

DHBNZ Safety and Quality Use of Medicines Group Newsletter



Volume 4 Number 3 July 2008

Quality Improvement Committee Projects Look-alike, sound-alike products/incidents

These were officially launched on July 1st and further introduced at an "Improving Quality Sector Forum" on July 11th. Slide/video presentations from July 1st are available on <http://www.patientjourney.org.nz>

The video presentations for July 11th are available on <http://www.gic.health.govt.nz>

The forum presentations include Dr Jonathon Gray, the director for the Welsh "Thousand Lives Campaign". Wales has a population size very similar to New Zealand with a similar distribution of rural and urban environments.

Nominations for working parties and pilot sites for the safe medication projects are now open. Contact Clare Kirk, Clare.Kirk@huttvalleydhb.org.nz, the overall project leader for further information.

The pilot sites for the Optimising Patient Journey Project have been selected and a series of collaborative learning sessions planned. Information on both the Safe Medication Management and Optimising the Patient Journey projects can be found on <http://patientjourney.org.nz>

Consultation on the draft National Incident Reporting Policy has closed. For further information on this project which includes the reporting of medication incidents, see <http://nzsip.comuniogroup.com>

Look-alike, sound-alike products/incidents

Frisium dispensed when *Frumil* prescribed. This has happened on more than one occasion and consideration should be given to how these two products are stored. Either store *Frisium* under *clobazam*, make sure the two products are not physically adjacent on the shelf or employ some sort of labelling system to differentiate them.

Enteral feeding tubes

In the absence of an international standard colour coding for enteral feed giving sets - which non-luer compatible enteral feed giving set is your DHB purchasing? Are they distinctive and do they look different to your intravenous giving sets to reduce the risk of confusion? A call from ADHB to aim for uniformity across DHBs is timely especially in light of the reported sentinel event that involved enteral feeds.

Enteral feeding tubes

Glacial Acetic Acid

MIMs have changed the way glacial acetic acid is shown in their drop down menu to emphasise that it is concentrated. While not eliminating the risk of glacial acetic acid being prescribed when dilute is intended it does reduce that risk. Thank you to those pharmacists who responded to my question about when they supply glacial acetic acid.

Glacial Acetic Acid

What's new?

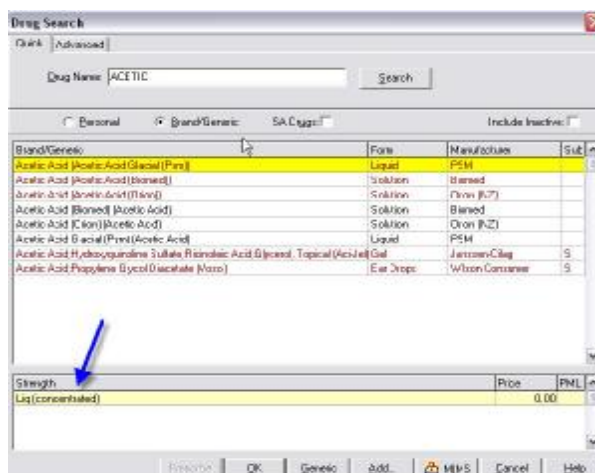
Pre-mixed potassium containing infusions

The extended range was officially registered and launched this month. An updated potassium chloride concentrate injection alert has been issued. Compliance with the alert's recommended actions will be audited six months following issue.

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Adverse Reaction alert- acute phosphate nephropathy associated with oral sodium phosphate (OSP) products for bowel cleansing

One DHB has expressed concern about the incidence of acute phosphate nephropathy associated with OSP used for bowel preparation prior to colonoscopy or bowel surgery.

Five episodes of significant adverse reactions to OSP have been seen in their nephrology department in the last two years. This reflects world-wide concern about the incidence of acute phosphate nephropathy associated with the use of OSP products.^{1,2}

Consideration should be given to which bowel preparation agent is employed particularly for patients with an increased risk of acute phosphate nephropathy; these include advanced age, diabetes, impaired renal function or perfusion, decreased intravascular volume, uncorrected electrolyte abnormalities, taking medicines that affect renal perfusion or function (e.g. diuretics, angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs) and possibly nonsteroidal anti-inflammatory drugs (NSAIDs)). Other bowel preparation agents available are sodium picosulphate and polyethylene glycol. No bowel preparation agent is adverse reaction free and the risks and benefits of each agent in different patient populations should be considered in choosing a suitable agent.

References

1. US Food and Drug Administration, Healthcare professional Sheet: Oral Sodium Phosphate Products for Bowel Cleansing URL: http://www.fda.gov/cder/drug/InfoSheets/HCP/OSP_solutionHCP.htm
2. Connor A, Sykes L et al. Acute Phosphate Nephropathy after sodium phosphate preparations BMJ 2008 Jul 17; 337 al 182

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

Upcoming events

6th Australasian Conference on Safety and Quality in Healthcare—Bold Aims Bold Outcomes, 1–3 September 2008, Christchurch Convention Centre. See this link for further information <http://www.conference.co.nz/index.cfm/aaqhc08>

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/>

HINZ Annual Conference and Exhibition—Improving and Exploiting our Information, 15–17 October 2008, Rotorua Convention Centre. See this link for further information http://www.hinz.org.nz/media/2008_conference/HINZ2008ConferenceProgramme.pdf

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>

Heath Research Council, Innov08 Weaving Innovation into Health, 3–5 November 2008, Wellington. See this link for further information <http://www.innov08.org.nz/>

Useful links and articles

Cina J, Gandhi T et al. How many hospital pharmacy medication dispensing errors go undetected. J. Comm J Qual Patient Saf.

Thomas AN, Panchagnula U. Medication-related patient safety incidents in critical care: a review of reports to the UK National Patient Safety Agency. Anaesthesia 2008 Jul; 63 (7): 726-733