DHBNZ Safety and Quality Use of Medicines Group Newsletter

Volume 2 Number 3, October 2006

Attention
Wanted a person with a passion for improving integration systems between primary and secondary care to join the group? Please contact Beth Loe (details overleaf) for further details or to register your interest.

What's New

National Medicines Strategy

The Ministry of Health has been gathering information from relevant groups as a basis for the development of a national medicines strategy. The three areas of focus for the strategy are:

- access to medicines
- quality of medicines
- rational use of medicines

Representatives from the Ministry attended the August meeting of the group to present the background to the strategy development and to listen to the views of the group. A summary of the key strategies that the group believed should be included in a national medicines strategy have since been submitted to The Hon Peter Dunne MP who is leading this project. It is envisaged that a draft national medicines strategy will be released for consultation in November 2006.

Bar Coding

A report on the bar coding of medicines has been prepared by the Funding and Performance Directorate, Ministry of Health and has been submitted to and accepted by the Minister. This report recommended that medicines should be bar coded to individual dose level. A group led by the Ministry that includes practising health professionals will now prepare a consultation document on application of a bar code point of care system in New Zealand public hospitals. The acceptance at ministerial level of the principles that barcodes on medicines has the potential to significantly reduce medication errors in New Zealand is a major step forward in improving patient safety.

Good Prescribing Practice

Thank you to everyone who provided feedback on the proposed abbreviations alert. We have incorporated many of the suggestions and compromised on others because of divergent feedback from different health professional organisations. The alert is currently being formatted for printing and will hopefully be ready for publication early in 2007

Warfarin

- All DHBs should have received copies of the warfarin DVD from PHARMAC. The DVDs were distributed to anticoagulant clinics/nurses and hospital pharmacies. If you haven't received a copy please contact your hospital pharmacy to ask about them. PHARMAC made a decision based on production costs to provide DVDs and not videos. Many hospitals are still using video players rather than DVD players but with the current trend to the use of DVDs it may be time to invest in this technology.
- Glaxo SmithKline warfarin information booklets: Glaxo plan to re-print an updated version of these when the current stocks are exhausted.

National Drug chart

This has now been sent out for final consultation, apologies for the Waitemata logo, it was intended that this print run would be generic and this version is not the version currently in use at Waitemata.
It is likely that parts of the chart will be compulsory but that others can be generic to a DHB so please feedback with this in mind. E.g. the warfarin nomogram is likely to be DHB specific unless a New Zealand wide nomogram can be agreed.

EpiQual

Epiqual is a ministerial advisory committee on epidemiology and quality assurance. EpiQual fully support the concept of medicines reconciliation and are keen for the concept to be adopted nationally.

The World Health Organisation has also prioritised medicines reconciliation as one of its top 6 strategies. EpiQual are planning to hold a workshop to bring together stakeholders and plan the way forward for this concept.

Intravenous Infusion alert

It is planned that a baseline audit of intravenous infusion equipment and practice in all DHBs is needed before the alert and the associated paper is released. A simple audit sheet is being designed with this in mind.

Recent issues highlighted by practitioners

An 81 yr old man who spoke little English, presented to ED with a 10 day history of severe abdominal pain, nausea and vomiting. He had a background of end stage renal failure, secondary to hypertension and he was on peritoneal dialysis. The admitting H/O charted his medications from a previous discharge summary. The medication list consisted of a number of medications including insulin. He was administered insulin and suffered a prolonged hypoglycaemic episode. On investigation it was found that the patient was not a diabetic and that his relatives had not had the insulin discharge prescription filled because they were sure he had never previously been on it. This case illustrates the usefulness of "Medication Reconciliation", on admission. "Reconciliation" involves taking a medication history from the patient and reconfirming that with the patient's GP, community pharmacy or other sources. Previous discharge summaries can be a good source of information for patient's medical history and medication list but should not be used as a sole source of information. Particularly vulnerable are patients on multiple medications and those with English as a secondary language.

Upcoming events:

The Joint Commission's 20th Annual National Conference on Quality and Patient Safety: Decisions that Count, November 16 – 18th 2006, Chicago. See this link for further information
www.jcipatientsafety.org/show.asp?durki=12360

Society of Hospital Pharmacists of Australia 5th Biennial Clinical Conference: Racing Towards Clinical Goals, November 9 – 11th 2006, Melbourne. See this link for information
www.shpa.org.au/docs/clinconf06.html

Useful links and articles

Healthcare Commission, press release: Healthcare watchdog urges hospital to improve management of medicines. 11th Aug 2006
http://www.healthcarecommission.org.uk//newsandevents/pressreleases.cfm?cit_id=4251&FAArea1=customWidgets.content_view_1&usecache=false

Wetternick TB, Skibinski KA. Using failure mode and effects analysis to plan implementation of smart i.v. pump technology. Am J Health System Pharm. 2006 Aug 15; 63(16):1528-38

Poon EG, Cina JL et al. Medication dispensing errors and potential adverse drug events before and after implementing bar code technology in the pharmacy. Ann Intern Med. 145(6): 426-34

Psaty B. M., Burke S.P. Protecting the Health of the Public — Institute of Medicine Recommendations on Drug Safety. NEJM. 2006 Oct 26; 355:1753-55

Rogers G, Alper E, Brunelle D, Federico F, et al. Reconciling medications at admission: Safe practice recommendations and implementation strategies. Joint Commission Journal on Quality and Patient Safety. 2006 Jan; 32(1): 37-50

Feedback:
Ongoing feedback about this publication is welcome. Please feedback to Beth Loe, National Co-ordinator:
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