

SAFE & QUALITY USE OF MEDICINES GROUP

Meeting

Thursday 5th March 2009 Time: 9.30am to 15.30pm

Attendees

Chai Chuah (Chair)	Beth Loe (National Coordinator)
Mary Seddon (CMDHB)	Frances McClure (GP)
Gigi Lim (Auckland University)	Avril Lee (Waitemata)
Marilyn Crawley (Waitemata)	Gillian Bohm (MOH)
Tim Maling (C&CDHB)	Peter Moodie (PHARMAC)
Adam McRae (PHARMAC)	David Woods (bpac ^{NZ})

Invited

Desiree Kunac (NZPhVC)	Jane Brown (ACC)
Dylan Tapp (ACC)	Clare Kirk (SMMP)

Minutes

Item	Agenda	Notes/comments	Action Required
1.	Apologies	Peter Black, Nigel Millar, Roy Morris,	
2.	Minutes of previous meeting	<ul style="list-style-type: none"> These were accepted 	
3.	Matters arising	<p><u>i. PreMec proposal</u></p> <ul style="list-style-type: none"> Still awaiting reply <p><u>ii. Potassium pre-mixes</u></p> <ul style="list-style-type: none"> No reply from Centre for Study of Diabetes to date Usage figures from DHBs who have provided this information indicates that approximately 95% of Glucose 10% use would be GIK infusions Need to consider suitable iv fluid for paediatrics and Australia have recently reached a consensus on a suitable fluid There needs to be consideration for hospital pharmacies managing iv fluids (rather than stores) <p><u>iii. Look alike sound alike medicines: Expert Advisory Group</u></p> <ul style="list-style-type: none"> Look alike medicine issue was highlighted in the sentinel event release because of the mEslon incident No further correspondence from Medsafe re-expert advisory group <p><u>iv. Resus medicines presented in syringes</u></p> <ul style="list-style-type: none"> PHARMAC have responded to the letter from SQM PHARMAC mistook that the letter was in response to a consultation rather than a new issue PHARMAC requested SQM provide details of the required medications in syringes <p><u>v. Use of cytotoxic injections in the community</u></p>	<p><u>i. PreMec proposal</u></p> <ul style="list-style-type: none"> Contact chair of PreMec (Beth) <p><u>ii. Potassium pre-mixes</u></p> <ul style="list-style-type: none"> Liaise with Baxters (Beth) Follow up with Centre for the Study of Diabetes (Beth) Investigate appropriateness of Medicines Control Group involvement (Gillian) <p><u>iii. Look alike sound alike medicines</u></p> <ul style="list-style-type: none"> Contact Medsafe for an update on formation of expert advisory group (Beth) <p><u>iv. Resus medicines in syringes</u></p> <ul style="list-style-type: none"> Send list to PHARMAC (Marilyn) <p><u>v. Use of cytotoxic injections in</u></p>

		<ul style="list-style-type: none"> • PHARMAC have responded to SQM's letter asking for an indication of numbers of patients that would be treated with pre-filled syringes and an indication of the cost for the commercially available syringes • Rheumatology Association have replied to SQM's letter suggesting that methotrexate used in the rheumatology setting is anti-metabolic and anti-inflammatory and that it is misleading to use the term "cytotoxic" in the context of low dose weekly treatment. A study to show that accidental methotrexate skin contact is not dangerous was also mentioned. • The study was in 6 volunteers and did not look at long term effects or into the effects of possible aerosol inhalation/ingestion • This issue is wider than the availability of pre-filled syringes but also concerns disposal of the syringes and vials, patient training to self administer, credentialling of DHB nurses etc. <p><u>vi. Paediatric Safety Concerns (supply of special stoppers for use with liquids)</u></p> <ul style="list-style-type: none"> • SQM have written to PHARMAC and awaiting reply • Further discussion clarified that this would be an item in the pharmacy contract (cf child resistant closures) rather than a PHARMAC matter • It would be necessary to choose the stoppers funded with care because they are not all reliable <p><u>vii. Waikato initiatives</u></p> <ul style="list-style-type: none"> • These were mentioned in the December newsletter and there has been a very positive response & requests for further information • Warfarin – further discussion about the warfarin toolkit they had produced for their small hospitals, what was the cost, could it go into production immediately etc. • Still a lot of gaps in warfarin management e.g. in rest homes and private hospitals • Each region needs to have standardised management for patients both in the community and in hospital • One way forward may be a workshop involving consumers, haematologists, cardiologists, GPs etc with rules and required outcomes set out prior to the workshop • Need information on actual numbers for warfarin related adverse events prior to the workshop 	<p><u>the community</u></p> <ul style="list-style-type: none"> • Look at steps in the process (Gigi) • Contact President of the Rheumatology Association and invite to the next meeting (Beth) <p><u>vi. Paediatric Safety Concerns</u></p> <ul style="list-style-type: none"> • Write to DHBNZ SIG group regarding the stoppers being funded under the pharmacy contract (Beth) <p><u>vii. Waikato initiatives</u></p> <ul style="list-style-type: none"> • Contact Waikato for further information regarding their toolkit (Beth) • Investigate possibility of holding workshop (Beth) •
4.	Group membership		•
4.i	Resignation	<ul style="list-style-type: none"> • Debi has had to resign because Trust has re-considered their priorities and can no longer support her membership • Roy is unable to attend meetings on the dates that were arranged to allow Nigel to attend • Discussion about face to face meetings because of the above and budget considerations 	•

		<ul style="list-style-type: none"> Consider video conferencing particularly if this would allow both Nigel and Roy to continue with their membership 	
4.ii	PHARMAC membership	<ul style="list-style-type: none"> After some discussion it was agreed that PHARMAC membership should remain as two for the present and would be re-considered in six months 	<ul style="list-style-type: none">
4.iii	Meeting dates	<ul style="list-style-type: none"> Leave status quo for present while possibility of videoconferencing is investigated 	<ul style="list-style-type: none"> Investigate possibility of videoconferencing (Beth)
4.iv	Appointment of consumer	<ul style="list-style-type: none"> Send out summary of c.v.s' for group to consider 	<ul style="list-style-type: none">
4.v	Health Professional applications	<ul style="list-style-type: none"> Send out summary of c.vs' for group to consider Discussion around process for 6 year rotation of membership (as per TOR) i.e. re-applying for positions and decision as to whether they remain members or not Inaugural members should indicate whether they wish to resign their membership or reapply by March 31st 	<ul style="list-style-type: none">
5.	Annual report	<ul style="list-style-type: none"> Quotes for printing have been requested 	<ul style="list-style-type: none"> Have printed and distribute as agreed previously
6.	QIC update	<ul style="list-style-type: none"> 2nd sentinel event release o February 23rd, 8% were medication related M-Eslon incident highlighted in media as packaging related incident HDC picked up the need for standardisation and a national drug chart Looking to expand projects e.g. possibly picking up safer surgery (no. of incidents were related to surgical site errors) and/or early warning scores Concerned about progress on a no. of the programmes and will be asking for updates Discussion about possible overlap with "Health Round Table" (HRT)programme, all DHB CE's have signed up to HRT conducting medication safety seminars to which at least some DHBs are sending staff Need to ensure alignment with SQM and SMMP programme 	<ul style="list-style-type: none"> Find out details of Health Round Table initiative from lead CE (Chai) Include in summary report for next CE's' meeting (Beth)
7.	Safe Medication Management Programme update	<ul style="list-style-type: none"> Two workshops planned before mid-April to assess chart standards (Waiarapa & Mid Central) Chart Standards planned for sign off by steering group in May Timeline for finalising the national drug chart design, pilot and evaluation to be in place for May steering group meeting Medicines Reconciliation – planned for toolkit to be developed and ready for June, 1st DHB (with no experience of MR) to be initiated by December. Planned to initiate 5 DHBs' SMMP will provide experienced resource person for roll out and evaluation Need to consider SMO leadership to ensure HO involvement in process Standardised reporting and a website to upload the data to were suggested as requirements Envisaged as secondary care initiative but DHBs can choose whether they extend to primary care Legislation work stream – progressing the changes 	<ul style="list-style-type: none"> Circulate bar coding discussion document to SQM members (Beth, Clare)

		<p>needed to allow e prescribing, the Universal list of medicines, all interested parties are working together and the funding for this has been signed off</p> <ul style="list-style-type: none"> • Unit dose/bar coding – a discussion document regarding the barriers/ advantages etc. has been circulated to steering group members • The safety benefits of bar coding down to unit dose were re-iterated by SQM 	
8.	Clinical Leadership Group (CLG)	<ul style="list-style-type: none"> • Senior Medical Officers have written a paper for MOH on the formation of a CLG • Ask that the SMOs' include medication safety in the brief for their proposed CLG • Discussion about the interim CLG and what should happen in the future • Is the interim CLG necessary because they are currently acting as a technical group • SQM is happy to act as technical group and has the expertise • This proposal needs to be taken to the steering group and if agreed some of the working group would need to present the standards to SQM • Suggestion for a CLG appropriate to each work stream rather than just one, this would extend involvement to larger number of clinicians and reduce work load for each clinician involved, these work stream specific CLG's would be appointed by the steering group • Interim CLG to continue until SQM make alternative proposal 	
9.	Drug chart (NAIMS)	<ul style="list-style-type: none"> • Discussion around whether NAIMS is correct acronym because when conducting a pilot it would be difficult to contain the chart to acute medical and surgical wards because of the movement of patients between areas e.g. onto AT&R wards • Recommend the chart should be titled National Medicines Chart, sub-titled; Adult Medicine and Surgery 	
10.	NZPhVC update	<ul style="list-style-type: none"> • Desiree reported on the International Medication Safety Network meeting in Chicago, key themes were i) safe labelling and packaging, the network would like to include examples of look alike sound alike packaging for parenteral products on their website ii) proactive drug name review, David Yu (ISMP Canada) & Health Canada are conducting a review of proprietary drug names iii) the Network is keen to link with pharmacovigilance centres as they are a source of preventable event data iv) incidents related to fentanyl patches were highlighted as a growing concern • A business case for a pilot medication error reporting system has been approved by Medsafe and a contract is being finalised 	<ul style="list-style-type: none"> • Website details to be circulated via Beth (Desiree) • Send examples of look alike parenteral products to Desiree (Beth)
11.	ACC update	<ul style="list-style-type: none"> • Dylan presented an update of ACC accepted treatment injury claims (Jul 2005 – Jan 2009) • ACC notify adverse drug reaction claims to Medsafe and ACC understanding is that Medsafe then notify CARM, this pathway to be clarified • Discussion about the seemingly long time interval between an allergy report and the warning appearing 	<ul style="list-style-type: none"> • ACC to clarify whether the reports they send to Medsafe are forwarded to CARM (Dylan, Jane) • Investigate the process following CARM confirmation of an allergy to

		<p>on the patient's NHI</p> <ul style="list-style-type: none"> • There is a need for real time updates to NHI information for primary and secondary care (primary care can not currently access the warning linked to the NHI) • CMDHB have designed an information poster about penicillin allergy 	<p>identify where delays arise in linking to the NHI (Desiree)</p> <ul style="list-style-type: none"> • Write to Alan Heskett DGG IT asking about availability of NHI linked warnings in primary care (Beth) • Circulate CMDHB allergy poster (Beth)
12.	Colour coded wristbands	<ul style="list-style-type: none"> • Enquiry from a DHB as to whether there was a national colour coding standard because they were considering introducing a wristband to indicate drug allergy • Internationally there is no data to show that using colour coded wristbands are useful and there are incident reports of errors arising from their use • 3 different colours to indicate drug allergy already in use around NZ • All 3 colours are used in different DHBs to indicate different risks e.g. risk of falls, gas in eye during retinal surgery • SQM do not support the use of colour coded wristbands • If a DHB chooses to use them then they should ensure that if a patient is transferred between care settings e.g. to another DHB, private rest home/hospital the wristband is removed to prevent confusion and errors 	<ul style="list-style-type: none"> • Include SQM stance in next newsletter and put information on website (Beth) • Reply with decision to relevant DHB (Beth)
13.	Patient Information Leaflet	<ul style="list-style-type: none"> • Auckland DHB wondered if SQM could suggest a funding source for this leaflet so that it could be available nationally • This is just one example of a PIL designed to prevent medication errors, other DHBs have developed them • Suggested that it be available on the website with other examples • Discussion about developing a generic PIL for all settings 	<ul style="list-style-type: none"> • Discuss with Auckland and if appropriate put on website (Beth) • Agenda development of generic alert (Beth)
14.	Etoposide/etoposide phosphate	<ul style="list-style-type: none"> • Unlikely to be an issue in NZ but need to ensure protocols are clear • Send the South Australian alert to the heads of oncology and haematology departments with a covering letter informing that a NZ alert is in preparation 	<ul style="list-style-type: none"> • Send Australian alert to oncology/haematology with letter (Beth) • Develop alert (?)
15.	High Risk Medicines		
15.i	Unfractionated heparin	<ul style="list-style-type: none"> • Defer to next meeting 	<ul style="list-style-type: none"> • Develop an alert (Beth)
15.ii	Warfarin	<ul style="list-style-type: none"> • Collated feedback circulated to consultation list for further comment, final feedback to be sent to Glaxo Smith Kline • Toolkit progress, PHARMAC have postponed further work on this 	<ul style="list-style-type: none"> • Collate comments for "red book" review (Beth) • Investigate Waikato "toolkit" (Beth)
15.iii	Morphine	<ul style="list-style-type: none"> • Following alert release, query from one DHB regarding availability of naloxone in all settings where DHB staff administer morphine – should this include patient's homes? • The alert was not intended to cover this setting 	<ul style="list-style-type: none"> • Reply to DHB (Beth)

		<p>where patient's own morphine is given</p> <ul style="list-style-type: none"> • Would expect staff who carry morphine to also carry naloxone 	
15. iv	Intravenous Infusions	<ul style="list-style-type: none"> • Feedback on position statement and alert • Incomplete draft of audit report presented and feedback on format given 	<ul style="list-style-type: none"> • Finalise alert & position statement (Beth) • Complete audit report and circulate prior to release (Beth, Gigi)
15.v	IT cytotoxic injection	<ul style="list-style-type: none"> • Evaluation tool has been piloted and commented on by one DHB • Feedback from SQM to be included • Send out with reasons for evaluation, a vignette and if possible link to NPSA video site 	<ul style="list-style-type: none"> • Send out guidelines with evaluation and information on the NPSA video to haematology & oncology centres (Beth)
15.vi	Colchicine	<ul style="list-style-type: none"> • Alert in final format • Design PIL 	<ul style="list-style-type: none"> • Design PIL (??) • Circulate alert (Beth)
15. vii	Oral Methotrexate	<ul style="list-style-type: none"> • Alert in early stages of preparation 	<ul style="list-style-type: none"> • Agenda next meeting (Beth)
16.	Renal drug dosing	<ul style="list-style-type: none"> • Alert updated into current format 	<ul style="list-style-type: none"> • Circulate for comment (Beth)
17.	Look alike sound alike names and packaging		
17.i.	Lighting/eye sight	<ul style="list-style-type: none"> • No progress - remove from agenda 	
17.ii	INN v BAN	<ul style="list-style-type: none"> • Currently no funding available and no organisation will take responsibility for developing information campaign • Ask developers of universal medicines list to look at providing information to the public about the changes from BANs to INNs 	<ul style="list-style-type: none"> • Write to technology project manager (Beth)
18.	Paediatric alert related to HDC report	<ul style="list-style-type: none"> • Draft prepared by paediatric pharmacist to be circulated 	<ul style="list-style-type: none"> • Circulate draft alert (beth)
19.	E medication briefing paper	<ul style="list-style-type: none"> • No progress – remove from agenda 	
20.	Primary Care Issues		
20.i	Colchicine/ allopurinol in acute gout	<ul style="list-style-type: none"> • Bpac journal article, agenda next meeting • Does the datasheet and information in Mims for colchicine reflect current dosing recommendations 	<ul style="list-style-type: none"> • Write article (Peter or his registrar) • Check datasheet & Mims
20.ii	Favourite lists	<ul style="list-style-type: none"> • Project in Nelson looking at ensuring favourite lists up to date but mainly related to whether they are on the schedule or not 	
21.	International System for DI classification	<ul style="list-style-type: none"> • No progress 	<ul style="list-style-type: none"> • Agenda next meeting (Beth)
22.	Allergy alert system and education	<ul style="list-style-type: none"> • CMDHB have produced a poster to highlight which antibiotics are penicillins/ cephalosporins etc because they identified that clinicians were not always aware that e.g. Augmentin was a penicillin 	<ul style="list-style-type: none"> • Distribute poster to group (Beth)
23.	Alerts of Toniq dispensing system	<ul style="list-style-type: none"> • Toniq are investigating how these would work in practice • Need to involve the other dispensary software providers 	<ul style="list-style-type: none"> • Contact LOTS re-warnings when project further advanced (Beth)

24.	BPAC articles	<ul style="list-style-type: none"> • Annual report in draft 	<ul style="list-style-type: none"> • Finalise annual report article (Beth)
	House of Commons Patient Safety Select Committee	<ul style="list-style-type: none"> • Coming to NZ , would any members like to arrange meeting? 	