Department of Health
An Roinn Sláinte
Männystrie O Poustie
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World Health Organization

3rd Global Patient Safety Challenge
‘Medication Without Harm’

29th November 2018, Mossley Mill, Newtownabbey

Symposium learning summary

Our 'Thank You'

This is a summary of the outcomes of the Department of Health Symposium that was held to launch the World Health Organisation (WHO) 3rd Global Patient Safety Challenge 'Medication Without Harm' in Northern Ireland and also to help shape our response to the Challenge.

In essence this is our 'thank you' to those that attended the Symposium, your contribution really helped to make this event a success. This newsletter, provides a summary of the key points and the learning outcomes discussed at the event.

The Event itself

A very damp wet late November day did not dishearten those from attending the Symposium in Mossley Mill, 71 people from across the HSC kindly gave up their day to attend.

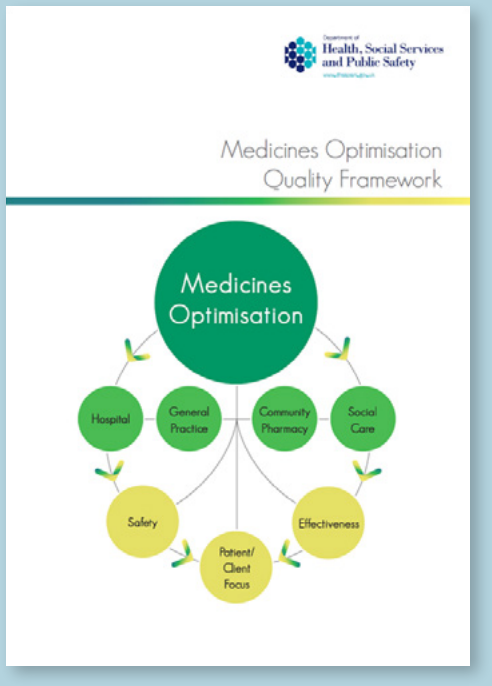
In March 2017 WHO launched their third global patient safety challenge: 'Medication Without Harm'. The previous two challenges were: 'Clean Care is Safer Care', followed a few years later by ' Safe Surgery Saves Lives'.

This Challenge gives us an opportunity in NI to reflect on how we currently support our systems and staff to ensure that patients receive and use their medicines safely and identify how we can improve. To provide a flavour of current activity in medicines safety practices, a number of bodies / teams presented their work at table stands. These included Clinical Education Centre, regional Medicines Optimisation Innovation Centre, regional Medicines Governance Team, HSCB Primary Care Medicines Management, regional Medicines Information, Making Insulin Treatment Safer Team (MITS) and the National Pharmacy Association. Space was also allocated for poster displays, showcasing a wide range of innovative work from across the HSC, to support safe use of medication. These were available throughout the day for people to view and discuss at refreshment breaks.

Paula O'Kelly from the HSC Leadership Centre facilitated the event. She was excellent at keeping everyone to time and also ensuring that we had some fun in the process.

Tweets capturing the Event can also be found at #medicationwithoutharm

Cathy Harrison, Deputy Chief Pharmaceutical Officer, launching the Medication Without Harm Symposium



Medication safety - where are we now?

Cathy Harrison, Deputy Chief Pharmaceutical Officer gave the opening address, acknowledging that Health and Social Care in NI is starting from a 'good' position in its response to the WHO Challenge. She provided the current context of the DOH Quality 2020 Framework and that medication safety is aligned to it via the Medicines Optimisation Quality Framework.

This Framework was developed in response to gain safer and better patient outcomes from medicines and ensure effective use of healthcare resources. Cathy outlined the establishment of our regional Medicines Optimisation and Innovation Centre, whose role is to ensure better health outcomes for the population through the consistent delivery of best practice relating to the use of medicines. She noted some examples of current initiatives which are supporting medication safety whilst also acknowledging the need for further gap analysis, systemic testing and scale and spread.

Cathy played this vimeo to illustrate the importance of medication safety for patients.

Cathy reminded the audience of our established infrastructure to support medication safety within primary and secondary care but also shared our awareness of the burden of medication harm within NI in the form of an infographic, the data informing this was extrapolated to our NI population from published studies. This was the first time that the draft infographic had been shared publically and will become available once finalised. She also acknowledged the recently produced 'Learning from medication Incidents in Northern Ireland' report which is a review of medication incidents reported in 2017, produced by the NI Medicines Governance Team and the HSCB Pharmacy Co-ordinator. The report provides an understanding of the main types of medication incidents reported and the main factors identified which led to the incidents occurring.

moic
Medicines Optimisation Innovation Centre
Smarter Medicines Better Outcomes

Simon Peitersen WHO, presenting the 'Medication Without Harm' Challenge

Reduce the level of severe, avoidable harm related to medications by 50% over 5 years globally

Simon Peitersen, Public Health Consultant, WHO, Patient Safety And Risk Management Unit, Geneva discussed the background and aims and objectives of the Medication Safety Challenge.

The goal of the Challenge is to reduce, severe, avoidable medication-related harm by 50% in the next five years, by addressing harm resulting from errors or unsafe practices due to weaknesses in health systems.

Simon discussed the objectives of the Challenge which are to

- **RAISE** awareness of the problems of unsafe medication practices and medication errors, and the Challenge as a vehicle to address this issue
- **DEVELOP** guidance/materials/technologies/tools to support the setting up of safer medication use systems for reducing errors
- **BUILD** capacities of healthcare professionals to reduce the risk of medication-related harm through education and training, developing competencies
- **EMPOWER** patients/families to become actively engaged in decisions, ask questions, spot errors, manage their medications
- **ENGAGE & SEEK COMMITMENT** of key stakeholders /partners/industry to raise awareness of medication-related harm and support implementation of the Challenge

He provided guidance on how NI should respond to the Challenge. This included; undertaking a gap analysis bringing together experts and stakeholders to examine the four domains of the WHO Challenge: Patients and the public, Healthcare professionals, Medicines and Systems and Practice and the three priority areas: High Risk Situations, Polypharmacy and Safer Transitions of Care.

Simon provided guidance on national and local implementation of this Challenge, which includes;

- Political commitment
- Coordination mechanisms (Strategic advisory groups, technical groups)
- Implementation plan
- Situational analysis
- Stakeholder analysis and engagement
- Alignment to other programmes and projects
- Infrastructure and initation of quality improvement activities
- Development of actions / interventions, including early priority actions
- Patients and family engagement

What's working well...? Even better if...?

Attendees were asked to describe what they felt was 'working well?' and 'what could be better?' with respect to the four domains of the Medication Without Harm Challenge.

These are summarised under each domain.

Patients and the public

What's working well?	Even better if...?
Expert patient groups, diabetes UK, Liver Group, Parkinson's Excellence Network	Focus on health literacy
Integrated care pathways	Co-production
Intelligent devices e.g. blood glucose monitoring	Patient representatives on medicines safety meettings / more patient engagement
Patient decision aids	Co-decision making
Some 'early' Apps to support adherence for the elderly and domiciliary care use	Encompass patient portal
'Choice and medication' website in mental health	Development of more intelligent devices for monitoring high risk medicine use
Accessibility to community pharmacy	Consistent use of patient aids
Practice based pharmacists within GPs	More development of adherence Apps and IT solutions
Patient information leaflets in every pack	Clear education messages / campaign
	Consider the holistic management of the patients rather than the 'illness'
	Mobilise community pharmacy to engage with WHO Challenge

Healthcare Professionals

What's working well?	Even better if...?
Education	
Good undergraduate curricula	Human factors education across the HSC
FYO teaching	Increased use of teacher practitioners
	More multi-disciplinary medication safety education
	More regional approach to training at postgraduate level
Incident reporting	
Incident reports driving governance agenda and education	More visible use of data to change behaviour
Culture of openness	No blame culture
Learning shared from reports and incidents	Information needs to filter down to frontline staff
Workforce	
Development and integration of pharmacy services at ward level and one stop dispensing	The ward based pharmacy model was a common standard
Medicines optimisation in older people	Staffing levels to match the requirements
Networking, closer liaison and joined up working with other professionals medics, pharmacy nursing staff	More support provided to junior nurses
Practice based pharmacists	Patient safety is a priority from the boardroom to the bedside
Non medical prescribers	Non medical prescribing becomes embedded into routine practice
Good specialist clinics (nurse / pharmacist)	Process for non-medical prescribing made easier and standard
	Extension of current good practice in acute to community
	Regional standardisation of policies / documentation / single community Kardex
	Use of data to highlight variation in practices
	More resources e.g. innovation groups, QI support
	Co-ownership and multi-disciplinary involvement

Medicines

What's working well?	Even better if...?
Access to new treatments Availability of formulations Strong regulatory function NI formulary National injectable medicines guide Yellow card reporting Local policies and procedures Tall-man lettering on packaging Pre-filled syringes Information leaflets in boxes Supported living- MDS packaging Medication review to reduce complexity Robotic dispensing Regional tendering Risk assessment in the procurement of medicines	Packaging choice for patients Stop parallel imports Patient involvement in the tender process Risk stratification includes high risk medicines, information on previous incidents and awareness of critical medicines on outer packaging.

Systems and Practices of Medication

What's working well?	Even better if...?
ECR / IT	More access to ECR e.g. community pharmacists and community services Encompass and e-prescribing with barcoding of patients
Training on medicines / non medical prescribing	Reflective practice, training / experience / on the job Training was multidisciplinary
Patient and public involvement	Empower patients, education / run campaigns, Listen more Holistic joined up patient management and treatment
Patient bedside medicine lockers	Needs to be standardised across NI
Focus on high risk medicines	More focus on high risk medicines
Safety network / infrastructure starting to make progress but complex	More joined up, clearer roles and responsibiltiies and accountability More joined up policies / procedures and guidelines
Increased reporting and learning	Learning more joined up between AIs / SAIs and primary and secondary care. Clearer infrastructure Learning was quicker and focused

Barbara Campbell,
sharing the HSCQI journey

Barbara Campbell, Programme Manager for HSCQI shared her experiences of the NI Quality Improvement journey using a little help from some familiar faces from the Wizard of Oz! She expressed that there was a desire in NI for change, people care, 'have a heart' to want to improve systems for patients and staff. Change, she said, also requires bringing together those with the 'brains' that know the issues and importantly to have the 'courage' to do things differently.

Barbara quoted the following from Paul Batalden, Senior Fellow, Institute for Healthcare Improvement

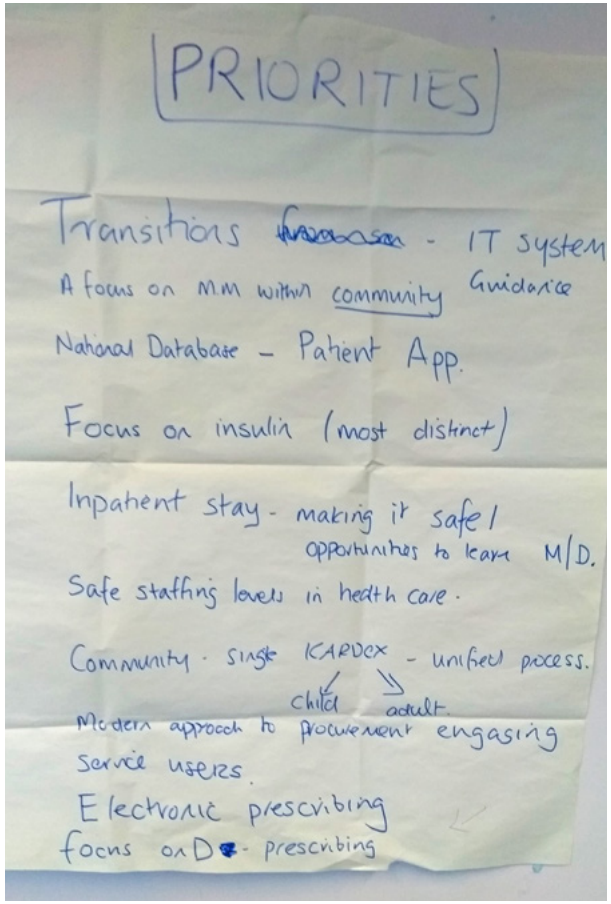
> 'Health and social care will not realise its full potential unless change making becomes an intrinsic part of everyone's job, every day, in all parts of the system'.

She shared the following video to demonstrate why taking a quality improvement approach to medication safety will make a difference.

Table discussions

People were then asked to discuss in their tables one key priority to start their quality improvement journey which would support the four domains of the WHO Challenge.

This was summarised at the Event as shown below.



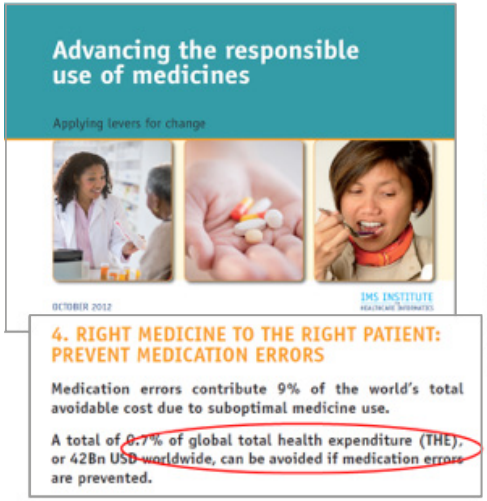
Dr Michael McBride, Chief Medical Officer addressing the afternoon session of the Symposium

Moving from 'Good' to 'Great'

After lunch the Chief Medical Officer **Dr Michael McBride** opened the afternoon session. He acknowledged the previous WHO Global Patient Safety Challenges that reduced the risk of harm associated with surgery and healthcare associated infection and gave the call to action that this is the responsibility of all healthcare professionals to rise to this latest challenge.

'Ensuring medicines are used safely must become second nature to all of us, just like washing our hands.'

Dr McBride, CMO



Global Calculations which include 186 countries: *IMS MIDAS, 2009 and 2011; World Bank 2009; WHO 2009; USD in 2011*

Dr McBride told us that medicines are the most common medical intervention within our population.

'70% of the population are at any one time taking prescribed or over the counter medication to treat or prevent ill-health. The economic burden from unsafe practices and medication errors is estimated at $42 billion USD annually.'

Dr McBride, CMO

Dr McBride discussed the changes in digital health, with personalised medicine, wearable devices, point of care diagnostics and artificial intelligence. He commented that these will radically transform the practice of medicine but that we cannot become complacent especially given the context of an aging population, with more long term co-morbidities than previous generations, taking more medicines of increasing complexity. He thanked all healthcare professionals for their tireless work in ensuring excellent care and firmly believes that as a consequence NI will be able to meet the WHO target of reducing severe, unavoidable medication related harm by a further 50% over the next five years.

Creating the NI medication safety vision

Attendees were set their own challenge to create an 'elevator pitch' for their key priority area identified in the morning session. **Paula O'Kelly** explained how to do this with the help of the Framework used by Pixar to tell stories;

- **Once upon a time** (the situation)
- **Every day** (the impact the situation has)
- **One day** (what the improvement interventions are you used to bring about change)
- **Because of that…** (the activities, processes put in place)
- **Because of that…** (the activities, processes put in place)
- **Until finally** (the goal you achieved)

Groups were invited to be creative and use images taken from magazines provided on the tables to produce their elevator pitches. A selection of their creative inegnuity is shown here.

There was fierce completion between the tables and Paula's strict time keeping held them to their two minute time allowance for presentation.

A clap-o-meter method was used to assess the best elevator pitch, with Dr McBride acting as judge. However it proved difficult to assign a true winner so the prize of chocolates was distributed equally to all.

Next steps

Cathy Harrison concluded the Symposium by summarising what had been learnt in terms of priority areas and also how there was a great need for digital health to greatly contribute to medication safety. She proposed that there would be merit in establishing communities of practice to enable staff and patients to come together to help address the identified challenges of the WHO campaign.

She thanked everyone for their contributions and that the learning from the Event would support the development of the Department of Health's proposed plan to respond to the Challenge.

A consultation of this plan will occur during March / April and will be circulated to all those who attended the Symposium and other key stakeholders.

The plan will be formally launched on the morning of 10th May at Mossley Mill, Newtownabbey so please keep the date!

L to R: Angela Carrington, Medication Safety Lead DOH, Cathy Harrison, Deputy Chief Pharmaceutical Officer, Dr Michael McBride, Chief Medical Officer, Simon Peitersen, Public Health Consultant WHO, Prof Michael Scott, MOIC Director, Barbara Campbell, HSCQI Programme Manager

10 May 2019, Mossley Mill, Newtownabbey

Launch of the 'Medication Without Harm' Challenge response plan