Minutes of the meeting of
Medication Safety Expert Advisory Group
(MSEAG) on 28 November 2018

Location	Monarch Room, Willeston Conference Centre, Level 11, 15 Willeston Street, Wellington
EAG Members	Alan Davis (Chair), Sandra Fielding (Deputy chair), John Barnard, Gareth Frew, Avril Lee, Lucy McLaren, Bev Nicolls, Shelley Pakoti, Rob Ticehurst, Dave Woods
Ex officio	Charlie Charters (MMDS), Sunita Goyal (ACC), Janet Mackay (PHARMAC), Bryan Simpson (NZF), Michael Tatley (NZPhvC)
Commission staff in attendance	Billy Allan, Caroline Tilah, Susan Melvin, Kat Lawrie (minutes)
Apologies	Andi Shirtcliffe, Matt Doogue, Peter Jansen, Beryl Wilkinson, Sharon Kletchko, Doreen Liow, Chris James

Meeting commenced at 9.50 am.

Introduction and matters arising from previous meeting

1 Welcome, apologies

Alan welcomed everyone to the day and noted the apologies to the meeting. Introductions were made to Michael Tatley (NZPhvC, in place of Desiree Kunac) and Susan Melvin, new Patient Safety Advisor at the Commission. For the benefit of new members, the group all introduced themselves.

2 Declarations of interest

The group were reminded to raise any conflicts during today's meeting or let Kat know of any new relevant conflicts of interest to note.

3 Minutes from previous meeting August 2018

The minutes were confirmed as an accurate record.

4 Actions review from previous meeting August 2018

180801 Anticoagulants – inappropriate use
This issue is on the agenda for this meeting (item 11).

180802 National Medication Chart (NMC) suite review
Two RMOs from Waikato have been recruited.

180803 – National Medication Chart review
The review has been delayed until February 2019 as DHB hospitals are under considerable pressure with the introduction of the opioid QSM, and midwifery strikes.

180501 Alert 17 - Alteplase + tenecteplase
A response is still pending from Nelson Marlborough DHB (contact was made last week).

180502 Always report and review (ARR) events for medicine related events
This issue is on the agenda for this meeting (item 12).

180503 Medicines alert groupings
The business case for the management of medicines alert groupings is in development. Medsafe (Chris) to be asked for an update for the February meeting. Concerns were raised around this not being progressed. The Chair requested that Matt Doogue provide 'a one page' paper on the risks involved in not implementing the medicine alert groupings.

Action: Chris James to be asked for an update on the status of the business case for the medicine alert groupings.
Action: Matt Doogue to be asked to provide a paper on the risk involved in not implementing the medicine alert groupings.

180510 International forum on quality and safety in healthcare
Sandra to forward her report to be circulated with today's minutes.

Action: Sandra to send pdf of her report to circulate to Kat Lawrie and Billy Allan.

180511 Compounded tramadol suspension
The compounded tramadol from biomed will soon be available as an unapproved and unfunded medication. It is still not readily available for primary care. Next year Biomed will submit a medicines approval application to Medsafe and a funding application to PHARMAC. Currently hospitals are undertaking their own compounding, but are now able to buy the suspension from Biomed.

180513 Medication error reporting in NZ
The Chair has written to the Director General regarding the funding of a medication error reporting and learning programme for New Zealand, with a response received. The Ministry is to discuss this with the Commission. The Director General of Health has been invited to the next MSEAG meeting and is keen to attend.

171108 Oxygen prescribing - #O2 The Fix
Waitematā are sending a memory stick to the Commission with the educational materials. Avril apologised on behalf of the team for the delay. The material will be added to the Commission's website and widely circulated, with marketing and socialisation to encourage DHBs to utilise the toolkit.

Billy provided an update on the REX inhalers (161123). This was an issued highlighted through the MERP where same coloured actuators and interchangeable caps on the REX range of inhalers were identified as a serious medication safety risk. REX have revised their salbutamol inhaler labelling with release to the market. There is a long lead time to get things changed but it will be coming out shortly supported with letters to GPs and pharmacists.

Strategic focus

5 Follow-up from our workshop last meeting

Where to from here?

Caroline summarised the discussion from the August EAG, on page 51 of the papers for today's meeting.

To inform the workplan for 2019/20

Susan circulated a print out of a driver diagram to lead a discussion to inform the programme plan and the group were asked to vote on the change ideas they felt were most important to include in the coming programme plan. The driver diagram was a summary of the change ideas from the workshop at the last MSEAG meeting. The discussion continued later in the morning (minuted below).

The group broke into 4 groups to discuss the change ideas that were most popular:

- Development of pathways to prevent harm (6 votes)
- Digital/IT integration – one source of truth (5 votes)
- Health equity – "to improve health equity you may need inequitable interventions targeted (context of patient environment)" (5 votes)
- Capturing patient experience (co-design approach) (4 votes)
- Review refinement of existing medication QSMs (opioids/eMedRec) (4 votes)
- Provide clarity on guidance for medication data collection, monitoring and analysis for adverse events reporting. (4 votes)

Priority actions from the groups were:

- Increasing patient awareness and knowledge of being on a pathway to harm – how do we increase patient knowledge and understanding?
- Reducing variation
- Identify the groups most at harm and provide information
- Equity should be a part of all conversations, around all inequities
- What is the role of the Commission, what is role of the Medication Safety team?
- Medication data – what is it telling us? What are we missing?

A discussion was then held around identifying some questions for the Director-General for February's MSEAG.

The group agreed:

- We need uniformity around the questions and how they are framed
- What are the Minister's expectations?
- How can the Ministry help improve medication safety?
- How does the Ministry want issues escalated?
- What does the Ministry want to know from HQSC (in relation to medication safety)?
- How do we link incident/harm information?
- What are the challenges – eg, the new Therapeutic Products Bill?
- Within the national guidelines and recommendation, what scope is there for greater leadership and direction from the Ministry?

Technology to support safe medicines practice

6 Proposal to discontinue the eMedicine Reconciliation (eMedRec) QSM (paper)

The original intent was implementation of electronic systems and prescriptions and by 2014 all DHBs were going to be well on their way to an electronic solution. Unfortunately, most of the DHBs aren't yet using systems that support eMedRec.

Only two DHBs are reporting the full set of eMedRec QSM markers to the Commission and the Executive Leadership Team (ELT) at the Commission have suggested retiring this quality and safety marker (QSM).

The group discussed removing the marker and agreed:

- There is no other way to measure medication safety at present
- The Commission's ELT should be advocating and encouraging more DHBs to submit, rather than removing the marker
- There are a lot of precursors for DHBs to eMedRec systems – a plan to implement will need to be different for each DHB

The benefits of the marker include:

- We have evidence that dangerous errors are being intercepted
- Those DHB hospitals with eMedRec functionality would not have achieved this without the QSM. Publicly reporting the QSM has supported and advanced the adoption of eMedRec. This would not have happened without the focus, drive and leverage of the national QSM at DHB and vendor levels.

There are concerns that:

- Some data can cast a negative light on a DHB, but they still need to be encouraged to submit QSM data – they will not be criticised but commended for their data submission (there needs to be a mind shift change)
- Ideally in future, reporting should be wider than from the hospital MedRec as patients return to primary care where there are also medication safety issues
- There is still a wide gap between DHBs and their electronic systems – some providers are very behind the leading DHBs
- If the marker was extended to include manual reporting the resource would be insurmountable for some services
- 15 DHBs should be capable of reporting currently but only 2 are actively submitting data, (ie, the 15 DHBs have the MedRec functionality but are not yet using it or are not reporting their QSM data)

The group's consensus is that the QSM shouldn't be lost and that we need to note what has been achieved and come up with a plan on how to improve going forward.

Action: Billy to respond to ELT noting that the MSEAG does not support the retirement of the eMedRec QSM.

7 Bicillin L-A (benzathine benzylpenicillin tetrahydrate) datasheet, labelling and NZF changes

Bryan Simpson joined the meeting by teleconference, joined by Ruth Ferguson, Senior Clinical Editor, NZF.

Rob Ticehurst presented on the Bicillin LA datasheet and labelling changes. The product will now only have 1.2 million units on its packaging, removing all references to the milligram strength.

Historically the packaging has reflected the dosage as 900 mg. This has been discovered as an error, as the dosage in each syringe is actually 1016 mg.

A discussion was held:

- NZF have been asked by Medsafe to remove all references to the 900 mg strength from the Bicillin L-A monograph.
- Bryan has investigated international packaging which seems to have been amended to reflect 1016mg and 1.2 million units.
- There is no context or evidence to explain why 900mg is wrong, which will lead to confusion among providers familiar with the medication.
- Changing the datasheet will not change practice overnight.
- New Zealand and Australian guidelines typically dose benzathine penicillin in mg/kg (not units/kg). Other jurisdictions (eg, North America) typically dose in units/kg.
- Loss of reference to milligram strength could lead to confusion and error.
- Pfizer are happy to retain 900mg on their packaging but Medsafe have advised them to remove all reference to milligrams
- Usage for children makes part doses necessary.

It was agreed that an offline conversation would be held between Billy Allan, Rob Ticehurst, Medsafe, and NZF (Bryan Simpson). Bryan will add a link to Pfizer's 'Dear Healthcare Professional' letter that describes the change in strength description for Bicillin L-A and links 900 mg/2.3 mL and 1,200,000 units/2.3 mL.

Action: NZF to add a link to the Pfizer Bicillin L-A Dear Healthcare Professional' letter from the NZF Bicillin L-A monograph.

Action: Billy to arrange a meeting between Rob Ticehurst, Medsafe (Alison Cossar, Manager, Product Regulation Branch), NZF (Bryan Simpson) and HQSC (Billy Allan) to discuss the change in Bicillin L-A strength expression.

8 Presentation – Integrated Community Pharmacy Services Agreement – an update

Alan welcomed Warwick Gilchrist, Programme Manager – Pharmacy, Central TAS to the meeting to present on the new Integrated Community Pharmacy Services Agreement.

A discussion followed:

- Is there still funding for quality improvement activities? There is funding for community health outcome improvements and service improvements around admissions; also a funding line is available that DHBs can allocate ($4.1m nationally) to pharmacy initiatives.
- Community pharmacy is being promoted in the wider network of care, for a range of minor ailments – this has the potential to improve quality and safety of medication provision.
- The aged residential care sector is technology-limited. In the central region some progress is being made but nationally it's a big piece of work.
- Keeping up communication with all sector providers and agencies is very important.

9 Medicines management digital services update

There has been a lot happening removing barriers:

1. The Director-General signed a waiver to enable unsigned prescriptions to be recognised as legal prescriptions. This is only to apply when a prescription has a unique barcode and is both:
    a. Electronically generated by a prescriber from an approved electronic system integrated with the NZePS; and
    b. Dispensed via a pharmacy dispensing system that electronically matches the barcode stored in the NZePS broker.

It is expected that this will encourage the development and adoption of medicines management digital services across primary care.

2. There is 6-7 years of national dispensing data available in the NZePS data repository. An application program interface (API) has been developed to enable access a person's community dispensed medication data based on their NHI. This is being piloted across the DHBs in the Midland region for use in their emergency departments and for medicines on admission review and reconciliation.
3. Similarly, the Conporto EDM (event detection and mitigation) tool has been integrated with the NZePS. CCDHB and HVDHB are piloting the use of the Conporto EDM in their emergency departments to access a person's community dispensed medication data.
4. The increased adoption of electronic prescribing and administration (ePA) systems within residential care facilities has enabled prescribing and dispensing to be undertaken using the medication chart. The Auckland metro are undertaking a project to facilitate the removal of a paper prescription in this instance. This will significantly reduce the amount of bureaucracy involved and eliminate the potential for discrepancies and transcription errors.
5. CCDHB addiction services opioid treatment service (OTS) pilot utilising MediMap and the NZePS is starting in the new year. The electronic systems are currently being tested. The prescriber and pharmacist will be able to look at and update a person's medication chart in real-time.
6. Interest in adopting and rolling out MedChart has increased. A recent study has shown that the use of ePA in hospital can reduce the number of adverse drug events by up to 70%.

Programme management and projects

10 Thank you and presentations

This was the last meeting for three members: the Chair and Clinical Lead, Alan Davis; Avril Lee, original member, member of the MSEAG's predecessor the SQM, and clinical lead for the opioid collaborative; and David Woods, long-term member and member of several working groups.

The chair thanked Avril and David for their valued contribution to the group and dedication to medicine safety over a significant length of time, and presented gifts and cards.

Caroline Tilah, the Commission's Manager Patient Safety, thanked Alan for his leadership, wise counsel, service and dedication to the MSEAG and medication safety over several years, and presented a gift and a card form the members.

11 Working group update – Compound working group (paper)

An update from the working group was received. It was noted that:

- Thirty three New Zealand standardised oral formulation (NZSOF) extemporaneous compounded batch sheets have been completed. Thirty one will be put forward for hosting on the PSNZ website; two withheld as there are now funded proprietary products for these medicines.
- It is anticipated that the new batch sheets will be available on the PSNZ website in February 2019.
- The availability of the batch sheets will be supported by a publicity piece and a FAQs document.

The MSEAG offered congratulations on this piece of work being progressed.

12 Always report and review (ARR) event candidates (action 180502; paper)

A paper 'Always report events: potential targets-4' was received. After debate and working with ACC, the Commission's Medication Safety Specialist looked at several potential candidates for a medication ARR event, but has not been able to identify anything that meets the criteria for a true ARR event. The recommendation was made that the group holds off on any recommendation for a medication related ARR event until there are robust system level supports in place for a true ARR event. Potential candidates may involve:

a. Prevention of oral/enteral misconnections with intravenous lines when the ENFit oral/enteral connectors become widely available in New Zealand; or
b. Prevention of intravenous line misconnections with intrathecal cannulae when the NRFit neuraxial specific connectors are introduced into / marketed in New Zealand.

A discussion was held around what would fit appropriately on an ARR list. It was agreed that the MSEAG would deferrer recommending a medicine related ARR event for inclusion in the Commission's ARR event list, until the necessary system level support is in place to make any proposed ARR event a rare event.

13 Working group update – Specify Brand Advice (paper)

The Specify Brand Advice (SBA) guidance was reviewed and updated in May 2018. Since the May 2018 review, the SBA working group has reconsidered the evidence behind the criterion for narrow therapeutic index medicines. Whilst the criterion remains unchanged, there is insufficient evidence to support narrow therapeutic index SBA status for any medicines currently on the New Zealand market. There must be clear evidence of clinical risk before recommending an item be assigned narrow therapeutic index SBA status.

The SBA working group therefore recommended that:

1. The SBA guidance be amended with the removal of the narrow therapeutic index SBA examples currently included, and
2. Those medicines currently assigned narrow therapeutic index SBA status through the NZULM have this status removed.

If in the future Medsafe approves a medicine where there is a significant clinical risk when switching between different brands of the same medicine the SBA guidance (and the NZULM) can be amended.

The recommendations were approved.

14 Anticoagulants – inappropriate use (action 180801; paper)

It was agreed that this item would carry over to the next meeting.

15 MSEAG Terms of Reference revision (paper)

An updated version of the MSEAG's terms of Reference had been circulated. It was agreed that this item would carry over in the next meeting.

Other business

16 Topics and guest speakers for next MSEAG

The Director-General is hopefully attending the February meeting, as previous discussed.

Sandra Fielding, MSEAG Deputy Chair, will act as Chair until a new appointment is made.

Alan will continue to attend the Medicines Management Digital Service Sector Oversight Group until a decision is made around a new MSEAG Chair and Clinical Lead.

Alan thanked the group and made his farewells as chair.

17 Meeting dates 2018/2019

Future meetings for 2019 will be in Wellington:

27 February 2019
22 May 2019
28 August 2019
27 November 2019

Meeting closed 3.17pm.