

# SAFE USE OF MEDICINES GROUP

## Meeting

Friday 20<sup>th</sup> February 2004

Time: 9.30am to 3.30pm

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### Attendees

Dwayne Crombie (Waitemata) – Chair  
 Tim Maling (Capital Coast)  
 Avril Lee (Waitemata)  
 Beth Loe (Project Manager)  
 Mary Seddon (Counties Manukau)  
 Allan Pelkowitz (Auckland)  
 Marilyn Crawley (Waitemata)  
 David Kibblewhite (Waikato)  
 Peter Black (Auckland)  
 Elizabeth Plant (Taranaki)

### Invited

Tracey Barron (PHARMAC)

### Minutes

Item	Topic/agenda	Notes/comments	Action Required
1.	Apologies	Gillian Bohm, Sarah Schmitt, Gershu Paul	
2.	Minutes of meeting 8 <sup>th</sup> Dec 03	Approved	
3.	High Risk Medicines		
3.i	Heparin	<ul style="list-style-type: none"> <li>• Mary had circulated an alert, to be recirculated for comments</li> <li>• Comments that heparin being replaced by LMWH so indications for IV heparin need to be reviewed re risk benefit and appropriateness</li> <li>• Add suggested national policy/guideline on the back of the alert</li> <li>• Find out what is being used within Auckland and in other DHB's represented by group</li> </ul>	<ul style="list-style-type: none"> <li>• Recirculate draft guideline (<b>Beth</b>)</li> <li>• Auckland region to draft protocol to consult with cardiologists, neurosurgeons and other users</li> </ul>
3.ii	Potassium	<ul style="list-style-type: none"> <li>• Make small changes to format and take out " flagging with tape", finalise Feb 27th</li> <li>• PHARMAC need a letter with strengths of premixes we would recommend</li> <li>• Circulate alert to groups detailed on alert with letter asking for feedback on concentrations of premixes</li> </ul>	Finalise alert ( <b>Tracey</b> ) Letter to PHARMAC ( <b>Beth</b> ) Circulate alert with letter, 4 -6 weeks for consultation ( <b>Beth</b> )
3.iii	Diltiazem	<ul style="list-style-type: none"> <li>• Letter from Medsafe</li> </ul>	Collect details of incidents

		<p>circulated, PHARMAC have asked for details of incidents to refer to PTAC</p> <ul style="list-style-type: none"> <li>Alternative strategies, look at discharge letters so that only certain strengths are recommended, look at diltiazem use in primary care (big PHO's, IPA's)</li> </ul>	<p><b>(Beth)</b> Collect primary care usage <b>(Beth)</b></p>
3.iv	Warfarin	<ul style="list-style-type: none"> <li>Need date alert no. and review date on alert</li> <li>Add in patient understanding and awareness to alert</li> <li>Put sample clinical and patient guidelines and nomograms on website</li> <li>Pharmac have been approached to fund a video, current one 25years old</li> <li>Electronic prompt for GP's to check INR's, no resource available to do this</li> <li>Letter from Medsafe circulated, need to reply saying the issue is related to patient confusion not prescribing or dispensing</li> <li>PHARMAC would like details of warfarin incidents</li> <li>Ask PS to review warfarin labelling to include brand on labels</li> <li>Important that GP's are contacted on discharge, electronic discharge summaries need to have box for GP contacted on discharge</li> </ul>	<p>Changes to alert (<b>Avril</b>) Possibility of video (<b>Tracey &amp; Beth</b>) Letter to Medsafe re patient confusion (<b>Beth</b>) Invite Stewart Jessamine to next meeting in Wellington (<b>Beth</b>) Collect details of warfarin incidents (<b>Beth</b>) Letter to PS re labelling (<b>Beth</b>)</p>
3.v	Insulin	<ul style="list-style-type: none"> <li>Incidents collected from 6 DHB's, wide variety of incidents, stat dosing highest no. late doses or not given doses, iv doses, infusion rate not correct or not monitored and changed according to protocol</li> <li>To look at having separate insulin charts, raise the question of not using sliding scale infusions, protocols, importance of appropriate pump technology, no free flow and ability of pump to check dosing</li> <li>Insulin alert</li> </ul>	<p>Contact Jeff Braavadt (ADHB) and Rick Cutfield (WDHB) re sliding scale insulin and protocols (<b>Beth</b>) Insulin alert (<b>Beth</b>)</p>
3.vi	Morphine	<ul style="list-style-type: none"> <li>PHARMAC now funding only one slow release morphine tablet brand &amp; this will help with tablet confusion.</li> <li>Labelling of liquids recently</li> </ul>	<p>Draft morphine alert</p>

		<p>changed and different strengths now different colours</p> <ul style="list-style-type: none"> <li>• Morphine incidents; not all DHB's report on incidents by drug</li> <li>• Problems with pump technology, oral to sub-cutaneous adjustment</li> <li>• Emphasise need for double checking and care when dispensing or administering morphine prescriptions</li> </ul>	
Additio nal items	Other high risk drugs/areas to be considered	<ul style="list-style-type: none"> <li>• Cytotoxics generally &amp; particularly Methotrexate intrathecal &amp; oral</li> <li>• Intravenous infusions</li> <li>• Good prescribing eg thyroxine/digoxin, prn prescribing</li> </ul>	Add to list of areas to concentrate on
6.	Primary/Secondary interface	<ul style="list-style-type: none"> <li>• Document to be reviewed with a summary of recommendations</li> <li>• Known facts; 40% of both admission and discharge summaries include errors, pharmacists recognised as experts at admission histories &amp; medicines, medical education could need review</li> <li>• Possible actions: <ul style="list-style-type: none"> <li>i. have acute/elective medication discharge summaries ie separate from discharge summary</li> <li>ii. prioritise patients requiring pharmacist taken medication history</li> <li>iii. Standardise way of recording medicines</li> <li>iv. Use of patients own medicines in appropriate areas</li> <li>v. Patient held record, community pharmacy generated</li> </ul> </li> </ul>	Review interface document ( <b>Avril/Elizabeth</b> )
10.	Issues in Primary Care	<ul style="list-style-type: none"> <li>• Problems are currently unknown, ask quality managers what they are</li> <li>• Capture of community errors?</li> <li>• One area that could be highlighted is cardiovascular drugs eg <math>\beta</math> blockers &amp; statins post MI shown to reduce readmissions</li> </ul>	Ask quality managers in large PHO's what problems are (?) Highlight cardiovascular drugs in primary care at May workshop
4.	Information technology	<ul style="list-style-type: none"> <li>• 3 Auckland DHB's are looking at e prescribing as a group</li> <li>• Need an update on what all the DHB's are doing</li> <li>• Electronic robot to deliver</li> </ul>	Update on what DHB's doing re computer systems ( <b>Elizabeth/Marilyn</b> ) Pyxis business cases ( <b>Elizabeth &amp; Marilyn</b> )

		<p>medicines</p> <ul style="list-style-type: none"> <li>• Barcoding</li> <li>• Hospital Pharmacists conference-learning from unsafe practices 10/11/12 Sept 2004</li> <li>• Pyxis: can this group recommend Pyxis or at least set out benefits, change management issues etc that would help a business case</li> </ul>	
5.	Drug Information Service	<ul style="list-style-type: none"> <li>• Need feedback from Evan re uptake for advertised DI service and whether the service is open to new customers</li> <li>• The service needs to feedback on queries at a local level</li> </ul>	Update at next meeting ( <b>Evan</b> )
6.	Good Quality Pharmacy service	<ul style="list-style-type: none"> <li>• Look at paper next time and decide what the major focuses should be and then put into a format to issue</li> </ul>	
9.	Name & logo for group	<ul style="list-style-type: none"> <li>• Safe use of Medicines Group, DHBNZ</li> <li>• Logo good but change colours to red/black/yellow</li> </ul>	Change logo colours ( <b>Tracey</b> )
	Website	<ul style="list-style-type: none"> <li>• Needs to be accessible to everyone</li> <li>• Logo to go on and contact through the website</li> </ul>	Set up website ( <b>Beth</b> )
8.	Quality Use of Medicines Strategy & workshop	<ul style="list-style-type: none"> <li>• Looking at the Pharmac QUM document, is it workable, could it be better &amp; who should manage it</li> <li>• Building blocks based on Australian experience</li> <li>• Overview; funding, resourcing, implementing drawing on Australian experience and Pharmac document</li> </ul>	To have teleconferences weekly to organise workshop ( <b>24<sup>th</sup> February 1st one</b> )
11.	Medication errors	<ul style="list-style-type: none"> <li>• Concern re incident databases not being able to report on errors related to an individual drug</li> <li>• Chairs of DTC's have discussed databases and quality managers have a brief</li> <li>• Taranaki are willing to market their system for \$1000, AIMS+ also available</li> </ul>	Need more information on what information different DHB's are collecting and how it is stored
12.	Date of next meeting	Monday 22 <sup>nd</sup> March 9.30 to 13.00, Centra Auckland Airport Hotel	To plan workshop