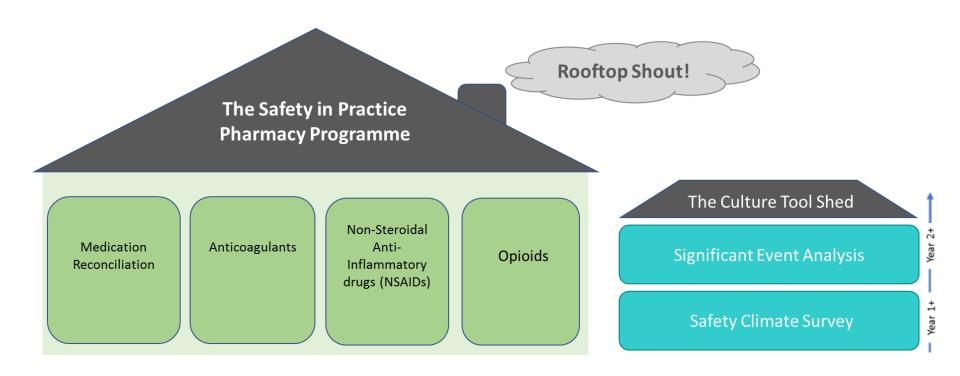


SiP is a **quality improvement** programme providing **tools** and **training** to primary care teams.

The SiP DHB team facilitates this learning for 3 years after which you graduate with **skills**, **tools** and **know how** to address other high risk areas as a team!



Each year select one of the green modules you wish to focus on as well as a culture tool

### What's involved?

- > Attend 4 Learning sessions per year learn Quality improvement skills and exchange ideas and experiences.
- Submit monthly data for your module
- ➤ Receive an incentive of \$5400 + GST per year for first 3 years participation





Clinical Modules – small monthly audits helping pharmacies identify areas to focus on for improvement

## **Anticoagulants**

This module helps pharmacies check that their processes for managing patients on these high risk medicines are robust and safe. It focuses on informing and educating patients.

# **Opioids**

Opioids are associated with significant patient harm. This module focuses on pharmacies using safe and reliable processes when managing and educating patients prescribed an opioid.

#### **NSAIDs**

NSAIDs are implicated in 30% of hospital admissions for adverse drug effects, some of which is avoidable. This module helps pharmacies manage and educate patients prescribed NSAIDs.

## Medication Reconciliation

Over 40% of medication errors are believed to result from inadequate medication reconciliation. This module focuses on reviewing discharge prescriptions and providing patients with an up to date medicines list.

Safety Culture Tools – Give teams insights into their organisational culture related to safety

### **Safety Climate Survey**

This is an opportunity for your whole team to provide anonymous feedback on the working culture in your pharmacy. Your team reflects on and discuss the results, and decide on opportunities for improvement together.

## **Significant Event Analysis**

A semi-structured approach to assist pharmacies to analyse a patient safety incident or near miss that has occurred and make changes to reduce the chances of similar events occurring again.



