and FHHS</td>
<td>March 2013</td>
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<td></td>
<td>Insulin Chart – &amp; Administration guidelines</td>
<td>Currently in development phase</td>
<td>ACQSH, OSQH, Endocrine Network</td>
<td>June 2013</td>
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<td></td>
<td>Other charts</td>
<td></td>
<td>OSQH</td>
<td>2013-15.</td>
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<td>Deliverables</td>
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<td>National Labelling Recommendations OD 0350 Site Implementation</td>
<td>Tender procurement for State supply of labels</td>
<td>HCN</td>
<td>October 2012</td>
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<td></td>
<td>Implementation and education</td>
<td>AHS</td>
<td>November 2012</td>
<td></td>
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<td></td>
<td>Audit of implementation</td>
<td>AHS</td>
<td>March 2013</td>
<td></td>
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<td></td>
<td>Safety risk register</td>
<td>OSQH</td>
<td>November 2012</td>
<td></td>
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<tr>
<td>Pharmaceutical Review Policy</td>
<td>Follow-up report (2010) has been finalised and posted on OSQH internet site. Areas that require action include:</td>
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<td></td>
<td>Standardisation of documentation of adverse drug reactions and reporting of events which occur during admission to Advisory Committee on the Safety of Medicines (ACSOM).</td>
<td>WA Clinical Alert Business Group/OSQH</td>
<td>June 2013</td>
<td></td>
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<tr>
<td></td>
<td>Review of ICT platforms for medication management.</td>
<td>HIN/OSQH</td>
<td>2013-2015</td>
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<td></td>
<td>Ensure patients are provided education on the safe use of their medicines – WWA MMP documentation</td>
<td>MMP – Med Safety Network</td>
<td>Jan 2013</td>
<td></td>
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<tr>
<td>Residential aged care facility interim chart/tool for WA</td>
<td>Improve communication across continuum between hospital site and RACF.</td>
<td>OSQH/AHS</td>
<td>2013-2015</td>
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<td></td>
<td>ACSQH are in process of developing a national tool for use.</td>
<td>ACQSH</td>
<td>2013-2014</td>
<td></td>
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<tr>
<td>Tallman lettering</td>
<td>Addressing risk of medication errors due to Look-a-like/Sound-a-like Medications</td>
<td>HIN/OSQH</td>
<td>To be addressed at a later date, subject to HIN strategic planning</td>
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<td></td>
<td>Incorporate with existing eMMS i.e. iPharm.</td>
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<td>Implementing best practice in medication management</td>
<td><strong>Antimicrobial Stewardship</strong>&lt;br&gt;Systematic approach to optimisation of antibiotic utilisation&lt;br&gt;The appropriate use of antibiotics and the limitation of unnecessary antibiotic administration/exposure&lt;br&gt;- Optimising diagnosis&lt;br&gt;- Selecting appropriate antibiotics&lt;br&gt;- Optimal dosing</td>
<td>Progress and support sites to uptake ACQSH recommendations.&lt;br&gt;Action plan to be developed</td>
<td>OSQH / AHS</td>
<td>Jan 2013</td>
</tr>
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<td></td>
<td><strong>Adverse Drug Reaction (ADR) Documentation</strong>&lt;br&gt;Standardisation of procedure and documentation of adverse drug reactions that occur&lt;br&gt;- During the patient’s current admission&lt;br&gt;- Prior to current hospital admission</td>
<td>Review current ADR documentation processes&lt;br&gt;Consult Specialist Groups&lt;br&gt;- WA Clinical Alert Business Group&lt;br&gt;- Medication Reconciliation Network&lt;br&gt;Standardise forms and reporting of ADR to ACSOM where appropriate&lt;br&gt;Audit documentation of ADR on NIMC, medical notes and red alert bracelets are utilised.&lt;br&gt;Review use of Clinical Indicator 6.1&lt;br&gt;Preccription of drugs for which there is a known previous adverse reaction (allergic, hypersensitive, harmful and other unfavourable reactions) without the prescriber's documented.</td>
<td>WA Clinical Alert Business Group OSQH, AHS and Medication Safety Network</td>
<td>July 2013</td>
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<td></td>
<td><strong>MedAlerts System</strong>&lt;br&gt;ICT system (TOPAS/webPAS) to alert clinician to Medical Alerts including Serious Adverse Drug Reactions</td>
<td><em>MedAlert System</em>&lt;br&gt;• WA Clinical Alert Business Group review and standardisation MedAlert process across WA hospitals of MedAlerts documented onto TOPAS/webPAS&lt;br&gt;• Serious Adverse Drug Reactions to be prioritised onto TOPAS/webPAS.</td>
<td>WA Clinical Alert Business Group OSQH, AHS</td>
<td>July 2013</td>
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<tr>
<td></td>
<td></td>
<td>OSQH</td>
<td>June 2013</td>
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<td>VTE Risk Assessment and Appropriate Prophylaxis</td>
<td>WA sites involvement in current pilot study Assessment of VTE Risk Assessment Tool in NIMC and associate use of WA Anticoagulation Medication Chart. {ACQSH developing modification of VTE risk assessment tool for NIMC (pharmacological prophylaxis only)}</td>
<td>AHS involved</td>
<td>Analysis by March 2013</td>
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| EMM Systems | • Implementation Guide planning for electronic medication management systems.  
• Ensuring quality electronic medicines management systems supporting safer medication use.  
• Scope EMM requirements for WA Health sites. Provide report for triaging and selection on to HIN priority list. | OSQH /AHS | 2014-2015 |
| Increase surveillance, reporting and learning from medication events | Evaluation and Research | • Outcome measure/s for medication safety – identifying method of coding for adverse medication outcomes.  
• Ensuring programme evaluation and implementation of systems for reliable and relevant ongoing monitoring and feedback on medication safety.  
• Encouraging innovative and targeted research into medication issues and strategies. | | |
<p>| Adverse Drug Event (ADE) Reporting | Promote reporting of adverse drug events through Clinical Incident Monitoring System (CIMS) (NOTE: Not to be confused with Adverse Drug Reactions (ADRs) which are defined as response to a drug that is noxious and unintended that occurs at doses used in humans for prophylaxis, diagnosis, or therapy of disease,(WHO). Adverse drug events are defined as preventable or unpredicted medication-related events which result in harm to patient. ADRs should not be reported to CIMS, where all ADEs should be. | AHS | Dec 2012 |</p>
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| Continuous improvement in medication management | Medication Safety Self Assessment  
  The MSSA is a performance evaluation process, designed to raise hospitals’ awareness of the features of a safe medication system.  
| | High Risk Medicines  
  Promoting safer outcomes from high risk medicines  
  - Anticoagulants,  
  - Insulins,  
  - Narcotics,  
  - Chemotherapy,  
  - Potassium/Electrolytes  
  - Systems (wrong route of administration, use of standard abbreviations etc) | Medication Safety Alerts.  
  To be developed and distributed to all clinicians involved with the prescribing, administration and dispensing of medications  
  Including:  
  - Enteral feeding (Risk of confusion with parenteral lines)  
  - Enoxaparin safety issues (prescribing for patient weight and renal function)  
  Co-ordinated alert distribution with ACQSH for distribution of alerts  
  Review of Intravenous Potassium Chloride OD1969/05  
  **WA Anticoagulation Chart Audit 2011/12**  
  - Tertiary site involvement – RPH, SCGH, FHHS  
  - Audit to be undertaken Nov 2011, report June 2012  
  - Provide quality information on use of anticoagulants for OSQH an ACQSH  
  Review use of warfarin clinical indicators at AHS.  
  ◊ Patients receiving warfarin as an inpatient with an INR>5  
  ◊ Patients prescribed hospital initiated warfarin whose loading doses are consistent with approved protocol  
  ◊ Patients discharged on warfarin that receive written information regarding warfarin management prior to discharge  
  **Standardised Abbreviations**  
  AHS to audit and report on prescribing standards of approved standardised abbreviations across primary and secondary healthcare. | WAMSG/ OSQH ACQSH WAMSG/ OSQH OSQH OSQH/KF AHS (In conjunction with NIMC audit) | Dec 2012 June 2012 Dec 2012 June 2013 August 2012 yearly thereafter |
# Roles and Responsibilities for Implementing Medication Safety Programs in WA

<table>
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<th>Domain</th>
<th>WA Body</th>
<th>Strategy</th>
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| Timely access to medicines                       | WATAG and WADEP                              | • Encourage health services and individual prescribers to apply the standards and guidelines developed by the Committee for everyday clinical practice.  
• Advise on the clinical efficacy and cost-effectiveness of drugs referred to it that are included in, or proposed for inclusion in, the formulary of any public hospital in WA, and will recommend via the Western Australian Therapeutics Advisory Group (WATAG) whether there are sufficient grounds to list any drug, the conditions of listing, and (if required) guidelines for the use of the drug.  
• Consider registered drugs that are specialised in nature and/or impose high costs or raise important issues of therapeutics, public safety or other relevant matters. |
| Department of Health & Area Health Services      |                                              | • AHS to implement agreed Commonwealth PBS Reform and APAC Guidelines in WA public hospitals.  
• Implement the WA Pharmacy Reforms outlines in the HRIT Review of public hospital pharmacy departments in Western Australia.                                                                                                                                                                                                                                                                                                |
| Medicines meet appropriate standards of quality, safety and efficacy | WATAG, WADEP, WAMSG, WAPDC.                | • To develop best practice standards and guidelines for drug use in Western Australia based on scientific knowledge of clinical efficacy, safety and cost effectiveness, and to give advice on drug use where appropriate  
• Assess the quality and quantity of available data and information related to medication safety and take appropriate actions to improve data / information sources                                                                                                           |
<table>
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<tr>
<th>Domain</th>
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<tr>
<td>Quality use of</td>
<td>Office of Safety and Quality in Healthcare</td>
<td>• Coordinate, promote, evaluate and otherwise oversee initiatives to improve medication safety in the public health care system in Western Australia in alignment with National Safety and Quality Health Service Medication Safety Standard 4. &lt;br&gt; • Oversee the implementation of national and state-wide directives related to medication safety. &lt;br&gt; • Oversee the implementation of strategies to promote culture change regarding behaviours inhibiting improving medication safety (i.e. Medication Safety Alerts) &lt;br&gt; • Coordinate implementation and maintenance of the: &lt;br&gt;   • Medication Reconciliation Program in SQuIRe Plus &lt;br&gt;   • Pharmaceutical Review Policy &lt;br&gt;   • National Inpatient Medication Chart (NIMC) &lt;br&gt;   • Recommendations on the User-Applied Labelling for Parenteral Medicines and Lines. &lt;br&gt;   • WA Anticoagulation Chart &lt;br&gt;   • Paediatric NIMC</td>
</tr>
<tr>
<td>medicines</td>
<td>Pharmaceutical Services Branch</td>
<td>Support safer outcomes through standardisation and best practice in processes for ordering, supplying, storing and administering of medicines'</td>
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<tr>
<td>Domain</td>
<td>WA Body</td>
<td>Strategy</td>
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</table>
|        | WATAG/WAMSG | • To undertake such research and gathering of information from the scientific literature and other sources as may be necessary, including the conduct of drug usage evaluations  
• To initiate and promote educational programmes relating to drug therapy, and to disseminate drug information to health services and members of appropriate professional groups in Western Australia  
• Facilitate communication regarding medication safety between relevant stakeholders involved including hospital and community health care professionals, consumers and policy makers  
• Make recommendations regarding the implementation of national and state-wide directives related to medication safety, and to coordinate the implementation as appropriate  
• Advocate and seek Executive Support for initiatives to improve medication safety in public health care system in Western Australia  
• Provide advice to the Department of Health on medication safety issues as required  
• Make recommendations regarding strategies to promote culture change regarding behaviours inhibiting improving medication safety |
Existing State-based initiatives underway to improve quality and safety of medicines in WA Hospitals

Various state-wide initiatives have been developed to complement or support the implementation of the National Medicines Policy in WA:

(i) Commonwealth PBS Reform and APAC Guidelines

As part of a strategy for improving the continuum of care for patients moving between the hospital and community setting, the Commonwealth and WA governments have been working together to improve the way patients access their medication. The reforms are designed to make it safer, easier and more convenient for patients to receive appropriate pharmacological care by applying the Commonwealth’s Pharmaceutical Benefit Scheme (PBS) to public hospitals.

Participation in the PBS Reform Program requires hospitals to agree to implement a set of guidelines developed by the Australian Pharmaceutical Advisory Council, known as the APAC Guidelines. These Guidelines aim to achieve the continuum of quality use of medicines between hospital and the community.

This policy identifies the APAC Guideline that corresponds to each of the pharmaceutical review standards. By achieving the pharmaceutical review standard, the corresponding APAC Guideline will also be implemented.

(ii) WA Pharmacy Reform

In 2004 a review of public hospital pharmacy departments was undertaken in Western Australia. The key recommendations of the Aldous Review have been incorporated into the Pharmacy Reform Project that is being undertaken by the Health Reform Implementation Taskforce. The Pharmacy Reform Project is very broad in scope, containing many components. The focus of the Quality Improvement component of the Pharmacy Reform Project is to implement the APAC Guidelines. By achieving the pharmaceutical review standards within this policy, the corresponding APAC Guideline will also be achieved.

(iii) WA Therapeutic Advisory Group (WATAG)

The role of the Western Australian Therapeutics Advisory Group (WATAG) is to promote rational therapeutic drug use in WA. In addition to supporting the quality use of medicines, WATAG provides independent advice to health professionals, health services and the Department of Health regarding the use of drugs and therapeutics in the public hospital and wider community setting in WA. Three subcommittees are established under WATAG, namely the Western Australian Psychotropic Drugs Committee, Western Australian Drug Evaluation Panel and Western Australian Medication Safety Group (WAMSG).

The primary aim of WAMSG is to reduce patient harm associated with medication errors. This sub-committee operates by involving stakeholders and local experts to develop standards that may be uniformly applied throughout the WA Health System. A number of
Working Groups have been established under WAMSG, such as a Medication History Working Group, Heparin Working Group, Anticoagulation Steering Committee and Ommitted Medications Working Group which may advise on strategies or initiatives that can be implemented to achieve the standards contained in this policy.

(iv) Pharmaceutical Review Policy

A Pharmaceutical Review Policy and Operational Directive were endorsed by the Director General for implementation across the WA public health system in March 2007. The policy was developed to ensure that:

- Accurate medication histories are recorded on admission to hospital
- A clinical pharmacist reviews patients’ medication charts on a daily basis
- Patients are educated about their medications during their stay in hospital and on discharge
- Health services actively promote medication safety.

Phase 1 of the project – Policy implementation has been completed
Phase 2 - a baseline audit and gap analysis to determine the current level of compliance by WA Health Services against the five standards outlined in the Pharmaceutical Review Policy.
Subsequently, a Business Case was developed and submitted to the State Health Executive Forum in December 2007, identifying resource requirements for health services to comply with the five standards.
Phase 3 – Follow-up audit to review compliance with standards after resource requirements have been addressed.

(v) National Inpatient Medication Chart (NIMC)

The Australian Council for Safety and Quality in Health Care set up a National Medication Chart Working Group (NMCWG) to provide leadership and direction to meet the challenge of reducing patient harm resulting from error in medication documentation processes.
The roll out of the NIMC in WA was completed in June 2006. A post implementation audit was conducted in March 2007. During the roll-out of the NIMC the Department of Health identified the need for a number of specialist auxiliary charts to be developed to supplement the main NIMC. The auxiliary medication charts developed to date by the QID are the Long Stay NIMC, Variable Dose Chart and the Paediatric NIMC.

WAMSG and WATAG have also developed an Anticoagulation Chart for WA Health Services that has been mandated for use across WA Health.
(vi) **SQUIRE CPI Medication Safety Program Targeting Medication Reconciliation**

Based on the learnings demonstrated by the IHI “Saving 100K Lives” program, the Office of Safety and Quality in Healthcare has established the Medication Reconciliation Program as a component of the Medication Safety cluster of the SQuIRe CPI program.

Medication reconciliation is the process of obtaining and confirming a medication history, reconciling any discrepancies and subsequent clinical liaison. The process has been shown to significantly reduce medication errors.

Medication reconciliation is a key component of the WA Pharmaceutical Review Policy (March 2007). Project teams are expected to demonstrate significant progress towards implementing all four of the following elements:

- a. Medication History
- b. Confirmation
- c. Reconciliation
- d. Medication Liaison

WA Medication Safety Network, which has medication reconciliation project officer/medication safety pharmacist representation, started in 2010 and met throughout 2011 to develop a standardised audit tool and guide for medication reconciliation and a medication management plan for WA Health.

(vii) **WA Clinical Alert Business Group**

This group was established through the Office of Safety and Quality in Healthcare in response to a need to develop guidelines for proper use of the Clinical Alert System (MedAlert) and standardise the process of documentation of adverse drug reactions across WA Health. The Business User Group comprises of clinical and coding staff representatives from the Area Health Service hospital sites (SMAHS, NMAHS, CAHS, WACHS) including:

- A Medical representative from each service.
- A Senior Pharmacist representative from each service.
- A representative from Clinical Coding from each service.
- Executive Sponsor – a senior executive whose span of control includes business units/areas of utilising the function.

**References:**

3. Data obtained from ‘Learning from Clinical Incidents: A snapshot of Patient Safety in Western Australia 2008-2010’.
Delivering a Healthy WA