QuIC NEWSLETTER

ISSUE 11

MAY 2016

Ballarat Health Services
Putting your health first

NSQHS STANDARDS

'The starting point for improvement is to recognize the need'
Masaaki Imai

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Standard 2 Portfolio
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UPDATES

Bedside Audit Results

Bedside Audit Results have been collated with reports about to be sent out in the next week or so. Some changes have been made to the report format, with an approach to a more simple design. We appreciate any feedback that you may have.

Some improvement is shown in most areas. Well done to all! Overall Acute have shown to be the same as last year with improvements in Patient ID, Risk Management and Communication Boards.

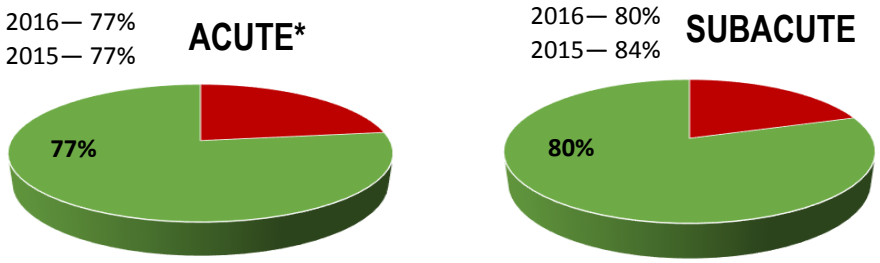
Sub Acute results have dropped slightly but a good performance overall in Risk Management and BPMH.

When reports are received each Clinical Area is to:

- Review their results and evaluate against (Acute or Sub-Acute) aggregate data
- Respond to and implement any local changes where required

Please forward all queries and completed Action Plan workbooks (once received) on completion to Alison Eldridge alisonel@bhs.org.au or your QuIC Representative.

**ICU/CCU not yet included in Aggregate*



STANDARD 2 AUDIT UPDATE

Standard 2 Survey/Audits: Data currently being collated and a report will be available

STANDARD 7 AUDIT UPDATE

Standard 7— Samples for Blood Bank Testing Audit: Good response received from all areas involved, thank you for your participation. Data is currently being collated, reports currently being completed.

STANDARD 1 AUDIT UPDATE

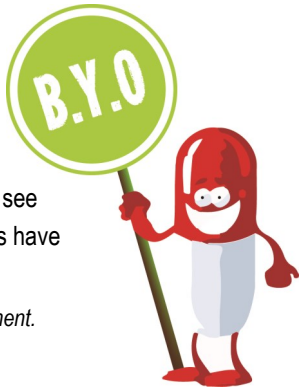
Clinical Documentation Audit: All areas should now have their results and be putting any actions required into place.

Focus month for May is Standard 4 Medication Safety - ***See over page for details***

May Focus Standard 4

Medication Safety

MEDICATION SAFETY NEWS & UPDATES



Patients own medications

Please encourage patients to bring in their own medications where ever possible. This helps to:

- Obtain an accurate medication history, and has details of the patient's community pharmacy.
- Ensures that the patient has continuity in the medications they are used to taking, and when discharged we can see exactly what medications they have to continue with. It also helps with explaining to the patient what medications have been stopped or changed.

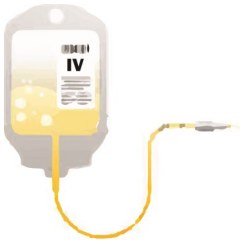
*Please familiarise yourself with the relevant protocol **"Medications – Use of Patients own"** if you have not already seen this document.*

Use oral dispensers for all oral and enteral medications

Oral dispensers (syringes) must be used for the measurement and administration of liquid oral and enteral medications. Inadvertent use of an IV syringe to measure and administer oral liquid or enteral medications

Supply Department codes for ordering oral dispensers and compatible enteral feeding systems:
S:\All Users\Safety Enteral Feeding System\Supply department codes_oral dispensers_enteral feeding systems_Adult.xls

Intravenous administration times



The 'Recommended Administration Times' section of the drug chart refers mainly to oral dosing. Most intravenous medications (especially antibiotics) must be split evenly across the 24 hour period.

*For example: Piperacillin 4.5 g IV tds must be given 8 hourly (not **0800**, **1200** and **1700** or **0800**, **1400** and **2200**), otherwise an extended period of time can elapse with no antibiotic coverage. If in doubt seek advice from the Prescriber or your clinical Pharmacist.*

When intravenous antibiotics are first charted, after checking they have not already been administered on another chart (e.g. ED, Theatre, another hospital) they should be administered as soon as practicable rather than waiting for a 'suitable' time slot on the drug chart.

The 'Sepsis Kills' website (http://www.cec.health.nsw.gov.au/programs/sepsis) states that "The mortality rate for adult patients with septic shock is around 25 per cent. It has been shown to increase by 7.6 per cent for every hour of delay after the onset of hypotension, in starting antibiotic therapy". As such early administration is vital.

SEPSIS KILLS®
RECOGNISE · RESUSCITATE · REFER

RISKMAN INCIDENTS/ADVERSE EVENTS

Gentamicin

A number of Riskmans have highlighted gentamicin doses being given too close together.
Please remember:

- Dosing is not to be more frequent than 24 hourly.
- All orders for gentamicin MUST have the time to be administered written on by the Prescriber. *(i.e. gentamicin 480 mg IV daily without a time is not acceptable).*
- For new orders; other paperwork (e.g. ED, Theatre, another hospital) must be checked to see if a dose has been given earlier to avoid inadvertent dose duplication.

Gentamicin dosing is complex, the clinical Pharmacist responsible for that patient should be notified as soon as is practicable (preferably before the dose is given) to provide guidance and the **BHS Gentamicin Drug Guideline** referred to.

All adult doses are added to sodium chloride 0.9% 100 mL and administered over 30 minutes.

5 Rights of Medication Administration

During March one of the two serious incidents that occurred included that of an oral analgesia being administered via the IV route. The patient had a localised reaction with no ongoing complications.

The "5 Rights of Medication Administration" were not followed in this incident highlighting the critical importance of checking this every time a medication is administered.

✓ the **right** patient ✓ the **right** drug ✓ the **right** dose ✓ the **right** route and the **right** time. ✓

AUDITS — MAY 2016

DD Register Audit

To allow for accurate, legal usage and documentation of drug of dependence.

Audit tool is available in the s:/ drive QuIC folder to either print or to enter data directly

S:\QuIC\Std 4 Medication\Audits\DD Register\ TEMPLATES

Transdermal Patch Audit

Audit tool is available in the s:/ drive QuIC folder to either print or to enter data directly.

S:\QuIC\Std 4 Medication\Audits\Transdermal Patch\ TEMPLATES