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

Location	PHARMAC office, Mercer Street Wellington
Chair	Alan Davis
EAG Members	Sandra Fielding (Deputy chair), Gareth Frew, Lucy McLaren, Shelley Pakoti, Te Rina Ruru, Rob Ticehurst
Ex officio	Andi Shirtcliffe Ministry of Health, Chris James Medsafe, Desiree Kunac MERP NZPhVC, Janet Mackay PHARMAC, Nicolette McDonald NZPSHA, Sunita Goyal ACC
Invited guests	Tracey Watson Clinical Lead eMeds Management Taranaki DHB, Alastair Kenworthy Director Health Information Standards Ministry of Health, John Fountain Clinical Lead bpac^{nz}, Catherine Proffitt Manager Access Equity PHARMAC
Commission staff in attendance	Carmela Petagna, Charlie Charters, Billy Allan, Dee Alexander
Apologies	Avril Lee, Bev Nicholls, Beryl Wilkinson, Dave Woods, John Barnard, Matt Doogue

Meeting commenced 9.35 am

1 Welcome, apologies and declarations of interest

Alan welcomed Shelley and Nicolette to their first meeting as members, and welcomed everyone to the day. Apologies and declarations of interest were noted.

2 Minutes from previous meeting 28 November 2017

Updated minutes including the circulated corrections to medicines alert groupings and potential safety issues regarding paracetamol dosage were confirmed as read and correct.

Minutes were confirmed as an accurate record.
Moved by Sandra Fielding and seconded by Gareth Frew.

The terms of reference were discussed. These include recording and circulating the minutes for feedback and approval no later than a fortnight following the meeting date, and publication of minutes on the Commission's website within six weeks of the meeting being held. It was agreed the current process of waiting until the next quarterly meeting for final approval is too long, and when the minutes are uploaded to the website at six weeks, this will be the approved final version not a draft. Their ratification at the following EAG meeting then should be just a formality. This places an onus on members to provide their feedback on the draft minutes in a timely manner.

3 Actions review and matters arising

<u>NZF for children dosing guideline for oral paracetamol (171111)</u>

The circulated email reply dated 5 January 2018 from NZF Managing Editor Bryan Simpson was discussed. It was noted the 5g total maximum daily dose had been removed prior to the MSEAG communication with NZF, and that other groups including Medsafe and MERP had also

expressed concern directly to NZF about the 5g total maximum daily dose which exceeded the adult 4g maximum daily dose.

Loss of the bpac^{nz} dose calculator (which used lean body weight) means there is now no quick way to confirm one's dose calculations. MSEAG members expressed concern about this.

No dose banding means that another potential back up safety check for calculations is missing. Multiple calculations are required which increases the potential for error, and while other medications also require multiple calculations, paracetamol is unique in that the likelihood of harm from an error with paracetamol is a higher risk, due to its very high frequency of use, perception it is safe, mg vs mL confusion and mix ups between the two strengths available. In any setting, a two-step calculation can lead to error. It was noted that the tabled MERP quarterly report contains an oral paracetamol tenfold dose calculation error.

The NZ Formulary has advised that to take these matters any further will require evidence of either actual harm, or of clinician difficulty calculating doses.

The EAG has ongoing medication safety concerns regarding oral paracetamol. The group is interested in how NZF notify users of significant changes, for example when the 5g dose was added, then removed.

Action (180201): Add query on how stakeholders are notified by NZF to agenda for discussion at next EAG.

<u>NZ Formulary representation on MSEAG</u>

A letter dated 1 February 2018 to the Chair of MSEAG was received from the NZF Chief Executive Murray Tilyard and Managing Editor Bryan Simpson, writing to express interest in NZF representation (through the Managing Editor as part of their designated duties) on the MSEAG. There was consensus that a presence from NZF would add value to the MSEAG and the Commission team would now communicate with the NZF to follow up the appointment process.

Action (180202): Reply to NZF.

<u>Medicines alert groupings (171105)</u>

This action was completed however the matter is still active. The medication safety specialist wrote to bpac^{nz} on behalf of the MSEAG on 22 December 2017, and followed up on 14 February 2018.

A reply was received from Tony Wilson, Chief Operating Officer, advising:

- initial work has largely concluded
- there is a continued need to update the groups
- the future governance for the alerting groups work is to be discussed at the next NZF advisory group meeting
- bpac^{nz} to keep us appraised of future developments

The matter was further discussed. MSEAG agreed this is an important issue, the alert groupings will quickly become out of date if there is no active plan for governance and maintenance outlining who is responsible for ongoing updates of the alert groupings as new products reach the NZ market.

The group agreed

- alert groupings are an important and ongoing medication safety issue
- this work will never be over

- to ensure governance and ongoing processes are in place to keep alert groups up to date
- medication safety advisory group to be kept informed

Action (180203): Wait for feedback from NZF advisory board on future governance for the alert groupings process.

Always report and review (ARR) events (171103)

The ARR list is a subset of serious adverse events that are preventable. The circulated paper, of potential events, was discussed.

ARR came from the UK Never Events policy and framework, and are incidents that should never happen because system guidance, tools, and barriers are in place (for example safety measures in place around concentrated potassium chloride, daily methotrexate). Most ARR don't cause actual harm, but this is by near miss rather than by design. Reporting ARR can highlight potential harm, and be used as a safety indicator. An important issue is how ARR data will be reviewed and used to change behaviour and culture. In NZ we don't currently have robust systems around adverse events reporting, and variability exists in both reporting and interpretation. There is some work the medication safety team is looking at to strengthen a systematic approach to classifying medicine related incidents and how we learn from them.

The challenge is the last step in the reporting process, and rather than relying on voluntary reporting, for example by pharmacists, there needs to be a system change to capture these events as part of routine practice.

Sunita reminded the group of her declared interest as a Board member of the Pharmacy Defence Association. The Chair noted that this was not a conflict of interest within the context of this discussion.

The group agreed an ARR for medication safety should be included as part of national adverse events reporting, and if possible, be applicable across all health care settings. Agreement was not reached on a specific ARR event. The group agreed discussions would continue.

Action (180204): Further research required around potential medication ARR events.

Alteplase and tenecteplase HQSC alert 17 (170511)

While the use of alteplase is increasing across the country, only twelve DHB hospitals have responded to confirm that they have completed the Alert action plan. It is a patient safety matter to ensure that the mitigation actions in the action plan are implemented across the sector.

Action (180205): Follow up with stroke network to influence completion.

4 WHO global patient safety challenge

The circulated matrix was discussed. The purpose is to capture an update from each agency, of activities supporting the WHO medication without harm challenge, and document what is being done across the four domains. This will provide a foundation to coordinate a sector wide response for NZ.

In response to the WHO global patient safety challenge, the English Department of Health and Social Care established a Short Life Working Group (SLWG) to provide advice to the Secretary of State for Health and Social Care on the scope of a programme of work to improve medication safety. The SLWG has recently published its review and recommendations in 'The Report of the

Short Life Working Group on reducing medication-related harm'. The Report recommends the establishment of a medication error and safety programme as well as a number of priorities to create positive change in medicines safety.

Action (180206): Circulate UK working group report and follow up with organisations to complete the matrix.

Learning from adverse events

5 Patient story

The Northland DHB patient video (with the story about the patient who had ciprofloxacin administered against a documented allergy to ciprofloxacin, suffering a significant reaction) represents a powerful learning tool, and has been widely shared. The story was published in the Northland Quality Accounts, and shown at the Commission's staff and board meetings generating significant discussions as a strong reminder of the importance of addressing medication safety issues. The video is being used as an ongoing learning tool at nursing education sessions in Northland and in some private hospitals to teach safety culture and influence behaviour change in clinical staff.

Action (180207): MSEAG members are encouraged to identify relevant patient stories and bring these to the attention of the Commission staff for potential write up and development as key learning and engagement resources.

6 Project mapping repository

The circulated paper proposing to set up a mapping repository was discussed. The purpose would be to share knowledge around who is working on what, and provide a central database of medication safety initiatives, a place to potentially find knowledge and quality improvement tools. The role of the Commission is to add value by facilitating the sharing of initiatives and connecting interested parties together across the medication safety networks. ACC currently publishes some data, and DHBs have internal projects that could be duplicated, for example a recent initiative in Auckland around the amiodarone ampoule size on resuscitation trolleys.

The Commission's role would be to curate and share the information. This idea supports sharing across the twenty DHBs, growing the engagement across the medication safety networks, and in line with the NZ health strategy of one team, and the Pharmacy Action Plan.

There was acceptance that the development of a medicines safety initiatives repository would be worth investigating further. The hospital pharmacists' research repository could be reviewed for the database structure.

Action (180208): To investigate how a medicines safety initiatives repository might look and operate.

7 Specify brand criteria

The circulated document was discussed (Specify brand criteria paper_v5 5May16-Final). There was lack of clarity as to whether the sector is aware of this document, and whether it has been maintained. It was noted the paper is almost two years old with no revision. NZ needs to be able to flag some medications as 'specify brand'. Many different products are available, and there needs to be oversight and a scanning of these products, when it is implemented into NZULM and signed off.

Currently there is no-one reviewing which medicines fit into these criteria. There is a list of 40 'specify brand' products, but Medsafe has thousands of generics they approve. There are incidents reported to MERP where an error may not have happened if the medication had been prescribed by brand so need greater awareness among HCPs on the importance of specifying brand.

The group would like clarification on

- is the document still applicable?
- where is the current list?
- who is responsible for keeping it current?
- how is information disseminated to vendors, prescribers and end users?

This is a reactive process, and the medication safety NZULM working group is in place to provide advice in response to queries.

Action (180209): Follow up and clarify queries around current list and processes, add as agenda item for next MSEAG meeting.

Technology to support safe medicines practice

8 The Taranaki eMeds journey

Tracey Watson (Clinical Lead for eMeds Management in Taranaki DHB) presented on the eMeds journey in Taranaki, one of the initial national pilot sites. The systems are nearly fully implemented, but not fully integrated either between hospital systems, or at transitions between primary/secondary care. Ongoing challenges include increased workload, and less time for patient education. Health technology in itself will not improve medication safety. In implementing any system, success is dependent on how it is used. There will be unintended consequences which need to be proactively identified, resourced and managed. The situation has now become IT driven, not clinically driven. It is time for a major review of strategy, leadership and governance around the eMeds patient journey.

9 HISO Health Information Standards Organisation

Alastair Kenworthy (Director Health Information Standards, Ministry of Health) and John Fountain (HISO Clinical Lead bpac^{nz}) provided an update on medicines-related information standards initiatives.

NZULM is in place as an important standardised information resource for the sector, and now it's about integration with the clinical systems used in primary care and our hospitals. NZULM clearly should be implemented by DHBs, and for them needs to be positioned as a mandatory standard. It is now in the DHB Operational Policy Framework that DHBs must support the development and adoption of all HISO standards, including NZULM. HISO is also working on providing practical guidance to vendors on how to implement NZULM into systems, and expects to post this for public comment in April.

HISO will take the Australian national guidelines for onscreen display of clinical medicines information to public comment in the same timeframe, with a view to endorsement. Work is also continuing on a first draft of a prescribing data standard, looking at the medicine as well as the reasons for prescribing.

HISO has adopted new terms of reference with a stronger emphasis on progressing adoption of the standards, having an adoption plan and driving it in the sector. HISO takes its priorities for new medicines information standards from the medicines management digital services sector oversight group. Relationships are being built with national sector groups to partner on standards

work with HISO. Increasing engagement with pharmacy organisations would be useful. HISO wants to work transparently and is open to increasing communication pathways across all sector networks.

There are two main projects currently. One is the development of a business case for a single national electronic health record. There are differing perspectives on what constitutes a medicines list, a conditions list, an allergies list. There is no national standard for gathering data for allergies and ADR. Some systems are not SNOMED based. The other project is looking at the NZF which is currently an electronic textbook, you can't do much with it, and developing this to include coding which would make it more useful. Initially we are looking at indicators and coding these. GP practices and hospital systems will then need to integrate these into their systems to benefit from this work. HISO is considering putting out the indications work as a national standard; this is a tool not a solution. Building the tool means the systems can all talk to each other. HISO intends that the standards will be mandatory.

10 eMedicines programme progress

An infographic has been developed as a summary of the eMedicines message and value. The conversation needs to change from MedChart, eMedRec and ePharmacy to a higher level, of a shared care record. We need to be more future focussed. What is the vision for eMeds Management in 4-5 years? Moving from silos to a coordinated approach, adjusting what we do now based on our learnings, not based on what we started ten years ago.

An oversight group has started meeting. It is understood that the current scope is focussed on the digital medicines management agenda with a priority on NZePS. In time this may extend to looking at a broader medicines strategy, with interest from the group in being kept informed of developments.

Action (180210): Charlie to provide the draft Terms of Reference and Membership List for the Digital Oversight Group as it currently stands to the medication safety team.

11 MERP

The quarterly report (Quarter 3 2017) had been circulated. MERP is a voluntary online reporting system, initially focused on primary care. This quarter there were 331 reports received, the most received in a quarter to date. Fourteen high priority reports were included for MSEAG consideration.

12 Future of medication error reporting and learning in NZ

A progress update on the future of medication error reporting in NZ was circulated. The Commission facilitated a meeting in December 2017 attended by around thirty representatives from across the sector, and a time limited action group was established. The action group met in February and is exploring sustainable funding models for the ongoing reporting and learning from medication errors across New Zealand.

Desiree (on behalf of the NZPhvC) gratefully acknowledged the contribution of Medsafe, PHARMAC and particularly the Commission in facilitating these meetings.

Presentations

13 MercyAscot

Nicolette McDonald (Pharmacy and Allied Services Manager, MercyAscot) presented on medication management in MercyAscot, a private hospital. Admissions are elective, all patients

are spoken with prior to admission and eDischarge and medication cards (yellow cards) are used for discharge. Standards are monitored with organisational wide reports.

SAFERsleep is an electronic peri-operative prescribing system that interfaces with a hospital's healthcare information system. Patients are seen preoperatively for a medication history which is updated at admission. This information is used by anaesthetists in theatre, who can prescribe, edit and stop medications. Post-surgery, a medication reconciliation is undertaken for most patients. Regular reviews and audits are undertaken to look at the data. This process has improved medication management at MercyAscot for patients throughout their hospital stay and was recently highlighted in an external hospital audit as being a well-integrated process.

14 PHARMAC equity work

Catherine Proffitt, Manager Access Equity at PHARMAC, presented on PHARMAC's new equity workstream. PHARMAC's objective in the NZ Public Health and Disability Act 2000, 'to secure the best health outcomes reasonably achievable from pharmaceutical treatment and from within the amount of funding provided', is the fundamental driver for this work. The programme aims to eliminate inequity of access to medicines noting there are multiple barriers to equity at a system as well as an individual level.

Initial work includes building evidence and making connections, a literature review on barriers to access of medicines, community based pilots in partnership with the Commission's primary care programme, and a burden of disease analysis for pacific people which has never been done before.

Desiree left the meeting at 3pm.

Alignment with other programmes

15 Partners in care

Work continues with the Partners in care team on the Raising the Bar on the national patient experience survey medication discharge project, with workshops completed in three DHB, and follow up intervention planning underway. The Let's Talk, Our Communities Our Health Open Forum will be held in Wellington 8 and 9 March 2018.

Programme management and other projects

16 Programme quarterly report

A quarterly report was circulated. The Commission is undergoing an internal change process further developing the intelligence and improvement hub structure, and supporting the four strategic priorities. Activities across work-streams have included strengthening leadership and networks with new EAG members and updated working groups, high risk medicines with ongoing safe use of opioids work, consumer work with the medication discharge project, and medicines management with a focus on the future of error reporting and developing a high level value proposition document for the eMeds programme.

Cross programme activities also included collaboration with the adverse events team on integrated reporting, a face-to-face meeting to resolve ARRC medication charting issues, and meetings with the new PHARMAC access equity programme team.

17 Programme planning for 2018-19

Programme planning priorities for 2018-19 were discussed. In the context of reshaping the Commission's programmes, moving from a topic focus to more of a sector focus. Medication safety has been confirmed as an enduring programme, with a need to relook at the utilisation of resources within the Commission to support this ongoing work. The programme strategy will reflect the strategic priorities of improving consumer experience, improving health equity, reducing harm and mortality, and reducing unwarranted variation in patterns of care. A priority will be to maintain networks and resource the expert advisory group, an appointed clinical lead and to strengthen clinical leadership for medication safety across the sector. Partnership funding will need to be developed in response to any new and emerging projects. Responding to the WHO global challenge will also be a priority.

Medication safety sits across both the intelligence hub and the improvement hub, and also across all sectors, mental health, primary, secondary, community and aged residential care. Ongoing work needs to reflect how this need for integration is addressed.

The MSEAG confirmed the importance and value of the medication safety programme and the need for improved visibility to drive ongoing quality improvement in this area.

Other business

18 Topics and speakers for next meeting

Sandra Fielding will present a patient story to illustrate the importance of informed consent in administering medications. MSEAG members are encouraged to make suggestions on areas of interest.

19 Future meetings

Costing will be undertaken prior to deciding dates/venues for future meetings after May 2018 (Auckland vs Wellington).

Next meeting will be 30 May 2018 in Auckland

Meeting closed 3.31pm