Issue 14,
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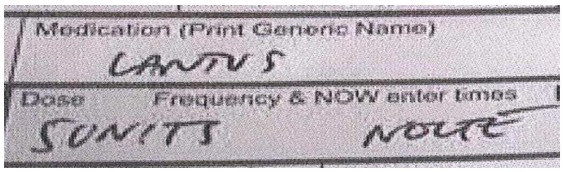
Ballarat Health Services

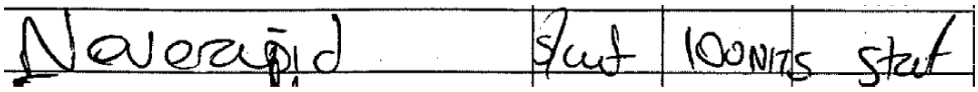
Medication Safety Newsletter

Insulin Prescribing Blitz– U can make a difference

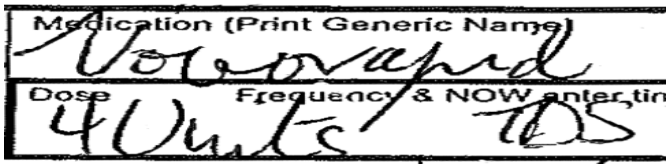
Insulin is a high risk medication.
Multiple errors have occurred at BHS where "U" from the word units has been misinterpreted as "O" leading to a ten fold overdose or a near miss.
This risk is potentially catastrophic. Examples include:



5 or 50 units?

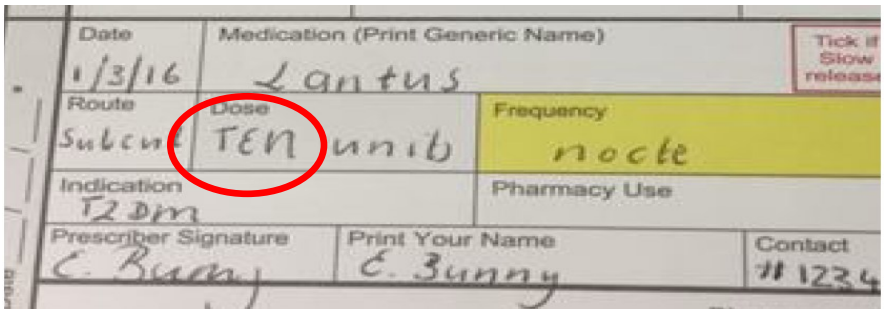


10 or 100 units?



4 or 40 units?

<u>Insulin should be prescribed using words</u>



Prescribe Infusion Volumes for Intravenous Medications

Nursing and Midwifery Practice Development Committee, Nursing and Midwifery Advisory Council, Medication Management Committee and Doctors in Training have agreed that prescribers when prescribing drug infusions will need to write on the medication chart/prescription, the medication to be administered and any fluids that will be required to administer the medication, where the infusion volume required is greater than 150ml. This may or may not be a change for medical staff~~,~~ and nursing staff.

Infusion fluids, greater than 150ml, will be prescribed on either the National Inpatient Medication Chart (NIMC) or the Intravenous Orders form (MR645), as appropriate for each IV medication ordered. For example: IV Vancomycin 1gm in 250mls 0.9% Normal Saline will need to be written by prescriber as "IV Vancomycin 1gm in 250mls 0.9% Normal Saline" (need to specify volume if greater than 150 mLs) and should NOT be written as 'IV vancomycin IV 1gm'

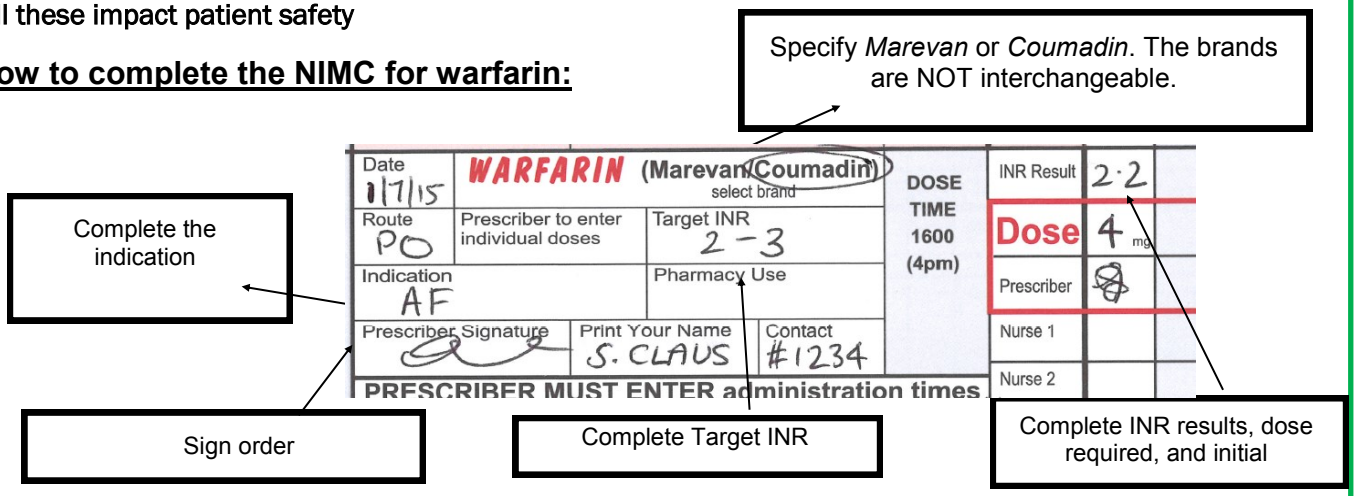
Prescribing Warfarin – Complete NIMC Section.

An audit of warfarin prescribing at BHS found only 53% of patients had the warfarin order completed fully on the NIMC. Information missing included:

- NO Brand name (7%)
- NO Indication (37%)
- Did not specify Target INR (7%)
- No Doctors signature (2%)

All these impact patient safety

How to complete the NIMC for warfarin:



Complete the entire warfarin section on the NIMC to prevent error

Levothyroxine is the new name for Thyroxine

The Therapeutic Goods Administration (TGA) changed the name of Thyroxine in February 2017 to levothyroxine, bringing Australia inline with international nomenclature.
Prescribing software, dispensing labels and shelf labels have been updated to include the updated name.
No changes to the actual product have occurred.
Where appropriate the name "levothyroxine" should be used – including prescribing and BPMH completion.

DD register entries MUST include full name & UR

CPP0496 Medication Security has been updated. It now states **all drugs of dependence (schedule 8's and schedule 4D's) register entries must include the patients full name and UR number**.
Auditing has highlighted, often both identifiers are used, but not always. Please ensure we update our practice.

Complete ADR box

BHS is aiming for no patients to be prescribed a medication to which they have a known allergy without valid documentation.
The first step is to complete the ADR box on all forms where medications are prescribed – including the NIMC and prescriptions. Completion of the ADR box involves attaching appropriate ADR sticker, listing allergies (or NKDA) and what reaction occurs & signing the box.
CPP0573 Adverse Drug Reactions (including allergies) – Recording and Reporting explains it is the first prescriber's responsibility to complete the ADR box on the NIMC and prescriptions, although if this is accidently missed, a nurse, pharmacist or other prescriber can complete this section.

NO medications should be administered or dispensed without the ADR box being completed.

An audit of 111 prescriptions found 43% of scripts did not have the ADR box completed appropriately. It is expected that the box be signed, with either NKDA stated or the medication and reaction recorded. en