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New Zealand
National Quality Improvement Programme
Safe Medication Management
Global GS1 Healthcare Conference

Hong Kong 6-8 October 2009



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Presentation Outline

- Background and objectives
- The SMM programme
- Progress after 15 months
- Lessons learnt



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Background

- National Quality Improvement Programmes
 - Safe Medication Management (SMM)
 - Optimising the Patient's Journey
 - Management of Healthcare Incidents
 - Infection Prevention and Control
 - National Mortality Review Systems
- Overseen by Ministerial appointed Quality Improvement Committee (QIC)



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Background – SMM Programme

- 2002 Report
 - 150 died, 400 permanently disabled, 3,500 temporary disabled per year in NZ hospitals from medication errors
 - 40% of hospital spending on “adverse events”
 - 67% of hospital spending on adverse events were from “preventable adverse events”

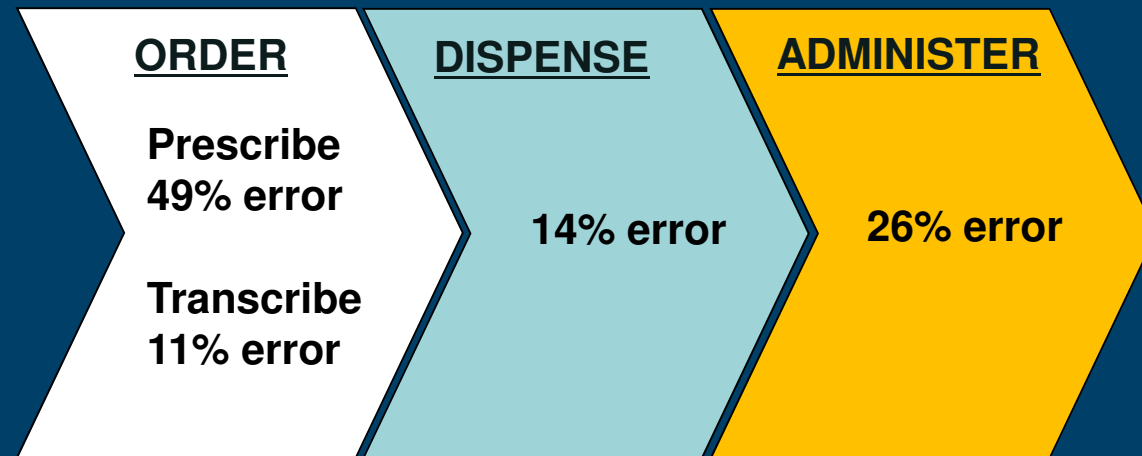


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Background - SMM Programme

- Errors in the hospital medication use process



** Extract from the Safe Medication Management Programme report on the Pathway and Barriers to Unit Dose Packaging



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Background – NPSA 2009 report

- 811,746 reported incidents
- 72,482 medication incidents
 - 76% acute care
 - 96% no or low harm
 - 100 deaths or severe harm
- Serious harm medication incidents
 - 41% administration
 - 32% prescribing
 - 71% related to unclear/wrong dose or frequency, wrong medicine and omitted/delayed medicines



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Objective of SMM Programme

- SMM is a 4 year Programme
 - Improving processes and system
 - Aimed at reducing errors & harm
 - Rollout to all public hospitals
- Launched in June 2008 (15 months)



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The SMM programme

- Clusters:
 - Medication Chart / E-Prescribing
 - Medication Reconciliation
 - Unit Dose/ Bedside Verification
 - Standardise and Link Systems
- Foundation Workstreams:
 - Legislation
 - Primary Care/Secondary Interface
 - Evaluation, Standards & Common Language
 - Culture
 - Training, Education & Support
 - Governance (Programme & Handover)
 - Communications



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Progress

- Participation
 - Multi-disciplinary working groups – more than 60 clinicians from 21 DHBs
 - Pharmacists, doctors and nurses seconded
 - Consumer and Primary Care representation
- Communications
 - Strategy and toolkit
 - Sector stakeholder engagement
 - Website
- Medication Chart
 - Medication charting standards finalised
 - 1st in a series of national medicines charts finalised and to recommend 2 x DHB for trialling (Sept to Nov 09)



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Progress

- ePrescribing
 - 2 hospitals to trial ePrescribing
 - Legislation barriers identified
 - Pathway to remove barriers clearly identified
 - Clinicians working group to define standards
- Medicine Reconciliation
 - 5 hospitals already doing MR
 - Targeted patient groups / services
 - Some commonality, no formal standards
 - 2 hospitals interested at eMedRec solution
 - MR standards approved
 - Building experienced resource team & toolkit
 - 5 more hospitals to implement MR by December 09



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Progress

- Unit Dose Packaging / Bedside Verification

- Report recommends

- advocacy programme for product barcoding
- adoption of global standards for barcoding and product identifiers
- Medsafe support contingent on an agreed standard
- PHARMAC support contingent on minimal or no cost impact and where compliance is mandated utilisation must be possible, especially UDP
- Clarify relationship between product barcoding and the Medicines Terminology (NZULM)

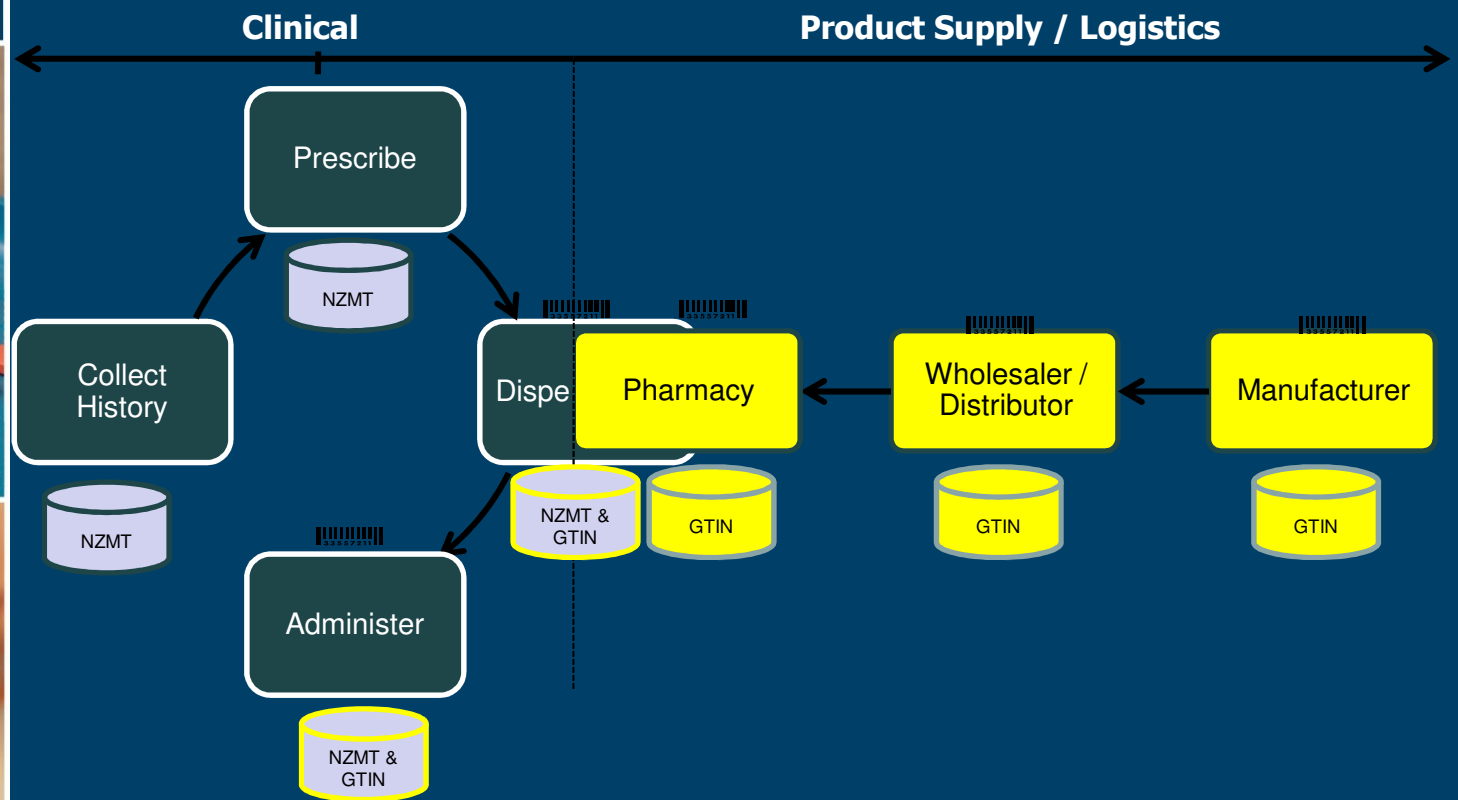


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Progress

- One barcode can be used from manufacturer to the bedside yet support both clinical and product supply needs





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Progress

- Standardise and link systems
 - Stocktake of current disparate systems (hospitals, primary care, pharmacies)
 - Identify current “missing” links
 - Priority driven by what clinical problems to be solved
- Common language –
 - NZ Universal List of Medicines
 - Adverse Drug Event (ADE)



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Progress

- Primary / Secondary Care
 - Part of the medication management continuum
 - Link to eDischarges and eReferrals collaborative
 - incorporate medication management requirements
 - national standards endorsement
 - Primary Care network established – incl. General Practice, Pharmacy, Aged Care initially
- Governance
 - Clinical involvement / engagement
 - Interim clinical leadership panel
 - Long term governance structure



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Lessons Learnt

Environment for Success

- Organisational culture, support and commitment
- Strong leadership (multiple levels)
- Communication & change management
- Commitment to “standards” approach
- Leverage pilot learnings with others



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Lessons Learnt

- Approach - incremental change
 - Stabilising foundations
 - Pathway of practical steps towards the vision
 - Iterative steps (do, feedback and modify)
- Problems properly identified & baseline measured, evaluation criteria
- Agree processes and standards before looking at solutions.
- Effect change by – Inspiring, guiding, engaging, advice & direct assistance, influence networks

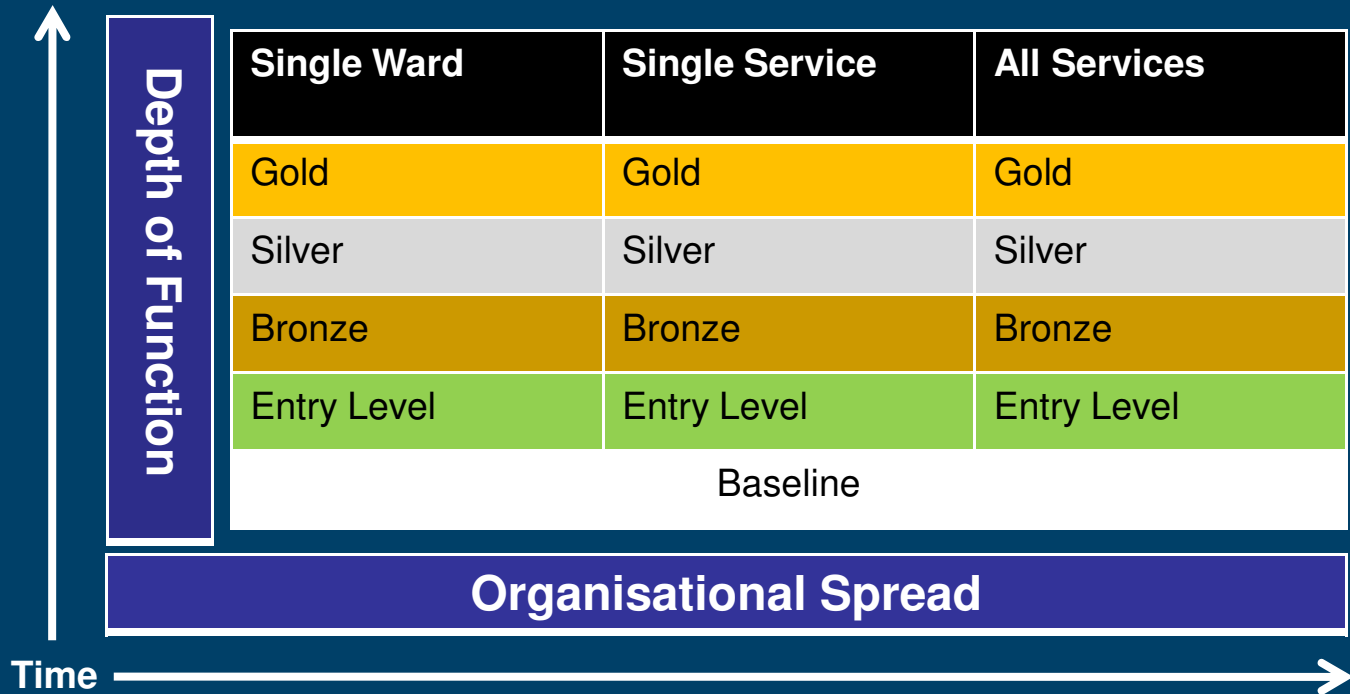


NQIP

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Approach – incremental change



Incremental Steps

Start simple and spread, then add depth



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Thank You