DHBNZ Safety and Quality Use of Medicines Group Newsletter

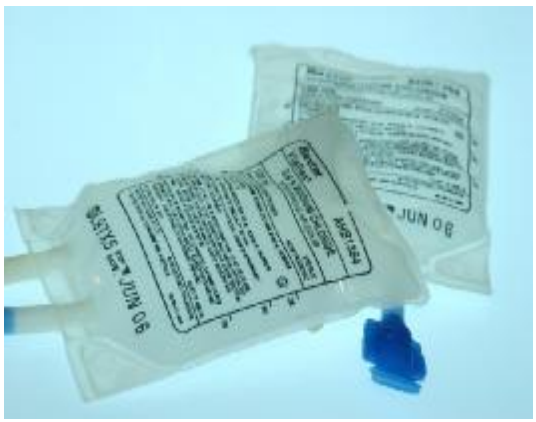
Volume 1 Number 4

What's new?

Minutes of the most recent meeting of the group on 25th August 2005 are available on the website.

Strategy document
This is currently being printed and should be ready for release this month.

Potassium Chloride and Heparin Pre-mixed infusion bags
PHARMAC sent out a consultation document on 30th September 2005 on the process for national contracting of bulk IV fluids and dialysis fluids. This includes the range of heparin and potassium chloride solutions that should be considered for national contracts. If you have not received a copy and wish to comment please contact me and I will forward the document to you. Deadline for comments is Friday 21st October 2005.



Abbreviations alert
Thank you to everyone who commented on the draft alert. The comments were many and varied but there was overwhelming support for an alert on the subject. In making changes to the alert the group will attempt to reflect the comments made where possible.

Insulin and warfarin

Work is continuing on these two medicines. Please could anyone who has adopted new charts, policies or procedures or has developed a teaching package around the use of either of these medicines contact me. The group would like to build on work already undertaken rather than develop new tools and then find they already exist.

Diltiazem

The diltiazem alert and identification chart are ready for issue. The group has no budget to cover the cost of ensuring that individual GPs and community pharmacists as well as wards and departments in DHB hospitals receive a copy. We hope to be able to identify individuals in each DHB who are able to ensure that colour copies are printed, laminated (identification chart) and distributed within their DHB.

Recent Issues Highlighted by Practitioners

Penicillin V Syrup

A dispensing error involving penicillin V syrup where the wrong strength was dispensed has been highlighted by one DHB. The similarity in packaging and labelling of the two strengths was identified as a major contributing factor in the error.

Available morphine preparations

Waitemata DHB has produced an A4 identification chart for the oral morphine preparations currently funded by PHARMAC. Any DHB who would like a copy of the chart please contact Beth Loe or David Ryan (David.Ryan@waitematadhb.govt.nz).

WHICH MORPHINE??

Upcoming Events

Society of Hospital Pharmacists of Australia 27th Federal Conference: Medicines Managers: The Next Generation, 10th – 13th November 2005.

See this link for further information www.shpa.org.au/docs/fedconf05

UK National Patient Safety Agency Conference: Patient Safety 2006, February 1st – 2nd 2006 See this link for further information http://www.patientsafety2006.nhs.uk/about

Institute for Health Care Improvement 17th Annual National Forum on Quality Improvement in Health Care, Dec 11th - 14th 2005 See this link for further information http://www.ihi.org

Useful links and articles

Medication Errors in intravenous drug preparation and administration: a multicentre audit in the UK, Germany and France, Quality and Safety in Health Care 2005; 14: 190-195

Evaluation of the implementation of the alert issued by the UK Patient Safety Agency on the storage and handling of potassium chloride concentrate solution, Quality and Safety in Health Care 2005; 14: 196-201

Frequency, type and clinical importance of medication history errors at admission to hospital: a systematic review, Canadian Medical Association Journal 2005; 173(5): 510-515

Feedback

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

Fax 09 441 8957 Email Beth.Loe@waitematadhb.govt.nz or via the website www.safeuseofmedicines.co.nz