

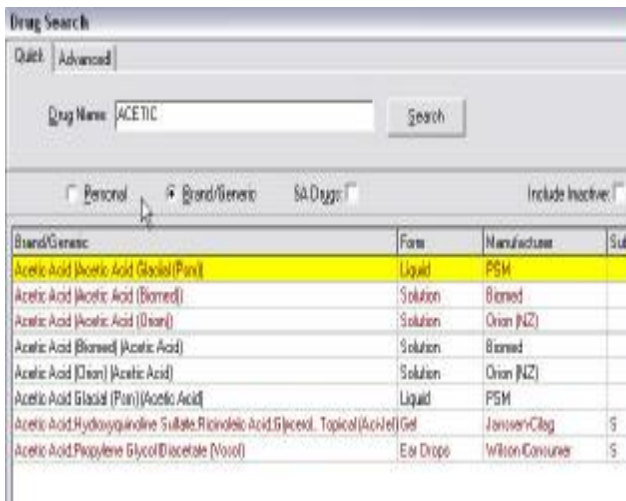
DHBNZ Safe and Quality Use of Medicines Group Newsletter



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What's new?

Glacial Acetic Acid



A recent incident involved a GP inadvertently prescribing glacial acetic acid which was dispensed by the pharmacist and used by the patient causing burns to the area it was applied to. The picture shows how easy it is for a GP to inadvertently click on the wrong acetic acid preparation. SQM group and MIMS are working to try and change the listing to prevent this error being repeated. Does glacial acetic acid need to be listed in MIMS? Please let Beth Loe know if you use glacial acetic acid in your practice so that we can gauge how and when it is used.

Pre-mixed potassium containing infusions

The wider range of concentrations could soon be available and an updated alert is in preparation. It is anticipated that the wider concentration range will enable hospitals to remove potassium chloride concentrate injection from the majority of their wards. SQM group appreciate that this has taken a long time but hope that therapeutic guidelines can be reviewed to significantly reduce the need for concentrated potassium chloride injection to be stocked on wards. Now is the time to consider how the new concentrations should be stored and used. While preventing errors there is the potential that different errors will be created.

Quality Improvement Committee (QIC)

The governance and accountability structure for all five QIC projects has been agreed and lead Chief Executive Officers (CEs) appointed.

The 5 national projects and lead CEs are:

- Optimising the patient journey—Geraint Martin (CMDHB)
- Infection prevention and control—Garry Smith (ADHB)
- National Mortality Review Systems—MOH
- Safe Medication Management—Chai Chuah (HVDHB)
- Management of Health Incidents—Craig Climo (WaikatoDHB)

Management of Health Incidents—many of you will have seen the media reports in February related to the serious and sentinel events reported in DHB hospitals. QIC coordinated the preparation of the report on the incidents for the media and then explained in the media why the number of incidents varied between DHBs and what had been learnt from them. This first ever national collation of serious and sentinel event reports identified some incidents occurring in multiple DHBs, either when this was not expected or in greater numbers than expected.

Wrong site surgery was more common than expected and multiple incidents involving chemotherapy were identified. Two DHBs had incidents where 10 x the recommended dose had been administered. Neither of the two DHBs concerned were aware that the same problem had occurred elsewhere.

There were multiple incidents across 5 DHBs when oral medicines had been administered intravenously. These involved dissolved paracetamol tablets, paracetamol syrup, PEG feeding formula and total enteral nutrition.

Some of these incidents could have been prevented by ensuring the use of oral syringes that do not fit intravenous lines for the administration of all oral liquid medicines



Upcoming Events

National Medicine Symposium 2008 QUM - what does it really mean for you? 14-16 May 2008, Canberra Convention Centre.

See this link for further information http://www.nps.org.au/site.php?page=3&content=/resources/content/mediainfo_nms2008.html

Patient Safety Congress 2008- everyone's responsibility, your chance to act, 22-23 May 2008, London.

See this link for further information <http://www.npsa.nhs.uk/corporate/events/patient-safetycongress/>

The National Forum on Safety and Quality in Healthcare, 29-31 October 2008, Adelaide Convention Centre.

See this link for further information <http://www.sapmea.asn.au/conventions/forumsqhc2008/index.html>

International Society for Quality in Healthcare, 25th International Conference, 19-22 October 2008, Copenhagen.

See this link for further information <http://www.isqua.org/isquaPages/copenhagen08.html>

Health Research Council Ninth Global Forum on bioethics in research— ethics of research involving indigenous peoples and vulnerable populations,

3-5 Dec 2008, Auckland.

See this link for further information <http://GFBR9.hrc.govt.nz>

New Zealand Healthcare Pharmacists' Association Conference 2008 Celebrating Diversity, Diverse people—diverse roles, 19-21 September 2008, Waipuna Hotel and Conference Centre, Auckland.

See this link for further information and call for abstracts <http://www.conferenceteam.co.nz/nzhpa/>

Institute for Healthcare Improvement—20th Annual Forum on Quality Improvement in Healthcare, 8-11 Dec 2008, Nashville.

See this link for further information— <http://www.ihl.org/IHI/Programs/ConferencesAndSeminars/20thNationalForumonQualityImprovement.htm>

Useful links and articles

Joint Commission Sentinel Event Alert— Preventing Paediatric Medication Errors Issue 39 April 11th 2008 http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_39.htm

www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_39.htm

HM Government/Department of Health, Pharmacy in England Building on strengths— delivering the future. April 2008

<http://www.official-documents.gov.uk/document/cm73/7341/7341.pdf>

British Medical Association/NHS Connecting for Health, Joint Guidance on Protecting Electronic Information

<http://www.connectingforhealth.nhs.uk/systemsandservices/nhscrs/publications/staff/jointguidance.pdf>

Van der Sijs H, Aarts J et al. Turning off frequently overridden drug alerts—limited opportunities for doing it safely. J Am Med Assoc. 2008, April 24.

Feedback

Ongoing feedback about this publication is welcome. Please feedback to Beth Loe, National Coordinator: Fax 09 441 8957, Email Beth.Loe@waitematadhb.govt.nz or via the website www.safeuseofmedicines.co.nz