DHBNZ Safety and Quality Use of Medicines Group Newsletter

Volume 2 Number July 2006

What's new

Intrathecal chemotherapy and intravenous vinca alkaloids: feedback on the consultation document was reviewed at the group's June meeting and will be discussed with NZHPA. The Australian Quality and Safety Council has recently issued an alert and guidelines on this subject. Please see http://www.safetyandquality.gov.au/council/vincristine/index.htm

Good Prescribing Practice: a draft alert on abbreviations has been circulated for consultation to: Pharmacy, Nursing and Medical councils/colleges and to Chief Medical Officers, Chief Pharmacists, Directors of Nursing and Chairs of Drug and Therapeutic Committees or Medical Advisory Committees where these are known. The closing date for submissions was July 10th.
www.safeuseofmedicines.co.nz

Bar Coding of Medicines: the Ministry of Health is preparing a discussion document on the bar coding of health products including medicines. It is anticipated that a pilot project to assess the infrastructure necessary, the costs and the practical difficulties associated with implementing the technology at a DHB level will be tested in one or two DHB's.

Packaging and Labelling of medicines: following on from the issues highlighted in the last newsletter (Volume 2 Number 1 May 2006) a further letter has been sent to both the Trans Tasman Labelling Group and Medsafe reiterating that packaging and/or labelling can and does influence patient safety on a practical level.

Diltiazem: Lenore Jansen from Waitemata DHB recently presented on diltiazem at the hospital grand round. Her presentation is available on the website if anyone would like to either use all or part of it.

Potassium: PHARMAC have consulted on the listing of various pre-mixed intravenous fluids in Section H of the Schedule, closing date for feedback was July 13th 2006. Some of the fluids listed are currently unregistered products. While applications for registration with Medsafe have been made for some of the preparations others have yet to begin the process.

Recent issues highlighted by practitioners

Carvedilol:

Two cases of a dispensing error discovered when checking prescriptions for carvedilol have recently occurred. In both cases two strengths of the tablets had been included in the dispensed item. It was lucky that the dispensing error was detected before issue because individual strips of tablets in a box are not always checked. The error is easy to make because the original packs and strips look identical - same size and colour of strip and printing. Please take extra care when dispensing or checking prescriptions for carvedilol and consider storing the different strengths in different locations.

Incident reporting: the incident report of accidental colchicine overdose in the last newsletter (Volume 2 Number 1 May 2006) was supported by 9 other cases involving either accidental overdose or suicide with colchicine within the Auckland Region. CARM have 2 cases of accidental overdose resulting in death from colchicine (these might be included in the Auckland statistics). Accidental overdose would not automatically be reported to CARM which raises the issue of medication error /incident reporting and where should errors/incidents be reported.
Hospital Incident Reports: all hospitals have their own incident reporting systems to include incidents involving medication errors. Therefore all incidents involving medication errors, either prescribing, dispensing or administration should be reported through your individual hospital reporting system.
Community pharmacies and GP's: would usually have incident recording systems within their practices.
ACC: Since 1st July 2005 when ACC changed their compensation scheme from Medical Misadventure to Treatment Injury, all medication incidents that result in injury to the patient should all be reported to ACC.
Adverse Drug Reactions: Adverse drug reactions should be reported to CARM. CARM collects and evaluates spontaneous reports of adverse reactions to medicines, vaccines, herbal products and dietary supplements from health professionals in New Zealand. Their reporting forms are available on their website; http://carm.otago.ac.nz

Upcoming events

4th Australasian Conference on Safety and Quality in Health Care: Raising the bar for quality, Melbourne Exhibition and Convention Centre, 21 - 23 August 2006. See this link for further information www.aaqhc.org.au/conference/conference_speaker.asp

Improving Medication Safety: Sharing the Lessons Learnt, Stamford Plaza Sydney Airport Hotel, 28 – 29 September 2006. See this link for further information http://www.changechampions.com.au/Forms%20&%20Programs/Sept_06_Medication_Safety_Program.pdf

Useful links and articles

Jenkins D, Gokani R Failure modes and effects – a tool for evaluating packaging safety http://www.pjonline.com/pdf/hp/20060 5/hp_200605_safety.pdf

Wan Yuet. Economic burden of avoidable adverse drug reactions and non-compliance in the UK. J Med Econ. 2006: 9, 27-44.

Miller MR, Clark JS et al. Computer based medication error reporting: insights and implications. Quality & Safety in Health Care 2006 15; 3: 208-213.

ISMP & FDA Campaign to Eliminate Use of Error-prone Abbreviations http://www.ismp.org/tools/abbreviations/default.asp

Feedback

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

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