



Reducing harm from parenteral opiates & levomepromazine in community patients with palliative care needs

A Quality Improvement project



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The problem & identified opportunity to improve

Unsafe & In-efficient use of parenteral opiates & levomepromazine (procurement, prescribing & administration) for patients with life limiting illness in the community

- Deemed 'high alert' medication, multiple agencies & transitions
- Limited healthcare professional proficiency with medication & dose ranges, absent or unwieldy processes, sub-optimal communication
- Suboptimal symptom control, increased risk patient harm
- Inefficiency & waste - medicines, healthcare professional time
- Concerning Medication Safety Incidents in previous 6 months
 - Medication related events 55% (n=88) community reported incidents via National Incident Management System [NIMS] 2019-22
 - All Medication incidents denoted a category as per NCC-MERP index
- Organisational & reputational damage arising from complaints
- Use of QI methodology for problem analysis, measurement, stakeholder engagement & test improvement ideas via PDSA cycles

Baseline Data & Analysis of the problem

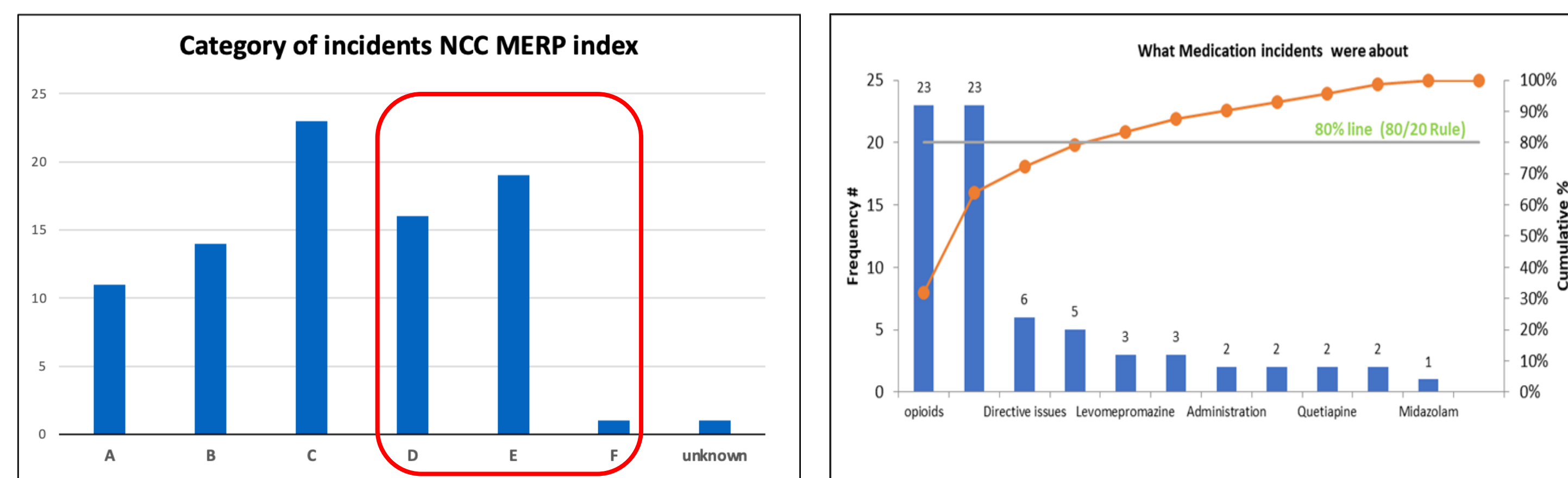


Fig. 1: NCC-MERP index medication events 2019-22

Fig. 2: Pareto chart - Medication related events

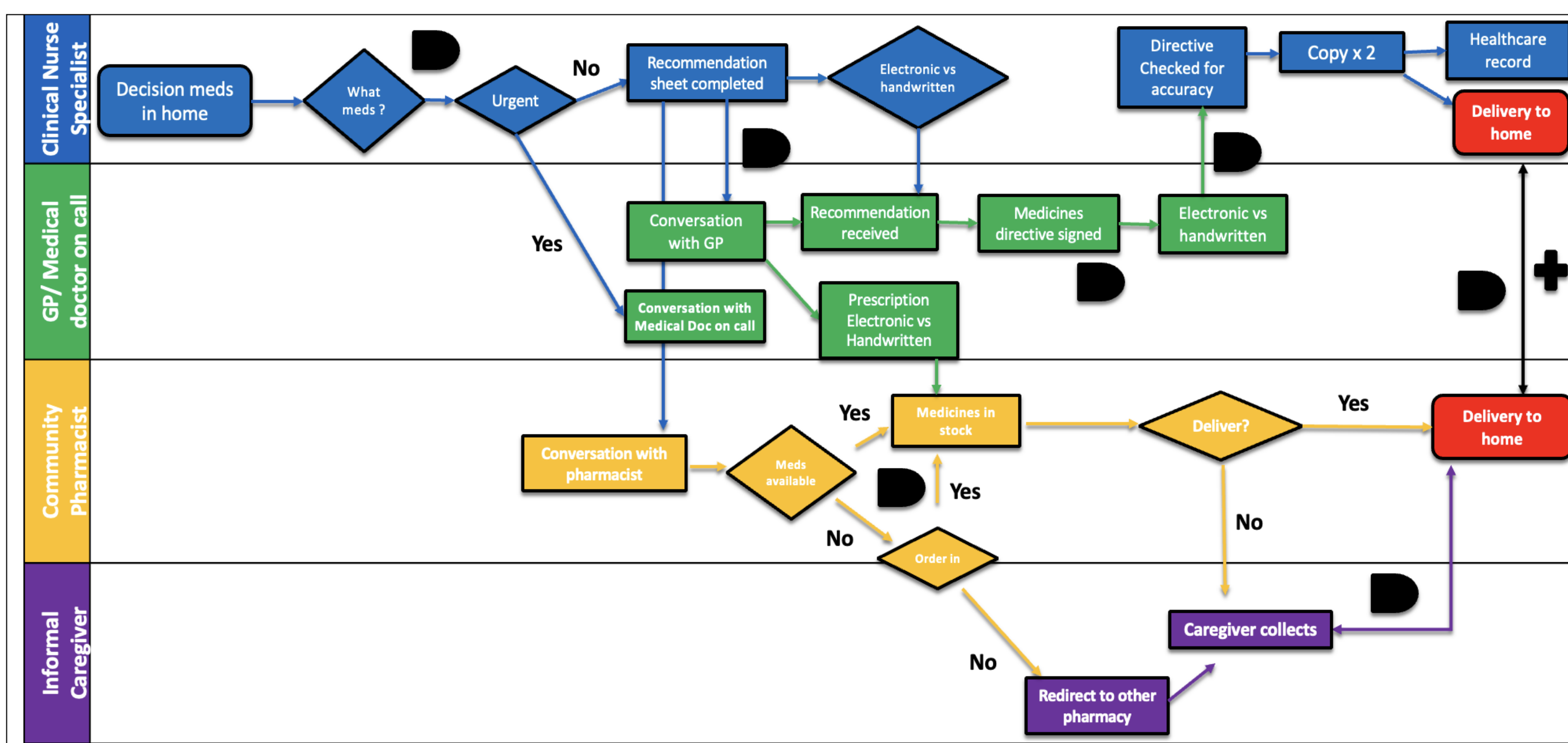


Fig. 3: Process map of parenteral medication procurement in community

Project Aim

To reduce **preventable*** medicines related harm** from 20 incidents per year to **Zero** through **safe, timely, co-ordinated prescribing & administration** of parenteral opiates & levomepromazine for patients with life limiting illness in receipt of community specialist palliative care in the Mid-west

* Preventable harm associated with prescribing, dispensing or administration errors

** Medicines Related Harm – Category E-I as defined by National Co-ordinating Council Medication Error Reporting & Prevention (NCC-MERP) index

Driver diagram

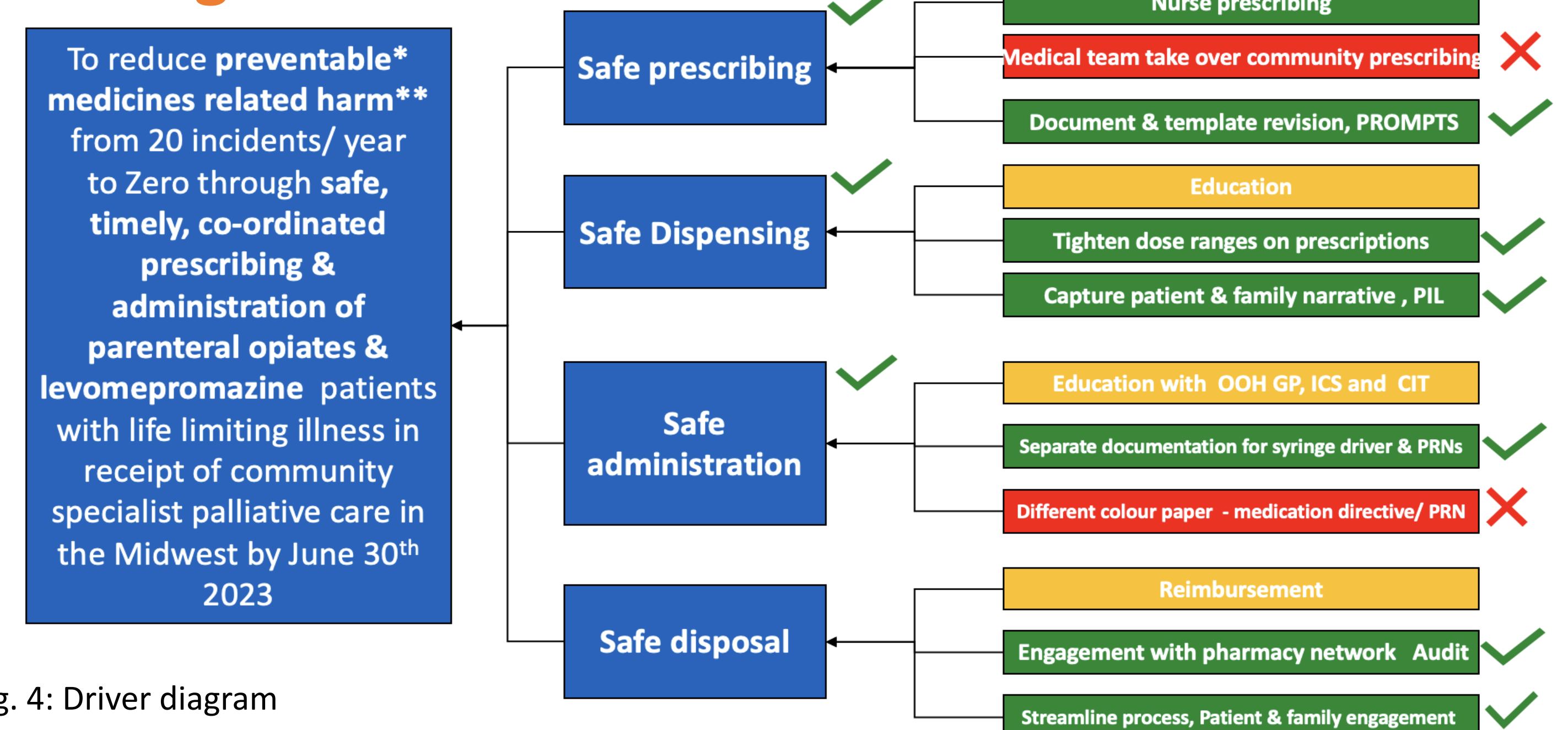


Fig. 4: Driver diagram

Outcome Measures - Medication Related Events

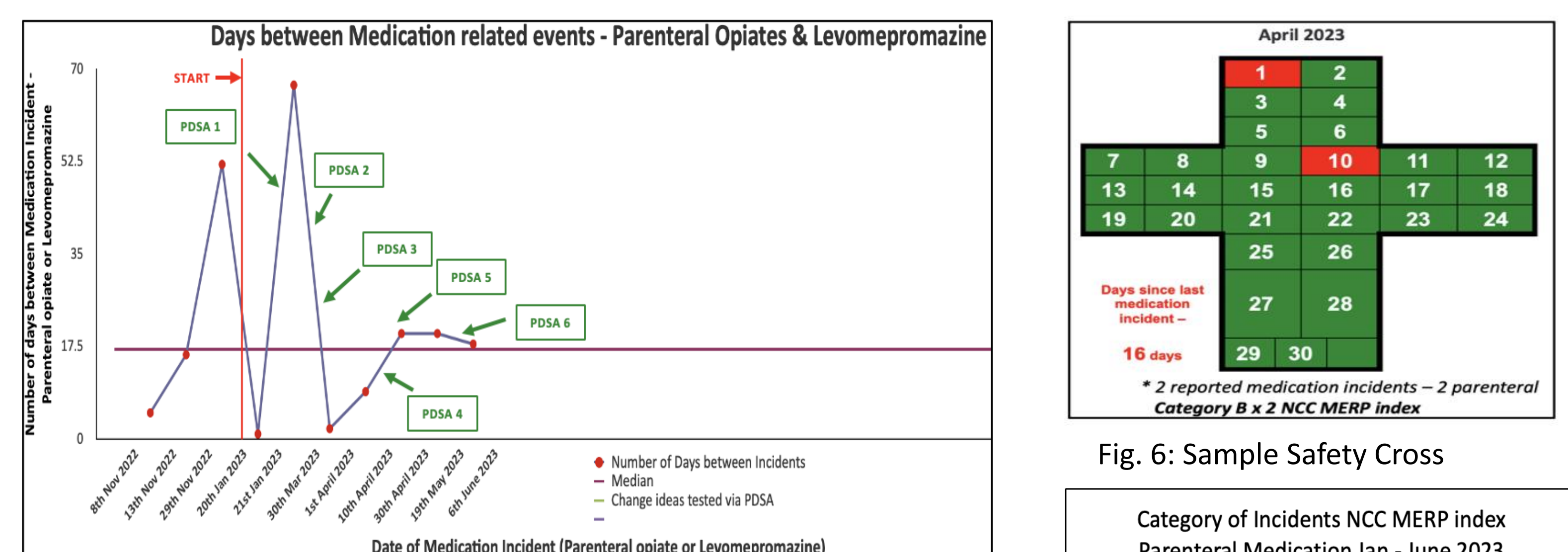


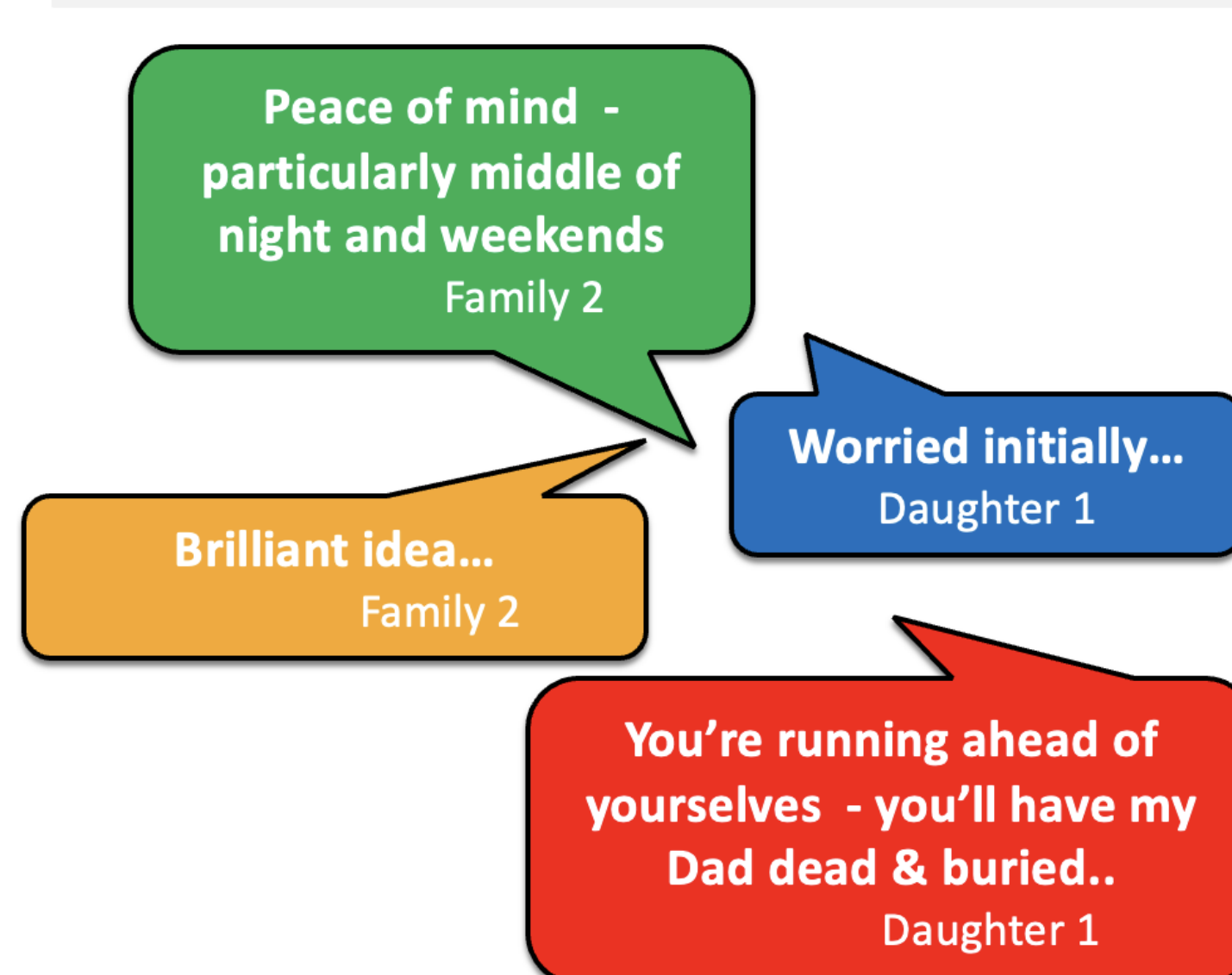
Fig. 5: T-chart depicting time(days) between medication related events

Fig. 6: Sample Safety Cross

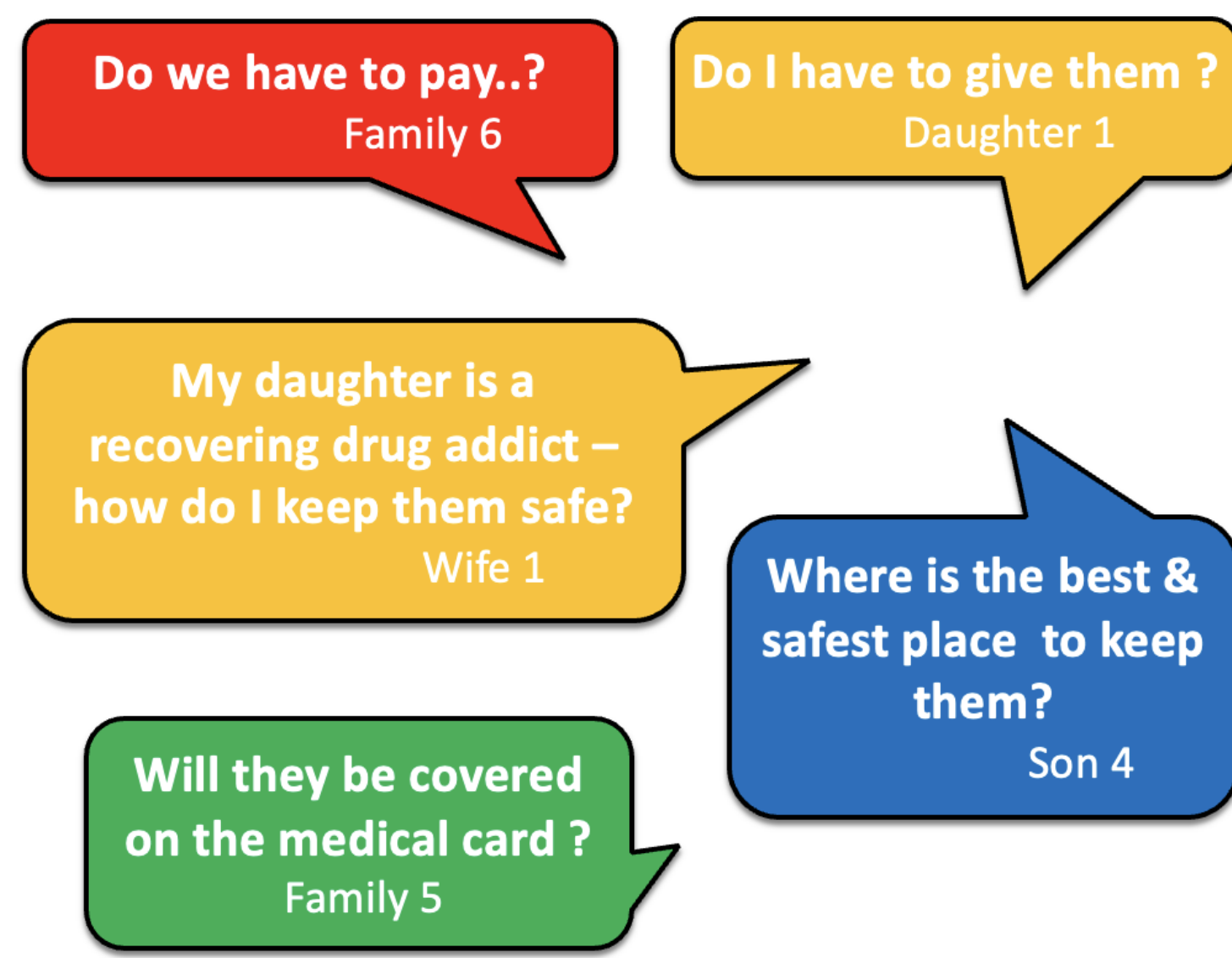
Fig. 7: NCC-MERP index medication related events 2023

Patient & Family narratives

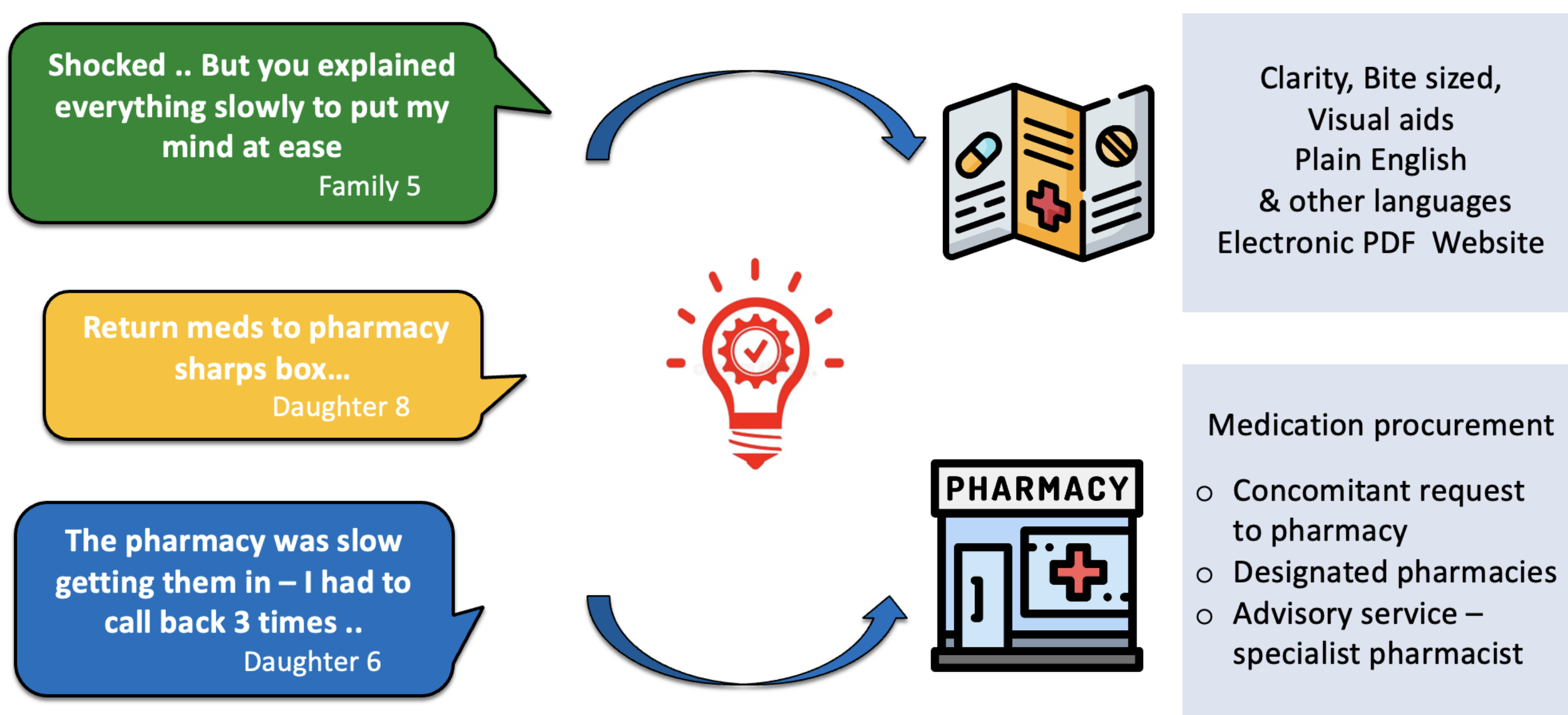
a. Diverse initial perceptions of injectable medicines at home



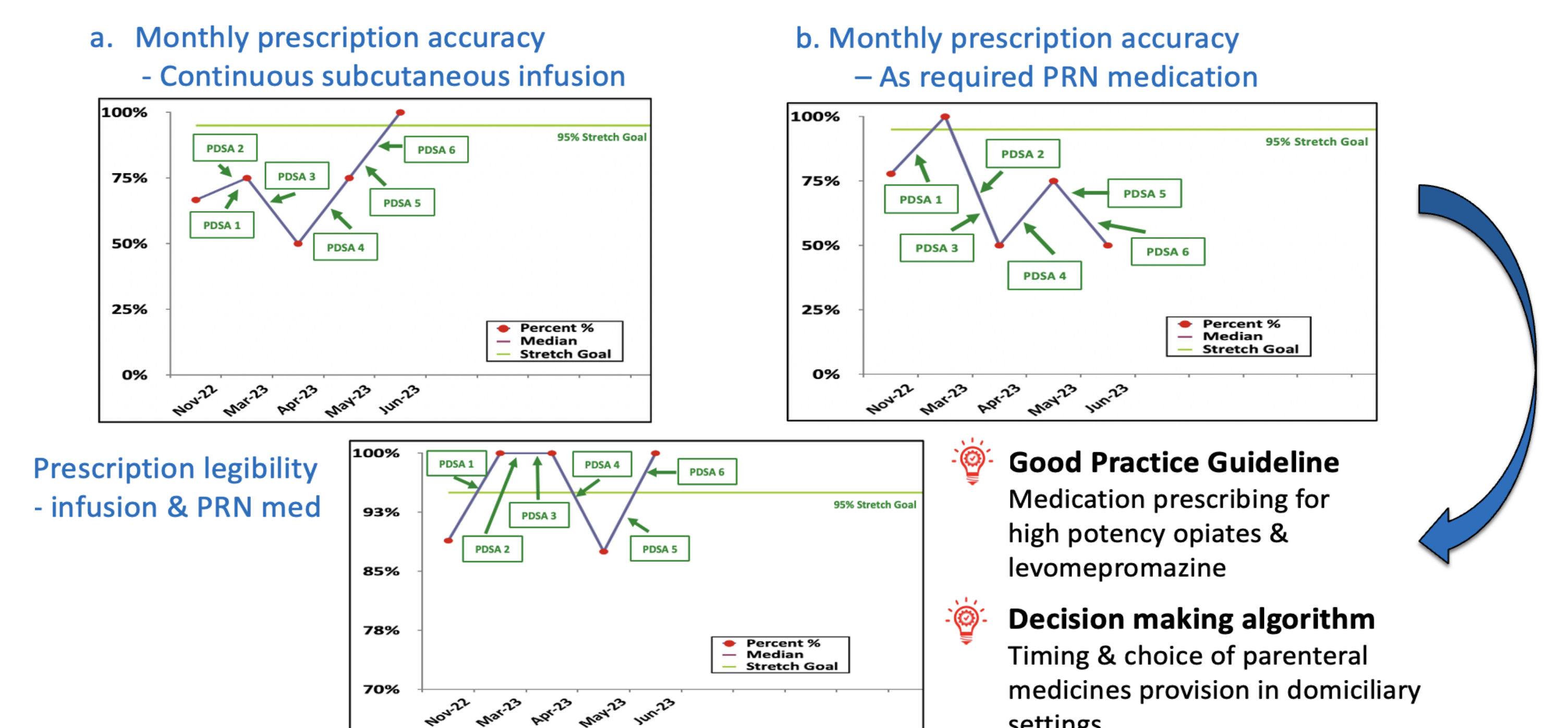
b. Concerns about purchase, storage & administration



Please tell us what we can improve..



Process Measures



HAVE we managed to reduce harm from use of parenteral opiates & levomepromazine in the community ?

- Not yet - but we remain optimistic!
Efforts to date focused - internal stakeholders & getting our own house in order
- Decision making around parenteral medication more judicious & considered
Timing & quantity of medicines - cost-efficiencies, less waste, ? reduction in time spent
- Perspectives of patient & families invaluable to mould new initiatives
- Dialogue & debate across team collectively about tackling parenteral medication safety
- Shift in culture of reporting