# DHBNZ Safety and Quality Use of Medicines Group Newsletter

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## What's new

### Potassium:

PHARMAC have consulted on the proposed concentrations of potassium chloride pre-mixed bags to be listed in Schedule H of the Pharmaceutical Schedule. The availability of some of the concentrations will be dependant on registration with Medsafe.

### Direct to Consumer Advertising of Prescription Medicines:

The Ministry of Health has issued a consultation document setting out options regarding this. Closing date for submissions is April 28th. To view the consultation document and make a submission see www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/8daa2bc24bcff5d9cc25712400778549?OpenDocument SQM will be making a submission.

### Diltiazem alert:

This has been issued to DHBs for distribution to wards and departments in hospitals and to general practitioners and community pharmacies. If you have not received a copy of the alert it is available on the website (www.safeuseofmedicines.co.nz) or contact me direct.

### Warfarin:

A considerable amount of work is going on around the country surrounding warfarin and to avoid duplication of effort it would be good to know what is happening where. The group is aware of the development of information leaflets in various languages, a pictorial flipchart for counselling people for whom English is not their first language, a check list for hospital and practice nurses to use when they are counselling patients and guidelines for GPs either starting or managing patients on warfarin. We are sure there are other initiatives around the country but currently have no details.

Please contact me if you do have a warfarin initiative or if you would like further information about the projects mentioned.

### Intrathecal Chemotherapy and Intravenous Vinca Alkaloids:

A consultation document on draft recommendations for the safe administration of intrathecal chemotherapy and intravenous vinca alkaloids has been circulated to hospital pharmacy managers and a wide group of oncologists and haematologists. Please circulate to oncology/haematology nursing staff and any pharmacists or doctors involved in oncology/haematology who have not received a copy. The closing date for submissions is May 12th. The draft document is available on the group's website www.safeuseofmedicines.co.nz

### Barcoding:

The group is again meeting with representatives from the pharmaceutical industry, the Ministry of Health and other groups with an interest in barcoding at our April meeting to try and progress the barcoding of medicines in New Zealand.

## Recent Issues highlighted by practitioners:

### Similarity of ampoules:

Dexamethasone and Ketamine

There have been at least 2 incidents where ketamine (Pfizer brand) has mistakenly been injected for dexamethasone (DBL brand). In one case the patient required intubating while in the other the patient was already under a general anaesthetic.

The similarity in labelling between the two products was identified as a factor in the error occurring.

***Please bring it to the attention of your theatre and ITU staff where lighting can also be a contributing factor***.

Fentanyl and Heparin

These two products (both DBL brand) have similar labelling which could cause error. CMDHB have produced an alert highlighting the similarity between the product labels. Please contact Anne Blumgart (Ablumgar@middlemore.co.nz) if you would like a copy of the alert.

The group have written to Medsafe and the Medicines Adverse Reactions Committee regarding the dexamethasone and ketamine incidents to highlight our concerns regarding the similarity of labels contributing to medication errors.

Colchicine

There has recently been a case report of a fatality in a young man related to an accidental overdose with colchicine. It should be noted that accidental overdoses with colchicine are universally fatal. Please be aware and inform the patient when prescribing or dispensing colchicine for acute gout that they should not take more than five 0.5mg tablets in 24 hours or twelve 0.5mg tablets over four days and of the need to stop therapy immediately and see a doctor if they experience nausea, diarrhoea, vomiting or a burning sensation of the throat, stomach or skin. Consider only prescribing a maximum of 6 tablets for patients with acute gout so that they are unable to accidentally overdose. Medsafe issued new guidance on the use of colchicine for acute gout with updated dosage recommendations in Prescriber Update Vol 26 No 2 December 2005 www.medsafe.govt.nz/profs/PUarticles/PDF/PrescriberUpdate_Dec05.pdf. Please review your prescribing based on these guidelines.

## Upcoming events:

8th Annual NPSF Patient Safety Congress, Leadership for Safety: The Time is Now, May 10 – 12th 2006, San Francisco. See this link for further information www.npsf.org/congress/program

National Medicines Symposium, 7th –9th June 2006, Canberra. See this link for further information www.nps.org.au/events

## Useful links and articles:

Scott JT. Rundall TG. et al. Kaiser Permanente's experience of implementing an electronic medical record: a qualitative study BMJ. 2005 Dec 3; 331(7528):1313-6

Victoria State Government, Quality and Safety Branch of the Department of Human Services for their Risk Watch Newsletters: www.health.vic.gov.au/clinrisk

National Patient Safety Agency, Anticoagulant Risk Assessment: www.npsa.nhs.uk/site/media/documents/1570_NPSAanticoagulantriskassessment.pdf

Safer Health Care reports from NPSA conference: Green M. French S et al. In the Bag: Innovation at the Patient Discharge Interface www.saferhealthcare.org.uk/IHI/Topics/DischargingPatients/CaseStudies/InTheBag.htm

Ongoing feedback about this publication is welcome. Please feedback to Beth Loe, Project Manager:
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