

# SAFE & QUALITY USE OF MEDICINES GROUP Meeting

Thursday 14<sup>th</sup> February 2008 Time: 9.30am to 3.30pm

## Attendees

Beth Loe (National Coordinator)	Gillian Bohm (MOH)
Avril Lee (WDHB)	Peter Moodie (PHARMAC)
Gigi Lim (Auck Univ)	Marilyn Crawley (WDHB)
Elizabeth Plant (Taranaki)	Adam McCrae (PHARMAC)
Tim Maling (C&CDHB)	Mary Seddon (CMDHB)

## Invitees

Rachel Taylor (ACC), Julian Tommei (Q&R Managers), Michael Tatley (NZPhvC), Desiree Kunac (NZPhvC), Anita Frew (ACC)

## Minutes

Item	Agenda	Notes/comments	Action Required
1.	Apologies	Frances McClure, Kevin Hague, Debi Lawry, Dwayne Crombie, Roy Morris, Peter Black, Nigel Millar	
2.	Minutes of previous meeting	<ul style="list-style-type: none"> <li>These were agreed</li> </ul>	
3.	Matters arising	<p>i. <u>Group membership</u></p> <ul style="list-style-type: none"> <li>Awaiting reply from DHB NZ on expenses for the consumer, Debi's travel expenses &amp; Beth's costs</li> <li>Kevin is aware that he is often unable to attend meetings because of his other commitments and intends to raise this issue at the next CEs meeting</li> <li>Awaiting BPAC nomination</li> </ul> <p>ii. <u>Inequitable funding issues</u></p> <ul style="list-style-type: none"> <li>Reply from Deputy DG Health saying they hope to resolve anomaly as soon as possible</li> </ul> <p>iii. <u>PreMec proposal</u></p> <ul style="list-style-type: none"> <li>Elizabeth has prepared a proposal to take to PreMec, Kevin unable to contact Graham Robinson. To prevent delay suggested that Dwayne be asked discuss proposal with Graham Robinson</li> </ul>	<p>iii. <u>PreMec proposal</u></p> <ul style="list-style-type: none"> <li>Talk to Kevin and Dwayne and send proposal to Graham Robinson (<b>Beth</b>)</li> </ul>
4.	Safe Medication Project Update	<ul style="list-style-type: none"> <li>The transfer of funding from the MOH to DHB NZ will occur soon</li> <li>Management /steering group for all the QIC projects are Chai Chuah (Hutt), Clive Climo (Waikato), Geraint Martin (CMDHB), John Peters (NMDHB)</li> <li>It is anticipated that project positions will be advertised next month</li> <li>Currently unaware of how money will be distributed to DHBs</li> <li>Medication error incident reporting requires a baseline measurement so that any changes can be measured. Voluntary reporting prevents accurate measurement, an alternative is to use trigger tools (eg IHI tools)</li> <li>Need an agreed classification first but it is</li> </ul>	<ul style="list-style-type: none"> <li>Write to John Peters indicating that there needs to be a link between the Safe Medication and the Incident Reporting projects. SQM needs to be involved in determining the information collected for medication incidents i.e. causal factors, taxonomy and classification of medication incidents. The collection of data should extend to primary care, private hospitals and rest homes. (<b>Beth, Mary</b>)</li> </ul>

		<p>important that there is a subset of medication errors. Taxonomy also needs to be considered</p> <ul style="list-style-type: none"> <li>• Evaluation needs to be built into this project</li> <li>• SQM needs input into the taxonomy/classification</li> </ul>	
5.	QIC update	<ul style="list-style-type: none"> <li>• QIC are coordinating release of DHB serious/sentinel event information to the media on 21<sup>st</sup> February</li> <li>• The actual reports are not being released but a template for collecting both the incident and the outcome information has been developed</li> <li>• All the medication related incidents will be brought to the next meeting</li> <li>• The request for this information has raised the profile of sentinel events within the DHBs who are now aware of the figures</li> </ul>	<ul style="list-style-type: none"> <li>• Bring medication related events to next SQM meeting (<b>Mary</b>)</li> </ul>
6.	ACC update	<ul style="list-style-type: none"> <li>• ACC have just integrated their treatment injury database with the central claims database</li> <li>• 70% of 15 000 treatment injury claims were accepted and 14% of accepted claims are medicines related</li> <li>• Information collected only relates to making a decision on cover and not the background to the incident happening</li> <li>• Number of events reported has declined and this is a concern</li> <li>• Need a campaign to target hospital doctors to report particularly in areas where reporting to ACC is not a normal part of practice (i.e. orthopaedics automatically report to ACC)</li> <li>• Currently medical error reports are forwarded to the appropriate registration body for further investigation, this is seen as a barrier to incident reporting to ACC because of the risk of being reported to registration bodies</li> <li>• Sentinel events are currently shared with Medsafe</li> <li>• Graphs illustrating the incidence of medication related treatment injuries were presented &amp; discussed</li> </ul>	<ul style="list-style-type: none"> <li>•</li> </ul>
7.	NZPhvC	<ul style="list-style-type: none"> <li>• Need for a group to look at the collaborative data from DHBs and report on it, NZPhvC one possible group</li> <li>• Currently near misses and primary care medication related incident reports are not collected</li> <li>• PHOs are, however, starting to ask the centre about what to do about any reported incidents</li> <li>• A possible link between DHBs' incident reporting systems and centre could be a monthly download of incidents sent to the centre for reporting</li> <li>• Taxonomy and classification would have to be standardised</li> <li>• PHOs could be encouraged to start collecting incident reports and use the same system</li> <li>• Suggest that NZPhvC be involved in the incident reporting project</li> <li>• NZPhvC to present to QIC next week and SQM will support them there, a detailed proposal with a timeline and the potential funding necessary should be included</li> <li>• This proposal is linked to both the Safe Medication and the Incident Reporting projects</li> </ul>	<ul style="list-style-type: none"> <li>• Design questionnaire to determine how individual DHBs are currently collecting incident data (<b>Gillian</b>)</li> </ul>

		<ul style="list-style-type: none"> <li>• SQM should inform PreMec that this is a possible project requiring funding to encourage reporting in primary care</li> <li>• Funding through ACC was discussed but the majority of the ACC research funding has been allocated to HRC for distribution</li> <li>• It was suggested that NZPhvC could apply to HRC for research funding and use the link between ACC/HRC and incident reports</li> <li>• Need to identify how each DHB is currently collecting incidents</li> <li>• Draft questionnaire and determine mechanism to collect data later</li> </ul>	
8.	Annual Report	<ul style="list-style-type: none"> <li>• Look at gaps in report and find writers</li> <li>• p4 Conferences –complete Marilyn and Avril</li> <li>• p4 Medication alerts – move to Chapter 5 and is complete</li> <li>• p4 Chapter 2 either words or table – no need for both</li> <li>• p10 Chapter 6 Amalgamate e records, e prescribing and HISAC</li> <li>• p11 Chapter 6 Move medicines reconciliation to Chapter 5</li> <li>• p11 Chapter 6 International Classification of drug interactions- take out</li> <li>• p11 Chapter 7 Primary Care – remove names and edit down</li> <li>• p11 Chapter 7 Something on community pharmacy, needs adding – completed Avril</li> <li>• p17Chapter 8 Re-word title and put in sub-title</li> <li>• p18 Chapter 10 Future Challenges and Objectives</li> <li>• sub-group to look at order etc before text goes to external editor (<b>Mary &amp; Tim</b>)</li> </ul>	<ul style="list-style-type: none"> <li>• p3 Optimising Use of Medicines Strategy – <b>Gillian</b></li> <li>• p3 CARM – <b>NZPhvC</b></li> <li>• p3 MARC – <b>Tim</b></li> <li>• p3 PHARMAC – <b>Adam</b></li> <li>• p3 ACC – <b>Rachel</b></li> <li>• p7 Chapter 4 Good Prescribing Practice – <b>Elizabeth</b></li> <li>• p10 e prescribing etc – enlarge – <b>Elizabeth</b></li> <li>• Check something on MR complete- <b>Beth</b></li> <li>• P18 Chapter 9 Consumer awareness - <b>Avril</b></li> </ul>
9.	HDC report- Medication Safety in Paediatric Care	<ul style="list-style-type: none"> <li>• Incident concerning overdose because dose calculated on weight in pounds when dose/kg intended</li> <li>• Parents talk in pounds, health professionals in kg</li> <li>• Plot of weight on percentile chart would have alerted nurse that weight incorrect</li> <li>• Suggest we issue an alert based on need for all scales to weigh in kg only and that all paediatric patients should have a percentile chart on which their weight is plotted</li> <li>• It was suggested there was a need for a paediatric formulary- this should be discussed later in the year and the Paediatric Society should be involved</li> </ul>	<ul style="list-style-type: none"> <li>• Write to HDC asking if they are contacting every paediatric department about this incident or would they like us to do so (<b>Beth</b>)</li> <li>• Draft an alert (<b>Beth &amp; paediatric pharmacist</b>)</li> </ul>
10.	DHB medication safety groups	<ul style="list-style-type: none"> <li>• Defer to next meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Agenda next meeting (<b>Beth</b>)</li> </ul>
11.	International System for DI classification	<ul style="list-style-type: none"> <li>• Defer to next meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Agenda next meeting (<b>Beth</b>)</li> </ul>
12.	E prescribing briefing paper	<ul style="list-style-type: none"> <li>• Defer to next meeting</li> <li>• Request that Nigel circulate the paper the week before meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Circulate paper one week before next meeting (<b>Nigel</b>)</li> </ul>
13.	Primary Care Issues	<ul style="list-style-type: none"> <li>• There is a concern about the prescribing of colchicine and allopurinol in acute gout, because GPs are still using old guidelines and stopping allopurinol</li> </ul>	<ul style="list-style-type: none"> <li>• Write to software vendors and PHO's (<b>Beth</b>)</li> <li>• Develop tool for audit of 20</li> </ul>

		<p>in an acute attack</p> <ul style="list-style-type: none"> <li>• Old guidelines kept in GPs personal folders (favourites) and these remain unchanged unless the GP updates them</li> <li>• Is there a system whereby the software vendors could ensure personal folders are updated?</li> <li>• Highlight to PHOs that this is a risk and could they request vendors to consider changing personal folders as a function of the system</li> <li>• Suggested we audit 20 GP practices to see if personal folders updated</li> <li>• Additional problem is that in the drop down boxes on some hospital electronic discharge systems the old dosage is still in place</li> <li>• Could Medsafe develop ability to e report adverse events to GPs systems</li> <li>• Discussed ways of communicating to GPs the risks involved and ensuring that personal folders updated other than through software vendors e.g. HDC, Medical Assurance Society, DHB organisational risk register ,DHBNZ SIG, MOH</li> <li>• Need new ways to communicate with GPs</li> </ul>	<p>GP practices <b>(Beth)</b></p> <ul style="list-style-type: none"> <li>• Write to chief pharmacists highlighting possible issue with electronic discharge summaries <b>(Beth)</b></li> </ul>
14.	Look alike sound alike names and packaging	<ul style="list-style-type: none"> <li>• SQM should take the lead and invite all parties involved to the next Wellington meeting for half day workshop with examples of the problem</li> </ul>	
14. i	Lighting/eye sight	<ul style="list-style-type: none"> <li>• Defer to next meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Eyesight/lighting <b>(Nigel)</b></li> </ul>
14.ii	Resus trolley syringes	<ul style="list-style-type: none"> <li>• Defer to next meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Write to HPAC <b>(Marilyn)</b></li> </ul>
14.iii	INN v BAN	<ul style="list-style-type: none"> <li>• This has been included in nursing textbook</li> <li>• Article submitted to BPAC</li> <li>• Article has been put in Nursing Journal</li> </ul>	<ul style="list-style-type: none"> <li>• Write to Medsafe about our concerns and suggest an awareness campaign/ patient information leaflet <b>(Beth)</b></li> <li>• Investigate if this can be highlighted in Pharmaceutical Schedule <b>(Adam)</b></li> <li>• Add to NOIDS where applicable <b>(Beth)</b></li> <li>• Investigate re-write of UK PILS and how it can be published &amp; distributed <b>(Beth &amp; Adam)</b></li> <li>• Raise issue with MARC <b>(Beth)</b></li> </ul>
15.	Alerts of Toniq dispensing system	<ul style="list-style-type: none"> <li>• Draft warnings for 6 drugs</li> <li>• Comments from community pharmacists include; no more than 2 warnings per drug, have counselling messages as a checklist that can be printed off</li> </ul>	<ul style="list-style-type: none"> <li>• Review warnings and send out for comment <b>(Beth)</b></li> </ul>
16.	BPAC articles	<ul style="list-style-type: none"> <li>• Article on INN v BAN submitted</li> </ul>	<ul style="list-style-type: none"> <li>• Talk to BPAC <b>(Beth)</b></li> </ul>
17.	High Risk Medicines		
17.i	Potassium & heparin pre mixes	<ul style="list-style-type: none"> <li>• No further communication from Baxters about labelling of the heparin pre-mixes</li> <li>• Baxters have heard nothing on registration of potassium pre-mixes</li> <li>• Baxters pricing heparin syringe manufacture and stability based on single strength and volume, all</li> </ul>	<ul style="list-style-type: none"> <li>• Write to Medsafe asking for a timeline around potassium pre-mix registration because planning a re-run of alert <b>(Beth)</b></li> <li>• Contact Biomed about</li> </ul>

		DHBs using syringes would have to standardise	manufacture of heparin syringes ( <b>Beth</b> )
17. ii	Warfarin	<ul style="list-style-type: none"> <li>• Possible carrying case for toolkit identified and being costed</li> <li>• PHARMAC have suggested funding of toolkit in preference to QUMap this financial year because of limited timeframe. They currently have quotes and expertise available</li> <li>• Discussed that toolkit should go out as SQM product</li> <li>• Is it possible for community pharmacy to have access to INRs, this has been implemented in the UK</li> <li>• Might be possible in Auckland but difficult to introduce</li> <li>• If the availability of an INR became part of the pharmacy contract then this could be introduced (cf clozapine blood test results and dispensing)</li> </ul>	<ul style="list-style-type: none"> <li>• Forward toolkit contents to Adam (<b>Beth</b>)</li> <li>• Write to DHB NZ SIG asking for change in pharmacy contract so that warfarin becomes a complex medicine and an INR result is necessary pre-dispensing (<b>Beth</b>)</li> </ul>
17.iii	LMWH	<ul style="list-style-type: none"> <li>• This has been distributed</li> <li>• One PHO has replied and is developing a website for their GPs and will put the alert on the website</li> </ul>	
17.iv	Morphine	<ul style="list-style-type: none"> <li>• Comments on current version of alert include changing the order because the information does not flow</li> <li>• Have action points highlighted in a box on the front page and put detail on the back</li> <li>• Cut down and change words around dose reduction in renal and liver impairment</li> </ul>	<ul style="list-style-type: none"> <li>• Make changes to words and order (<b>Marilyn</b>)</li> <li>• Circulate to group for comment (<b>Beth</b>)</li> </ul>
17.v	Intravenous Infusions	<ul style="list-style-type: none"> <li>• 2 completed audit forms received to date</li> <li>• Concern from some DHB legal advisors that it is an OIA and can not put in commercially sensitive information</li> <li>• Not an OIA, it is a quality improvement audit and information is intended primarily to inform individual DHB's on their current position and when the information is collated no DHB will be identifiable</li> <li>• Ask CE's to remind Q&amp;R managers to complete audit</li> </ul>	<ul style="list-style-type: none"> <li>• Request CE's to remind Q&amp;R managers to complete audit (<b>Kevin</b>)</li> </ul>
17.vi	Good Prescribing Practice	<ul style="list-style-type: none"> <li>• Mims complies with alert apart from u v units and mEq v mmol</li> <li>• Following discussion with Pharmacy Council the use of u in electronically generated prescriptions will not be a risk</li> <li>• Mims have been asked to remove mention of mEq because NZ nurses and doctors are unfamiliar with this and it is confusing</li> </ul>	
17. vii	IT cytotoxic injection	<ul style="list-style-type: none"> <li>• Guidelines are now on the website which is updated and active again</li> <li>• Need to be circulated to hospitals via chief pharmacists</li> <li>• Talk to Medsafe</li> </ul>	<ul style="list-style-type: none"> <li>• Circulate guidelines to chief pharmacists (<b>Beth</b>)</li> <li>• Investigate taking guidelines and presenting to haematologists (<b>Beth</b>)</li> <li>• Send alert to Baxters (<b>Beth</b>)</li> <li>• Contact Medsafe about their work (<b>Beth</b>)</li> </ul>
17. viii	Colchicine	<ul style="list-style-type: none"> <li>• When re-formatted send out for final comment and circulate</li> </ul>	<ul style="list-style-type: none"> <li>• Re-format and send round for sign off by group (<b>Beth</b>)</li> </ul>

17.ix	Oral Methotrexate	<ul style="list-style-type: none"> <li>• Avril and Marilyn volunteered to draft an alert</li> </ul>	<ul style="list-style-type: none"> <li>• Draft alert (<b>Avril, Marilyn</b>)</li> </ul>
18.	Renal drug dosing	<ul style="list-style-type: none"> <li>• Defer to next meeting</li> </ul>	<ul style="list-style-type: none"> <li>• Re-format alert (<b>Tim</b>)</li> </ul>
	Acknowledgment of contribution	<ul style="list-style-type: none"> <li>• Discussion around acknowledging stakeholders who have made an effort to contribute to the work of the group with particular reference to Baxters</li> </ul>	<ul style="list-style-type: none"> <li>• Design a certificate to acknowledge contribution (<b>Beth</b>)</li> </ul>
19.	Date and venue for next meeting	<ul style="list-style-type: none"> <li>• April 10<sup>th</sup> Auckland (venue to be announced)</li> </ul>	