

SAFE & QUALITY USE OF MEDICINES GROUP Meeting

Thursday 10th April 2008 Time: 9.30am to 3.30pm

Attendees

Beth Loe (National Coordinator)
 Avril Lee (WDHB)
 Marilyn Crawley (WDHB)
 Adam McCrae (PHARMAC)
 Mary Seddon (CMDHB)
 Frances McClure (GP)

Gillian Bohm (MOH)
 Gigi Lim (Auck Univ)
 Elizabeth Plant (Taranaki)
 Peter Black (ADHB)
 Roy Morris (Otago)

Minutes

| Item | Agenda | Notes/comments | Action Required |
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| 1. | Apologies | Debi Lawry, Dwayne Crombie, Peter Moodie, Nigel Millar, Tim Maling, Julian Tommei | |
| 2. | Minutes of previous meeting | <ul style="list-style-type: none"> • Item 4, letter re-incident reporting change John Peters to Craig Climo • Agreed | |
| 3. | Matters arising | <p>i. <u>Group membership</u></p> <ul style="list-style-type: none"> • Kevin has taken leave of absence from West Coast DHB therefore we require a new chair. This will be confirmed at next national CE's meeting. Potential candidate could be Chai Chuah (lead CE for Safe Medication project) • Awaiting reply from DHBNZ on expenses for the consumer, Debi's travel expenses & Beth's costs • Bpac have nominated Tony Fraser if the group agree to expand the membership • It was agreed that the membership should be extended to include bpac and that their nominee be accepted <p>ii. <u>PreMec proposal</u></p> <ul style="list-style-type: none"> • Letter from PreMec asking about delay in receiving a proposal from SQM • Dwayne needs a more definitive proposal to take to PreMec • Possibly improving communication by using email alerts "flagging" new medicines safety information on a website. For GP practices and individuals who do not use electronic tools hard copies would be posted • Initial project time needed to advertise and "sell" registering on the site to practices and individual practitioners <p>iii. <u>Paediatric alert related to HDC report</u></p> <ul style="list-style-type: none"> • Planned that a paediatric pharmacist from the telepaeds group of the Paediatric Soc will draft this alert • Discussion that weighing all patients an issue and should SQM write an alert about this, agreed that the issue would not easily be resolved with an alert | <p>i. <u>Membership</u></p> <ul style="list-style-type: none"> • Follow up funding with DHBNZ (Beth) • Write to bpac (Beth) <p>ii. <u>PreMec proposal</u></p> <ul style="list-style-type: none"> • Add detail to communication proposal (Beth, Dwayne) <p>iii. <u>Paediatric alert</u></p> <ul style="list-style-type: none"> • Liaise with telepaeds group (Beth) |
| 4. | Safe | <ul style="list-style-type: none"> • The majority of the Auckland SQM members met | <ul style="list-style-type: none"> • Invite Paul Cressey from |

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| | Medication Project Update | <p>with Chai Chuah, lead CE for the Safe Medication project in February to discuss a draft project plan</p> <ul style="list-style-type: none"> • CEs have been finalising the governance, finances and steering group for all projects • Hoped that project managers will be appointed shortly • Elizabeth raised concerns that SQM were missing an opportunity to expedite using GTINs, the bar coding of medicines down to unit dose level • No clear way for SQM to be able to expedite this happening • Adam and Elizabeth volunteered to be members of the steering group for the safe medication project • Mary will be on steering group as QIC representative | <p>HISAC to next meeting at 11.30</p> <ul style="list-style-type: none"> • Write to GSINZ asking what assistance would help place GTINs, unique identifiers down to unit dose level on medicines • Email Chai re; volunteers for steering group and invite to June meeting |
| 5. | QIC update & medication related sentinel event information | <ul style="list-style-type: none"> • Mary presented an update on what was happening to the 5 QIC projects, governance and reporting structure signed off, lead CEs and national steering group appointed • The review and release of sentinel event information by QIC in Feb had had mixed media coverage, some sensationalist some balanced • It had alerted DHBs to the incidence of these events and also highlighted events that were thought to be uncommon but that had occurred in more than one DHB e.g. multiple cases involving products given intravenously - paracetamol syrup, PEG feeding formula, dissolved paracetamol tablets etc • Plan annual reporting of sentinel and serious events • What is SQMs role in the annual events reporting, does NZ need a patient safety agency or similar • Discussion about encouraging incident reporting by GPs - feeling they want to report incidents but that they would need incentives before reporting • Could build into Cornerstone Accreditation Programme so that a practice's incidents are reviewed monthly • Build reporting into DHB-PHO contract • What about near miss reporting to learn from those | <ul style="list-style-type: none"> • Include some of the information from Mary's presentation in next newsletter (Beth) |
| 6. | Annual Report | <ul style="list-style-type: none"> • Objectives from strategy document to be included at the start of each chapter, progress on the objectives detailed in the chapter and future challenges to be identified • Need a glossary • Discussed various other changes, additions and deletions • Add appendix to include the alerts | <ul style="list-style-type: none"> • Re-write p 3 (Mary) • MARC section - (Frances) • National Medication chart (Beth) • Re-write some of workshop section (Beth) • High risk medicines & medicines reconciliation (Beth) • Primary care (Frances & Gigi) |
| 7. | Incident reporting | <ul style="list-style-type: none"> • Letter sent to Craig Climo re links between this project and safe medication project | <ul style="list-style-type: none"> • |
| 8. | DHB medication safety groups | <ul style="list-style-type: none"> • An Auckland region medication safety group is being established and will report back with a view to other groups being established • Quality conference in Christchurch in August, planning a session | <ul style="list-style-type: none"> • |

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| 9. | International System for DI classification | <ul style="list-style-type: none"> • One of the editors for Meyers textbook on drug interactions had proposed that a Cochranes collaborative could establish such a classification but there has been no contact since • There are 3 lists worldwide, each lists about 200 serious interactions • An easy solution would be for GPs to be able to apply the filters to what comes up from MIMS but currently this has to be paid for by individual GPs • Who funds MIMS? | <ul style="list-style-type: none"> • Try and establish who funds MIMS for GPs (Gillian/Beth) |
| 10. | E medication briefing paper | <ul style="list-style-type: none"> • Defer to next meeting | <ul style="list-style-type: none"> • Circulate paper one week before next meeting (Nigel) |
| 11. | Primary Care Issues | <ul style="list-style-type: none"> • There is a concern about the prescribing of colchicine and allopurinol in acute gout, because GPs are still using old guidelines in their personal lists and stopping allopurinol in an acute attack, • Concerns raised about the transfer of care between secondary care and rural hospitals and in hospitals providing respite care: availability of medicines, accuracy of discharge prescriptions and accuracy and update of prescriptions being used at the rural/respite hospital • Many of the safety concerns would be reduced by effective medicines reconciliation and when this project is developed transfer of care should be included • Relates to patients own medicines going to hospital, what happens to them, discharge medications, who dispenses them and when • All DHBs should have a policy around what happens to patients own medicines • Electronic medication repository work stopped in Auckland region until concerns surrounding Testsafe (laboratory test results repository) are resolved • Needs to be included in future challenges | <ul style="list-style-type: none"> • Write to software vendors and PHO's (Beth) • Develop tool for audit of 20 GP practices (Beth) |
| 12. | Look alike sound alike names and packaging | <ul style="list-style-type: none"> • Invite Medsafe, anaesthetists, MOH, Pharmac, RMIANZ, NZ Therapeutic Products Assoc. and HISAC to meeting on June 12th • Venue at MOH? 12.30 for lunch • Agenda: Problem definition 20min, Actual examples 10min, anaesthetic tray 20min, discussion on how the risks could be minimised and possible solutions, conclude –3 accomplishable action points | <ul style="list-style-type: none"> • Invitations (Gillian, Beth) • Venue (Gillian) • Problem definition (Mary/Tim) • Actual examples (Marilyn, Elizabeth) • Anaesthetic tray (Alan Merry) • Discussion (Dwayne if available) |
| 12. i | Lighting/eye sight | <ul style="list-style-type: none"> • Defer to next meeting | <ul style="list-style-type: none"> • Eyesight/lighting (Nigel) |
| 12.ii | Resus trolley syringes | <ul style="list-style-type: none"> • Awaiting reply from HPAC | <ul style="list-style-type: none"> • Agenda next meeting (Beth) |
| 12.iii | INN v BAN | <ul style="list-style-type: none"> • Poster designed by Hawkes Bay DHB pharmacy sent to all chief pharmacists • Awaiting reply from Medsafe regarding the need for information to be available nationally • INNs will be included in Notes on Injectable Drugs • MARC are unable to help • When will all drug names be changed? | <ul style="list-style-type: none"> • When will all names be changed (Beth) • Develop business case to take to QIC (Gillian, Beth) • Send examples of PILS etc from UK to Pharmac (Beth) |

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| | | <ul style="list-style-type: none"> • Need funding for a national policy, write to QIC requesting funding of a PIL, education programme and alert, include a business case | |
| 13. | Alerts of Toniq dispensing system | <ul style="list-style-type: none"> • No progress on alerts for the 6 drugs • Report of glacial acetic acid being prescribed, dispensed and used when dilute acetic acid was intended • Working with MIMS to change the drop down menu that currently lists 6 acetic acid preparations, all listed “acetic acid....” to reduce risk of doctors accidentally prescribing the wrong preparation • Should this be added to Toniq list of drugs? • Does glacial acetic acid need to be in any list, is it used? • Was the incident reported to CARM? | <ul style="list-style-type: none"> • Review warnings and send out for comment (Beth) • Check whether glacial acetic acid does need to be listed (Beth) • Reported to CARM? (Beth) |
| 14. | BPAC articles | <ul style="list-style-type: none"> • Article on INN v BAN in latest journal • Need content for next journals | <ul style="list-style-type: none"> • Talk to BPAC (Beth) |
| 15. | High Risk Medicines | | |
| 15.i | Potassium & heparin pre mixes | <ul style="list-style-type: none"> • Potassium pre-mixes have been registered, just waiting official confirmation • Change alert to reflect this, change prescribing practice, educate doctors and remove potassium concentrate injection from wards • DHBs need to change their protocols and guidelines to reflect pre-mixed concentrations • Develop evaluation form to send with alert and say that it will be sent out for completion at a later date • Send updated alert etc to MACs/PTACs • Baxters have quoted a price for heparin pre-mixed syringes, need to assess uptake etc | <ul style="list-style-type: none"> • Contact Biomed about manufacture of heparin syringes (Beth) • Assess possible uptake of heparin syringes (Beth) • Re-draft alert, design evaluation form (Beth) |
| 15.ii | Warfarin | <ul style="list-style-type: none"> • Branding of toolkit to match with warfarin DVD • Some documents already branded • Would ACC be willing to co-fund? | <ul style="list-style-type: none"> • Forward remaining toolkit contents to Adam (Beth) • Write to ACC (Beth) |
| 15.iii | LMWH | <ul style="list-style-type: none"> • Letter from doctor concerning definition of renal impairment and use of MDRD v creatinine clearance in the alert • The information in the alert is correct | |
| 15.iv | Morphine | <ul style="list-style-type: none"> • Feedback generally favourable and alert welcomed • Comments about size of CD safes precluding good storage • Investigate availability of larger CD safes • Morphine products may be due to go for tender • Suggestion that language should be more direct • Some want alert split into storage and prescribing issues • After discussion it was agreed to produce one alert but split action points into two areas • Alert needed on oxycodone particularly for primary care, bpac planning an article so we could run safety piece in the same edition | <ul style="list-style-type: none"> • Make changes to alert (Marilyn, Beth) • Circulate to group for comment (Beth) • Investigate availability of larger CD safes (Beth) • Add oxycodone to list of high risk drugs |
| 15.v | Intravenous Infusions | <ul style="list-style-type: none"> • 6 DHBs still to return completed audit • Completed audits still arriving • Follow up with DHBs concerned • Suggested Auckland University nursing or pharmacy summer studentship to analyse data and write report, supervisor Gigi, oversee report Beth | <ul style="list-style-type: none"> • Follow up missing audits (Gillian, Beth) • Summer studentship (Gigi) • Review alert and position statement (Marilyn, Beth) • Send to group for comment |

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| | | <ul style="list-style-type: none"> Alert and position statement need to be finalised ready for distribution when report complete | (Beth) |
| 15. vi | IT cytotoxic injection | <ul style="list-style-type: none"> No progress | |
| 15. vii | Colchicine | <ul style="list-style-type: none"> When re-formatted send out for final comment and circulate | <ul style="list-style-type: none"> Re-format and send round for sign off by group (Beth) |
| 15. vi ii | Oral Methotrexate | <ul style="list-style-type: none"> No progress | <ul style="list-style-type: none"> Draft alert (Avril, Marilyn) |
| 16. | Renal drug dosing | <ul style="list-style-type: none"> Current version of alert discussed, very wordy, no specific advice and some areas of contention (e.g. metformin, LMWH advice v LMWH alert etc) | <ul style="list-style-type: none"> Volunteered pharmacist from Taranaki to make changes (Alban Clareburt) |
| 17. | Date and venue for next meeting | <ul style="list-style-type: none"> June 12th Wellington (venue to be announced), to include workshop starting 12.30 | <ul style="list-style-type: none"> Invite Sheila Swan for update on national medicines strategy for 12 noon (Beth) |