

SAFE & QUALITY USE OF MEDICINES GROUP

Minutes

Thursday 3rd December 2009 Time: 9.30 to 14.30

Attendees

Marilyn Crawley (Waitemata)

Gillian Bohm (MOH)

David Woods (bpacNZ)

Beth Loe (National Coordinator)

Tim Maling (C&CDHB)

Mary Seddon (CMDHB)

Adam McRae (PHARMAC)

Avril Lee (Waitemata)

Beryl Wilkinson (Consumer)

Peter Moodie (PHARMAC)

Sandra Fielding (BOPDHB)

Invited

Dylan Tapp (ACC)

Shane Hunter (SMMP)

Clare Kirk (SMMP)

Jane Brown (ACC)

Minutes

Item	Agenda	Notes/comments	Action Required
1.	Apologies	Nirasha Parsotam, Chai Chuah, Gigi Lim, Frances McClure, Peter Black, Anne Kemp	
2.	Welcome Sandra Fielding		
3.	Minutes of previous meeting	<ul style="list-style-type: none"> These were accepted 	
4.	Matters arising	<p><u>i. Potassium pre-mixes</u></p> <ul style="list-style-type: none"> Follow up with Centre for the Study of Diabetes <p><u>ii. Resus medicines presented in syringes</u></p> <ul style="list-style-type: none"> Marilyn has written an extended list of medicines that would have safety benefits if available in syringes or minibags It would be helpful if the group were able to provide PHARMAC with an estimate of monthly usage volumes <p><u>iii. Linking of patient allergy status to NHI</u></p> <ul style="list-style-type: none"> MOH presented at the last SMMP meeting on this The whole system is now being reviewed and the new platform will not go live until the review is complete At the present time there is a huge variation in what information is loaded onto the NHI by different DHBs e.g. some DHBs will add information about a dog being on a property Unless the allergy information is entered by CARM it is not necessarily validated information The validated information from CARM is entered at CARM It would be helpful to have an indication on the timeline for the review Could SQM indicate what a perfect system would be e.g. what information should be available, where it 	<p><u>i. Potassium pre-mixes</u></p> <ul style="list-style-type: none"> Follow up with Centre for the Study of Diabetes (Beth) <p><u>ii. Resus medicines in syringes</u></p> <ul style="list-style-type: none"> Seek usage information (Marilyn) <p><u>iii. Linking of patient allergy status to NHI</u></p> <ul style="list-style-type: none"> Contact Tim Harvey at MOH regarding the timeline (Beth) Produce a short paper on the ideal system (Mary)

		<p>should be available and taking into account e prescribing</p> <ul style="list-style-type: none"> • There had been two near misses recently at one DHB and they now alert labelling bottles containing penicillin related antibiotics <p>iv. <u>Process map for alert development</u></p> <ul style="list-style-type: none"> • Defer to next meeting <p>v. <u>Technical advisory group/clinical leadership group</u></p> <ul style="list-style-type: none"> • The proposal agreed at the last meeting was forwarded to SMMP • The proposal will be discussed at the next SMMP steering group meeting 	<p>iv. <u>Process map for alert development</u> Agenda next meeting (Beth)</p>
5.	Group membership		
5.i	CMO nominated member	<ul style="list-style-type: none"> • No nominations have been received from the CMOs group to date • Following discussion it was agreed that Tim Maling would seek clarification from the CMO group regarding representation for the group on SQM 	<ul style="list-style-type: none"> • Continue to seek CMO representative (Tim)
5.ii	Possible conflict of interest	<ul style="list-style-type: none"> • Nirasha has been seconded to SMMP for 4 months and wanted to clarify with the group if this would be considered a conflict of interest 	<ul style="list-style-type: none"> • Agreed that this did not represent a conflict of interest • Conflict of interest register to be updated (Beth)
6.	QIC update	<ul style="list-style-type: none"> • Reports from all the quality improvement programmes are due tomorrow • This weeks serious and sentinel event release indicated that 27% of incidents were falls related • Two priorities identified by QIC are; increasing the consumer voice and primary care • The MOH is considering disestablishing QIC and establishing a national quality agency within the MOH, feedback from the sector has been that such an agency should be independent of the MOH • Releasing time to care has not increased medication error reporting 	
7.	NZPhVC update	<ul style="list-style-type: none"> • Mary provided an update on the medication error project , a steering committee has been established; QIC members (Mary), Medsafe member and two NZPhVC members • Initial plans for the project include GP, community and hospital pharmacy portals • Phase 1 of the project starting January 2010 • Discussion around the work that Rob Ticehurst is undertaking to ensure no duplication. His work is around interventions 	
8.	ACC update	<ul style="list-style-type: none"> • ACC presented their latest medication related treatment injury figures • Large number of claims related to allergic/anaphylactic reactions to antibiotics • Drug administration errors in rest homes have been a consistent source of claims • Number of claims involved CVAs/cerebral haemorrhage associated with warfarin and or polypharmacy involving aspirin/warfarin in the elderly 	

		<ul style="list-style-type: none"> • Number of claims regarding renal failure related to long term lithium therapy – the NPSA issued a safer lithium practice alert on December 1st • The information from ACC goes to CARM via Medsafe – legally can not go direct from ACC to CARM 	
9.	Safe Medication Management Programme	<ul style="list-style-type: none"> • <u>National drug chart</u> pilot at BOP DHB in week 7, favourable feedback received especially from nursing staff • Lakes and Hutt Valley DHBs are writing project briefs for their chart pilots • Discussion around whether the chart piloted should be the scannable version or not • Proposed that the scannable version should be as close as possible to the non-scannable version but if the scannable version was not as user friendly they should be different • <u>The medicines reconciliation</u> (MR) pilots in South Canterbury, West Coast and Mid Central are going well with improvement in discrepancy rates and good clinician engagement • 3 other pilots starting in the New Year • The future plan is to provide a plan and offer assistance when required to DHBs wanting to introduce MR • <u>e learning resource</u> on safe prescribing SMMP have asked Dr Bowers & Dr Maling to develop this • It was mentioned that Waikato and Waitemata had already produced e learning resources related to safer prescribing • <u>E prescribing/administration pilots</u>: both the Otago and Taranaki project plans have been approved • Canterbury and CM DHBs are presenting their project briefs to the next meeting of the SMMP steering group • DHBs will need to seek waivers from MOH for electronic signatures because changes to the legal status are unlikely to be passed before Aug 2010 • <u>Yellow card</u> – producing standards for these will be discussed further by SMMP • <u>CLG & TAG</u>: Clare noted the proposal received from SQM and this would be discussed at the steering group meeting • The national health board have established a clinical reference group after calling for nominations from colleges • No clarity around their role but it is reported to include discharge summaries, medication safety & to provide clinical advice to the information technology board • <u>National Quality Agency</u>: this proposal is to go to cabinet next week • <u>National Formulary</u>: consultation had been coordinated by SMMP, SQM feedback was sent to the MOH • <u>NZULM</u>: it is hoped this can proceed further in January but there remains an issue with Pharamcodes 	<ul style="list-style-type: none"> • Write to Chai Chuah regarding the clinical reference group noting SQMs concern that close links with other groups working on medication safety are important (Beth)
10.	Future direction for	<ul style="list-style-type: none"> • Proposal for a meeting of all groups working on quality and safety has been stalled because of Chai's 	<ul style="list-style-type: none"> • Complete review of what organisations operate in other

	SQM	<p>changed role, for the proposal to be successful it needs a strong champion</p> <ul style="list-style-type: none"> • Discuss at February meeting • Comparison with other jurisdictions is almost complete • Informal approach has been made to Geraint Martin regarding SQM chair 	<p>jurisdictions (Beth)</p> <ul style="list-style-type: none"> • Agenda for next meeting (Beth) • Write to Geraint Martin, cc DHB NZ requesting new chair (Beth)
11.	2010 meeting dates	<ul style="list-style-type: none"> • 4th February videoconference 9am • 8th April face to face Auckland 09.30 – 14.30 • 3rd June videoconference 9am • 5th August face to face Wellington 09.30 - 14.30 • 7th October videoconference 9am • 2nd December face to face Auckland 09.30 – 14.30 	

Technical Agenda

1.	High Risk Medicines		
1.i	Unfractionated heparin	<ul style="list-style-type: none"> • Alert in rough draft and the proposed recommended actions were discussed • Baxters have responded to the letter sent regarding the discontinuation of supply of the heparin pre-mixed bags apologising and detailing the work they are doing with a view to recommencing manufacture • Estimated usage figures for pre-mixed bags has been collected and will be forwarded to Baxters 	<ul style="list-style-type: none"> • Circulate finalised draft prior to next meeting (Beth) • Contact Baxters with estimated usage of the premixed bags (Beth)
1.ii	Intravenous infusion audit report	<ul style="list-style-type: none"> • Ready for distribution 	<ul style="list-style-type: none"> • Complete distribution (Beth)
1.iii	IT cytotoxic injection	<ul style="list-style-type: none"> • University of Auckland students did not complete the proposed IT methotrexate project having changed the topic to monoclonal antibodies • Agreed the proposed evaluation should be circulated 	<ul style="list-style-type: none"> • Circulate evaluation to oncology/haematology centres (Beth)
1.iv	Oral methotrexate	<ul style="list-style-type: none"> • Consultation on the draft alert to proceed – to include rheumatologists, dermatologists and oncologists 	<ul style="list-style-type: none"> • Send out for consultation (Beth)
1.v	Funding proposal for warfarin/insulin toolkits	<ul style="list-style-type: none"> • Work ongoing 	<ul style="list-style-type: none"> • Complete proposal (Beth, Gillian)
1.vi	Cytotoxic injections in the community	<ul style="list-style-type: none"> • No progress to date 	<ul style="list-style-type: none"> • Draft guidelines (Beth)
2.	Renal drug dosing	<ul style="list-style-type: none"> • Comments on the re-worked alert generally positive, some changes discussed • Add a statement linking the creatinine clearance should be considered a trigger when prescribing in renal impairment • Agreed that it should be the first in a series of alerts for different classes of drugs 	<ul style="list-style-type: none"> • Provide sentence on renal impairment related to creatinine clearance level (Tim) • Complete changes to alert and circulate (Beth)
3.	Paediatric alert related to HDC	<ul style="list-style-type: none"> • Telepaeds meeting provided additional feedback • Paediatric group would like a firm recommendation on a paediatric text 	<ul style="list-style-type: none"> • Liaise with Paediatric Society about recommended text (Beth)

	report	<ul style="list-style-type: none"> Following discussion about the proposed NZ national formulary and whether this would include specialist paediatric information – they will agree what the recommended text should be The draft alert has highlighted the need for national guidelines on dosing in obese children and this will be followed up with the Paediatric Society Feedback from the consultation and the telepaeds meeting to be incorporated into the alert 	<ul style="list-style-type: none"> Make changes to alert and circulate to SQM for comment (Beth)
4.	Etoposide/ etoposide phosphate	<ul style="list-style-type: none"> First draft to be circulated prior to next meeting 	<ul style="list-style-type: none"> Complete first draft (Marilyn) Circulate (Beth)
5.	Patient Information leaflet for all settings on medication safety	<ul style="list-style-type: none"> Electronic copies of PILS available in other DHBs to be circulated to developers Discussion around what else could be done regarding medication safety e.g. a national medication safety week or day Tim proposed a common set of principals about medication error and what strategies work to reduce error that all DHBs should be aware of 	<ul style="list-style-type: none"> Circulate PILS already available (Beth) Develop PIL (Gillian, Avril, Mary, Beryl) Write a short paper on what actually works to reduce medication error (Tim)
6.	Primary Care Issues	<ul style="list-style-type: none"> The Pharmacy Council have written to Medsafe regarding the look-alike labelling between generic products from any one manufacturer and the increased risk of dispensing error Medsafe are working on labelling guidelines The Health & Disability Commissioner should be informed about the issues 	<ul style="list-style-type: none"> Follow up with Medsafe about the guideline development (Beth) Write to HDC regarding look-alike labelling issues (Beth)
7.	Allergy alert system and education	<ul style="list-style-type: none"> There have been several instances at CMDHB of patients prescribed and given Augmentin despite documented allergy to penicillin There is a need for an alert and a bpac journal article/education 	<ul style="list-style-type: none"> Draft alert and bpac article (Mary)
8.	Alerts of Toniq dispensing system	<ul style="list-style-type: none"> The alerts should be live on Toniq April 2010 Toniq have been asked by community pharmacists for insulin alerts and have requested that SQM suggest appropriate alerts The alerts need to be included in the other dispensary systems e.g. LOTs and i soft e pharmacy 	<ul style="list-style-type: none"> Draft insulin alerts (Beth) Contact other dispensary system manufacturers regarding the alerts (Beth)
9.	BPAC articles	<ul style="list-style-type: none"> LMWH advice was included in last bpac journal. Working on process map for articles Put bpac articles on SQM website 	<ul style="list-style-type: none"> Draft process map (Beth & David) Upload bpac articles to website (Beth)