# DHBNZ Safe and Quality Use of Medicines Group Newsletter

Volume 1 Number 5

## What's new

**Potassium and heparin pre-mixed bags:**
This is finally moving forward. PHARMAC has established a sub-committee to review the comments from the consultation and the committee has met once already. In addition Baxter's have applied to Medsafe to register two pre-mixed potassium dilutions that are currently unavailable.

**Diltiazem:**
The group are currently establishing a network of contacts within the DHB's who have an interest in medication safety and who will distribute the alert to primary and secondary care. The group is keen that the alert should be sent out with a laminated identification chart to individual GPs and community pharmacies as well as to wards and departments in hospitals. I hope to send out the alert in the next week or two but individual DHB's have specific plans around the alert and its distribution and it may well not be available locally until early next year.

**Wafarin:**
A toolkit on warfarin is planned for 2006. It is hoped this will include; an alert, examples of protocols, the warfarin video, warfarin counselling tools, a counselling checklist for both practice and hospital based nurses and a quick guide for practice nurses involved in responding to changes in patient's INR with dose changes. If any primary care organisation or hospital has developed any tools around the use of warfarin then please could you inform the group. Any work done by another organisation would be acknowledged if it was shared nationally.

**Strategy Document:**
The official launch is planned for the 13th December. The group have identified 10 actions that we believe could make a significant difference nationally and these


will be the focus of the group's activities for the next 12 -18 months. The document is available on the website www.safeuseofmedicines.co.nz

**Abbreviations alert:**
To be sent out for wider consultation in the New Year. We are sure that there will be wide range of feedback to consider. It is impossible in an alert to cover every possible abbreviation and situation and we have concentrated on unacceptable common abbreviations that are known to cause confusion.

**Barcodes:**
The group made a submission to the Joint Agency Establishment Group on the draft labelling requirements for medicines document. In addition we invited representatives of interested parties to our last meeting in November. This was to identify the current barriers to the inclusion of a readable global standard unique identifier on medicine labels and to seek a way forward. Two perceived barriers were found not to be insurmountable; the re-issuing of cancelled numbers and the use of Pharmacodes within community pharmacy. No clearly defined way forward was identified but various groups represented at the meeting agreed to look further into the issues and bring information back to another meeting in the 2nd quarter of 2006.

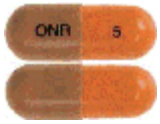
**Recent Issues Highlighted by Practitioners:**
Oxycodone: there have been several reports of errors in the prescribing, dispensing and administration of oxycodone in practice.

Examples:

- Hospitals have had prescriptions for Oxycontin® 15mg bd but Oxycontin® tablets are only available as 10, 20,30 or 40 mg and the tablets which are slow release become immediate release when they are cut or broken.
- A prescription written as Oxycodone MR 10mg am, Oxycodone MR 5mg pm and Oxycodone SA 5mg 2hrly prn. Who knows what MR and SA stand for and what the patient would have been given.

Doctors are unfamiliar with the preparation and its prescribing.
Pharmacists are unfamiliar with the preparation and often supply on a controlled drug requisition without seeing a prescription.
Nurses are not familiar with the preparation and its prescribing and historically they associate capsules with sustained release formulations and in this case the capsule is fast acting.

Please be aware of the different formulations and strengths of oxycodone that are available and take extra care when prescribing, dispensing or administering these preparations. Middlemore hospital pharmacy has produced an identification chart indicating the release characteristics of the different formulations together with illustrations of the formulations. If anyone would like a copy of this then please contact Beth Loe (see below).
If any other newsletters or safety alerts have been produced about oxycodone and they can be shared with other DHB's or practitioners then please let Beth Loe know.




**5mg**


**20mg**

Upcoming Events

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

National Medicines Symposium: June 7th-9th 2006, Canberra See this link for further information
http://www.nps.org.au/site.php?page=3&content=/resources/content/mediainfo_nms2006.html

Useful links and articles

Cost of medical injury in New Zealand: a retrospective cohort study. J Health Serv Res Policy. 2002 Jul;7 Suppl 1:S29-34

Using a bar-coded medication administration system to prevent medication errors in a community hospital network.
Am J Health Syst Pharm. 2005 Dec 15; 62(24):2619-2625

Anticoagulants: how safe are our systems? Clinical Pharmacy Europe 2005 Sept-Dec 22-26

Safety Matters: 2005 Sept issue 1st edition of NPSA newsletter
www.npsa.nhs.uk/site/media/documents/1333_safetymatters.pdf

Unexpected increased mortality after implementation of a commercially sold computerised physician order entry system Peadiatrics 2005; 116: 1506-1512

Feedback

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

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