

What's new?

Colour coded wristbands

Following a request for information regarding the use of colour coded wristbands in the last newsletter, the issue was discussed at the March SQM group meeting.

There is no uniform approach in New Zealand to the colours used to indicate different risks, e.g. red bands are used to indicate different risks in three different DHBs; a high risk of falls, drug allergy and gas inserted into the eye during retinal surgery.

Three different colours are used to indicate drug allergy in New Zealand; blue, red and green.

Reviewing the international evidence^{1,2} and the current practice in New Zealand, SQM group recommend that colour coded wristbands should not be used. DHBs and other organisations who continue to use colour coded wristbands should ensure that their policies, procedures and practice include removing any colour coded wristbands when patients are transferred between hospitals or other care settings e.g. rest homes, private hospitals etc. This will reduce the risk of incidents caused by the receiving organisation using a different colour coding system. Any colour coding system should also be consistent across a whole organisation.

References

1. National Patient Safety Agency. Design and specification of patient wristbands: Evidence from existing literature, NPSA-facilitated workshops, and a NHS Trusts survey. Available at: www.npsa.nhs.uk
2. ISMP Alert: Confusion over meaning of color coded wristbands March 9 2006 URL: www.ismp.org/Newsletters/acutecare/articles

Potassium pre-mixes

Discussions about increasing the range of registered potassium chloride pre-mixed infusions available are ongoing—these include a paediatric fluid, a concentrated formulation for use in ITU and a bag suitable for GIK infusions. In the interim, Baxters have manufactured a section 29 product at the request of one DHB—a 500ml bag of 10mmol potassium chloride in 10% glucose.

Storage of pre-mixes

One of the recommendations in the potassium chloride concentrated injection alert, issued Aug 2008, was to review the storage of premixed potassium fluid bags especially if the number of different preparations stocked was increased. One DHB has done just that and sent the following picture of a storage area. While the pink potassium pre-mixes do stand out it does highlight the need to review storage of solutions, especially premixed potassium solutions, to allow stock rotation and reduce the risk of accidental wrong product selection.



Paediatrics—use of oral syringes with enteral feeding systems

Many incidents are reported internationally where oral medicines drawn up in intravenous syringes have been mistakenly administered intravenously. This is a particular problem when the oral medicine is to be given via an enteral feeding system. The Children's Hospitals Australasia Group published standards for oral syringes and enteral feeding systems last year. For further information contact Beth Loe—
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Incidents and cautions

Look Alike Medicines

Pancuronium and Suxamethonium injection



Another near miss incident involving these two drugs has been reported by a New Zealand DHB. In this case, pancuronium was nearly administered instead of suxamethonium during an urgent Caesarean section. The ampoule had been mistakenly put in the wrong section on the anaesthetic trolley. The two drugs were well separated on the anaesthetic trolley but the ampoule had been placed in the wrong section during the set up of the trolley despite precautions at the DHB to prevent such an event occurring. Under bright theatre lighting the colour differentiation between red and pink writing on ampoules becomes indistinct. The difficulty in reading pink labelling on ampoules was also highlighted by intravenous nurses at the look alike sound alike workshop

held by SQM group last year. SQM group will be writing to AstraZeneca concerning the labelling of the two products but please bring this to the attention of theatre staff and review policies and procedures to reduce the risk associated with the look alike labelling and packaging.

Upcoming Events

Improving patient safety by effective clinical management, 29-30 May 2009, Wellington. See this link for further information: <http://www.conferenz.co.nz/inaugural-patient-safety-conference.html>

7th Australasian Conference on Quality and Safety in Health Care, Bridging the Gap, 7-9th Sept 2009, Sydney. See this link for further information: <http://www.aaqhc2009.org.au/>

Bridging the gap—addressing the needs of children and young people from a patient safety perspective 17th June 2009 London. See this link for further information: <http://www.npsa.nhs.uk/corporate/events/bridging-the-gap-addressing-the-needs-of-children-and-young-people-from-a-patient-safety-perspective/>

Useful links and articles

Scroggs J. Improving patient safety using clinical needs assessments in IV therapy. *British Journal of Nursing (BJN)*, 2008; Oct 23-Nov 6; 17 (19): S22-8.

Boockvar K S, Liu S et al. Prescribing discrepancies likely to cause adverse drug events after patient transfer. *Qual Saf Health Care* 2009; 18: 32-36.

Sweidan M, Reeves JF et al. Quality of drug interaction alerts in prescribing and dispensing software. *Med J Aust* 2009; 190 (5): 251-254.

Marshall S, Harrison J & Flanagan B. The teaching of a structured tool improves the clarity and content of interprofessional clinical communication. *Qual Saf Health Care* 2009; 18: 137-40.