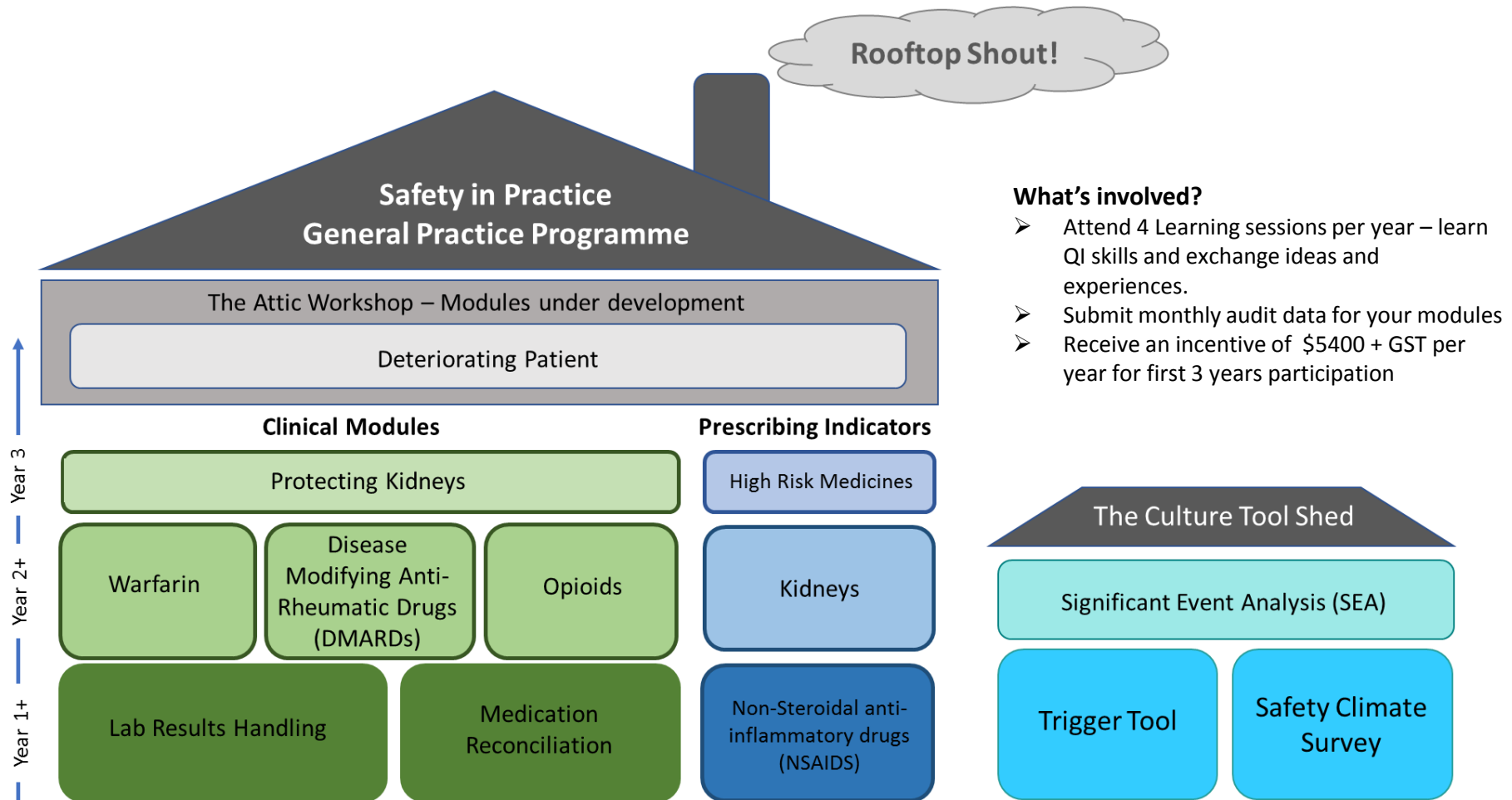


SiP is a **quality improvement** programme providing **tools** and **training** to primary care teams.

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!



In year 1, select a core module (dark green ), a culture tool and the NSAIDs Prescribing Indicator. In years 2+, select any clinical module (green) a culture tool and a prescribing indicator.

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

|   |  |  |  |
|---|--|--|--|
| <b>Medication Reconciliation</b><br>Over 40% of medication errors are believed to result from inadequate medication reconciliation. This module focuses on reviewing all discharge summaries with both medication reconciled, records updated and patients understanding of changes being reviewed within 7 working days. |  | <b>Results Handling</b><br>A lack of integrated systems to manage lab test ordering and results handling is a key contributor to the rate of error in primary care. This module focuses on implementing robust processes to ensure all lab results are actioned within 7 days and patients are reliably and appropriately informed of their results when required. |  |
| <b>Warfarin</b><br><br>This module helps practices check that their processes for managing patients on this high risk medication are robust and safe. It focuses on processes for blood test monitoring, as well as informing and educating patients.   | <b>Opioids</b><br><br>Opioids are associated with significant patient harm. This module focuses on practices using safe and reliable processes when prescribing, monitoring and educating patients prescribed an opioid. | <b>DMARDs</b><br><br>While clinically effective, disease modifying anti-rheumatic drugs (methotrexate and azathioprine) can be associated with significant patient harm. This module focuses on their safe prescribing, reliable monitoring and good patient education.  | <b>Protecting Kidneys</b><br><br>Acute kidney injury can be caused or contributed to by medications. This module focuses on preventing AKI in high risk patients, as well as identifying AKI early and managing it appropriately |

**Prescribing Indicators** –patients are automatically identified by practice audit tools where prescribing fits into a suite of indicators identifying high risk. Practices decide how they want to manage these patients and adjust their systems to reduce harm

|   |  |   |
|---|--|---|
| <b>NSAIDs</b><br>NSAIDs are implicated in 30% of hospital admissions for adverse drug effects, some of which is avoidable. This indicator gives practices data on which patients have received NSAID prescribing that is identified as high risk. | <b>Kidneys</b><br>Damage to kidneys from medications are a common cause of patient harm. This indicator helps practices identify patients who have been prescribed medication that are higher risk for them, or which require monitoring to ensure they are safe to use. | <b>High Risk Medicines</b><br>This indicator helps practices identify patients who are on medications recognised to be high risk if they are not appropriately prescribed and/or monitored. Medicines of focus include sodium valproate, warfarin, methotrexate and amiodarone. |
|---|--|---|

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

|  |   |  |
|--|---|--|
| <b>Safety Climate Survey</b><br>Staff are encouraged to complete an anonymised survey around the working culture of the organisation and the results are analysed as a team to assess opportunities for improvement. | <b>Trigger Tool</b><br>A simple checklist used to screen medical records for potential harm. This facilitates structured, focused and rapid review of a sample of medical records to identify potential harm. | <b>Significant Event Analysis</b><br>A semi-structured approach to assist practices to analyse a patient safety incident that has occurred and make changes to reduce the chances of similar events occurring again. |
|--|---|--|