

# DHBNZ Safety and Quality Use of Medicines Group Newsletter



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## What's new?

### National Drug Chart

The sub committee met in February and agreed on changes to the proposed drug chart. These changes have been incorporated into a draft chart which should be available for discussion and approval at the group meeting on April 19<sup>th</sup>. Feedback to individuals who responded to the consultation will be after this date.

### Good Prescribing Practice - Abbreviations Alert

This should be released this month.

### Intravenous Infusion Practices Position Statement and Alert

Thank you to all who provided feedback on this. The feedback will be reviewed at the April meeting of the group.

### QIC (Quality Improvement Committee)

This ministerial advisory committee was formerly EpiQual. Two members of SQM (Kevin Hague and Mary Seddon) have been appointed to this committee.

### Towards a NZ Medicines Strategy Consultation

This closed on 30<sup>th</sup> March, SQM sent a response and is also submitting a document with a broader perspective linking and aligning this document with the actions put forward in the SQM strategy.

### Heparin

Great news; pre-mixed bags are now available from Baxters. Two strengths (100 iu and 50 iu per ml) and three

preparations (25 000iu per 250ml, 25 000iu per 500ml, 10 000iu per 100ml) are available. To minimise the risk of error with stocking multiple strengths and volumes, SQM suggests that all NZ hospitals standardise on 100units/ml strength in either the 100ml or 250ml volume. Please feedback if this approach is acceptable and which volume is preferred for your institution.

### Recent Issues Highlighted by Practitioners

Newly funded AstraZeneca injections look very similar; 10ml ampoules of fentanyl 500microgram, water for injection and sodium chloride



Taranaki DHB initially raised this issue with Pharmac and SQM has followed this up. Thanks to Pharmac who have acknowledged that there are problems with the packaging and labelling of pharmaceuticals. Pharmac have undertaken to review their notification procedure in an attempt to alert DHB hospitals to packaging similarities prior to stock being introduced to the wards. They will also work with suppliers at the contracting stage and endeavour to consider product differentiation.

### **Water for Injection ampoules**

People have indicated that there has been considerable wastage and increased risk associated with the newly contracted brand. If any individual or DHB has figures for the number of ampoules wasted or examples of inappropriate practice (e.g. entering the plastic ampoule through the base with a syringe and needle) then please could they contact Beth (see below)?

### **Packaging and labelling alerts**

Many DHBs issue an alert when problems with packaging/labelling that present a risk are identified. SQM suggests that a standardised format for national use is developed which allows for individual DHB logos. Each DHB could then produce their alerts in a consistent format. This would facilitate sharing alerts with other DHBs, improve communication on common problems and improve safety for our patients. Please send your alert format to SQM so that we can develop a national version.

### **Risk associated with differential prescription charges e.g. hospital discharge v PHO GP prescription**

We would like examples of problems that have arisen because of patients not filling their hospital discharge or outpatient prescription because they do not attract the reduced co-payment available to PHO GPs. There has been one major drug error reported when a GP transcribed a discharge prescription, prescribed the wrong drug which was subsequently dispensed and taken

leading to serious morbidity. We would like to keep a record of reduced access to treatment or errors that arise from this situation. Resolution of this issue is being discussed and it is expected that all co-payments will be consistent irrespective of place of prescribing by 2008/2009.

### **Upcoming events**

We Can Make a Difference - Medicines Safety and the Patient Experience, Practical Solutions Workshop: May 16 to 18<sup>th</sup> 2007, Te Papa, Wellington. See this link for further information [http://wecanmakeadifference.org.nz/conference\\_2007.php](http://wecanmakeadifference.org.nz/conference_2007.php)

4<sup>th</sup> New Zealand Clinical Research Conference "Science to Clinical": July 5<sup>th</sup> - 6<sup>th</sup> 2007, Sky City Convention Centre, Auckland See this link for further information [www.nzacres.org.nz/](http://www.nzacres.org.nz/)

### **Useful links and articles**

Leape LL, Fromson JA. Problem doctors—is there a system level solution? *Ann Intern Med* 2006;144:107-15

Glintborg B, Anderson S, Dalhoff K. Insufficient communication about medication use at the interface between hospital and primary care *QSHC* 2007;16:34-39

Howard RL, Avery AJ et al. Which drugs cause preventable admissions to hospital? A systematic review. *British Journal of Clinical Pharmacology* 63 (2), 136-147.

### Feedback

Ongoing feedback about this publication is welcome. Please feedback to Beth Loe, Project Manager:

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