Safe use of opioids collaborative

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Welcome to the second edition of the safe use of opioids collaborative newsletter

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A message from Dr John Krueger, Institute for Healthcare Improvement (IHI), USA

Dear Commission–NZ collaborative colleagues

On behalf of IHI and myself, thank you for the opportunity to be involved in the collaborative. I am grateful for the hard work in which you are engaged as you strive to protect patients from harm and make the use of opioid medications safer.

It was a privilege to be with you at the collaborative meeting in Christchurch. Your enthusiasm for this work, the rapidity with which you all picked up the quality improvement concepts and incorporated them into your projects, and your ability to work together toward a common shared goal really struck me as the key strengths that set you apart as a collaborative.

I am excited and honoured to be on this journey with you, impressed by what you have accomplished thus far and keenly interested to see what you will accomplish in the future.

Kind regards,
John Krueger MD, MPH

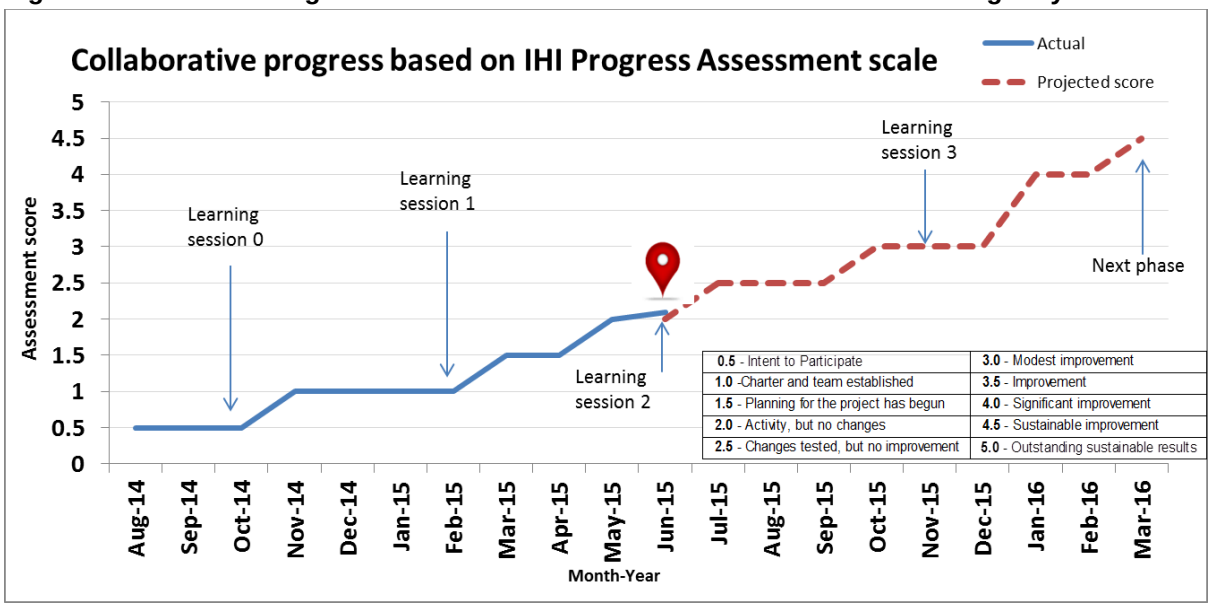
Collaborative update

The collaborative is now in action period two – the crucial time between the second and third national learning sessions (June–November 2015). Most district health board (DHB) teams have an identified harm area and site/s. The focus of teams has shifted away from their aim statements and baselines to developing and testing ideas for reducing opioid-related harms.

Most teams are focused on reducing opioid-induced constipation (supported by what their harm data tells them) with the rest targeting other harm areas.

Each collaborative team will have regular opportunities to self-assess its progress. Teams can rate their overall project using an assessment scale from the IHI. Self-assessments will be performed on a monthly basis, with an average score for all teams plotted against a national predictor of where teams should be positioned (Figure 1). The average national level score for June 2015 was 2.1, compared with an expected score of 2.0.

Figure 1. National average of DHB self-assessment scores versus national target by month



For background information about the formative nature of the collaborative, please refer to edition one of this newsletter.

Capital & Coast DHB profile

Capital & Coast DHB have been focused on improving opioid safety since 2011, well before the national collaborative was formed.

For the purposes of this collaborative, the team at Capital & Coast DHB initially chose to focus on reducing harm associated with transdermal fentanyl patch use in older adults. This was because clinical staff had suggested fentanyl patch use was causing patient harm, for example, respiratory depression/opioid-induced ventilatory impairment.

The team used the Model for Improvement as its quality improvement methodology. This approach uses plan–do–study–act (PDSA) cycles to test ideas, for example, by temporarily trialling a change on a small scale and assessing its impact.

The team completed three PDSA cycles to identify which patient groups were being treated with fentanyl patches, and the type and extent of harm. The team was surprised by the results. The data showed the number of reportable events specific to fentanyl patches was actually low… it was back to the drawing board!

The next step was to review the DHB's global trigger tool and adverse drug event trigger tool data. The data revealed that constipation was the most frequently reported opioid-related harm, with the largest proportion reported in 6 North Ward (orthopaedics), where there is a higher level of opioid use. Based on the findings the team decided to change the harm to opioid-related constipation.

Caroline Tilah, project lead, says the value of using PDSA was clear and useful for gaining valuable learning and knowledge.

'The data from our initial testing did not provide evidence that transdermal fentanyl patch use was causing harm,' she says. 'By using the PDSA method, information was provided that helped us identify the correct opioid-related harm area to target.

'Testing using PDSA cycles ultimately changed our harm focus – in our case to constipation, a common problem associated with opioid use'.

These valuable insights were shared with delegates at learning session two in Christchurch.

24 July 2015 – collaborative launch day on Ward 6 North! *(L-R) Capital & Coast DHB: Janice Young (medication safety pharmacist), Kimberley Fox (graduate nurse), Christina Fereti (registered nurse), Caroline Tilah (Executive Director Operations Quality Improvement & Patient Safety Directorate, and project lead), Joanna Simons (registered nurse); national safe use of opioids collaborative team: John Kristiansen (project manager), Prem Kumar (quality improvement advisor). Note: not all collaborative team members are pictured; many other ward staff also attended the launch.*

Learning session two

Learning session two was held at the Hagley Oval Pavilion in Christchurch in June 2015.

The focus of the learning session was on sharing and learning from each other, and gaining a deeper understanding about measurement and testing of change ideas using PDSA cycles. The delegates learned about quality improvement methodologies and tools through teaching and group exercises.

A survey of attendees showed they valued the opportunity to network, the discussions within their harm group/s and the protected time to get together as a team.

Dr John Krueger, a visiting fellow from the IHI, attended the learning session; his theory sessions and one-on-one mentoring were well received by delegates.

Presentations and materials from the learning session are on our website, and include two international perspectives from Dorthe Vilstrup Tomsen (Denmark) and Frank Federico (IHI), who both sent video presentations, which were shown to delegates. Dorthe shared her experiences around reducing harm form opioid-related constipation, and Frank encouraged and inspired delegates to work collectively to develop a 'bundle of interventions' to address opioid-related harm. The world is watching New Zealand!

Above: Delegates brave freezing conditions in Christchurch. Below left: Breakout session: the team from Canterbury DHB discusses uncontrolled pain measurement with Dr John Krueger. Below right: Dr John Krueger presents a session about measures, data collection, baseline data and graphs.

Dr John Krueger on the utility of Maslow's theory

In his 1943 paper, 'A Theory of Human Motivation', Abraham Maslow described a hierarchy of 'needs' that he theorised was needed in order for humans to achieve higher levels of emotional and psychological maturity. Starting with basic physiological needs, the hierarchy in ascending order progressed to include safety, love/belonging, esteem and self-actualisation. Maslow theorised that without a lower hierarchical need being met, higher level needs could never be sufficiently obtained. Though more contemporary research regarding human emotional development has failed to find critical evidence that supports that these hierarchies are universal, I have found Maslow's theory helpful in the ways in which I think about harm and the establishment of shared purpose.

The first way I find Maslow's theory helpful is thinking in terms of how patients experience health care delivery. In medicine we are charged with a simple directive of non-maleficence as embodied in the Hippocratic corpus and the Latin maxim 'primum non nocere', which translates roughly to 'first, do no harm'. Despite this, however, though generally unintentional, health care is fraught with harm. In 2000, the US Agency for Health Quality Research calculated that hospital errors ranked between the fifth and eight leading causes of death and that adverse drug event-related harms were the fifth leading cause of hospital death in the US. These harms are sadly found in similar proportions in other countries. How then can we ever expect patients to achieve those higher aspects of self-sufficient psychological adaptation and growth when they are in a health care environment in which they have to worry about their personal safety? Even when the basic physiological needs are met, our patients can only truly progress when they are in an environment in which they have confidence and feel safe, and that demonstrates a commitment to safety. A commitment to studying and improving safety illustrates a commitment to reducing harm and is a testament to health care's noblest cause.

The second way in which I find Maslow's theory helpful is how we in quality improvement relate to each other and our work. To be successful in quality improvement requires a certain amount of support – the physiological level of support from your colleagues and those you work with, if you will. Thankfully, you are blessed to work with a health ministry and Commission staff who recognise the importance of assuring the financial, physical, motivational and educational resources are there to support you in your quality improvement journey. But you are also supported by your colleagues engaged in this work and by a broader health care quality improvement community, that like you has committed to the struggle of improvement. In short, you have joined a community of humble but dedicated learners who, like you, are trying to learn and grow. This is where assuring we reach a level of psychological safety become important, because a large part of learning is failure. In fact, if you think about it, a great many PDSA cycles never turn out to amount to much of anything individually. Yet cumulatively, these same PDSA cycles become the iterative framework, along with the other quality improvement tools and data over

time, which turn a conceptual idea into an actualised evidence-based intervention. As Carlile and Christiansen illustrate, this is the environment needed to turn descriptive theory into normative theory. A safe environment should encourage failure as a natural part of learning and a necessary contribution to success. Failing small and safely is how we learn and gain confidence in our abilities and leverage our future success. Learning and trusting in a safe environment leads to higher-level appreciation and knowledge for the systems, psychology, epistemology and variation that play a role not only in your life but also the lives of those you serve.

Because of the belief – a belief now supported by data – that you will be successful and, through rapid iterative cycle testing and studying data over time, able to overcome various problems, you as a collaborative have been able to take on a problem that has never been tackled on such a large scale in any other country. While this is an enormous undertaking, you should find it empowering and know that the rest of the quality improvement world is watching to gain knowledge from your learning and accomplishments.

On the horizon

Monthly teleconferences

The focus of the regular monthly collaborative team teleconferences has shifted, for now, from regional to harm-based discussions:

- 26 August and 30 September 2015: point of transfer of care group, and constipation group
- 27 August and 1 October 2015: uncontrolled pain group, and respiratory depression group.

Learning session three

The third and final national learning session will be held in Auckland at the Heritage Hotel on 10–11 November 2015. This meeting will be a chance for DHB collaborative teams to share work from action period two, in the spirit of ‘all teach, all learn’.

Further information

Collaborative webpages

The Commission’s website has more information about the collaborative. Please visit us!

For further information, please contact: John Kristiansen, project manager, john.kristiansen@hqsc.govt.nz or 09 580 9056.