**Minutes** of the meeting of
Medication Safety Expert Advisory Group
(MSEAG) on 29 November 2017

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| **Location** | Novotel Auckland Airport, Auckland | |
| **Chair** | Sandra Fielding, Deputy Chair | |
| **EAG Members** | Nelson Aguirre<br>Matt Doogue<br>Gareth Frew<br>Avril Lee<br>Lucy McLaren | Bev Nicholls<br>Rob Ticehurst<br>Beryl Wilkinson<br>David Woods |
| **Ex officio** | Chris James, Manager, Clinical Risk Management, Medsafe<br>Andi Shirtcliffe, Chief Pharmacy Advisor, Ministry of Health<br>Janet Mackay, Senior Implementation Lead, PHARMAC<br>Peter Jansen, Senior Medical Advisor ACC | |
| **Invited guests** | Shelley Pakoti, Nurse Practitioner Primary Care, Observer<br>Alastair Kenworthy, Principal Architect and Director Health Information Standards, Ministry of Health<br>John Fountain, Clinical Lead, Bpac$^{nz}$<br>Jessica Nand, Team Leader, ICU Pharmacist, Waitemata DHB<br>Catherine Gerard, Health Quality Evaluation Manager HQSC | |
| **Commission staff in attendance** | Carmela Petagna<br>Charlie Charters<br>Billy Allan<br>Dee Alexander | |
| **Apologies** | Alan Davis<br>Desiree Kunac<br>Te Rina Ruru | |

Meeting commenced 9.35 am

## 1 Welcome, apologies and declarations of interest

Sandra Fielding welcomed everyone. Apologies were noted and declarations of interest updated.

## 2 Patient story

The Northland video played during patient safety week workshops was viewed. A patient attended the emergency department for medical admission as he was not responding to antibiotics prescribed by his GP. The patient had documented allergies, including to ciprofloxacin, and was wearing a MedicAlert bracelet. His allergies were noted and recorded, and he was fitted with a red hospital allergy bracelet prior to being transferred to the ward.

In the medical ward this patient was prescribed, dispensed, and subsequently given, five doses of oral ciprofloxacin, administered by four different nurses over several days. This was despite warnings in the notes, on the medication chart, and on the bracelet the patient was wearing. The patient developed a rash which progressed to potentially life ending Stevens Johnson's syndrome. Once the error was recognised, the ciprofloxacin was stopped and the patient eventually recovered. The patient's final comment in the video was "If it's on the file, it shouldn't have happened."
Learnings include

- avoidable event
- warnings in place not acted on
- safe prescribing/dispensing/administering processes would have prevented this
- never assume what has already been done is correct
- always check and check again

Discussion
- there have been many similar stories, this represents a pattern
- failing to follow safe processes occurred multiple times and by multiple staff members
- the patient knew he was allergic to some antibiotics but didn't know all the names
- allergy notes are often incomplete or incorrect
- some systems have a free text box leading to inconsistencies
- some systems have no decision support

Recommendations
1. Accurate allergy diagnosis is essential in all cases. About ten percent of patients labelled with an allergy don't actually have one. Failure of initial diagnosis means information is devalued even ignored.
2. Listen carefully to the patient and their support person, and if a patient says they have an allergy this must be checked and accurately diagnosed.
3. Standards need to be in place.
4. Standards must be included in system design.
5. System design is an important opportunity to make safety gains.

Video link can be shared through the Commission's website.

**3 Minutes of previous meeting on 30 August 2017**

Minutes were confirmed as a true and accurate record.
Moved by Avril Lee and seconded by Bev Nicholls.

There was a query relating to paragraph 15 regarding working group updates. Further clarification between the purpose and membership of the Compounding Advisory Group and the Compounding Working Group is required.

*Action: Dee to follow up with Dave*

**4 Action list review**
**Appendix 1 Updated November ACTIONS list**

170806 - Dose measuring devices for liquid medicines: To discuss the need for a liquid medicine delivery device working group at the next EAG
- It was agreed that not having a funded oral liquid medicine measuring device is a health equity issue
- Currently, only families that are able/willing to pay have access to these devices
- These devices have a significant role in ensuring the safe and effective use of liquid medicines in neonates, paediatrics and patients with feeding tubes – particularly for doses of less than a 5mL volume
- We cannot leave it up to chance that patients receive the correct dose or liquid medicine

*Action: Billy to submit funding application to PHARMAC for a range of funded, validate oral syringes and ENFit® oral syringes (for enteral feeding patients).*

**5 Learning from adverse events**

Potential medication related 'always report' events

At its last meeting MSEAG asked that three to four 'always report' medication events be put forward for consideration for inclusion in the next version of the Commission's National Adverse Events Policy.

A paper summarising 'always report' events from other jurisdictions had been circulated with the agenda. Discussion noted this paper is based on collecting best information internationally. It is therefore an important and helpful document and 'always report' events for medication are worth looking at. It was acknowledged this paper relates to secondary and tertiary care, but there is also an obligation to include primary care and to report community events.

Most medications are taken up in the community, but there is no formal provision to report in primary care. Although the Medication Event Reporting Programme works well, there are currently too many routes for reporting which reduces reliability and impact. The reporting system is fragmented.

A consistent universal process is required for all reporting across the entire system including primary, secondary, and tertiary care with a single portal. All practitioners need clear guidance and training on what is an error, what is an allergy, and how/where to report.

The system needs to be integrated with consistent reliable reporting, accurate information, timely sharing of information across agencies (the Commission, ACC, Medsafe) and capacity and responsiveness to act on reports.

It was also noted

- There are fifty-two SAC 1&2 events per year reported to the Commission
- Data is also collected by DHBs locally in hundreds more SAC 3&4 events
- We need a system in place to pay attention to information in SAC 3&4 events
- We can to learn from information already collected
- Medication is often only one of multiple contributing factors to event
- Although data is local, identified themes are usually general

*Action: Billy to draft a potential always report and review indicator*

ACC medication event claims data

Peter Jansen provided treatment injury data for claims accepted for medication adverse reactions between 1 July 2005 and 6 April 2017. He noted claims lodged with ACC cannot be taken as an accurate indication of occurrence of harm, nor quality of care.

- 67 serious injury claims account for 60% of the cost (Median $297,311)
- 10,000+ non-serious injury account for 40% of the cost (Median $127)
- over 99% are non-serious injury

Suggestions for 'always report' events include too much anticoagulant, lithium, or chemotherapy medication, toxicity/serious effects.

**6 Priorities for 2018/19** Carmela Petagna (paper circulated with agenda)

Carmela provided a programme activity update for the period September to November 2017, noting priorities for 2018/19 are to be informed and guided by MSEAG. Challenges include where to focus with a small team to add most value, what specific drivers to identify priorities, and how to incorporate a shifting focus from a topic focus to a broadening sector focus. Opportunities

include moving towards greater strategic alignment with the Commission identified priorities, building strong and sustainable quality improvement capability across the sector, and embedding the high risk medicines and opioid work.

Patient safety week was very well supported by the sector, and the three bilingual videos of health providers had 300 000+ social media engagement. There was strong media interest in the featured triple whammy from the updated Atlas of Variation Polypharmacy domain, and nearly 250 different providers ordered resources.

Sandra reported running a successful education session in Tauranga hospital during patient safety week reinforcing the importance of having an informed consent process in place around medications. Benefits of a multidisciplinary team approach were also discussed where multiple sources of information can help consumers understand and self-manage.

Major feedback themes for future priorities from the medication without harm workshops included patient data linked by technology, transitions of care including medicine reconciliation, health literacy and building cross sector leadership networks. All themes underpin patient safety.

*Action: Medication safety team to meet in January to discuss and develop a work programme for 2018/19*

**7 Health Information Standards Organisation (HISO)** Alastair Kenworthy, John Fountain

Supporting papers had been circulated with the agenda.
HISO has 30+ published standards.
Discussion:

1. Give greater emphasis to terminology, national standards, and providing guidance

   The existing NZ Universal List of Medicines (NZULM) and SNOMED terminology have been endorsed as the standard for NZ eMedicines systems. To support this, a clause has been inserted into the DHB operational policy framework (OPF) that requires adhere to HISO standards. Initially there is no timeframe within which existing systems (e.g. SAFERsleep, MediMap) have to transition to NZULM / SNOMED.

2. Adverse drug reaction (ADR) reporting data standards

   There is a work stream to develop ADR reporting standards. This foundational work is necessary so that any innovation in this area is against the standards to support interoperability, and to avoid the development of disparate systems.

   The standard will state the data elements that are required in ADR reporting, not the process for reporting. The next phase will be how the data feeds into clinical systems.

   Matt, Rob and Bev from MSEAG, and Chris from Medsafe will be involved in their HISO working group.

3. Use SNOMED (Systematized Nomenclature of Medicine)

   SNOMED terminology is a fundamental standard to have all systems 'talking' to each other, and will be pervasive.

   The new CVD risk calculator from the Ministry of Health will be based on SNOMED which has 350 000 terms, the whole NZ Health system will be based on this. It will reduce variation in capturing data and provide a depth of information we don't currently have.

It was noted that the MedDRA (Medical Dictionary for Regulatory Activities) is likely to be retained by Medsafe for international pharmacovigilance activities.

4. Prescribing data standards

HISO is to establish a prescribing standard. This will define the elements required for patients to receive medicines, including prescribing, dispensing and administration

A prescribing standard needs to be in place before the national eHealth record is established. Note that standardising terminology and data elements is separate to implementing a patient record system. A coding standard must be equally valid across multiple points - prescribing, dispensing and administering. This has significant patient safety implications.

A HISO prescribing standards working group is to be established with Bev as Chair. Expressions of interest are invited if MSEAG members would like to be involved in this working group.

MSEAG resolved that it:
1. Supports the establishment of a HISO prescribing standards working group and
2. Supports Bev Nicholls as the chair

*Action: Members to notify Alastair Kenworthy if they are interested in joining the HISO prescribing standards working group.*

5. Onscreen display of medications in a standard fashion

HISO is to develop a NZ standard for the on screen display of medicines information: how should the data be presented? What should it look like? These standards are necessary to ensure consistency between systems

The intent is to adopt the Australian Commission on Safety and Quality in Health Care's National Guidelines for On‑screen Display of Clinical Medicines Information (2016). (https://www.safetyandquality.gov.au/wp-content/uploads/2016/03/National-guidelines-for-onscreen-display-of-clinical-medicines-information.pdf).

MSEAG resolved that it supports HISO undertaking a consultation, review, adaption (if necessary) and endorsement of the Australian Commission National Guidelines for onscreen display of medicines information for NZ.

*Action: HISO update to be a standard agenda item for MSEAG meetings.*

## 8 #$O_2$ The Fix swimming between the flags Jessica Nand

Jessica presented on behalf of the Waitemata DHB / North Shore Hospital oxygen steering group. Following a death from the inappropriate use of oxygen, the team at Waitemata developed a local programme to upskill staff, to improve the prescribing, administration and monitoring of oxygen in North Shore hospital. A multidisciplinary approach was used.

Literature evidence and guidelines existed, so a steering group was set up and formal oxygen ePrescribing was introduced across the hospital, including target safety ranges. Policy was updated, baseline audits carried out, and a campaign launched. Post campaign evaluation showed an increase of prescribed oxygen from 12% to 49% in six months.

Discussion confirmed lack of oxygen prescribing is currently an area of widespread with a high risk for potential harm, and this is a critical message to educate all prescribers.

Jessica offered to share the Waitemata materials with other hospitals. The MSEAG endorsed the Commission working with the Waitemata team to disseminate the '$O_2$ the Fix' message.

Suggestions included making the toolkit available through the Commission's website, best practice oxygen prescribing to be promoted through a Commission blog, and promoting the toolkit through the Commission eDigest

It was noted that this work with best practice oxygen use will support the Commission's deteriorating patient programme and a national clinical trial of oxygen use in cardiac patients.

*Action: As an initial step, Billy to work with Jess to make the '$O_2$ the Fix' toolkit available through the Commission's website*

**9 Atlas of Healthcare Variation polypharmacy domain** Catherine Gerard

Catherine presented via video, a summary and explanation of the recent update to the polypharmacy atlas, and the new 'triple whammy' indicator.

The Commission has also developed an Advanced Form query tool that can be run over the MedTech general practice PMS (practice management system). This facilitates data analysis down to an individual patient level within a practice. This tool has been endorsed by the RNZCGP as a continuing professional development audit tool.

Discussion included the importance of information sharing, and how MSEAG can best support others to use this information to move from knowledge to action.

**10 Digital Medicines eMM update** Charlie Charters

A Programme update was provided by Charlie, including an update paper which was circulated with the agenda.

**11 Programme Quarterly Report**

Programme update: Carmela provided a programme update, speaking to the paper that had been circulated with the agenda. She highlighting a proposed programme realignment and change in the Commission's strategic direction to reduce silos with the establishment of two Commission hubs, an intelligence hub and an improvement hub. This has been further built on in the Commission's statement of intent 2017-21.
(https://www.hqsc.govt.nz/assets/General-PR-files-images/HQSC_2017_Statement_of_Intent.PDF)

Sector awareness of the WHO global patient safety challenge was increased throughout patient safety week, with an invitation to workshop participants to suggest future priorities for NZ in response to the challenge.

A stakeholder meeting on the future of MERP is planned at the PHARMAC meeting room in Wellington on 19 December 2017. Carmela invited MSEAG members express any interest to attend this meeting. This meeting is to decide next steps.

Safe use of opioids QSMs next steps: Billy and Avril updated the group on the safe use of opioids. Some DHBs are further along than others. Due to the release of other programme QSMs the timelines for the introduction of all the QSMs is being reconsidered. It is likely that there will be a three to six-month delay in the timeframe for the opioid QSMs. Nelson noted that DHBs will need to plan resourcing for the QSMs. Further discussion included the importance of QSM reporting

data to be electronic system generated with assessment templates created and shared. The ministry of health is also bringing out new quality indicators every quarter, which also require DHB resource.

Sandra thanked Avril for her contributions as clinical lead and for all her hard work, noting the important progress that has been made.

eMedRec QSMs update: Billy reported to the group the QSMs are currently in use by five DHBs all in slightly different ways, and current work is underway to align them.

Alignment with Mental Health and Addictions

An informal update paper from Roz Sorenson, National Programme Manager Mental Health and Addictions Quality Improvement Programme was discussed. The new government is launching an enquiry into mental health, and the Ministry of Health is preparing advice to the Minister. Andi requested to share the information in Roz's paper.

*Action: Carmela to request permission from Roz to share this paper more widely with the Ministry of Health*

Billy noted that the UK based medicine information leaflets on mental health medications (http://www.choiceandmedication.org/waitemata/) have been picked up again under the Commission's Mental Health and Addictions programme. This piece of work to secure funding for the licence and adaption to the New Zealand context, had stalled.

## 12 Update from working groups

Compounding advisory group: Dave informed MSEAG that a separate working group has been set up. A meeting is being hosted at the Commission on 4 December 2017.

*Action: Dave to provide a report at the next EAG meeting of the outcome of this meeting*

## 13 Other business and agenda items for next meeting

Medicines alert groupings: Clarification was sought over the status of the 'medicines alert groupings' work. This was a piece of work where medicines were grouped into structural classes (e.g. penicillins, NSAIDs), to facilitate allergy checking in electronic systems like MedChart.

This work was originally undertaken by the NZ Formulary (NZF), but this has now been questioned as it does not appear to be in the NZF contract. Has this work been concluded? What is the ongoing governance for this – management, sign-off, updating, development.

*Action: Billy to write to bpacnz (Tony Wilson, Project Manager bpacNZ) to ascertain the status and governance for the medicines alert groupings work.*

Nelson Aguirre last meeting: Nelson notified the group this would be his last meeting. Sandra thanked Nelson for his contributions to the group and for bringing a quality and risk management perspective.

Potential safety issues regarding paracetamol dosage: Dave has been made aware of feedback and safety concerns on how paracetamol dosing is presented in the New Zealand Formulary for Children monograph. These include

- Removal of the link to the ideal body weight calculator (in Best Practice Journal) without associated explanation
- Lack of dose banding to reduce the need for calculations

- Multiple calculations are required: a multiplication (mg/kg), conversion mL, and rounding
- The maximum dose for 1-month to 18 years is now 5g (for first 48 hours) – this is more than an adult would receive. (This is based on a UK data in an anaesthetic secondary care setting)
- There needs to be a clear distinction made between acute in hospital use and community use
- The way the information is presented is confusing, potentially unsafe, and could lead to prescribing errors

MSEAG supported Dave's concerns.

*Action: Billy to write to NZF for Children (through their online feedback) highlighting the MSEAG's safety concerns*

<u>2018 MSEAG meeting dates</u>

Dates agreed as

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| Wednesday 28 February | Wellington |
| Wednesday 30 May | Auckland |
| Wednesday 29 August | Wellington |
| Wednesday 28 November | Auckland |

Next meeting 28 February 2018

Meeting closed 3.34pm