

What's new?

Extended range of potassium pre-mixed infusion bags

The registration of the additional concentrations moved a step closer when Medsafe gave their registration priority status.

National Medicines Strategy

This was released on 14th December and is available on [http://www.moh.govt.nz/moh.nsf/pagesmh/7236/\\$File/medicines-nz.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/7236/$File/medicines-nz.pdf)

Quality Improvement Committee

Each of the five QIC projects has been assigned a lead DHB Chief Executive and the projects are set to proceed. Project manager positions for the medicines management project are likely to be advertised in early 2008.

Intravenous infusion Practice

Thank you to all the DHB Quality and Risk Managers who are conducting a baseline audit in each DHB to identify current practice. The audit is due to be completed by March 2008. The intravenous infusion practice alert and position statement will be released following completion of the audit.



National Medicine Chart

Thank you to all who fed back on the latest version. The subcommittee have reviewed the comments and are in the process of re-working the chart to take into account the practical problems that were pointed out in the feedback. It is hoped a trial of the chart can be organised as part of the QIC medication management project.

BANS v rINNS

The World Health Organisation agreed many years ago that drugs should all have a recommended international non-proprietary name (rINN). The problems arise when the rINN differs from the British Approved Name (BAN) that most of us are familiar with.

This has the potential for significant dispensing and administration errors if staff mistakenly think that different generic names refer to the same medicine. Never mind the confusion for patients. Supplies labeled with the rINN's furosemide (frusemide) and levomepromazine (methyltrimeprazine) are just two examples of products that have appeared on shelves in New Zealand.

Name changes that are particularly likely to cause dispensing errors and real confusion are cysteamine (BAN) and its rINN alternative mercaptamine. Mercaptamine is very similar to mercaptopurine. Levothyroxine (previously thyroxine) is very similar to liothyronine. While furosemide is similar to the BAN, frusemide, the same can not be said for levomepromazine and its BAN methyltrimeprazine.

The oestrogens will no longer be spelt with an "o" and acyclovir and cyclosporin become aciclovir and ciclosporin respectively.

These are just a few of the name changes that may land on pharmacy shelves. For a more complete list see the BNF list on <http://www.bnf.org/bnf/extra/current/450049.htm>

PHARMAC representatives on SQM are investigating if this issue can be highlighted in the Schedule. SQM will also be writing to Medsafe suggesting that both an advertising campaign and production of patient information leaflets around this issue would help prevent both dispensing and administration errors.

Upcoming events

Improving Medication Safety - sharing the lessons learnt, 5-7th March 2008, Melbourne http://www.changechampions.com.au/Forms%20&%20Programs/March_08_Medication_Program.pdf

QIT/AGPAL 4th International Conference Quality Carnivale, 17-19 April 2008, Melbourne. See this link for further information http://www.qip.com.au/uploads/files/7E2DADOC_QIP-AGPAL_Conference_Rego_Brochure.pdf

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>

The National Forum on Safety and Quality in Healthcare, 29-31 October 2008, Adelaide Convention Centre. See this link for further information and call for abstracts <http://www.sapmea.asn.au/conventions/forumsqhc2008/index.html>

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

Useful links and articles

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

Institute for Healthcare Improvement: Pharmacists to the (Early) Rescue: www.ihl.org/IHI/Topics/CriticalCare/IntensiveCare/ImprovementStories/FSPharmacisttotheEarlyRescue.htm

National Patient Safety Agency, Patient Safety Division: Information Design for Patient Safety 2nd edition 2007

<http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/design/information-design/>

National Patient Safety Agency: Design for patient safety: a guide to the design of the dispensing environment, Edition 1 2007

<http://www.npsa.nhs.uk/patientsafety/improvingpatientsafety/design/dispensing-environment/>



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