DHBNZ Safety and Quality Use of Medicines Group Newsletter

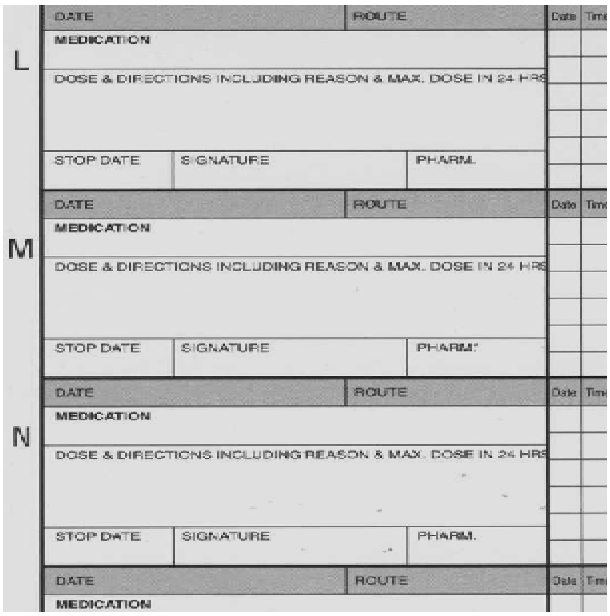
Volume 1 Issue 1 April 2005

What's new?

Welcome to this the first edition of a bi-monthly newsletter to be issued by the SQM Group.

The website
www.safeuseofmedicines.co.nz
The website is finally live and all articles should be accessible. After various problems with the website it is now up and running and there will be a feedback loop so that any comments can be fed straight back to the project manager.

Drug Chart
The final version of the suggested "national" drug chart has been circulated to all DHB's. The format of the drug chart may not meet the requirements of all DHB's but it is hoped that the prescribing and administration sections of the chart will be adopted nationally with individual DHB's adopting their own formats for the front and back pages.



Minutes of the most recent meeting of the group on 24th February 2005 are available on the website.

Warfarin alert
This was issued to all DHB CEO's, pharmacy managers, chief medical officers, Chairs of Pharmacy and Therapeutic Committees, PHO CEO's and pharmacist facilitators late 2004 or early 2005. Please let me know if your copies did not arrive. The alert is also available on the website www.safeuseofmedicines.co.nz

The group would be interested to know how different DHB's and PHO's circulated the alert within their organisations and to whom.

Coming soon

PHARMAC consultation on pre-mixed potassium and heparin dilutions is planned for April. This will be an opportunity to contribute to which pre-mixed concentrations of these two high risk medicines are needed.

Strategy document
The group has been busy writing a national strategy document which is currently on version 6. The group is planning to send the document out for wider consultation during April.

Diltiazem alert

Medication Alert

Diltiazem!

This will be the third alert to be issued by the group. It is in a final draft form ready to be sent out for wider consultation. There are two versions of the alert, one for primary and one for secondary care because of safety issues specific to each sector.

Hot Topics

Low Molecular Weight Heparin (LMWH)

The group have been asked to develop a protocol for the use of LMWH in patients with renal impairment by the Medicines Adverse Reaction Committee. This is because of a number of adverse reactions brought to the attention of the Committee in this group of patients. We would be grateful if any DHB that has a guideline or protocol for the use of LMWH in this patient population could share their guidelines with us. We are also concerned about the availability of anti-Xa monitoring in each DHB and would be grateful if all DHB's could feedback this information either by fax or E mail.

Developments around New Zealand

Auckland DHB and Capital and Coast DHB have both appointed medication safety pharmacists within their hospitals. Waitemata DHB has appointed two quality use of medicine project managers who are currently developing projects that involve both primary and secondary care.

Information sharing

Please let the project manager know if your DHB has projects or information that affect the safe or quality use of medicines that could be shared via the newsletter

Coming Events

3rd Australasian Conference on Safety and Quality in Health Care 2005, Adelaide Convention Centre, 11-13 July 2005. See this link for further information: www.sapmea.asn.au/conventions/aaqhc2005/index.html.

Health Informatics New Zealand Conference & Exhibition 2005: Sky City Convention Centre, Auckland, 2nd -5th August 2005. See this link for further information:

www.hinz.org.nz/2005_conference/program/draft-3-program-05.htm

Useful links and articles

United States Pharmacopoeia Patient Safety CapsLink website: produces newsletters that include medication error analysis from the USP Medication Error Reporting Systems and gives examples of documentation introduced by hospitals to reduce the risk of errors occurring: www.usp.org/patientSafety/briefsArticlesReports/capsLink/

M Lisby, L Nielsen & J Mainz, Errors in the medication process: frequency, type, and potential clinical consequences. International Journal for Quality in Healthcare, 17:1 (2005): 15-22 Link to Fulltext: http://intqhc.oupjournals.org/cgi/reprint/17/1/15

Feedback

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

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