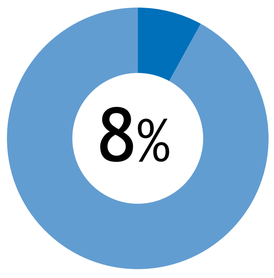
safety IN PRACTICE
every patient, every time

A large-scale initiative to improve NSAID prescribing safety: The story so far…

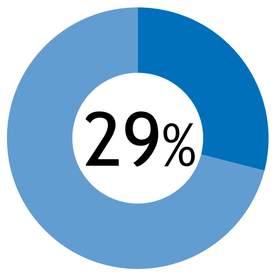
Dr Lisa Eskildsen, Planning, Funding & Outcomes, Auckland & Waitemata District Health Board & Safety in Practice Team

Context

Safety in Practice (SiP) is a quality improvement programme, using Model for Improvement methodology. SiP provides tools and training to primary care teams, to reduce preventable harm to patients.
Over the past 5 years the programme has focuses on proven high risk clinical areas, such as medicines reconciliation and anticoagulants.



of patients report being given the wrong medicine or dose in primary care [1]



of medication related patient harm identified in hospital originates in the community [2]

Non-steroidal anti-inflammatory drugs (NSAIDs) are a significant cause of medication related patient harm [3]

Aim

To reduce high risk prescribing of NSAIDs, in GP practices involved in Safety in Practice, by providing prescribers with information about high risk NSAID prescribing within their practice.

Intervention

61 general practice teams across Auckland & Waitemata DHB.

Data reports automated through the practices' in house audit tools -less work for practices and less intensive support.

Practices were given suggestions for change and guidance on best practice at Learning Sessions.

Improvement methodology transposes from other modules in SiP - support available from the SiP team and Primary Health Organisation facilitators.

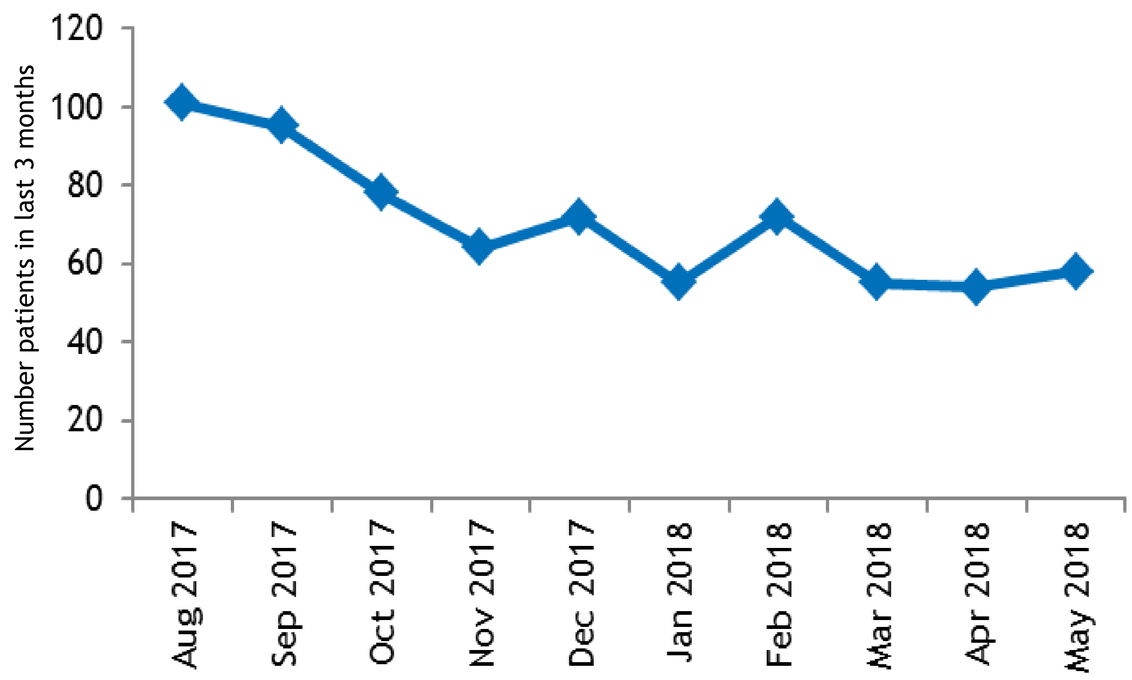
Practices left to action their reports themselves. Reporting to the SIP team only required the total number of patients each month within each category.

Changes & Lessons Learnt

- More time planning and undertaking smaller pilot could have made for smoother implementation versus benefits of trialling and learning from many practices feedback
- Collecting 3 months data confusing for practices and slow to show changes - changed to monthly this year
- Difficulty getting comparator data - data sharing permissions - unable to prove that intervention caused change
- Variability in engagement and what needed to stimulate change between practices - would be useful to be able to record this
- Many practices reported having dramatic effect on their awareness of issue and prescribing patterns
- Helpful that running along side other quality improvement work in SiP
- 2018/19 monthly data with options for practices of prescribing indicators with a focus on NSAID, kidneys or other high risk medicines

Measurement

- Measure 1: Total number of patients ≥65 years, no gastro-protection prescribed.
- Measure 2: Total number of patients with peptic ulcer, no gastro-protection prescribed.
- Measure 3: Total number of patients prescribed an NSAID with chronic kidney disease (Stage 3-5).
- Measure 4 (pictured): Total number of patients across all practices prescribed an NSAID with the 'triple whammy'; an ACE-inhibitor or ARB, diuretic and chronic kidney disease (Stage 3-5).



- Measure 5: Total number of patients prescribed an NSAID with heart failure.

References:
1. HQSC A Window on the quality of the NZ Healthcare 2017 2. Robb G et al NZMJ 2017;130(1460):21-32 3. NZ Centre for Adverse Drug Monitoring

Safety in Practice Team members: Dr Neil Houston, Dr Eleri Clissold, Harshna Mistry, Kelly Fraher, Ernesto Galaz, Sue French, Shona Muir, Sarah Young, Tim Denison, Michael Hammond, Sreeja Nair, Tim Wood, Dr Stuart Jenkins.
Clinical Audit Tool providers - Dr Info, Mohio, My Practice

@saferpracticenz info@safetyinpractice.co.nz www.safetyinpractice.co.nz

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