

DHBNZ Safe and Quality Use of Medicines Group Newsletter

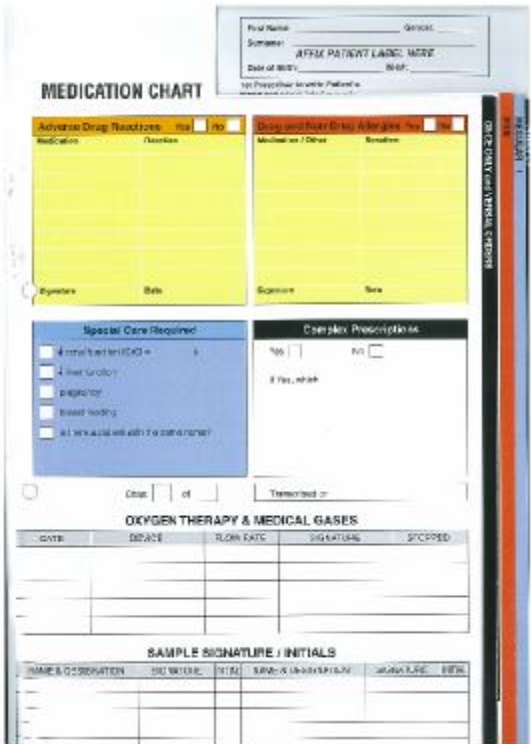


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What's new?

National Drug Chart

The new and very different looking chart together with a report on the consultation feedback has been sent to the people who provided that feedback in 2006 and to either Medicines Advisory Committees or groups working on drug charts in each DHB. Closing date for comments is 1st November 2007.



The introduction of a National Drug Chart has been incorporated into a larger safe medication management project being proposed by QIC (see below).

Quality Improvement Committee (QIC)

QIC, formally EpiQual, was established in early 2007 to provide leadership and a shared learning environment for the health sector, to ensure that innovations to improve the quality of healthcare can be more quickly adopted throughout the system. The committee's purpose is to work across the sector both as an advisor and facilitator, as well as to provide advice to the Minister. QIC has developed 7 priorities for a national quality improvement programme;

- a nationally consistent approach to managing healthcare incidents
- a national process for reviewing adult peri-operative deaths; and as strategy for developing local/regional child and youth mortality reviews
- a national collaborative to improve patient centeredness and the flow of patients through healthcare settings
- a programme for improving the management of medications across the health and disability sector
- a comprehensive education and training programme in quality improvement methods
- a national programme for the prevention and control of healthcare-acquired infections
- strengthening the consumer voice and improving consumer participation in the health and disability sector

The programme for improving the management of medications has been developed with input from SQM and also incorporates the bedside verification project developed by the MOH. This programme includes the introduction of a national medication chart as the first step in moving to electronic prescribing and medicines reconciliation.

This is a very exciting development in SQM's work for the safe use of medicines in New Zealand; watch this space for the next steps!

Medicines Reconciliation (MR)

SQM needed to put together a project plan around MR in a short time frame in order to inform the QIC proposal. This necessitated gathering people with experience of providing MR services together for a workshop at very short notice. Thanks to all those people who attended or who contributed their information by email or phone. There is an amazing amount of excellent work going on in NZ hospitals. Hopefully we can continue to develop MR services and develop a national toolkit that will facilitate the introduction of new MR services.

Website

We apologise but this is currently being re-designed and is therefore out of date. The new site design will enable the site to be identified by search engines and will be easier to access.

Good Prescribing Practice alert

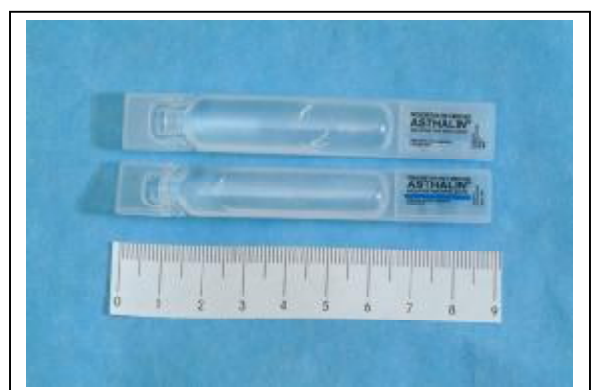
This has been issued. Primary care patient management system providers identified that the majority of the abbreviations allowed in their system were dependent on the formulary used. The alert has since been sent to formulary providers with a request that the "do not use" abbreviations list is followed.

Recent Issues Highlighted by Practitioners

Prednisone Dispensing Errors

There have been five reports this year where prednisone 20mg tablets have been dispensed when the prescription called for 5mg tablets. The labelling was correct in all cases. Further details of the cases and a root cause analysis are unavailable. Please review your dispensing practice and dispensary in an effort to reduce the risk of this incident happening.

Funded brand of salbutamol nebulers



Many hospitals are now stocking Asthalin[®] salbutamol nebulers and have highlighted

that the label print size makes it difficult to distinguish between the two strengths and that there is no other distinguishing feature. SQM will raise this issue with Medsafe, Pharmac and the manufacturer.

To reduce the risk: store the different strengths on different shelves or if possible only issue one strength to a ward.

Upcoming events

NZHPA Annual Conference 2007 "Strait Ahead" 28-30 Sept 2007, Wellington Convention Centre. See this link for further information

<http://www.confer.co.nz/nzhpa2007/>

International Forum on Quality and Safety in Health Care, 23-25 April 2008, Le Palais des Congrès de Paris. See this link for further information

<http://group.bmj.com/group/events/forum>

Useful links and articles

Wan Y. Pilot scheme to reduce injectable medication errors in UK hospitals:

<http://www.nelm.nhs.uk/record%20view/viewRecord.aspx?id=578585>

Nassaralla CL, Naessens JM et al. Implementation of a medication reconciliation process in an ambulatory internal medicine clinic QSHC 2007;16: 90-94

Barbar N, Cornford T, Klecun E. Qualitative evaluation of an electronic prescribing and administration system QSHC 2007;16: 271-278

Franklin BD, O'Grady K et al. The impact of a closed loop electronic prescribing and administration system on prescribing errors, administration errors and staff time: a before-and-after study QSHC 2007;16: 279-284

FDA Patient Safety News Sept 2007: Preventing patient deaths from fentanyl patches
<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/psn/transcript.cfm?show=67#3>

Raebel MA, Charles J, et al
Randomized trial to improve prescribing safety in ambulatory elderly patients
http://www.ncbi.nlm.nih.gov/sites/entrez?cmd=retrieve&db=pubmed&list_uids=17608868&dopt=Abstract

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