DHBNZ Safety and Quality Use of Medicines Group Newsletter

What's new?

Minutes of the most recent meeting of the group on 28th April 2005 are available on the website.

PHARMAC consultation on pre-mixed potassium and heparin dilutions. This has been delayed due to more urgent issues, such as the availability of flu vaccine that affected PHARMAC. One of PHARMAC's hospital pharmaceuticals contracts managers will be looking at this issue over the next few months.

Consultation on labelling: The Ministry of Health has issued a consultation document: draft labelling requirements for medicines under a joint Australia/New Zealand Therapeutic Products Agency. The closing date for submissions is June 13th 2005. The group will be making a submission on this paper but for others interested the document is available through the following link: www.jtaproject.com/hot.htm#Labelling

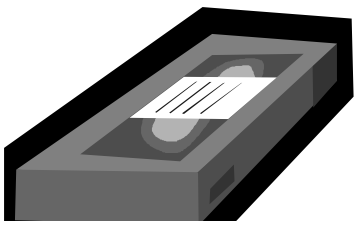
Diltiazem alert: This is in the final stages of production and it is hoped to issue the alert in the next couple of months.

Strategy document: this was sent out for consultation in April/May so that any feedback could be discussed and changes

Made to the document at the next meeting of the group on June 30th. Thank you for the comments received to date. The closing date for comments on the proposed strategy is June 20th.

Abbreviations alert: This gives a list of abbreviations considered inappropriate and a list of acceptable abbreviations. If anyone would like to comment on this alert and has not received it via E mail please contact me. Closing date for submissions is June 25th.

Warfarin: The group is planning to produce a video and DVD about warfarin for patients. The video/DVD is intended to reinforce the usual education provided for patients commenced on warfarin and for them to be able to watch at home. It is hoped to begin production in the next few months.



Counties Manakau DHB is currently working on a pictogram flip chart that illustrates the important points about warfarin for people for whom English is not their first language.

If any other District Health Board (DHB) or Primary Health Organisation (PHO) has a warfarin initiative that could increase the safety of patients prescribed warfarin that they are willing to share with other DHB's or PHO's then please let me know.

Insulin: the answers to the questionnaires sent to primary health care about the problems and issues surrounding insulin highlighted many of the same risks/concerns as those surrounding warfarin and were remarkably consistent around the country. If any organisation has begun an initiative on insulin use either in primary or secondary care please could they share this with the group. In the next few months the group will be reviewing the information and deciding on the way forward for reducing the risks associated with insulin use.

Medication error database:
Taranaki District Health Board have a computer programme for storing and reporting their secondary care medication incidents. They are willing to share the programme with other DHB's for no charge. Anyone who is interested please contact Tracey Watson at Taranaki Base Hospital Pharmacy,
E mail: tracey.watson@tdhb.org.nz

Recent Issues highlighted by practitioners:
Similarity of appearance of gentamicin and heparin ampoules once removed from boxes: the labelling on ampoules of Heparin 5000units in 1ml and Gentamicin 10mg in 1 ml are almost identical in appearance, both green writing, yellow band around neck of ampoule, size, DBL brand. In areas that store ampoules out of their original boxes this could be an issue.

Replacement of plastic ampoules with glass ampoules: Marcain 0.5% Spinal Heavy® plastic ampoules have recently been replaced with glass ampoules. Fentanyl is also only available in glass ampoules. This presents both a danger to patients and to anaesthetists from glass particles or shards. The danger to patients can be removed by using filter needles but these are not included in the pack.

Upcoming 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.

New Zealand Pharmacy Conference: Bridging the Gap, Auckland, 16th -18th September 2005. Keynote speaker on Friday 16th is Mike Cohen who is the President of The Institute of Safe Medication Practices. Day registration for the Friday is available. See this link for further information www.psnz.org.nz

Useful links and articles;

High Rates of Adverse Drug Events in a Highly Computerized Hospital
http://archinte.ama-assn.org/cgi/content/abstract/165/10/1111

How to Investigate the Use of Medicines by Consumers
www.who.int/medicines/library/par/who-edm-par-2004_2/WHOPAR2004_2_Consumers.pdf

Patient safety alert issued by the National Patient Safety Agency in the United Kingdom: Protecting patients with allergy associated with latex
http://81.144.177.110/site/media/documents/1071_Patient_safety_information.pdf

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