

# DHBNZ Safe and Quality Use of Medicines Group Newsletter



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## What's new

### Membership of SQM Group

Are you driven to try and change practice around the safe and quality use of medicines? Due to a resignation (see below), SQM group need a new member. Please see the attached flyer or the advert on the website and send in your C.V.

The group would like to thank Elizabeth Plant for her huge contribution to the work of the group; Elizabeth has been a member since the group's inception but her recent appointment as President of the Pharmaceutical Society along with her many other commitments has forced her to resign membership.

### National Drug Chart/Drug Chart Standards

Draft drug chart standards have been prepared by the SMM programme. Two DHBs will be asked to assess the standards and following this any necessary changes will be made. A national acute medical and surgical medication chart (NAIMS) based on the chart that SQM group were working on last year but that complies with the standards is to be completed and will be sent out with the final version of the draft standards. The chart will then be piloted at two DHBs before implementation nationally.

The standards will be available and will apply to all charts used in a hospital i.e. in specialist areas.

### Warfarin Red Book

Thank you to all those who have contributed feedback. If anyone else would like to suggest any changes to the red book content, please contact Beth Loe ([Beth.Loe@waitematadhb.govt.nz](mailto:Beth.Loe@waitematadhb.govt.nz)) before Christmas.

### Morphine Alert

The Morphine Alert has prompted feedback from clinicians with regard to the conversion factor that was included for changing a patient from oral to intravenous/subcutaneous morphine. Feedback suggests that individual clinicians use different conversion factors ranging from 3 to 1 to 6 to 1. The conversion factor quoted in the Alert is commonly quoted in the literature. The Alert could have pointed out that the conversion from one route of administration to another is a very inexact science and that the conversion factor used can vary.

Feedback has also highlighted that in some DHBs a number of morphine incidents have been related to the use of modified release morphine preparations in certain patients post operatively or in very sick patients. Absorption can be variable in both extent and timing in these patient populations and has been the cause of near miss opioid overdose. However, modified release morphine preparations have been used in some post operative patient populations for pain relief with no problems.

Please consider these points when reviewing any morphine guidelines or training in your practice.

## Cytotoxic drug use in the community setting

SQM has been advised that methotrexate injection is increasingly being prescribed for rheumatoid arthritis treatment in the community setting. In these cases the prescription is dispensed by a community pharmacy as a solution, in vials because this is the only form of methotrexate injection funded on the Pharmaceutical Schedule. The dose is then drawn up from the vial and administered; either by practice nurses or district nurses.

There is also a suggestion that bleomycin is being used in ophthalmology patients in the community.

Please inform Beth Loe if you are aware of any cytotoxic drug being prepared and administered by nurses in the community in your DHB so that SQM group can investigate ways to reduce the associated risks.

If your DHB already has policies, procedures or guidelines in place to manage these situations and you are happy to share them, then please send them to Beth Loe. Sharing of policies can reduce duplication of effort for all DHBs.

Because of the risks to staff posed by the preparation of methotrexate injection in these settings, SQM have written to rheumatologists, directors of nursing and primary health groups to highlight this issue. A request has been sent to PHARMAC to consider funding pre-filled methotrexate syringes for restricted use in the community.



## Allopurinol/colchicine prescriptions

Prescriptions for allopurinol generated from a "personal favourites list" in a PMS system can still retain the out dated direction "do not take during an acute attack." Patients have also assumed that because they are given acute treatment they should stop their maintenance treatment, i.e. allopurinol and it should be made clear to them that they need to continue taking the allopurinol. This outdated instruction should be deleted from favourites lists. Pharmacists dispensing prescriptions that include this direction should contact the prescriber for clarification. Also, this is a timely reminder to update outdated colchicine directions in "personal favourite lists" as per the recommendations in either the bpac<sup>NZ</sup> journal or Prescriber Update.

## Paediatric dispensing/administration incidents related to carbamazepine and omeprazole

Two cases have occurred recently where children have been admitted to hospital with major seizures due to sub-therapeutic levels of carbamazepine. In both cases this was related to difficulty in administering the prescribed dose of carbamazepine.

Case 1: Child admitted with carbamazepine levels of 6 (range 16–40). The parents had great difficulty in measuring the correct volume, prescribed dose = 3.3.ml

Case 2: Fluctuating carbamazepine levels, 9,20,12 and whilst the parents admitted missing doses, (they both worked fulltime and there were 5 children in the family), they also had trouble measuring the correct dose.

Carbamazepine froths when shaken and the air bubbles make it very difficult to measure the dose accurately using an oral syringe unless an adaptor cap is

## Carbamazepine cont..

supplied. The adaptor caps allow parents to push air back into the bottle and measure the dose more accurately.

Please consider how parents can measure the dose prescribed, sometimes a dose can be rounded up or down to make it easier. If this isn't a suitable option, advise parents that an adaptor cap and oral syringe, particularly for carbamazepine, will ensure that doses are both easier to and more accurately measured.



## Omeprazole:

Case 1: baby discharged from hospital with omeprazole suspension 2mg/ml. The next prescription is dispensed by community pharmacy as a 4mg/ml suspension and labelled correctly but the parents continue to give the same volume as previously and so give double the prescribed dose.

Is there a need to standardise the strength of omeprazole suspension prepared? Ensure the dose of any extemporaneously prepared mixture is explained clearly to parents and make sure that the mixture you have prepared will be given appropriately.

Omeprazole cases 2 and 3: community pharmacies have advised parents to open omeprazole capsules, rather than preparing a suspension, and sprinkle half the granules on babies tongues. This creates the risk of aspirating the granules into the lungs before swallowing and is an inaccurate way of presenting the dose.

## Insulin

Please take extra care when prescribing or dispensing insulin: two new insulin products have been added to the Pharmaceutical Schedule: Lilly Humalog Mix25 and Humalog Mix50. These will not automatically populate your dispensing system screens if you have not dispensed them before.

## Upcoming Events

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

International Society for Quality in Healthcare 26th International Conference, 11-14 Oct 2009, Dublin. See this link for further information—<http://www.isqua.org/>

## Useful links and articles

Ogrinc G. Mooney SC.et al. The SQUIRE (Standards for Quality Improvement Reporting Excellence) guidelines for quality improvement reporting: explanation and elaboration. Qual Saf Health Care 2008; 17 (suppl 1)URL: [http://qshc.bmj.com/cgi/content/full/17/Suppl\\_1/i13](http://qshc.bmj.com/cgi/content/full/17/Suppl_1/i13)



**Finally....A Happy and Safe Christmas and New Year to all our readers**

## 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](mailto:Beth.Loe@waitematadhb.govt.nz) or via the website [www.safeuseofmedicines.co.nz](http://www.safeuseofmedicines.co.nz)