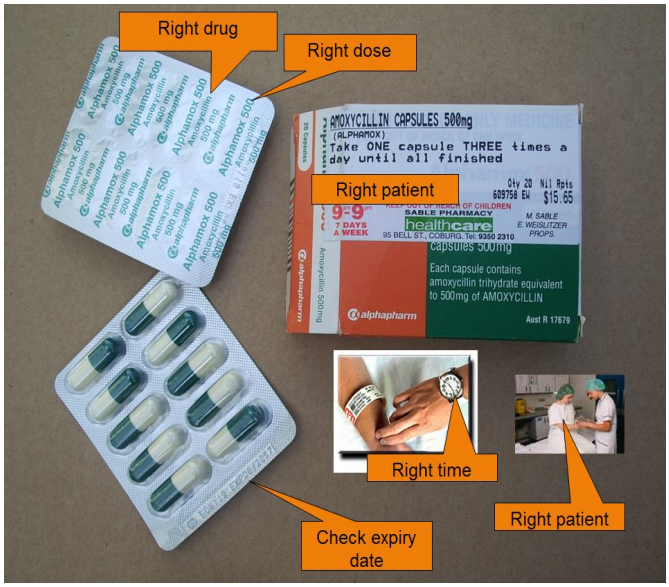
Issue 3, December 2014

Ballarat Health Services

Medication Safety Newsletter

6 Rights of Medication Administration



Prior to the administration of medications, the medication chart and each medication order must be checked to ensure that all components are documented and legible including:

Patient's name, DOB & identification [UR] number
Allergy status
Date written
Route of administration
Dose
Frequency
Prescriber's signature, name & contact details (once on chart)
Administration times

Always consider "Right" to refuse, "Right" therapeutic reason and "Right" Environment.

As per Medication Administration (CPP0287):

Right Drug

- Accurate interpretation of doctor's order
- Familiarity with drug. If unfamiliar, consult pharmacist or references such as MIMS
- Expiry date
- Allergy/sensitivity
- Correct time
- Correct form (i.e. slow release)

Right Dose

- Accurate interpretation of order
- Correct calculation. An Independent Double Check should be carried out if required
- Appropriate dose for patient, i.e. weight, age

Right Route

- Correct route for specific medication
- Appropriateness of route at current time, i.e. vomiting, nil orally
- Correct technique used (positioning, landmarks)

Right Time

- At recommended schedule (check actual order, not just times written in)
- Has it been previously given (i.e. has an appropriate time elapsed between doses?)
- Appropriateness at current time (i.e. Alendronate half an hour before other medicines in the morning)
- Concurrent medications

Right Patient

- Check identification using 3 patient identifiers (CPP0327 Patient Identification/Name Band)
- Be aware of patients with the same/similar name

Right Documentation

- Initial chart when medication is administered.
- Document the route if multiple routes are available
- Use the NIMC code if not administering

Medication Orders

Medication Orders (CPP0286) has been recently updated. The changes include:

- All medications (including combination products) are to be prescribed generically. There is a small exemption list where it is impractical or creates a higher risk of confusion to write the generic name. (e.g. insulin may be prescribed by brand name).
- Warfarin, oxycodone and hydromorphone require both the generic name and brand name e.g. oxycodone (Oxycontin). This is to reduce error between dose forms.
- Prescribers must include administration times for their medication orders.
- A list of medications that can be safely prescribed using multiple routes in the one order (e.g. IV/O). If administering medications prescribed with multiple routes, ensure the actual route of administration is documented each time.

TGA Adverse Drug Reaction (ADR) Reporting

The new Adverse Drug Reaction (including Allergies) Reporting and Recording Protocol (CPP0573) promotes the reporting of ADRs to the TGA where the ADR was:

- Due to a new medicine OR
- Because of a suspected drug interaction OR
- Unexpected OR
- Serious

TGA (Therapeutic Goods Administration) is the governing body in Australia for therapeutic goods, including medicines. The TGA monitors activities to ensure that medicines available within Australia are of an acceptable standard, and analyses post marketing adverse event reports.

ADRs can be reported to the TGA by accessing the ADR reporting link found on the BHS intranet under Useful Links, MIMS Online OR searching the web for TGA.

ADR REPORTING PRIZE: For the months of November and December fax/email your TGA report receipt number to pharmacy (94109 or pharm5@bhs.org.au) to go in the draw to win a $20 Coles Myer voucher.

High Risk Medications

To make it easier to remember, high risk medication posters are available on wards. During clinical handover all high risk medications must be highlighted, along with the patient's allergies.

The list of high risk medications in Riskman has more options and now matches the BHS list. Take an extra second to see if your drug is included.

Actions to Minimise Risk

Penicillins are classed as high risk due to the allergy risk. Posters are available in drug rooms highlighting which medications contain penicillins and other medications which can have cross sensitivity for patients with a penicillin allergy. Before administering any medications, ensure you confirm the patient's allergies and always check this against the medicine you are giving. Pharmacy labels have been updated with a warning on penicillin products and imprest stock now has a "contains penicillin" shelf label.

Another high risk medication group is neuromuscular blockers. Their storage has been updated with all neuromuscular blockers stored separately from other stock or stored in a separate container. Red signs which state "Warning: Paralysing agent-causes respiratory arrest" are being used.

High Risk Medications

Antimicrobials (amphotericin, aminoglycosides, penicllins)
Potassium and other electrolytes (calcium, magnesium, phosphate)
Insulin
Narcotics and all sedatives (general anaesthetics and opioids)
Cytotoxics (including oral agents)
Heparin and other anticoagulants (abciximab, apixaban, bivalirudin, dabigatran, dalteparin, enoxaparin, eptifibatide, fondaparinux, heparin, rivaroxaban, tirofiban, warfarin)
Other (clozapine, neuromuscular blockers)

Cold Chain Management

Cold chain management is a system of transporting temperature sensitive medication under refrigeration (i.e. between 2-8 °C) from the time the medication is manufactured up until the point of administration.

All temperature sensitive medications are now delivered to wards using an esky/cool bag. A new version of the fridge temperature monitoring chart is also being developed and will be released shortly. It is a track and trigger design to help recognise excursions.

Congratulations

Thank you to over 50 participants who submitted an entry into the "Find the Penicillin" word search competition. Jane Ryan from the Chemotherapy Day Unit was the winner of the $20 Coles Myer Voucher.

RiskMan Reports

In the last few months there have been several Riskman incidents where the incorrect Bradma was placed on the patient's medication chart. This highlights why it is so essential for the patient's name to be written below the Bradma on all charts where medications are ordered, as it is a vital second check. Over the next 6 months all forms where medications are prescribed/administered will have the addition of the spot to handwrite the patient's name below the Bradma. This will allow this second check to be performed routinely on these forms.