

DHBNZ Safe and Quality Use of Medicines Group Newsletter



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What's new

Adult, Acute National Medicine Chart

The eight week pilot has been completed at Bay of Plenty DHB. Feedback from users is positive but some practical issues were identified. These will be rectified prior to further pilots and will not have a significant impact on the overall design.

At the same time, discussions have been ongoing with Auckland DHB regarding a scannable version of the chart for use with their electronic medical record system.

Lakes and Hutt Valley DHBs are planning to pilot the chart on specific wards in early 2010. Feedback from all the pilot sites will inform the final chart design.

National incident reporting and prevention system pilot

The NZ Pharmacovigilance Centre has established a steering committee and is planning to initiate the project in early 2010. The aim of the pilot is to coordinate the capture, analysis and dissemination of information on medication errors to enhance the safety of the medication use system for New Zealanders.

Allergic reactions to antibiotics

Patients still continue to receive penicillin antibiotics despite previous documented allergic reactions to a penicillin.

An allergic or adverse reaction to any medicine should be reported to and verified by the Centre for Adverse Drug Reactions (CARD). The verified information is uploaded and linked to a patient's NHI.

Unfortunately, general practitioners can not view this and hospital doctors often need to search for the information.

Some DHBs are also uploading varied information including allergy information directly onto the NHI platform but this is only validated by internal DHB processes.

In a review of the NHI platform it was recognised that the medical warning facility was important and should be retained. The medical warning system is now under review and this will be completed before the new NHI platform goes live. The review recognises the need for the medical warnings to be readily available in both primary and secondary care.

The reports of allergic reactions to antibiotics frequently involve amoxicillin/clavulanic acid prescribed as Augmentin[®]. While better documentation of allergies and adverse reactions would help it seems that health professionals don't always recognise that Augmentin[®] contains amoxicillin and is therefore a penicillin. In many of the reported cases penicillin allergy is well documented but Augmentin[®] has still been prescribed and then administered. While Augmentin[®] is no longer the funded brand of amoxicillin/clavulanic acid it is the name commonly used by prescribers.



Example of a bracelet available from the MedicAlert[®] Foundation NZ

SQM group plan to write an alert and develop a poster to highlight the risk.

Incidents and cautions

Sound alike look alike names

Please be aware of the new product, **Avanza**[®] (mirtazapine) and take note that the name is very similar to an existing product **Avandia**[®] (rosiglitazone). Take extra care if selecting from a drop down menu if prescribing or dispensing by trade name. Minimise the risk of selection error by careful placing of the two products on dispensary shelves.

Humalog Insulin's

Do you know how many Humalog[®] insulin preparations are available?

There are three Humalog[®] insulin's available:
Humalog[®] - a rapid-acting insulin analogue
Humalog Mix25[®] - a pre-mixed formulation with both fast-acting and intermediate-acting insulin (25% Humalog and 75% neutral protamine lispro)
Humalog Mix50[®] - a pre-mixed formulation with both fast-acting and intermediate-acting insulin (50% Humalog and 50% neutral protamine lispro)

As with all insulin it is important when prescribing or dispensing to ensure that a patient will be using the correct formulations to prevent episodes of hypoglycaemia or hyperglycaemia. One DHB has reports of six prescribing and two administration incidents in a 10 week period between November and January involving Humalog insulin preparations. There have also been dispensing errors reported around the country where Humalog has been dispensed instead of Humalog Mix25 or Humalog Mix50.

As with all prescribing and dispensing systems cross check that you have selected the right item from the drop down menu—remember that there are three Humalog products available. Check what type of insulin the patient should be on e.g. rapid acting or a mixture of rapid and intermediate acting.

Confirming with the patient (or carer) can provide an extra check that the right insulin is

being prescribed or dispensed. This can be particularly important at handover points in the system i.e. hospital admission or hospital discharge.

Upcoming Events

Change Champions, 3rd Improving Medication Safety Seminar: sharing the lessons learnt, 9-10 March 2010 and The Deteriorating Patient, 11-12 March 2010. Both of these seminars will be held at Four Seasons Hotel, 199 George St, Sydney, NSW. See this link for further information-<http://www.changechampions.com.au/upcoming-seminars>

International Forum on Quality and Safety in Healthcare: improving quality, reducing costs, 20-23 April 2010, Nice, France. See this link for further information - <http://internationalforum.bmj.com/>

8th Australasian Conference on Safety and Quality in Healthcare: back to the future - unlocking the potential, 6-8 Sept 2010, Perth, Australia. See this link for further information - <http://aaqhc2009.cmail3.com/t/y/l/kkmil/klpllx/h>

Useful links and articles

Pequignot R, Belmin J et al. Renal function in older hospital patients is more accurately estimated using the Cockcroft-Gault formula than the modification diet in renal disease formula J Am Geriatr Soc 2009; 57; 1638-1643.

Barber ND, Alldred DP et al. Care homes' use of medicines study: prevalence, causes and potential harm of medication errors in care homes for older people Qual Saf Health Care 2009;18; 341-346.

Pownall M. Complex working environment, not poor training, blamed for drug errors URL: http://www.bmj.com/cgi/content/full/339/dec07_1/b5328

Coombes ID, Stowasser DA et al. Impact of a standard medication chart on prescribing errors: a before and after audit Qual Saf Health Care 2009; 18; 478-485.