GETTING IT RIGHT

MEDICINES STEWARDSHIP TOOLKIT

VERSION 01
DECEMBER 2022

CATAG
Council of Australian Therapeutic Advisory Groups

VERSION NUMBER
Version 1: December 2022

Recommended citation:
Council of Australian Therapeutic Advisory Groups.
Getting it Right:
Medicines Stewardship Toolkit.
CATAG, 2022.

DISCLOSURE
The Council of Australian Therapeutic Advisory Groups (CATAG) is supported by funding from NPS MedicineWise, an independent, not-for-profit public company funded by the Australian Government Department of Health and Aged Care. This funding is managed via a Services Agreement between NPS MedicineWise and the NSW Therapeutic Advisory Group, an independent, not-for-profit member-based organisation.

The views expressed are those of the members of CATAG and do not necessarily reflect those of the funder.
Conflict of interests: No relevant disclosures

| CONTENTS |

BACKGROUND

The Medicines Stewardship Guiding Principles provide a framework to assist health service organisations, including Drug and Therapeutics Committees (DTCs), to develop and implement medicines stewardship programs. This toolkit aligns with the Guiding Principles and provides detailed information regarding the planning, implementation, evaluation and sustainability of any stewardship program. A successful medicines stewardship program requires good planning.

For those organisations that are developing or have developed a program, this toolkit will provide a framework against which the process can be reviewed and help guide changes if necessary.

The medicines stewardship program plan will differ according to the healthcare setting and available resources. A quality improvement approach to planning and implementing is recommended and has been used for long-standing programs such as antimicrobial stewardship.[1]

The program plan should address the following actions:

1. Assess readiness to implement a stewardship program.
   - Review existing policies and prescribing guidelines.
   - Review local data, understanding baseline performance.
   - Develop a driver diagram.
2. Establish effective and credible leadership.
3. Determine priority areas for stewardship activities and create consensus criteria for the program.
4. Identify effective education interventions.
5. Document and implement the stewardship plan.
6. Ready the workforce.
   - Address barriers to staff engagement and implementation.
7. Define measurable goals and outcomes.
8. Develop and implement a communication plan.
9. Sustain the stewardship program.

STEWARDSHIP PROGRAM PLAN

ASSESS READINESS TO IMPLEMENT A MEDICINES STEWARDSHIP PROGRAM

The first step is collecting evidence to demonstrate the need for a stewardship program. This may include evidence (or data) from the local health service organisation to understand the baseline environment. Consider review of clinical incident data, or mortality and morbidity data to determine priorities. For example, unacceptably high rates of venous thromboembolism (VTE) support an anticoagulant/VTE prophylaxis stewardship program; an audit of psychotropic use in older people supports a stewardship program on the use of psychotropic medicines in hospital.

The next step is to review local policies, national or international standards and other referenced evidence. For example, literature on antimicrobial or opioid stewardship programs, along with national clinical care standards.[1-3] Once the evidence or need is established, determine the aim or purpose of the program. Include background information to define issues, outline the main driver for the stewardship program and the audience.

At this point it is useful to decide on preliminary recommendations/goals and highlight the key messages of the stewardship program.

These goals should fit within the "SMART" framework:

Specific.
Goals that are too vague and general are hard to achieve, for example 'be a better clinician'. Goals that work include specifics such as 'who, where, when, why and what'.

Measurable.
Ideally, goals should include a quantity of 'how much' or 'how many', for example 'to report on 4 dedicated audits per year'. This makes it easy to know when the goal has been reached.

Achievable.
Goals should be challenging, but achievable. Goals work best when they are neither too easy, nor too difficult. In many cases setting harder goals can lead to better outcomes, but only if there is an ability to achieve them. Setting goals which are too difficult can be discouraging and lead to an unsuccessful program.

Relevant.
The goal should seem important and beneficial to everyone implicated in the goal.

Time-related.
'You don't need more time; you just need a deadline.' Deadlines can motivate efforts and prioritise the task above other distractions.

DEVELOP A DRIVER DIAGRAM

A driver diagram will assist to systematically plan and structure the program. It will help to clearly understand the logic and progress of the program. It is a living document that can be updated at every team meeting, where drivers and change concepts can be discussed and agreed upon.
Follow the link for more information on driver diagrams:

ESTABLISH CREDIBLE AND EFFECTIVE LEADERSHIP

It is important to establish appropriate governance structures for the program. The governing body ensures that there is a level of hierarchy for:

- decision-making authority
- responsibility for program delivery
- risk mitigation.

A successful implementation team is a key factor in driving change and involves a group of multi disciplinary participants representing all stakeholder groups. Credible and effective leadership is required to support the initiative and effect change.

The stewardship team should be an interprofessional team that reflects a good representation of key stakeholders who can present relevant views. Assembling a group of dedicated individuals with influence and energy to lead and support this change is an essential component of this intervention. Team members should consist of different clinicians, have a shared objective, and work effectively within an environment of trust and interprofessional collaboration. Having consumer representation also enhances the conversation and enriches the discussions.

Essential skills and knowledge of the team should include clinical governance, clinical expertise in the targeted therapeutic area, specialist in medication safety/ Quality Use of Medicines (QUM) principles. Team members should also have expertise in implementation science, change management, organisational behaviour and the ability to influence behaviour of colleagues.

The stewardship team should include core representation from:

- executive (representing the ownership/ sponsorship of the program and/or finance or clinical governance)
- medical profession (including, where available, a clinical pharmacologist)
- nursing
- pharmacy (including specialist/advanced practice pharmacists)
- consumers, patient advocate, or community representative.

Other skills and expertise to consider, including in the stewardship team or accessed on an as-needed basis throughout the program, include:

- data analyst to enable data collection, analysis and systems
- information technology: clinical decision support and clinical surveillance systems
- epidemiologists
- patient safety specialist
- health economics (economic evaluation at different points in the program)
- risk management
- laboratory input (if appropriate).

Members of the stewardship team should have clearly articulated roles and responsibilities. Subject matter experts are required to assist stewardship programs to identify which QUM issues are relevant by identifying how and where these principles can be applied through the medicines management pathway and their priority.

The following tables outline different individual and group roles and responsibilities.

Table 1: Individual positions and their responsibilities

Individual position	Responsibilities
Executive leader	Represents the ownership/sponsorship of the program and/or finance or clinical governance). They ensure support and advocacy, as well as alignment with organisational priorities. They have primary organisational accountability for ensuring that the program is signed off and delivered.
Project officer/ lead/ Manager/ Coordinator	Person either from a key clinical department assigned to this position or from the quality improvement unit or employed especially for the program. Responsible for delivering the program to appropriate time frames, within budget and to quality, together with the Clinical/medical lead, and ensuring risk is managed and issues are resolved.
Clinical/ medical lead	Person, usually a doctor or pharmacist who is a subject matter expert. It might be a clinical pharmacologist, if available. Responsible for delivering the program in line with clinical practice standards in conjunction with the Project officer / lead / manager / coordinator. Responsible for providing feedback on proposed solutions in areas of expertise to support the Project officer in delivering program outcomes.
Clinical/ Medical champion	Person, most often a medical health care professional, who is important to engage so that they can promote and explain the program and set a positive example for colleagues to successfully deliver the program and sustain changes that have been achieved.
Pharmacist lead	A pharmacist who is a subject matter expert. Responsible for delivering the program in line with clinical practice standards. This person may be the Project officer/lead/manager/coordinator or work in conjunction with them. Responsible for providing feedback on proposed solutions in areas of expertise to deliver program outcomes.

Individual position/roles	Responsibilities
Nursing lead	A clinical nurse who is important to engage so that they can promote and explain the program and set a positive example for colleagues to successfully deliver the program and sustain changes that have been achieved.
Consumer/ Patient representative	Responsible for providing valuable perspectives for health services to consider when delivering care or changing how care is delivered. Helps the health service to incorporate consumer and community input into operations and planning. Helps test feedback on processes that can help improve clinical care quality. Responsible for providing a lived experience of the health services to help drive quality of care.

| Table 2: Groups and their responsibilities* |

Groups	Members	Responsibilities
Program working group	Project officer/lead manager/coordinator Clinical/medical lead Pharmacist lead Nursing lead	Manages day-to-day tasks and decisions. Develops and ensures implementation of program interventions and activities. Develops and ensures implementation of program evaluation. Identifies and escalates risk to the Stewardship committee.
Clinical/ advisory team	Hospital unit(s) representatives Quality improvement representative Clinical governance representative Consumer/ patient representative Subject matter expert	Has responsibility for delivering / embedding the program outcome. Provides clinical governance for the implementation of the project. Highlights and monitors clinical risks. Develops methods and materials for interventions and activities. Delivers program on time and in scope. Monitors program evaluation.
Stakeholders	All staff with an involvement in or connection to the project including: - clinical - support - consumer/patient	Provides different points of view into the problem and the solutions beyond the program working group. Provides specialist input as required.
Medicines Stewardship Committee	Executive representative Divisional/specialty unit representative Clinical group representative (e.g. nurse practitioner) Pharmacy representative Quality improvement representative Consumer/patient representative	Provides overall program governance and monitoring during set up and delivery stages. Makes decisions and provides accountability for those decisions. Identifies barriers and enablers. Delivers program on time and in scope.
Drug and Therapeutics Committee (DTC)	Medical specialists Clinical pharmacologist (where available) Infectious diseases physician/ clinical microbiologist (where available) Pharmacists Nurse representatives Clinical governance representative Patient safety representative Executive delegate (senior hospital administration and/or finance)	Oversight of the medicines management system within a hospital, local health district/ network or state/territory. Stewardship committee reports to the DTC. Manages relationship between the hospital/health service.
Clinical Governance Committee	Board directors Director of Medical Services Director of Clinical Services Director Excellence Innovation Chief Executive Officer	Provides overall governance and monitoring during sustain stage, as part of remit to oversee key areas including quality improvement, safety and timely care.
Consumer advisory committee	Consumer representatives Hospital representative Program representative	Enables extensive consumer input, feedback and communication across the health services and project committees. Helps health services to appropriately incorporate feedback from patients and communities into programs.

For ongoing success and to facilitate co-ordinated activity, medicines stewardship programs should identify, involve and communicate with key stakeholders within the organisation.

Communication and documentation from meetings should ensure clarity of the actions required, including the responsible person and the timeframe for completion.

* Note: not all health services will necessarily have the same groups. These suggestions should be considered a guide and the group or their equivalents should be considered in the context of how they relate to the stewardship program.

DETERMINE PRIORITY AREAS FOR STEWARDSHIP ACTIVITIES AND CREATE CONSENSUS CRITERIA FOR THE PROGRAM

As it is not always possible to initially achieve everything in a medicines stewardship program, it is necessary to determine priority areas for the program. For example, an antimicrobial stewardship program may initially focus on intravenous to oral dosing or monitoring antimicrobial levels.

A crucial step in development of the stewardship program is gaining consensus amongst clinicians – medical, pharmacy and nursing. As a starting point to creating discussion, consult with guideline-based criteria.

To adequately engage clinicians in discussion, the stewardship team needs to ensure that clinicians recognise that their input is necessary. The ultimate goal is to achieve consensus between all stakeholders involved with the program before proceeding to the next step.

Once consensus is achieved, proposed practice changes should be reviewed by the relevant hospital governance bodies (e.g. DTC, medication advisory committee, quality and safety unit). This can be accomplished by supporting recommendations with evidence, where available. If no clear evidence is available, current practice can be used to establish recommendations. Where possible, key stakeholders should give official endorsement for the medicines stewardship program.

IDENTIFY EFFECTIVE EDUCATION INTERVENTIONS

There are many possible interventions available for use in a medicines stewardship program and it is important to choose the right interventions for the program. Interventions may be multifaceted and could include any or a combination of the following:

- audit and feedback
- educational outreach
- clinical decision support
- decision aids
- factsheets
- expert-led seminars or rounds (oral presentations)
- auto-stop orders (on electronic prescribing)
- pharmacy medication review
- reminders (emails)
- posters illustrating the guidelines.

The choice is dependent on resources available, who the target audience is – the clinician versus the consumer – or the cause of the clinical problem. Depending on the program, it may be useful to map processes, to identify all steps involved and where any intervention may work. In mapping processes, also consider the local patient population, to help identify which interventions best suit the local context.

Interventions also need to be targeted to a specific audience. Clinicians of all relevant disciplines should be targeted, including medical practitioners, nurses, pharmacists and other health professionals.
The hierarchy of effectiveness of different intervention strategies is shown in Table 3.

| Table 3: Hierarchy of effectiveness of different intervention strategies and their perceived advantages and disadvantages (Reproduced from Journal of Pharmacy Practice and Research [2020] 50, 166–179) |

Strategy	Intervention	Advantages	Disadvantages
Persuasive and facilitative	Culture change and change leadership	- Has greater and longer-lasting effects than education and policies	- Requires highest effort to achieve
	Forcing functions/ equipment redesign/ automation/ computerisation/ electronic medication management	- Have greater and longer-lasting effects than education and policies - Includes decision support, alerts, standardise medicines ordering sentences, dose checking - Increases data accessibility	- High cost - Major practice change - Requires technological competence of individuals and organisations
System-based	Formulary restrictions	- Widespread conformity and impact - Readily accessible - Provides a forcing function	- May not provide the rationale for the change
	Prescribing guidelines and policy	- May be a medicines-specific or therapeutic approach - Can incorporate local information - Useful for junior medical staff - May be educational	- May be restrictive - Time-consuming to develop - May not be followed - Requires updating
Educational	Medicines bulletin	- Large circulation - Provides an opportunity to discuss the benefits and reasons for the change - Marketing tool - Educational	- Passive - May not be read - Information overload
	One to one (academic detailing)	- Can be very effective if delivered well - Allows for discussion	- Time-consuming - May need reminders or follow-up to maintain the change - The effect depends on the skill of the messenger
	Group presentation	- Time-efficient - Allows for discussion	- May be difficult to do often - Only reaches those present - The effect depends on the skill of the presenter
	Posters	- Frequent reminder - Promotes discussion - Can be strategically placed	- Passive - May not be read - Too many posters
	Social media	- Frequent reminder - Time-efficient - Large audience	- May not be read - Short lifespan - Requires technological competency

Different education interventions address different causes. Table 4 provides examples of different interventions and the causes they address.

| **Table 4: Interventions; descriptions, implementation, causes addressed, other uses.** |

Intervention	Description	Causes addressed
Audit and feedback	Provides clinicians (doctors, nurses, etc.) with a summary of their performance for the clinical problem, over a specific period. For example, antibiotics for specific indication and duration. Audience: group (e.g. unit/ department) or individual.	- Lack of awareness - Perception/reality mismatch, for example overestimating their performance or under-estimating the problem.
Clinical guidance/ guideline development	Development of new evidence-based clinical guidance/ guidelines or adaptation of existing ones by clinical experts working in your health service. This may include influential leaders in development.	- Lack of guidance - Fear of change due to 'no permission'
Education	Learning through: - lectures from peers or clinical experts - one's own experiences and problem-solving, such as in small interactive groups or one-to-one peer interactions discussing cases or evidence.	- Lack of peer support - Lack of knowledge - Lack of skills
Educational outreach/ educational visiting/ academic detailing	Facilitator trained on the clinical topic and causes of the clinical problem who meets (usually face to face, but also remotely via video) with clinicians, either as a group or individual, discussing cases or evidence. The facilitator can be an influential leader.	- Lack of knowledge - Lack of skills - Beliefs/attitudes acting as barriers (e.g. fear of change, negativity to change)
Clinical decision support	**Interventions including:** - alerts, prompts and reminders - use of electronic medication or test ordering (i.e. computerised physician order entry, order sets) - electronic decision support systems - sharing of patient information across settings (i.e. health information exchange) - clinical workflows/ algorithms/pathways	- Specific clinical decision(s) not being made at right time - Specific clinical role not making specific clinical decision(s) - Clinician cognitive burden.
Systems based	Creating the conditions for clinicians that make tasks that change healthcare easier or harder to complete such as in the workplace or administration e.g. changes to order sets or formularies at a setting level.	Opportunity for clinicians to reduce unnecessary healthcare is being missed due to conditions
Patient and consumer mediated	**Engaging patients and consumers to make decisions and participate in healthcare through:** - information: e.g. leaflets, factsheets about diagnosis/ treatment of the condition, including lifestyle advice - activation: decision aids and action plans (similar to clinical decision support), physiological monitoring, self-evaluation - collaboration: communication with clinicians, social support.	- Lack of knowledge - Expectation of the healthcare even when it's unnecessary - Adherence challenges - Opportunity to make clinical decision(s) is being missed

| DOCUMENTING AND IMPLEMENTING THE MEDICINES STEWARDSHIP PLAN |

A project management approach may be used to implement a medicines stewardship program, depending on the size of the program and the organisation.
It is important to have the plan documented fully, including the:

- rationale of the program
- aim
- terms of reference for the medicines stewardship committee
- stakeholders
- method, including multifaceted interventions
- communication plan
- evaluation method and chosen metrics
- expected outputs and outcomes
- sustainability plan
- nominated tasks to the relevant members of the stewardship team, and deadlines for ease of transparency and accountability.

Before rolling out the stewardship program hospital-wide, it is helpful to undertake usability testing and gain feedback prior to full implementation.
Perform an early audit of the program (e.g. after 1-month) to obtain feedback on how things are working and usability of audit and data collection tools to inform refinement.

| READY THE WORKFORCE |

Striving for a culture of improvement, positive change and innovative quality processes for patients helps drive the changes forward. Every interaction is an educational opportunity to raise awareness for all clinicians involved in the medication management cycle.

- **Address barriers to staff engagement and implementation**

Recognising barriers and obstacles is the first step to overcoming them in the change process. Addressing barriers directly and early in the process can effectively build trust, facilitate change and reduce resistance.
Barriers might include:

- malpractice concerns
- patient demands
- lack of time
- lack of decision-support
- lack of staff awareness of the issue
- providers rejecting the premise upon which an issue is based.

| Table 5: Recommended approaches to addressing implementation challenges
(adapted from Give the test a rest. A toolkit for decreasing unnecessary emergency department laboratory testing – Choosing Wisely Canada 2019) |

Challenge	Approach	Tactic
Culture change	- Consistent reiteration of the program message - Reinforcement of behaviours supporting the program - Supportive and encouraging management/leadership	- Leading by example and visibly driving change - Creating a communications strategy - Adding the program as an agenda item at different department meetings - Establishing accountabilities - Celebrating short-term wins and making it your own - Feeling supported by leadership to engage in transparent communication can be a major part of the solution to some utilisation issues and destigmatises 'failure' (or not meeting expectations)
Staff resistance	- Education and awareness - Eliciting staff feedback through an inclusive participatory approach	- Distributing program materials - Developing an awareness campaign - Dedicating time at each regularly scheduled department meeting to discuss the program
Resources	- Building a good case for implementing the program recommendations through robust data collection	- Providing evidence - Creating a sense of urgency - Demonstrating success - Making it fun

Utilise the appropriate team member to address specific barriers. For example, if there is a barrier relating to pharmacy, then engage with the pharmacist on the stewardship team.

DEFINE MEASURABLE GOALS AND OUTCOMES

It is essential to clearly define goals and make sure that outcomes are measurable. Choose a family of measures:

Outcome or primary measures

These are the main improvement outcomes that you are trying to achieve. The World Health Organization defines an outcome measure as a "change in the health of an individual, group of people, or population that is attributable to an intervention or series of interventions". Outcome measures are the quality and cost targets healthcare organisations are trying to improve. Outcomes measures aim to assess the effect of specific stewardship approaches in terms of whether patient outcomes and/or related costs have improved and/or adverse events have decreased.

Examples:

- Mortality
- Length Of Stay
- Patient Experience.
- Timeliness Of Care
- Readmission Rate

Process measures

These measures are developed to ensure that each aspect of the intervention is being carried out and delivered as intended. The measures capture and track the process and steps leading to the desired outcome.

Examples:

- Policies and processes are being followed correctly.
- Compliance with prescribing guidelines.
- Medicines utilisation data.

Balancing measures

Any intervention may create new unintended consequences that need to be measured. Balancing measures are used to monitor whether changes may cause new problems or unintended consequences.

Examples:

- Incidence of adverse reactions
- Duplication of therapy
- Inappropriate replacement therapy
- Readmission rates
- Adverse events.

Structural measures

These assess whether the essential structural elements of medicines stewardship are established and maintained.

Examples:

- Are the appropriate lines of reporting and policies available, such as appropriate governance, formularies and guidelines, in place?
- These may be measured using a self-assessment tool.

Measures should also have face validity (i.e. are credible) and content validity (i.e. cover all appropriate domains of the program).

There are usually many ways to measure the outcomes of the medicines stewardship program. The first step is to decide on the **data source**.

There are many sources available to gather data for measures:

- Chart or bedside audits. These can be done as a snapshot or performed weekly or monthly by the improvement team or logged daily by front-line staff.
- Electronic medication distribution or administration databases.
- Electronic medical record.
- Formal or informal surveys.
- Financial evaluations.
- Electronic laboratory results.

The next step is to determine a **data collection method**. Automated measurement of process, outcome and balancing measures helps ensure a more complete data set with sustainable monitoring, evaluation and reporting. It can also facilitate real-time measurement to provide feedback and improvement at an organisational, departmental, team, or individual clinician level. Teams should engage with the health service IT or digital health team to explore whether an automated solution to measurement is feasible at the organisation.

These measures provide the basis for developing **Key Performance Indicators (KPIs)** for the medicines stewardship program. The program can then be evaluated against selected KPIs, which are measures of impact used to evaluate the success of these programs as a quality improvement strategy. For example, see Key performance indicators for antimicrobial stewardship.

KEY PERFORMANCE INDICATORS

It is important to report these measures or KPIs to the appropriate governance committees such as the DTC or Quality Improvement Committee. These committees should include any audits or KPIs on their regular schedule, to ensure compliance.

Stewardship programs should produce an annual report of activity and achievements, which can then be used to promote and communicate the program. The annual report should be readily available to all key stakeholders. It could be available on intranet servers or linked via newsletters and consideration for a summary in the form of infographics for digestibility and ease of access.

DEVELOP AND IMPLEMENT A COMMUNICATION PLAN

Communication is important as it actually makes the change happen. In the beginning, communication involves providing consistent and relevant information about the program that is being planned and implemented for:

- stakeholders; involved in and affected by the program
- people in the whole health service; not directly affected by the program.

The communication plan differs from the strategy, in that it is about the practicalities of implementing the strategy; the "how to do it". Communication enables stakeholders to make the best possible contribution to the success of the program, and facilitates transparency, trust and confidence. Communication continues throughout the program.

Successful change relies on effective change management and communication strategies. There will be varied purposes of communication, from raising awareness and promoting the specific initiatives, to issuing program updates and providing feedback. It is important to clarify the purpose of the communication prior to its release.

Key components to include in the communication are:

- why the program is important
- what the interests of the audience are
- how the program will impact and benefit the audience
- how to motivate the audience to spread the word to others.

Do not underestimate the importance of a compelling narrative on successful and sustainable implementation. Consumer stories are often an effective way to engage clinical staff and focus on a common purpose. Like the educational intervention, communication may change depending on the target audience.

The communications plan is based on the program's narrative. It requires:

- being clear on which communication channels are suited for the type of engagement that has been identified for each stakeholder (inform, consult, involve, collaborate, empower)
- categorising stakeholders into audience groups
- developing a schedule (timelines) for communications
- identifying and planning for any risks.

Multiple avenues are needed to inform staff about the program and involves:

- formal channels to connect with stakeholders including health service intranet, verbal updates at weekly hospital rounds and department meetings, posters to advertise the program email updates, meetings/contact with administrative staff, lanyards
- informal means such as the Clinical Champion speaking to colleagues during the day and setting up networking events.

Find an example of a communication plan template here.[4]

COMMUNICATION PLAN TEMPLATE

SUSTAIN THE STEWARDSHIP PROGRAM

Once the stewardship program has been implemented and refined, there are several important ways to help sustain the practices supported by the stewardship program:

- Implement into policy.
- Ensure all new staff are trained in the desired practice. This may be achieved by including training in appropriate induction programs.
- Continue awareness of the program by displaying posters in relevant areas. Review and update regularly so these don't become stale.
- Implement annual in-services to maintain competency.
- Provide periodic measurement and feedback to clinicians. Remember any metrics must be directly linked to the aim.
- Build the program into day-to-day processes.
- Set regular intervals for review after implementation of recommendations.
- Ensure there is appropriate resourcing for ongoing development and monitoring of the program.

Following the successful implementation of a medicines stewardship program, it is important to celebrate the outcomes with the program team, other staff and consumers of the Health Service organisation. The outcomes of the program should not only be shared within the local health service organisation but also within the local health district, jurisdiction and nationally. Information sharing occurs through publication and presenting at conferences and meetings, networking with peers and professional organisations.

GLOSSARY

Drug and Therapeutics Committee (DTC)
is the group assigned responsibility for governance of the medication management system, and for ensuring the safe and effective use of medicines in the health service organisation.[5] These may also be known as a medicines advisory committee, pharmacy and therapeutics committee, drug committee, drug and therapeutics advisory committee, formulary committee or quality use of medicines committee.

Clinicians
includes nurses, midwives, medical practitioners, pharmacists and other registered individuals who deliver health care.

Health service organisation
is a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.[5]

A stakeholder
is defined as "any person, group or institution with interests in a project…who may be directly or indirectly affected by the process or the outcome."[6]

Medicines Stewardship program
is a suite of coordinated strategies and interventions to promote the quality use of medicines, tailored to patients' needs.

RESOURCES

STEWARDSHIP

- Australian Commission on Safety and Quality in Health Care and NSW Therapeutic Advisory Group Inc. (2014), National Quality Use of Medicines Indicators for Australian Hospitals. ACSQHC, Sydney. https://www.nswtag.org.au/qum-indicators/
- Medication Safety Self Assessment® for Australian Hospitals (2015), Clinical Excellence Commission, https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0011/326909/MSSA-Complete-Workbook-2015.pdf

ANTIMICROBIAL STEWARDSHIP

- The National Centre for Antimicrobial Stewardship has resources that outline the core principles of antimicrobial stewardship (AMS) that may be used in the implementation of a new or existing AMS program. https://www.ncas-australia.org/implementing-antimicrobial-stewardship
- The Commission's Antimicrobial Stewardship in Australian Health Care (AMS Book) supports AMS in specific settings. https://www.safetyandquality.gov.au/our-work/antimicrobial-stewardship
- The Australian Government also has a page on Antimicrobial Resistance that provides some guidance on antimicrobial stewardship. https://www.amr.gov.au/
- AMS toolkit provides information, resources and quality improvement (QI) tools for managers and clinicians to improve AMS programs in NSW health services. https://www.cec.health.nsw.gov.au/improve-quality/quality-improvement-toolkits/ams

OPIOID STEWARDSHIP

- Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard provides information on the Standard and other resources. https://www.safetyandquality.gov.au/standards/clinical-care-standards/opioid-analgesic-stewardship-acute-pain-clinical-care-standard
- These resources have been developed by NPS MedicineWise to support best practice in the safe use of opioids for acute pain in the post-operative period and emergency department. https://www.nps.org.au/safe-use-of-opioids-in-acute-pain

| ANTICOAGULANT STEWARDSHIP |

- Venous Thromboembolism (VTE) prevention. The CEC VTE Prevention Program aims to reduce the incidence of hospital-related VTE by ensuring that all patients are assessed for VTE risk and given appropriate prophylaxis.
  https://www.cec.health.nsw.gov.au/keep-patients-safe/medication-safety/vte-prevention.
  This toolkit provides information, resources and QI tools for managers and clinicians to improve VTE Prevention outcomes in NSW health services.
  https://www.cec.health.nsw.gov.au/improve-quality/quality-improvement-toolkits/vte

| POLYPHARMACY STEWARDSHIP |

- NSW Therapeutic Advisory Group. Resource Kit for Measuring Strategies to Reduce Harm from Polypharmacy in Australian Hospitals: QUM Indicators, Patient Reported Experience Measures and Risk Stratification Tools.
  https://www.nswtag.org.au/polypharmacy-qum-indicators-and-resources/

| BENZODIAZEPINE STEWARDSHIP |

- NSW Therapeutic Advisory Group Inc. (2021) Getting it right for sleep at night: Guidance for promoting sleep and reducing harm from inappropriate pharmacologic management of sleep disturbance and insomnia in hospitalised patients.
  https://www.nswtag.org.au/optimising-sleep-in-hospital-guidance-and-resources/

- Choosing Wisely Canada has a toolkit for reducing inappropriate use of benzodiazepines and sedative-hypnotics among older adults in hospitals.
  https://choosingwiselycanada.org/toolkit/less-sedatives-for-your-older-relatives/

| QUALITY IMPROVEMENT |

- Clinical Excellence Commission Quality Improvement Toolkits.
  https://www.cec.health.nsw.gov.au/improve-quality/quality-improvement-toolkits

- Clinical Excellence Commission Capability Development Guide for Employees

- Institute for Healthcare Improvement Building capacity and capability for improvement: embedding quality improvement skills in NHS providers

- Resources for Implementation Science Researchers.
  https://www.fic.nih.gov/About/center-global-health-studies/neuroscience-implementation-toolkit/Pages/resources.aspx

- Choosing Wisely Collaboration Implementation Toolkit Workshop 1.
  https://www.choosingwisely.org.au/assets/CW-Collaboration_Implementation-Toolkit-1.pdf

- Medicines Use Evaluation Guideline Journal of Pharmacy Practice and Research (2020) 50, 166–179.
  https://onlinelibrary.wiley.com/doi/abs/10.1002/jppr.1652

- Institute for Healthcare Improvement Model for Improvement – learn about the fundamentals of the Model for Improvement and testing changes on a small scale using Plan-Do-Study-Act (PDSA) cycles.
  https://www.ihi.org/resources/Pages/HowtoImprove

- Rapid Cycle Improvement: Controlling change.
  https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/quality-improvement/learn-about-quality-improvement-rapid-cycle-methodology.pdf

- Intervention selection based on what drives achievement of the project aim
  Institute for Healthcare Improvement – QI Essentials Toolkit
  (Free access after you register).

- Intervention selection based on categories of drivers of behaviour.
  COM-B ('capability', 'opportunity', 'motivation' and 'behaviour') model Driver diagram section for intervention selection; Pages 7–10

- The User guide for reviewing clinical variation from the Australian Commission on Safety and Quality in Health Care provides a six-step approach to the review of clinical variation data, and case studies that put those steps into action.

| REFERENCES |

1. Australian Commission on Safety and Quality in Health Care. Antimicrobial Stewardship in Australian Health Care Sydney: ACSQHC;2021.

2. Australian Commission on Safety and Quality in Health Care. Antimicrobial Stewardship Clinical Care Standard Sydney: ACSQHC;2020.

3. Australian Commission on Safety and Quality in Health Care. Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard – Acute care edition. Sydney: ACSQHC;2022.

4. UNC School of Medicine. Communication Plan. 2022; https://www.med.unc.edu/ihqi/resources/communication-plan/. Accessed 7 November, 2022.

5. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. In. Sydney: ACSQHC; 2017.

6. World Health Organization. Regional Office for the Western P. Health service planning and policy-making : a toolkit for nurses and midwives. Manila: WHO Regional Office for the Western Pacific; 2005.

| ACKNOWLEDGEMENT |

The **CATAG** toolkit for implementing a medicines stewardship program was adapted with permission from NPS MedicineWise and Choosing Wisely Canada.

CATAG

Council of Australian
Therapeutic Advisory Groups

www.catag.org.au