



**Ambulance Service
of New South Wales**

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T.A.B.L.E.T.S

TABLETS ARE BAGGED LETTING EMERGENCY TREAT SAFELY

Phill Good - Patient Safety Manager,
Ambulance Service of New South Wales

Darren Hoschke – District Officer,
Ambulance Service of New South Wales



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**The TABLETS project started in
2006 with 1 ambulance Station
and now it's State-wide
(178 Ambulance Stations)**



- Ryde Hospital Emergency Department staff had reported a high incidence of patients who were over 75 years of age arriving in the Emergency Department without their medications.
- Emergency Department staff have stated....



- Increased length of stay for patients in the Emergency Department.
- Increased cycle time for patients.
- Increased risk of adverse events occurring.
- Increased length of stay in hospital.
- Increased bed block in hospital wards.
- Decreased ambulance availability due to bed block in the Emergency Department.



Ambulance Service of New South Wales

2004 - 2005

Total responses for NSW was over 947,000.

2007 – 2008

was 1,118,000 – one call every 28 seconds)



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2004 - 2005

Out of 20,955 patients transported to Ryde Hospital 2,725 over 75 years of age

**Approximately 80% of these cases were transported by Ryde ambulance crews.
(approximately the same now)**



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**We approached the problem by
way of the Clinical Practice
Improvement methodology (CPI)**



Aim

To reduce the number of patients over 75 years of age transported by Ambulance Officers to Ryde Hospital without their medications by 100% in 6 months



A multi-disciplinary project team was formed to devise and implement solutions for the problem via the (CPI) Methodology.

The team consisted of:

Dr Peter Roberts – Ryde Hospital, Director Emergency Medicine

Robyn Gray – Ryde Hospital, Quality Risk Management Unit

Diane Reeves –NSCCH, Medication Safety Pharmacist

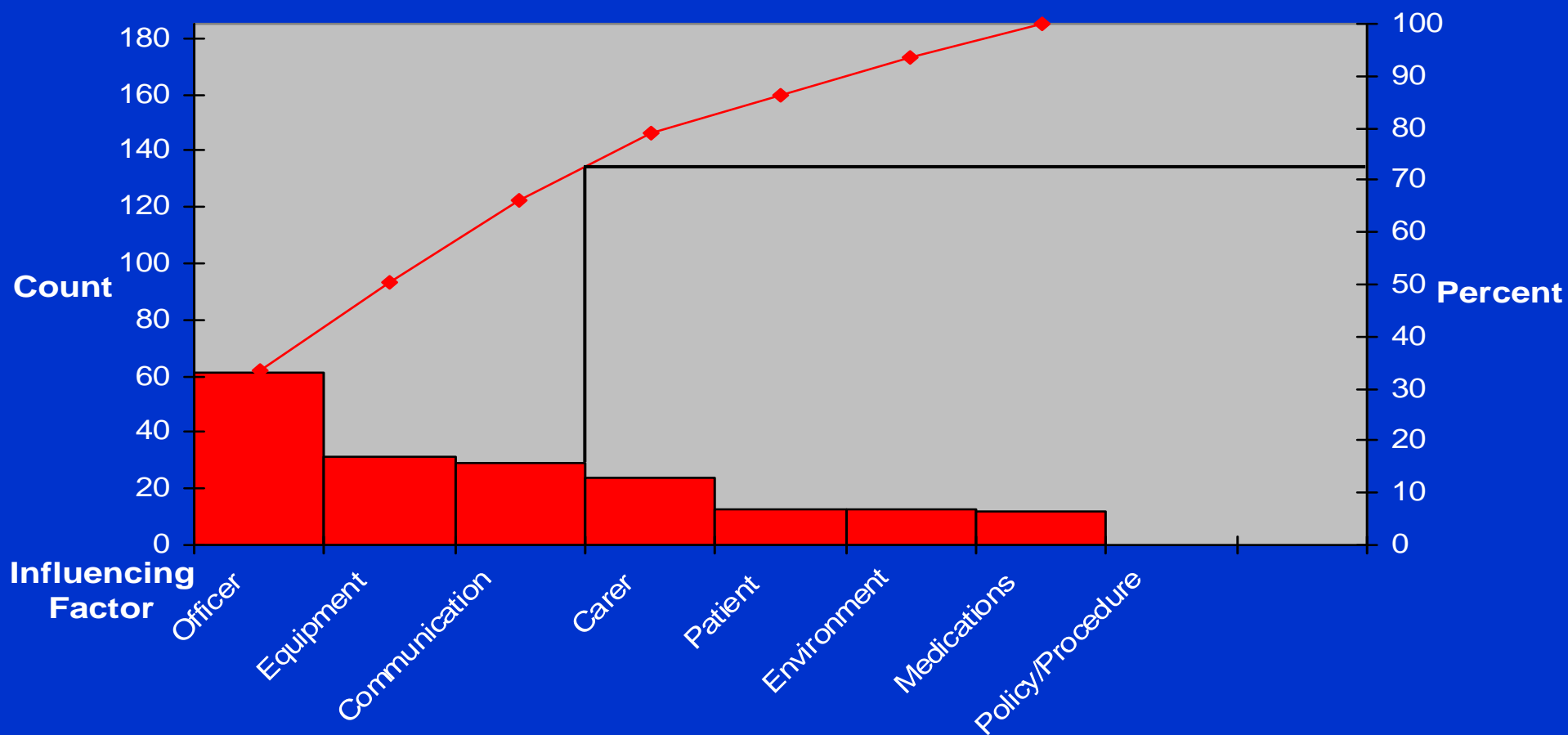
Phill Good – ASNSW, Patient Safety Manager

Darren Hoschke – ASNSW, Station Manager

Sheilah Harris - Consumer participant



Pareto distribution chart



Count	61	31	29	24	13	13	12	0
Percent	33.3	16.9	15.9	13.1	7.1	7.1	6.6	0
Cum%	33.3	50.2	66.1	79.2	86.3	93.4	100	0



INFLUENCING FACTORS BY OFFICER

- Medications not collected by officer
- Accidentally left behind
- Lack of awareness of importance of transporting medications
- No procedure or protocol
- Legal issues



INFLUENCING FACTORS BY COMMUNICATION

- Language barrier.
- Paramedics don't indicate medications to triage because they have recorded them on the PHCR.
- Triage not asking what medications patients are on.
- Confusion with who are bringing medications to the hospital.
- Untruths.



INFLUENCING FACTORS BY EQUIPMENT

- **No equipment available to place or carry patient medications**



INTERVENTIONS

- Instructions for officers to include medications with patients who are over 75 years of age (week one).
- Equipping one ambulance with clear plastic bags to hold medications (week two).
- Equipping all ambulances with clear plastic bags to hold medications, with BP cuff stored in bag (week three).
- Instruction label included on bag (week four).



- **Most significant interventions that gave a greater upward trend of compliance were:**

3rd intervention

- Instructions to place the BP cuff into the plastic bag

5th intervention

- Data field for recording “medications taken” stamped onto Patient Health Care Record (week ten).



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LABEL FOR INTERVENTION



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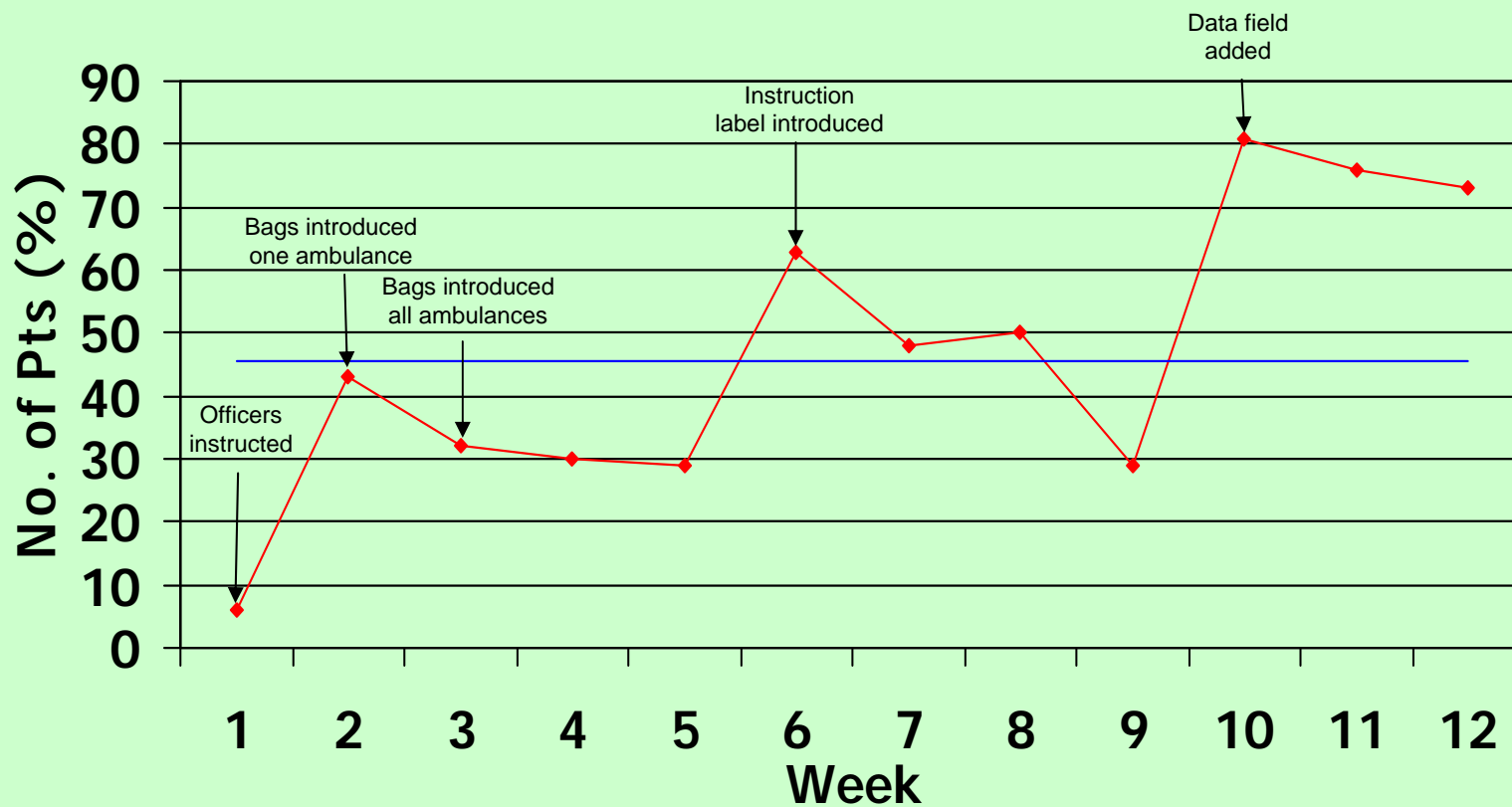
**MEDICATION
BAG**

**NAME
ALLERGIES:**

PLACE BP CUFF IN BAG

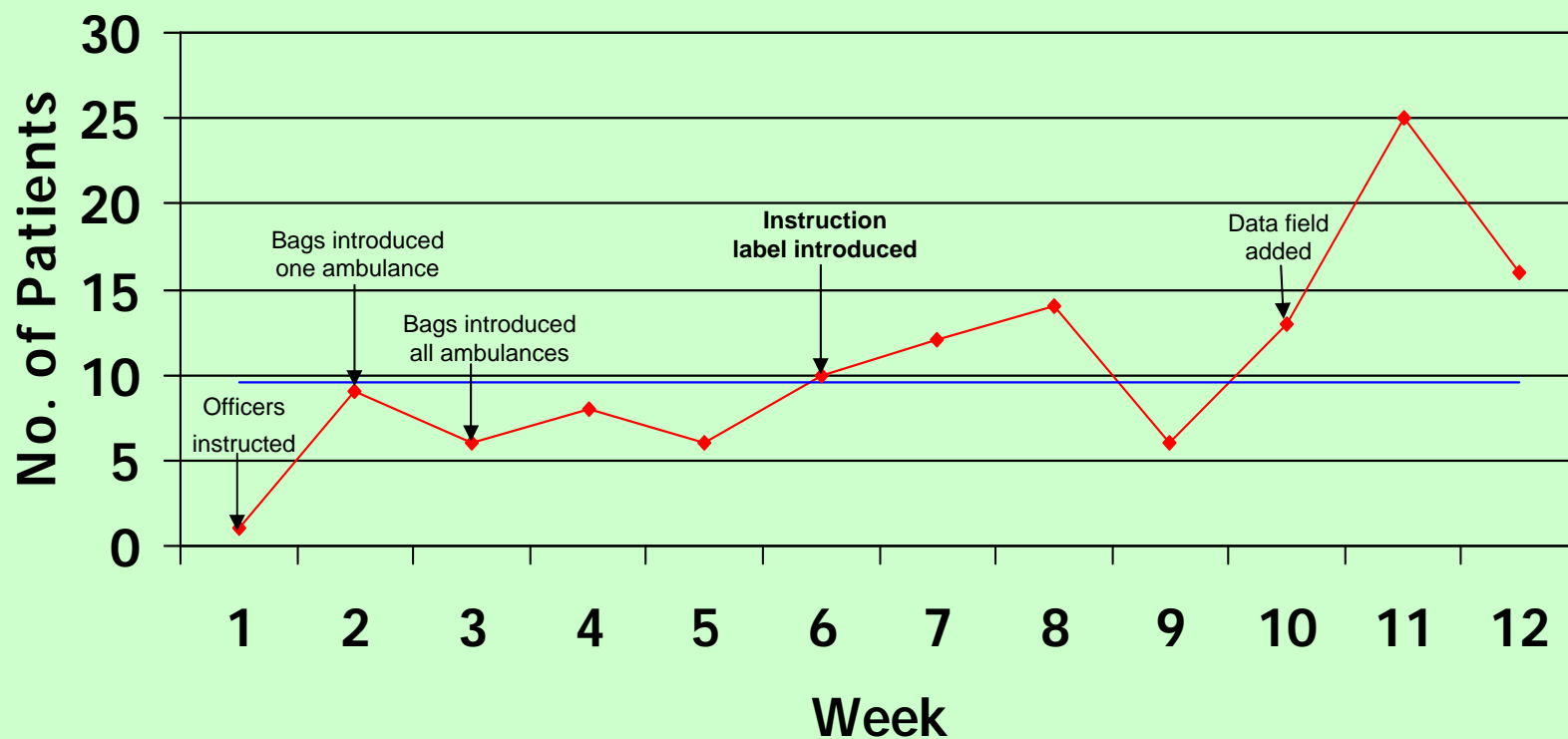


% Pts > 75 yrs arriving at Ryde with medications





Pts > 75 yrs arriving at Ryde with medications





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NEW STATE-WIDE AIM

To reduce the number of
Ambulance Service of New South Wales patients
transported to hospital without medications



State-wide strategies include

No 1

KPI Performance Target:

Target of 85%

Threshold 70%



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PATIENT HEALTH CARE RECORD				Vital Signs		Temperature		Pulse		Respiration		Blood Pressure		Oxygen Saturation		Glycemic Control		Other			
<p>AMBULANCE SERVICE OF NEW SOUTH WALES</p> <p>Patrol No: _____ Date: _____</p> <p>Call No: _____</p>				<p>Temp: _____</p> <p>Pulse: _____</p>		<p>RR: _____</p> <p>BP: _____</p>		<p>SpO2: _____</p> <p>Glucose: _____</p>		<p>ECG: _____</p> <p>Other: _____</p>		<p>ECG: _____</p> <p>Other: _____</p>		<p>ECG: _____</p> <p>Other: _____</p>		<p>ECG: _____</p> <p>Other: _____</p>		<p>ECG: _____</p> <p>Other: _____</p>		<p>ECG: _____</p> <p>Other: _____</p>	
<p>Patient Information</p> <p>Name: _____ Sex: _____</p> <p>Age: _____ DOB: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Emergency Contact: _____</p>				<p>Chief Complaint</p> <p>_____</p>		<p>History of Present Illness</p> <p>_____</p>		<p>Review of Systems</p> <p>_____</p>		<p>Physical Examination</p> <p>_____</p>		<p>Assessment</p> <p>_____</p>		<p>Plan</p> <p>_____</p>		<p>Disposition</p> <p>_____</p>		<p>Signature</p> <p>_____</p>		<p>Notes</p> <p>_____</p>	
<p>Medication</p> <p>_____</p>				<p>Allergies</p> <p>_____</p>		<p>Immunizations</p> <p>_____</p>		<p>Other</p> <p>_____</p>		<p>Other</p> <p>_____</p>		<p>Other</p> <p>_____</p>		<p>Other</p> <p>_____</p>		<p>Other</p> <p>_____</p>		<p>Other</p> <p>_____</p>			
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Current Medications

Patient on Meds.

Yes No

Unknown

Meds. with Pt. on scene

Yes No

Meds. transport with Pt.

Yes No



No 2

**The purchase of plastic bags
printed with the appropriate
information**

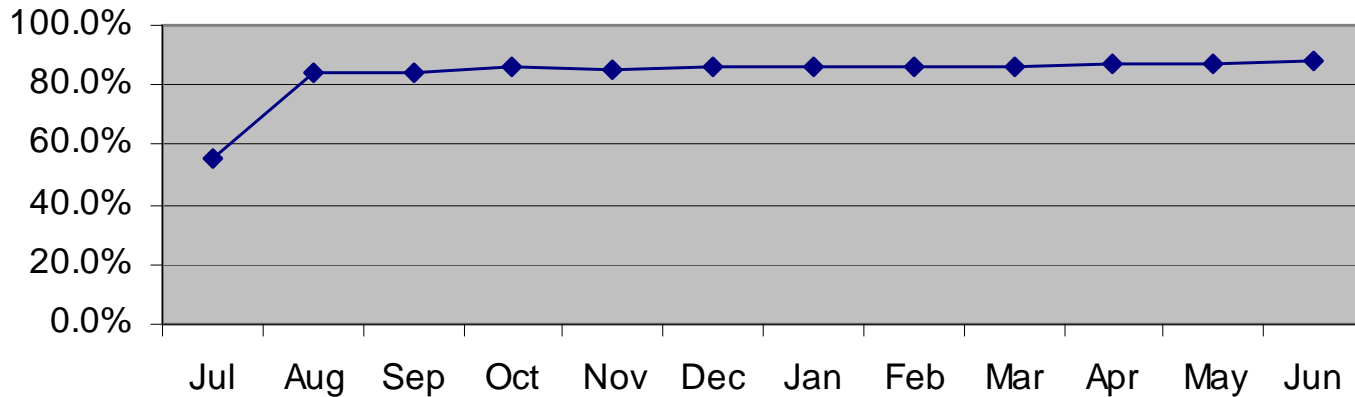
**Sept 2009 – Sept 2010 Ambulance
distributed State-wide**

**54,400 plastic bags printed with the
appropriate information**



July 2008–June 2009

Medication Safety - T.A.B.L.E.T.S.: % of patients who are on medication arriving at hospital with their medications





CURRENT PROBLEMS

- Medications are lost within the hospital
- Nursing homes and retirement nursing care unwilling to hand over medications
- Still have some officer and communication problems (of course)



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Quality Systems Assessment (QSA) Recommendations



1. Medication Safety

All PHO facilities should put in place a medication action plan which includes formal processes around high-risk medications.

(2009 QSA Ambulance Report – August 2010)



The Ambulance Service of NSW should develop and implement formal processes related to:

The management of look alike or sound alike medications in ambulance vehicles.



Checking and storage of S8 and S4 medications in ambulance vehicles.



Education programs for paramedics regarding safe handling of medications.

(2009 QSA Ambulance Report – August 2010)



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The End

Thank You
Phill Good