

Safe Medication Management Programme

Working parties for four of the work streams have been established and following a joint meeting on October 20th all the working parties will have met for the first time. Doctors, nurses, pharmacists, quality managers, consumers and information officers are represented on all the working parties. Each DHB has a key contact person for the Safe Medication Management programme so if you want to find out what is happening in each work stream then they are the people to contact.

The four work streams established to date are:

- medicines reconciliation
- standardise drug chart/e prescribing/e medication record
- standardise hospital medicine information systems/all systems connected with medication management linked
- barcoding/ unit dose packaging/ bedside verification

What's new

Potassium Chloride pre-mixes

Various DHBs have highlighted that no pre mix is available that matches their glucose/insulin/potassium (GIK) protocol. Not all DHBs are affected because of the variety of protocols used around New Zealand. SQM group have written to the Society for the Study of Diabetes and asked them to consider whether it would be possible to standardise on a single GIK protocol that would be suitable to use in the majority of patients. A request to have the potassium pre mix registered and marketed in New Zealand could then be pursued. If a standard protocol is not a option then a

standard potassium concentration in a particular strength of glucose could be an alternative.

Some hospitals have also indicated that the pre-mixes available don't cover the requirements for potassium replacement following ileostomy. There may be a case for reviewing protocols and seeing if a fluid that has been newly registered would suit the majority of cases. This would then allow the concentrated ampoules to be removed from ward stock and supplied on a named patient basis. This also allows a review of current practice for managing intravenous potassium supplementation on the wards e.g. how are wards preparing solutions with higher concentrations of potassium, what concentrations of potassium are being infused peripherally.

Morphine alert

This has been issued and sent to key people in all DHBs. SQM group decided to identify one person/group in the provider arm of each DHB who would take responsibility for ensuring the alert was circulated and the recommendations actioned within their hospitals. The alert has also be sent to the clinical leader in each PHO for circulation and action.

Warfarin

The "red book" is being updated. If you have changes you would like to see made then please email Beth Loe (Beth.Loe@waitematadhb.govt.nz) by October 24th with the suggested changes. I will also be asking people with a special interest in warfarin management for their input.

The warfarin toolkit is taking shape and we are trying to include as much of the innovative work from around the country as possible. If your practice, PHO or DHB has produced a tool used in warfarin management then please let me know and SQM group will consider including it in the toolkit.

Incidents

Be aware of different formulations of the same product and products with similar names when prescribing, dispensing or administering medicines. Incidents have occurred recently where folic acid was prescribed by an overseas trained hospital doctor and dispensed in a community pharmacy as folic acid. Folic acid is, of course, calcium folinate and was intended to antagonise the effects of methotrexate—in this case the pharmacist made a dispensing error but folic acid is easily mistaken for folic acid on a hand written prescription especially when that name is not commonly used and the medicine is infrequently dispensed in community pharmacy.

Another reported incident where the wrong dosage form was dispensed involved pegylated interferon. This was dispensed instead of standard interferon labelled three times weekly. Pegylated interferon should be given once weekly.

Extra care should always be taken when prescribing, dispensing or administering drugs that come in a variety of formulations with different release characteristics to ensure that the right product at the right dosing interval is picked.

Upcoming events

Innov'08—Weaving Innovation into Health, 3 -5 Nov 2008, Wellington. See this link for

Feedback

Ongoing feedback about this publication is welcome. Please feedback to Beth Loe, National Coordinator: Ph 09 486 8920 extn. 2442, Fax 09 441 8957, Email Beth.Loe@waitematadhb.govt.nz or via the website www.safeuseofmedicines.co.nz

further information <http://www.innov08.org.nz/>

Joint Commission Annual Conference on Quality and Safety- Safety and Quality Solutions driving sustained improvements, 19-21 November 2008, Chicago. See this link for further information-<http://www.jcrinc.com/29500/>

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>

International Forum on Quality and Safety in Health Care, 17-20 Mar 2009, Berlin. See this link for further information-<http://internationalforum.bmj.com/>

Useful links and articles

Poon EG, Cina GL et al. Medication dispensing errors and potential adverse drug events before and after implementing bar code technology in the pharmacy, *Ann Int Med* 2006; 145:426-434

Garden A, Bernau S et al. Undergraduate education to address patient safety, *NZMJ* 2008, 8 Aug;121(1279):119-21

Cross M. English NHS says patient consent necessary before record seen on screen, URL: http://www.bmj.com/cgi/content/full/337/sep24_1/a1814

Chamberlain N. The folly of rewarding silence while hoping for open reporting of adverse medical events- how to realign the rewards, *NZMJ* 2008, 22 Sep; 121 (1282):58-66