Medication Safety Watch

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Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Medication Safety Watch

A bulletin for all health professionals and health care managers working with medicines or patient safety.

Key messages

- Medicine nomenclature change increases risk of errors
- Link between use of abbreviations and medication errors
- NZ Formulary launched
- ACC medication safety case studies

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Medication alerts

These alerts provide information and required actions about high-risk medicines and situations and are issued to health care staff, managers and organisations. For more information contact Beth Loe at Beth.Loe@hqsc.govt.nz

REMINDER: Alert 14 on Oral Methotrexate was released in April and applies to both the primary and secondary care setting. Available from http://www.hqsc.govt.nz/our-programmes/medication-safety/projects/alerts/

Different medicine name nomenclature increases risk of error

International Nonproprietary Names (INNs) are the official generic names for pharmaceuticals, as designated by the World Health Organization (WHO). There are other nomenclature systems in existence such as BAN (British Approved Names), USAN (United States Adopted Names), AAN (Australian Approved Names). New Zealand does not specify which nomenclature to use in legislation or as part of the registration process but has advocated use of the INN (other than on products containing adrenaline and noradrenaline) in its medicine labelling guideline for the industry.

As a result of the changes, New Zealand is receiving an increasing number of INN labelled medicines. There is no official change-over period for the naming of these medicines in New Zealand so doctors, pharmacists, nurses and patients may first observe the change when they see the medicine or someone tells them. While most medicine names will not be affected, there is concern patients may be confused by names which do change. For example, patients who have supplies of the same medicine with different nomenclature may not take a medicine with an unfamiliar name or end up taking duplicate doses.

Figure 1 - Examples of common medicines facing a name change:

Current term	INN
thyroxine	levothyroxine
amoxycillin	amoxicillin
frusemide	furosemide
bendrofluazide	bendroflumethiazide
dothiepin	dosulepin
eformoterol	formoterol
methotrimeprazine	levomepromazine
oestradiol	estradiol

The following tips may minimise the confusion caused by medicine name changes:

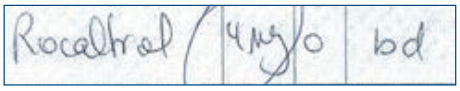
1. Inform health care staff (including part-time and locum staff) who deal with medicines of the name changes.
2. Use the NZ Formulary to check the name of the medicine as it lists both the INN and alternate name(s) for medicines.
3. Alert patients, carers and those who collect medicines on patients' behalf that the medicine name on the prescription or dispensing label has changed.
4. Update electronic systems that have medicine information with the new names.
5. Ensure dispensing systems can produce labels using the new name and can maintain effective ordering communication with pharmaceutical suppliers.
6. When dispensing original medicine packaging, ensure they all have either the former name or the new name but not a combination of the two.
7. Ensure the names are changed on repeat prescribing forms and on medicine administration record forms in aged care facilities.
8. Place reminders of medicines whose names have changed significantly in prescribing, dispensing and administration areas and in medicine storage areas in both the new and previous location.
9. Withdraw from clinical areas stocks of medicines whose names have changed significantly and are considered to pose a higher risk and supply them in containers labelled for individual patients.

Omission of medicines can result in treatment failure and is considered to be an error if there is not a valid reason documented in the patient's record.

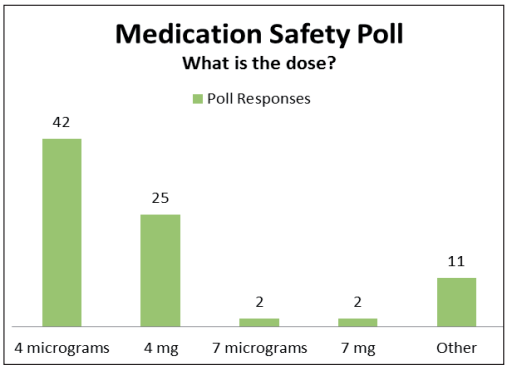
What's new?

Poll shows link between abbreviations and medication errors

Last month, the Commission ran a medication safety poll as part of our objective to improve prescribing, dispensing and administration practices. Readers were asked what they thought the dose was in this prescription.



Nearly half the 82 respondents were unable to read the dose correctly. The correct answer was 4 micrograms. Experience shows many medication errors occur because abbreviations are misinterpreted. For more information, see http://www.hqsc.govt.nz/news-and-events/news/514/



NZ Formulary now launched

About 130 key stakeholders and health professionals gathered in Wellington on 19 July to celebrate the launch of the New Zealand Formulary (NZF). The NZF is based on the British National Formulary and has been specifically adapted for New Zealand. It is considered to be a one-stop shop for high-quality and up-to-date information about medicines that are used in New Zealand. The NZF is available now, free of charge via http://nzformulary.org/

ACC treatment injury case studies

These case study-based reports with expert commentary are produced by ACC's Treatment Injury Centre to enhance patient safety. The case studies are based on information amalgamated from a number of claims. The name given to the patient is therefore not a real one. They provide excellent education and training material. Of particular interest is the paracetamol poisoning case available at http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_providers/documents/reference_tools/wpc112076.pdf

Incidents and cautions

Look- and sound-alike errors: NeuroKare and Neo-Mercazole

Two recently reported dispensing errors involved these two look-alike and sound-alike brand name medicines. Given the most common indication of these medicines, this mix-up could have disastrous clinical consequences for all concerned. While the current tablet colours are different, the similar packaging is of concern especially as NeuroKare is usually dispensed as an original pack so tablet colour is not easily viewed. *Minimise the risk of this incident happening by storing these medicines in generic name order or separating stock on the shelves.*

Unsafe abbreviations - tPA

tPA is a widely used abbreviation to cover alteplase, reteplaste and tenectaplase but actually refers to the medicine class, tissue plasminogen activator. Alteplase, reteplaste and tenectaplase have different dosing regimens so getting it wrong can have serious consequences for the patient. *Prevent mix-ups by specifying the actual tissue plasminogen activator i.e. generic medicine name rather than using the abbreviation tPA.*

Encouraging your patients to ask questions about medicines helps them to make more informed choices and increases the likelihood of using them safely and effectively.

Upcoming Events

- 10th Australasian Conference on Safety and Quality in Health Care, 3–5 September 2012, Cairns, Australia. http://wired.ivvy.com/event/FDHYLT/
- APAC Forum on Quality Improvement in Health Care, 19–21 September 2012, Auckland, New Zealand. http://www.ihi.org/offerings/Conferences/APACForum2012/Pages/default.aspx
- 5th International Medication Safety Network Medication Safety Conference, 15–17 Nov 2012 Abu Dhabi, UAE http://www.medicationsafetyconference.com/index.aspx

Contribute to Medication Safety Watch

Are you or your organisation working on a new medication safety initiative? Has there been a medicine-related incident or error that has happened that you would like to warn others about? If so, please contact: Nirasha.Parsotam@hqsc.govt.nz