Issue 15,
Apr/ May 2017

Ballarat Health Services

Medication Safety Newsletter

May is Medication Safety Month at BHS

To spread the medication safety message we have a new twitter account:

@Med_Safety_BHS

If you follow this account by the end of May not only will you receive important updates about medication safety, but you will also go into the draw to WIN a $20 Coles Myer gift card!

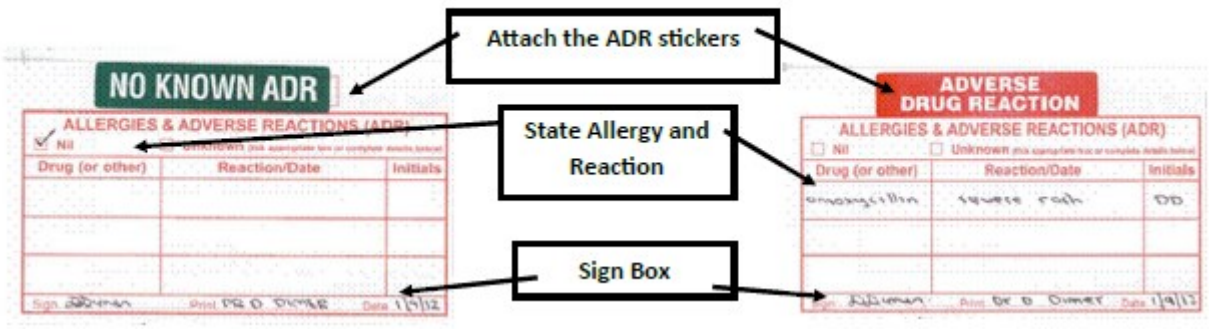
ADVERSE DRUG REACTION

Adverse Drug Reactions—Always Do It Right!!

A new organisational KPI has been introduced with a target of **NO patients to be prescribed a medication to which they have a known allergy without adequate documentation**. In the last month alone TWO patients (that we are aware of via riskman) have been administered a medication to which they have a known allergy without adequate documentation.

What is expected?
The **first prescriber** is responsible for:

- Completing the ADR box on the NIMC prior to any medications being prescribed or administered
- Entering the patients allergies into the **Bossnet Clinical Alert Manager (CAM)** including revoking/updating any ADRs which are no longer relevant
- Attaching the **ADR stickers** to the medication chart(s) in the designated places (front AND back)
- Stating the allergy and type of reaction



A recent audit across acute, subacute and mental health areas found that only 40% of ADR boxes were being completed appropriately (i.e. sticker, signed, drug and reaction). Together we can improve the safety of our patients.

Decision Support Survey

Do you use clinical references in your day to day work?
The Decision Support Survey is being conducted to see which ones you use, which ones you find helpful and which ones you wish you had access to.

Complete the Decision Tool Support Survey (less than 5 minutes) and you will go into the draw to WIN a $20 Coles Myer gift card!

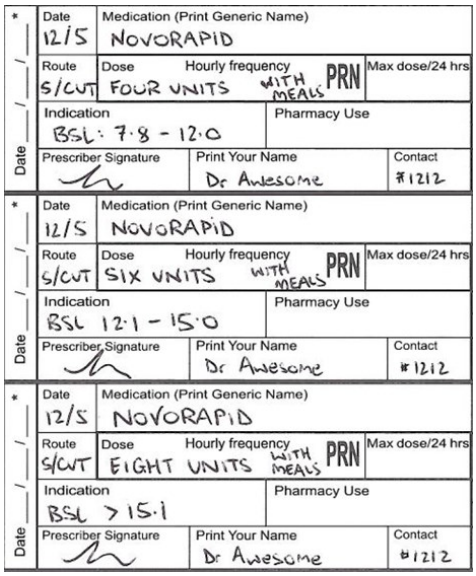
Survey link is: **www.surveymonkey.com/r/2KKGDN9**

Supplementary Insulin Orders

BHS has a protocol for sliding scale supplementary insulin in the Inpatient Blood Glucose Level Management in Adult Diabetes Patients (CPP0594).

The policy states a recommended supplementary dose of insulin according to meal time BGL, whether the patient has a pre-existing insulin regime and if they are:

- not eating or insulin sensitive
- eating
- eating and insulin resistant



Date	Medication (Print Generic Name)			
12/5	NOVORAPID			
Route: S/CUT	Dose: FOUR UNITS	Hourly frequency: WITH MEALS PRN	Max dose/24 hrs	
Indication: BSL: 7·8 - 12·0		Pharmacy Use		
Prescriber Signature	Print Your Name: Dr Awesome	Contact: #1212		

Date	Medication (Print Generic Name)			
12/5	NOVORAPID			
Route: S/CUT	Dose: SIX UNITS	Hourly frequency: WITH MEALS PRN	Max dose/24 hrs	
Indication: BSL 12·1 - 15·0		Pharmacy Use		
Prescriber Signature	Print Your Name: Dr Awesome	Contact: #1212		

Date	Medication (Print Generic Name)			
12/5	NOVORAPID			
Route: S/CUT	Dose: EIGHT UNITS	Hourly frequency: WITH MEALS PRN	Max dose/24 hrs	
Indication: BSL > 15·1		Pharmacy Use		
Prescriber Signature	Print Your Name: Dr Awesome	Contact: #1212		

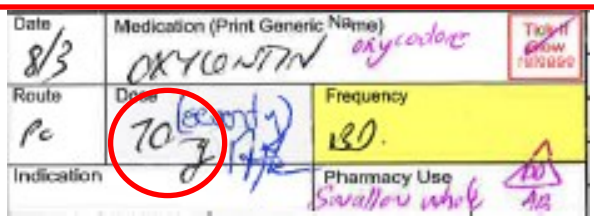
This is the recommended supplementary insulin order for a patient with a pre-existing insulin regime who is eating.

A recent spot audit found only 22% of patients had a supplementary insulin order written as per the protocol. This was predominantly because the prescriber nominated different insulin doses and/or different BGL ranges outside of protocl. Now is a good time to refresh your knowledge of this protocol.

On a positive note the same audit found that 66% of these orders had the insulin dose written in words which shows a good uptake of this new safety initiative.

Riskman Report

This Oxycodone (*Oxycontin)* order is from a Riskman submitted in April



The prescribed dose was 70mg (the patient's regular dose) but they were given 10mg on two occasions due to misinterpretation of the order. This may be explained by possible confirmation bias of the administrator because a 10mg dose of Oxycodone (*Oxycontin*) is much more commonly seen than a 70mg dose.

Strategies to prevent this type of error from occurring in the future include:

- Encourage prescribers to write the dose in words if it's an unusual order
- If you are not 100% sure of the prescriber's intent don't give the medication until you are
- Talk to the patient about their regular medications and doses
- Review the BPMH

Warfarin Orders

The April audit of Warfarin prescribing and counselling has shown some great improvements from previous surveys.

86% of warfarin orders on audited NIMCs had been fully completed, up from only 53% in August 2016.

Warfarin orders can be deemed incomplete for several different reasons:

- Not selecting the specific brand of warfarin
- Not documenting the indication for warfarin therapy
- Not documenting the target INR