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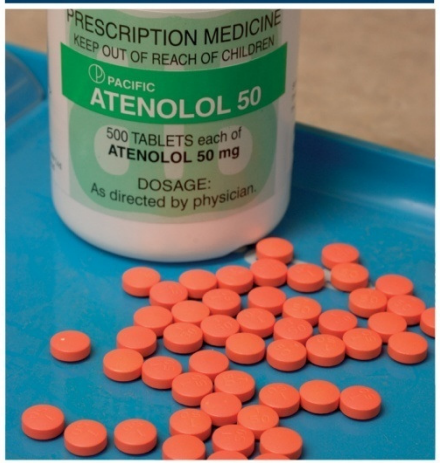

New Zealand
National Quality Improvement Programme
Safe Medication Management

Global GS1 Healthcare Conference

Hong Kong 6-8 October 2009

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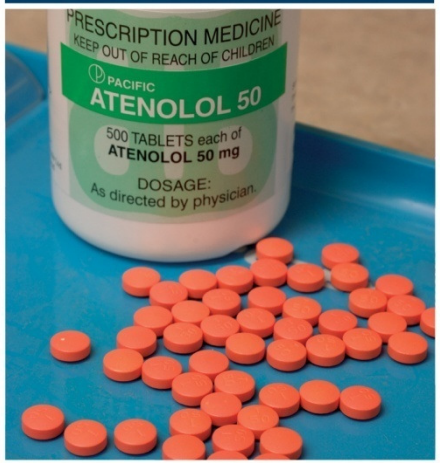

Presentation Outline

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

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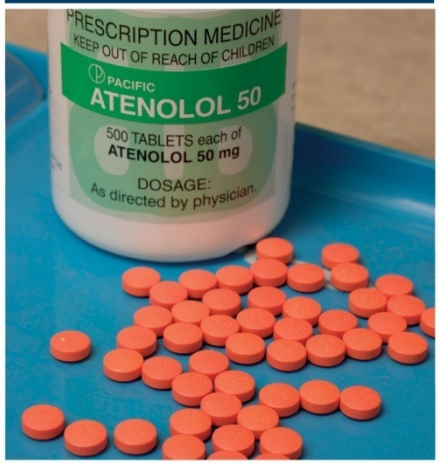

Background

- 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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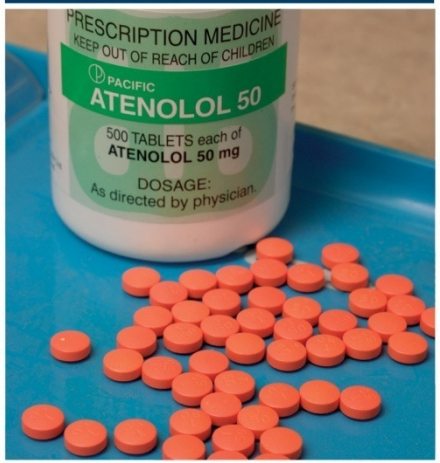

Background – SMM Progamme

- 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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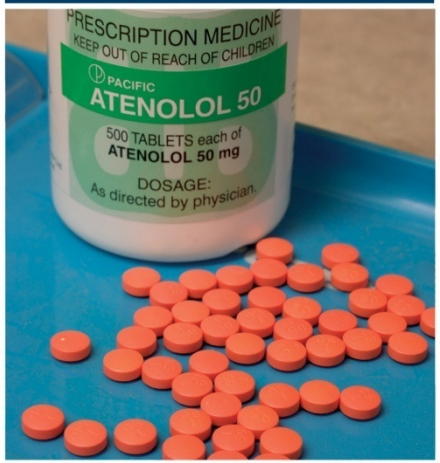
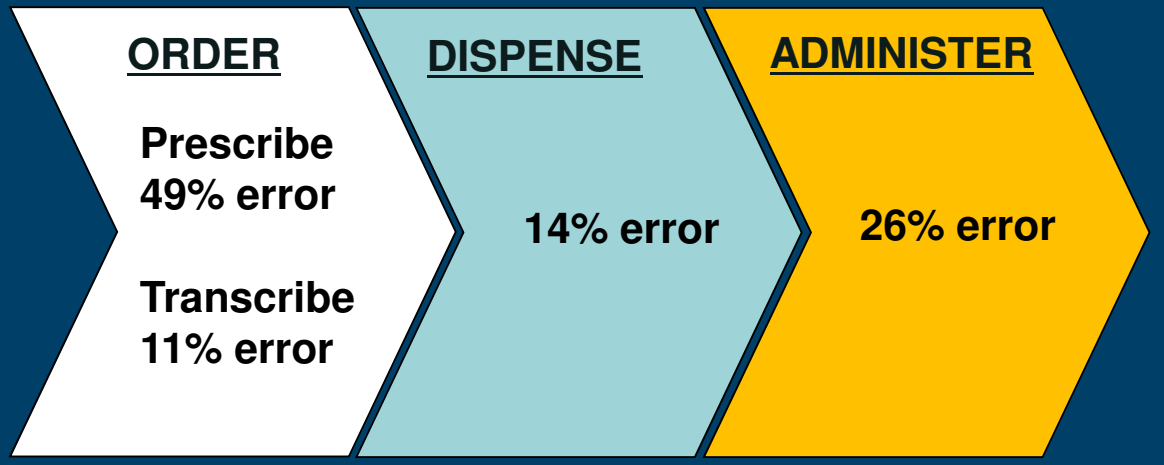


Background - SMM Programme

- 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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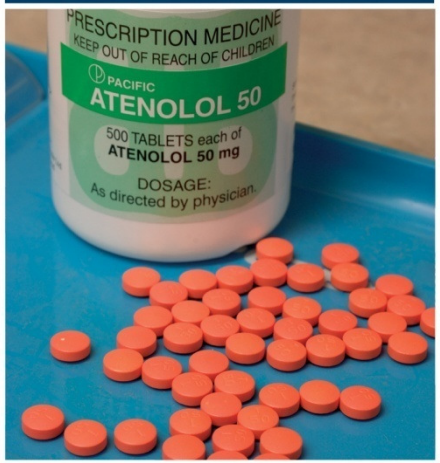

Background – NPSA 2009 report

- 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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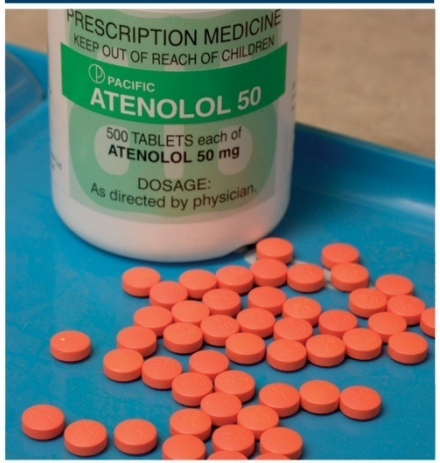

Objective of SMM Programme

- 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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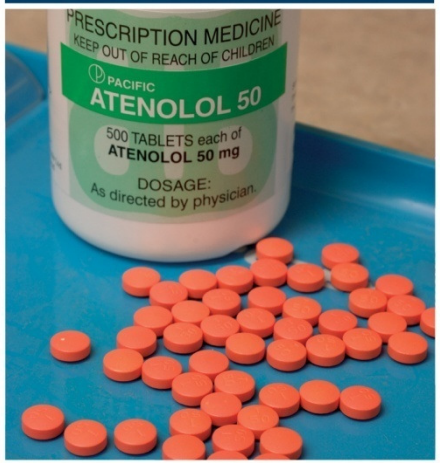

The SMM programme

- 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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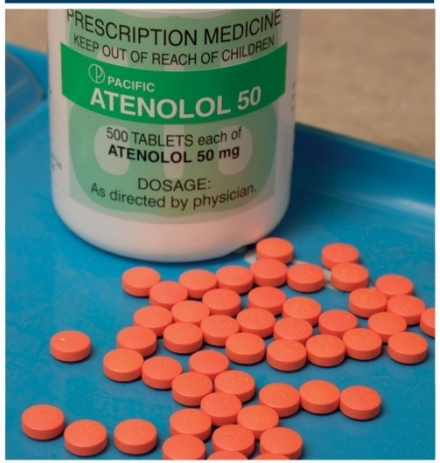

Progress

- 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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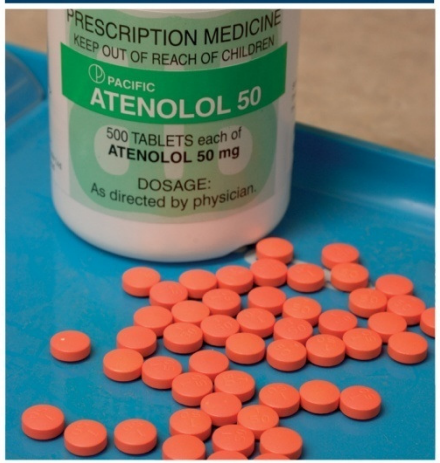

Progress

- 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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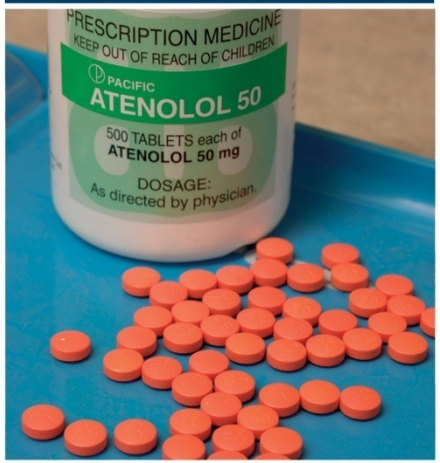

Progress

- 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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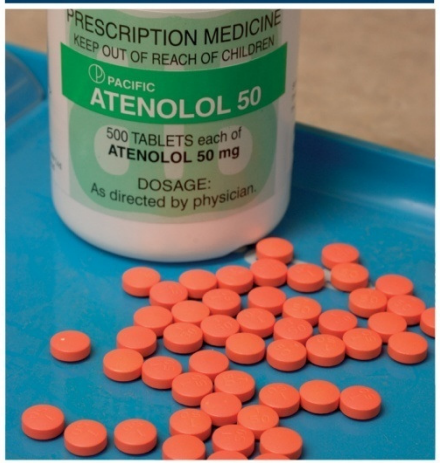
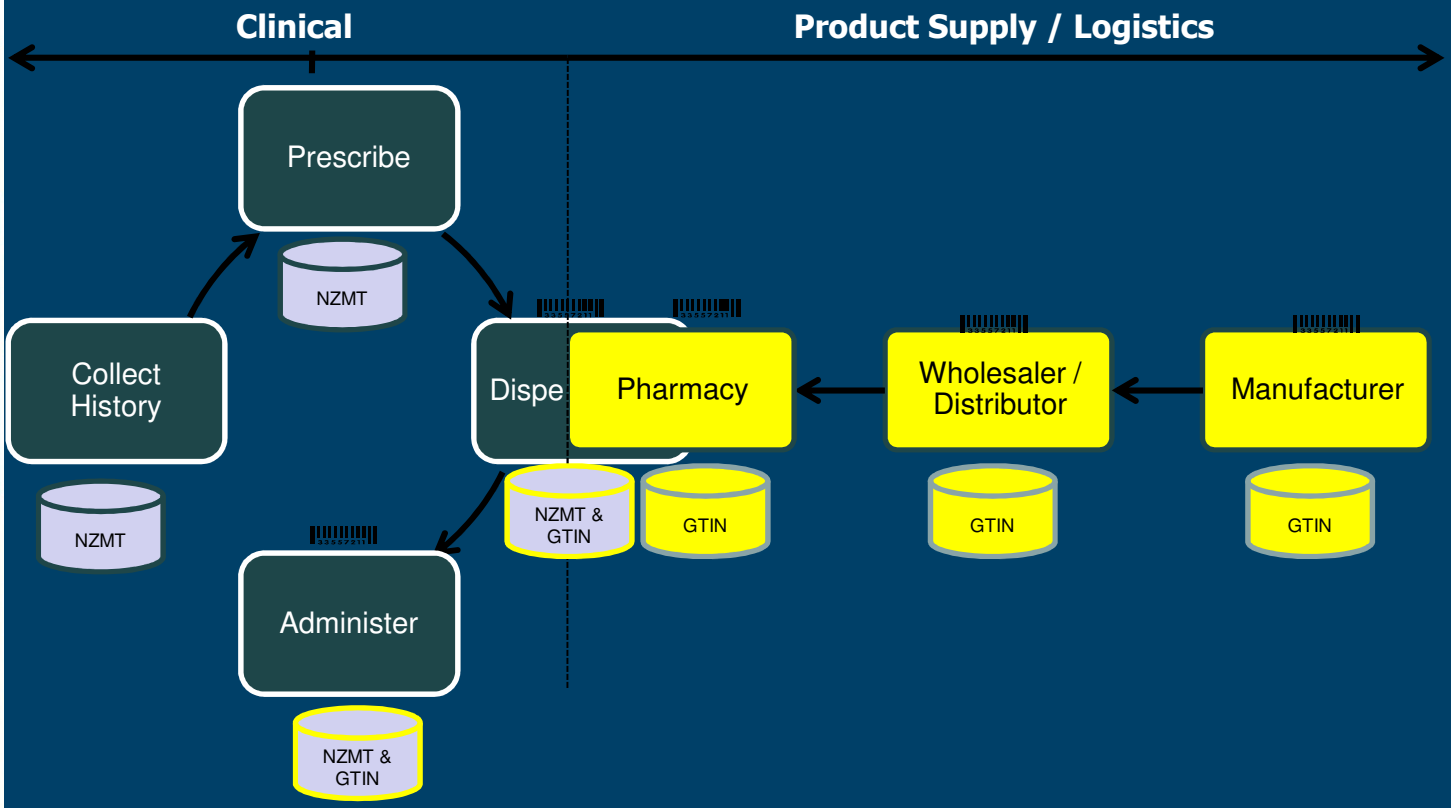


Progress

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



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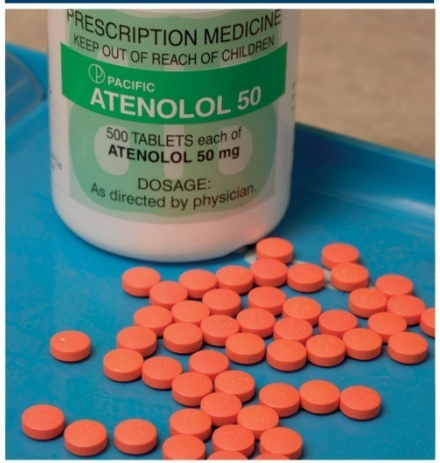

Progress

- 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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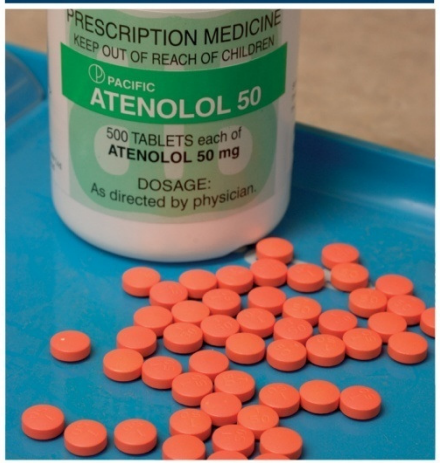

Progress

- 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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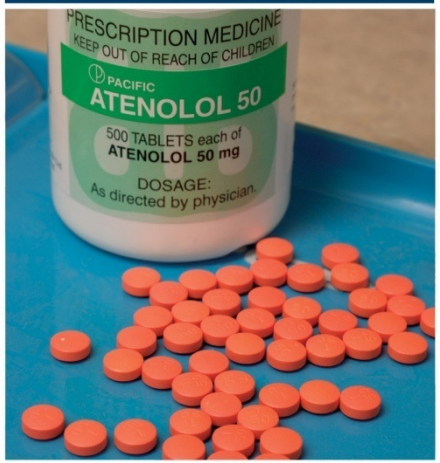

Lessons Learnt

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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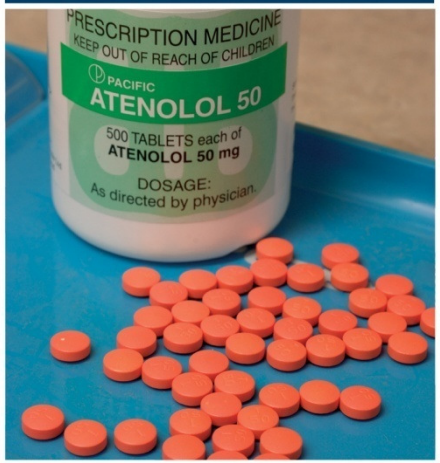

Lessons Learnt

- 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

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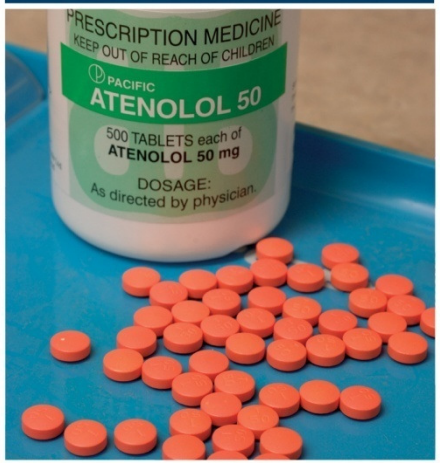

Approach – incremental change

Depth of Function

Time

Single Ward	Single Service	All Services
Gold	Gold	Gold
Silver	Silver	Silver
Bronze	Bronze	Bronze
Entry Level	Entry Level	Entry Level
Baseline		

Organisational Spread

Incremental Steps

Start simple and spread, then add depth

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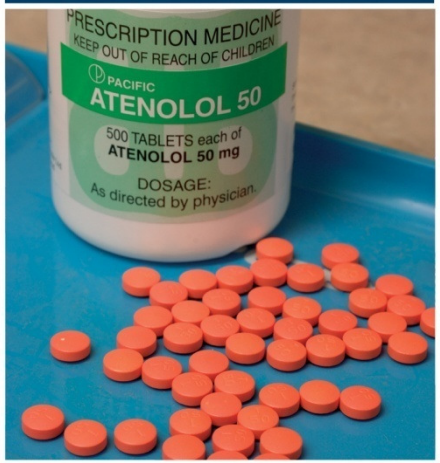

Thank You