Minutes of the meeting of the Medication Safety Expert Advisory Group (EAG) held on 31 May 2017, at Novotel Auckland Airport, Auckland

Present:	Alan Davis (Chair), Matt Doogue, John Barnard, Avril Lee, Beth Loe, Sandra Fielding (Deputy Chair), Lucy McLaren, Janet Mackay, Nelson Aguirre, Beryl Wilkinson, Rob Ticehurst, Bev Nicolls, Gareth Frew.
In attendance:	Carmela Petagna, Charlie Charters, Billy Allan, Charmaine Pene (minutes)
Guests:	Liz Price and Maria Vidovich (HQSC)
Invited ex officio:	Andi Shirtcliffe (MoH), Desiree Kunac (NZPhVC), Chris James (Medsafe).
Apologies:	David Woods

The meeting commenced at 9.14am.

1. Welcome, apologies and declaration of interest

Alan Davis welcomed everyone to the meeting. An apology from David Woods was noted. There were no changes to the members' declarations of interest.

2. Acknowledgements

The chair, Alan Davis acknowledged the presence of two new members and led around the room introductions.

a. Gareth Frew, EAG member – community pharmacy - Canterbury
b. Billy Allan (Seconded from Hawke's Bay DHB), as Medication Safety Specialist to the programme

3. Patient short stories

The focus of the consumer stories at this meeting focussed on issues of analgesics and pain relief - their use and misuse. Stories shared illustrated that some patients are not being appropriately informed when given medicines, and that the prescribing of pain relief at the doctor / general practice does not involve sufficient screening for potential risks / side effects of medication when giving pain relief.

Patient short stories drew on examples where:

a. Person suffering nausea and vomiting along with abdominal pain was prescribed anti-emetics, with apparent little attention given to problems being experienced with constipation. Complications led to presentation to the Emergency Department presentation (and almost required surgical intervention).

b. Person with head and ear pain prescribed pain relief and sent away, again little in depth assessment of any underlying conditions. Later revealed that serious brain underlying conditions were present.

c. A medication error case study from July 2016 was handed out relating to a 92-year-old living at home who received a GP prescription. When the medicine was dispensed by the pharmacy, the labelling was incorrect (the address was wrong) and this caused anxiety for the patient as to whether this was in fact the right medication.

It is noted that the patient stories link to Patient Safety Week and will enable ideas and key themes to be developed, with a focus on how community pharmacy can best be engaged in this activity.

4. Minutes of 08 March 2016 meeting.
The minutes were confirmed as a true and accurate record.

Moved: Sandra Fielding Seconded: Lucy McLaren

Based on feedback from the recent round of regional medication safety meeting, there was interest in the sector being able to read the minutes from the expert advisory meeting, so that there is some visibility of topics and issues being discussed at a national level. It was agreed that from now on the minutes (once verified by the members) will be published on the Commission's medication safety webpage as an approved draft.

5. Action list update (see appendix 1)

6. Terms of Reference (ToR) – Expert Advisory Group (Carmela Petagna)
The amended ToR had been circulated with the agenda. Further minor amendments were suggested. It was agreed that subject to these changes being made the ToR are now ratified by the EAG and will also be available on the Commission's website.

Moved: John Barnard Seconded: Avril Lee

Action: Carmela Petagna to make changes and publish.

7. Serious Adverse Event: policy update and potential 'always report' events for medicines.
Members were provided an overview of the updated policy which is yet to be formally released by the Commission – expected to be in early July 2017. The members have requested further information on the policy's 'change management' process. There would be a small list of "always report" events to start with, and this may be expanded over time. This was an area of interest for the EAG, and discussion would be given to what medication-related events it felt should be in this category.

Action: Secretariat to invite Sarah Upston, Adverse Events, HQSC to a subsequent meeting to discuss this further.

8. Members - Horizon Scanning
As a result of the recent medication safety regional workshops, the Chair, Alan Davis noted that a number of issues and themes are emerging (see also item 9.4 below). These included; Adverse Drug Reactions (ADR) / Allergies and having access to accurate and timely data to better inform decision-making.

9. Programme update

9.1 Patient Safety Week (PSW) (Liz Price / Marija Vidovich, Communications team, HQSC)

Patient safety week is an awareness-raising week coordinated by the Commission in partnership with ACC. Patient Safety Week to be held over the period 3 – 7 November 2017.

The 2017 theme is 'medication safety' and the overall purpose of the week is to:

- Create focus, energy, momentum and raise awareness of the importance of patient safety.

- Promote open communication between patients and health professionals about medicines. In particular, encourage consumers to ask questions about their medicines and health professionals to welcome and respond to these questions.

Feedback was requested on what the Group considered were the most important three to five questions relating to 'ask about your medicines'. A number of ideas and thoughts were shared and the communications team who will incorporate these into the overall planning. Andi Shirtcliffe recommended a teleconference with MoH on medication safety best practice and how community pharmacy can engage with PSW.

It was noted that PSW links to the WHO Global Patient Safety Challenge – Medication Without Harm and is being used as the platform to create energy to look at how the Commission, and the sector will embrace the Challenge.

Action: Secretariat to arrange teleconference with MoH. Participation to include Chair - Alan Davis and Specialist Advisor – Billy Allan.

Desiree Kunac spoke to a presentation from the International Medication Safety Network (IMSN) 11th Annual meeting relevant to Patient Safety Week – "Patients and the Public: Essential Partners in the WHO Global Patient Safety Challenge. The Canadian leaflet "5 Questions to ask about your medications" was provided to the members for information.

The members noted the presentation and there was no further action required.

9.3 Raising the Bar on the National Patient Experience Survey – next steps (Carmela Petagna)
The members noted the report which is to be published on the Commission's website. The report had also been circulated to all participating DHBs. It was confirmed by the programme team that the recommendations arising from the report are being considered and will feed into a second phase of work, again with a small group of DHBs. The report is available on the Commission website at https://www.hqsc.govt.nz/our-programmes/partners-in-care/publications-and-resources/publication/2927/

9.4 Medication Safety Regional Workshops (Alan Davis)
An update on the workshops conducted to date (two of the four) was provided by the Chair, Alan Davis. Key themes from the workshops are to be collated and will inform the medication safety programme in order to align priorities and work effort and also look at topics for future sector engagement and interest. The workshops have been well received to date and it is expected that these will continue once a year face to face.

9.5 Adverse Drug Event Trigger Tool paper (Beth Loe / Billy Allan / Alan Davis)
This paper is now being processed by the New Zealand Medical Journal (NZMJ) for publication. The final paper will be circulated when published.

Action: Secretariat to circulate when published.

9.6 ACC Discussion paper (Alan Davis / Carmela Petagna)
The cost of medication related treatment injury was noted by the members and a need to better understanding the details that sit beneath these figures. It was recommended that ACC be invited to an EAG so that members can gain a better understanding of the ACC data as a potential medication safety intelligence source, and that a meeting take place with ACC

to assess whether there is any interest in partnering in future work.

Action: Secretariat to organise a meeting with ACC, to start that discussion, and look to inviting ACC representatives to a subsequent meeting of the EAG.

10. Safe use of opioids collaborative (Avril Lee / Charmaine Pene):
Clinical Lead – Avril Lee informed the members of the shift from a formative collaborative to a programme work stream focus. Monthly teleconferences also continue to support the opioid network. She noted that the recent regional medications safety workshops include a session on opioids and provide a sharing opportunity across the DHBs. There is a need to obtain a commitment from DHBs to implement and spread the use of the harm bundles, or elements of the composite bundle incrementally.

Charmaine provided an update on the measurements workshop held in April which was to look at the feasibility of establishing some measures around improved processes for the safe use of opioids, and improved patient outcomes. There is a degree of data interrogation required (ie: the NMDS), which will be undertaken by Richard Hamblin and the health quality & evaluation team at the Commission. Once these results, and intelligence obtained from work being done by other DHBs, is obtained then a further workshop will be held with the aim of developing a national Quality Safety Marker (QSM) suite.

An abstract titled 'A national formative collaborative: reducing opioid related harm and building quality improvement capability in New Zealand' has been submitted for APAC September 2017. The programme is also working on developing a number of papers for publication based on the results of the national collaborative. The group was keen that DHB teams are also encouraged to disseminate their work and results, which helps with sector engagement.

The opioids group and the medication safety specialist have engaged with the Commission's Patient Deterioration programme who are reviewing the Adult Early Warning Signs chart. Feedback to that programme team is for the inclusion of opioid-related monitoring information to be included in the "optional" extras lines as the base of the chart which would align well across both programmes of work. This could include pain management scores, and bowel monitoring.

11. Medicines management digital services review (Charlie Charters)
The members were briefed on the review outcomes and recommendations. The members did not consider any further action is required currently but would be keen to be kept abreast of developments, given the importance of the digital platforms and impact across the medication safety agenda.

12. Electronic Medicine Management (eMM) – (Charlie Charters)
A programme update was provided by Charlie. In addition, there was discussion on the (eMR) Quality Safety Marker (QSM) as it appears there has been little traction in reporting against the process measures, by those that have implemented the system. There was support by the group to hold an eMR definitions workshop with the five participating DHBs and the system vendor. It would also be important to consider the impact of this work on any new electronic platform in the future eg: MedsMan.

Action: Programme team with members of the Commission's intelligence hub arrange a eMR definitions workshop with participating DHB representatives and the software vendor.

13. Aged Residential Care (ARC) medication chart evaluation report (Beth Loe)
It was noted that the report will be released when finalised. There is also work being completed on an implementation support guide to help those ARC facilities that are interested to introduce the "hybrid" chart. Whilst some ARC facilities are transitioning to electronic prescribing and administration systems, it is recognised that there is an ongoing requirement for a standardised ARC chart particularly for the smaller facilities. Once published, it was suggested that the ARC chart be promoted through HealthCERT and the NZ Aged Care Association (NZACA) and the Commission's website. The team will not be undertaking any new development work, but would look to review progress in this area in 12-18 months.

The members did not consider any further action required.

14. Medication Error Report Programme (MERP) (Desiree Kunac)
The MERP quarterly report (1st quarter 2017) was presented to the members. In regards to report relating to nicotinamide / nicotinic acid, the members recommended that a letter is sent to the New Zealand Dermatological Society Inc. This would highlight the confusion between the sound-alike medicines, and recommend that printed material be provided to patients. The information would need to clearly state which medicine (nicotinamide) the dermatologist is recommending (nicotinamide not being funded on prescription), and this advice would also be published through the Commission's medication safety webpage.

Action: Medication Safety Specialist / Chair to write to the New Zealand Dermatological Society and provide a statement for the Commission's website.

15. Recommendations from Medicines Adverse Reactions Committee (MARC): Opioids and benzodiazepines
(http://www.medsafe.govt.nz/profs/adverse/Minutes169.htm#3.2.1)
The MARC had reviewed the co-prescribing of opioids and benzodiazepines and the risk of serious side effects, and is promoting the Centers for Disease Control and Prevention (CDC) recommendations for prescribing opioids for chronic pain outside of active cancer, palliative and end of life care.

Members agreed that the Commission's ATLAS of Healthcare Variation – Opioids be reviewed to ensure that the commentary reflects the risks from co-prescribing opioids with benzodiazepines, and MARC's recommendations.

Action: The Medication Safety Specialist is to review, and if appropriate put forward amendments, to the Commission's 'Opioid ATLAS' to reflect MARC's recommendations.

16. Medicines regulation update (Chris James)
Chris James, Medsafe, briefed the members on the medicines regulation review. It is anticipated that the consultation draft of the revised legislation will be published in November post the election, with the Bill going to the House early 2018, and the legislation coming into force at the end of 2018. The members did not consider any further action is required.

17. Working Groups review (Carmela Petagna)
The members provided feedback and agreed to the working group table being updated to reflect groups that are actively engaged in work aligned to programme priorities.

Action: Carmela to update the list and provide to the EAG at the next meeting.

18. Working group updates

18.1 Safety requirements for eMM systems (Bev Nicolls)
Bev Nicholls provided an update to the members. Some points noted were medication charting and electronic systems in particular with relation to aged residential care ie: MediMap and 1-Chart. Mental Health potentially looking to an electronic medication chart system. Standards / protocols are important in relation to medicines charting particularly for consistency for prescribing. Reviews are occurring within the programmes (software). It was noted that neither are linked to NZ Formulary. There is an issue with text based allergy recording and stop dates on the drug charts.

This area of work is one that will need to be considered as part of the overall governance of the digital medicines management agenda. The EAG is keen to have an ongoing input into the clinical and patient aspects of safety and quality.

18.2 Compounding of liquid medicines (David Woods)
David provided an update via email. The revision of standard batch sheets and review of associated safety issues has started. A more complete report is expected in the next couple of months. A recently reported paediatric compounding liquid error has identified culturally specific issues and further education strategies are also being considered. The members did not consider any further action is required.

18.3 Safety Alerts and Signals: (Alteplase or tenecteplase Alert 17) (Beth Loe)
The draft alert was approved by the members for publishing on the Commission's website. Hospital Chief Pharmacists will be asked to complete the action plan and return to the Commission.

Action: Specialist advisor to follow up action plan with hospital chief pharmacists.

18.4 Methotrexate summary (Chris James)
Chris James advised that the national database is unable to provide a breakdown of the methotrexate dispensing dose below 10mg. No further analysis is possible.

19. Recent Serious Adverse Events (Beth Loe)
The members were briefed on this quarter's serious adverse events received by the Commission. As appropriate learnings will inform the development of safety alerts, safety signals and open book publications. This was timely currently given a big focus on medication safety in support of the WHO Global Medication Safety Challenge over the next five years.

20. Recommendations for the safe administration of intrathecal chemotherapy and intravenous vinca alkaloids in New Zealand (Beth Loe)
The guideline was originally published as a joint document from the New Zealand Hospital Pharmacists' Association (NZHPA) and the Safe and Quality Use of Medicines Group (SQM) in 2007. It is undergoing a review and refresh. Consultation with NZHPA, the Commission and DHBs (oncology pharmacists) is now finished and comments are being collated before going out for wider consultation, including oncologists. The final guideline will need to be approved by the NZHPA executive and EAG.

21. Other business:

21.1 The chair requested that the next EAG date of 23 August be changed to 30 August 2017 due to other commitments. Location to remain Wellington. This was agreed.

Action: Secretariat to send out updated calendar invites.

21.2 The November EAG location is confirmed as Auckland.

Next meeting: 30 Aug 2017, Wellington.

The meeting closed at 3.35 pm.

Actions discussed from previous meetings:

161125	Endorse the Pharmacy Council safety alert on the Commission's website and the Secretariat to support David Woods with virtual meeting Letter to MedSafe on colour standardisation of inhalers gs of the working group	Delayed due to website update.
161124a	To publish on the Commission's website the UK's patient safety alert on the risk of severe harm or death from errors with injectable phenytoin	Delayed due to website update.
161124b	To link the ISMP's statement about burns during MRI from transdermal patches with metal backing with the Commission's Transdermal Patch Alert To confirm which patches currently available in New Zealand contain metal	
161123	Communique to suppliers on the issue of interchangeability of inhaler bodies and need for differentiation. Copy of communique to PHARMAC and MedSafe	
161122	ARC medication chart test evaluation report to be circulated to members	Completed May 17
161121	Medicines management digital review to be circulated to members	Completed May 17
161120	Members invited to PSW planning group	Completed May 17
161119	Members to submit feedback on draft ToR	Completed May 17
161118	Industry group Medicines NZ, be invited to speak at the next EAG.	Update - Include SMI (Self Medication Industry Association) to invite for August EAG.
161117	Roadmap discussion during face to face meetings	Separate discussion with sector. Closed.
161115	Organise a virtual meeting with working group members to discuss the alteplase alert content	Completed Jun 17
161111	Distribute Adverse Event Reaction Workshop Summary report to EAG members	Expected to be distributed Jun 17.
161110	Review TORs and membership and provide feedback to Carmela / Charmaine by mid-January in order to promulgate a draft document as pre-reading for Mar EAG meeting	ToR ratified May 17 (subject to minor changes) see minutes.
161108	Provide a paper to the February Board Commission board meeting that incorporates an implementation plan to support the safe use of opioid work going forward	Deferred to the August Commission board meeting
161105	EAG members to provide input in developing a business case for continuation of MERP. Work with the NZ Pharmacovigilance Centre.	Completed.
161104	Request the Pharmacy Council to include checking paediatric doses with reference sources and child's weight in their next newsletter	Remains open.
161103	Write to TestSafe and HealthOne for further information on methotrexate oral tablet dosage.	See May 17 minutes for update. Closed.