In terms of improving safety for patients within the health system I can think of a couple of areas of deficiency which could be improved:

1. There seems to be a lack of process for reporting errors which happen in the community. For example we had a patient that was recently admitted with Lithium toxicity requiring a 5 days stay due to the private psychiatrist prescribing the wrong dose of lithium (10x therapeautic dose). Although this was feed back to the individual psychiatrist when I made an enquiry of pharmacy as to how to report prescription errors which have resulted in adverse outcomes I was told there is no system in place (ADRAC only collects information on drug side effects). This could potentially lead to certain prescribers continuing to prescribe erroneous scripts without any review process.

2. Within each health system VHIMS reporting often misses important events. I think an element of this is that there is no anonymous way of reporting errors and therefore for example if the error occurred within the medical team (and would not be appreciated outside the team) there may be reluctance for one team member to 'dob' in the error for fear of upsetting superiors etc.

Dr Sarah Whiting
General and Infectious Diseases Physician, Alfred Health