DHBNZ Safety and Quality Use of Medicines Group Newsletter

Volume 2, Number 4, December 2006

What's New?

National Drug Chart

Thank you to everyone that provided feedback on the draft chart and for the support shown for the concept. The deadline for comment was extended and we are now analysing all the feedback. A small sub-committee is planned to look at all the feedback and incorporate the suggested content and design changes where possible. Further feedback on the consultation will be given in the next issue of the newsletter.

Amiodarone

The group have highlighted concerns about amiodarone in the latest edition of the new BPAC journal, "best practice". Serious concerns have been raised about patients discharged from hospital on a loading dose of amiodarone and continuing on that dose long term, either because the discharge letter from the hospital takes a long time to reach the GP or the letter is not clear that the dose should be reduced. Another problem identified in an audit by Kowhai PHO identified is that the monitoring of patients on long term amiodarone is often not carried out by either primary or secondary care. The lead physician needs to be established to ensure that appropriate monitoring occurs.

Format of the group

There have recently been a few changes to group membership. Kevin Hague, CEO, West Coast DHB is the new chair of the group replacing Dwayne Crombie. Nigel Millar CMO at Canterbury DHB has replaced Jane Vella Brincat and Debi Lawry (Otago DHB) has replaced Emil Schmitt. Applications for the new member of the group advertised in the last newsletter are being considered.

Medicines Reconciliation and e pharmacy

What is happening in your DHB? The group will be asking what medicines reconciliation services are provided or planned around the country, who provides the service and what percentages of patients receive the service. Information on which e pharmacy system is being used or planned and what it is used for is also being collected. Information on e pharmacy systems was last collected in 2003 and many DHBs have changed or are in the process of changing their system since that time.

Intravenous infusions

Quality managers around the country have been asked to complete the audit of intravenous infusion devices and their management when the audit is sent out early in 2007. This will both inform individual DHBs about their own intravenous infusion device stock, policies and procedures and allow the group to gauge what national recommendations and information provision are necessary to improve safety around intravenous infusion therapy.

Diltiazem

Please respond to PHARMAC's consultation on the available diltiazem preparations in New Zealand: www.pharmac.govt.nz and go to consultation document through "new consultations".

Recent Issues Highlighted by Practitioners

Ceftriaxone or Cefotaxime

These two products (illustrated below could easily be mistaken for each other. They would often be stored in close proximity especially on wards where antibiotics are stored separately to other products. Consider removing one or both from ward stock/imprest and reviewing where they are located on the shelves in pharmacy to reduce the risk of error.

Clopixol Depot® or Clopixol Acuphase®

A near miss incident picked up by a pharmacist on a mental health ward: Zuclopenthixol Decanoate (Clopixol Depot®) injection was about to be administered to a patient. The prescription called for Zuclopenthixol Acetate (Clopixol Acuphase®). Further investigation revealed that this had happened before. The packaging for these two preparations is very similar. The risks of giving the monthly depot injection every 2-3 days are obvious and vice versa. It is suggested that hospitals remove all zuclopenthixol injections from acute mental health wards as a simple forcing function to prevent this incident occurring SQM will add this example to the others involving look alike/ sound alike packaging and names whenever there is an opportunity to highlight the issue of look alike/ sound alike names or packaging.

Upcoming events

International Forum on Quality and Safety in Health Care, List of speakers includes; Donald Berwick, Helen Bevan, Lucien Leape, Richard Smith, Rosa Sunol, Lloyd Provost, Paul Plsek, Sir John Oldham, Goran Henriks April 18th to 20th 2007, Barcelona. See this link for further information: http://www.quality.bmjpg.com

We Can Make a Difference – Medicines the Patient Experience, Practical solutions to medicines safety issues: May 16 to 18th 2007, Te Papa, Wellington. Further details available soon.

4th New Zealand Clinical Research Conference "Science to Clinical": July 5th – 6th 2007, Sky City Convention Centre, Auckland See this link for further information www.nzacres.org.nz/

Useful links and articles

www.npsa.nhs.uk-National Patient Safety Agency National Patient Safety Agency alerts NHS to risks with high dose morphine and diamorphine inj
http://www.npsa.nhs.uk/advice

Feedback

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