Issue 7, July/August 2015

Ballarat Health Services

Medication Safety Newsletter

Medication Safety May

The inaugural Medication Safety May has been judged a success due to the large number of entries into competitions and attendance at education.

Over 200 staff members completed Medication Safety training during the month. Medication Safety training is an organisational requirement for nursing, medical and pharmacy staff.

Over 50 Medication Safety Quizzes were completed. The quiz gave the Medication Safety team great feedback on staff knowledge of medication safety initiatives in place at BHS.

Prescriber of the Month was well received. Nominations were submitted for Natalie Smith, Holly Murphy, Timothy Ma, Fiona Perolini and Joshua Saunders. The medical staff who received nominations are commended for their commitment to medication safety practices.

Winners of the $20 Coles Myer Vouchers were;
Shannon Strjanovic (2 North) - Medication Safety Quiz
Holly Murphy—Prescriber of the Month
Bernie McIntyre (2S) - Medication Safety Humour

A public presentation regarding Medication Safety issues was held on the 25th May, with fantastic feedback from those who attended including;
"Event was professionally planned & delivered by speakers experienced in their subject."
"I would definitely attend future sessions"
"Please continue such public information sessions"

Medication Safety Humour
Why didn't the medication cross the road?
Because it was the wrong route!"

Cytotoxic Products

A Riskman report highlighted the importance of recognising cytotoxic medications.

A patient was admitted on a weekend and prescribed their regular medicines. The Patient's Own Medications were used. This included hydroxyurea which is a cytotoxic drug. As the local pharmacy had not indicated (i.e. label, sticker) that the product was cytotoxic, the drug was not identified as cytotoxic. Staff did not use cytotoxic precautions. It was only discovered it was a cytotoxic product once pharmacy supplied the medication on the Monday with a cytotoxic sticker on the label.

Staff are encouraged to look up any unfamiliar medications to determine if there are any special handling required (e.g. in MIMS or the AMH).
To further raise awareness of cytotoxic products, pharmacists will also place a cytotoxic sticker or endorse the medication order on the NIMC for all cytotoxic products.
Patients coming from theatre or BRICC CDU having received a cytotoxic product will have a cytotoxic sticker placed on the nurse initiated section of the NIMC by nursing staff. The chart will be endorsed with "cytotoxic product administered".

Refer to *CPP0017 Cytotoxic Precautions– Guidelines* for further information on cytotoxic precautions.

What is Tall Man Lettering?

Tall Man lettering is a combination of lower and upper case letters helping to make medicine names more easily distinguishable e.g. fluOXETine versus fluVOXAMine. Tall Man lettering reduces the risk of medication selection errors. It is applied to look alike or sound alike medications which are potentially harmful if confusion occurs. Look for Tall Man lettering on imprest barcodes, dispensing labels and insulin storage containers.

Discharges with Warfarin

The Warfarin drug guideline (*DRG0039)* has been updated following a Riskman report where a patient's GP did not receive important information regarding the patient's warfarin dosage plan after discharge.
All patients discharged with warfarin must receive written information regarding their dose, next INR (including a pathology slip) and a copy of MR/092.2 Summary warfarin & anticoagulation dosing (soon to be available on the wards) for their GP. Written information can include a medicines list or a warfarin book.

Information required at discharge and responsibilities summary table:

Discharge to:	Home		Nursing Home		Other hospital		To community based Program (HITH, GITH)		From community based program	
Responsible Person:	**Pharm**	**MO**	**Pharm**	**MO**	**Pharm**	**MO**	**Pharm**	**MO**	**Pharm**	**MO**
MR/092.2	√	*	√	*						√
Path Slip		√		√						√
Dosing Information	√	*					√	*		√
Verbal Counselling	√	*					√	*		√

*Note: if a clinical pharmacist is not on duty the written information becomes the responsibility of the treating medical team.

Guardrails Audit Feb-Mar 2015

An audit of *Alaris* pumps was undertaken in February & March. The *Guardrails* compliance rate was excellent with hospital wide compliance at 93%. All medications & fluids administered were in the *Guardrails* library.
The most significant issues found during this audit were:

- 20% of all IV lines were disconnected. Of these 40% were Y looped & 40% were not capped, yet most were going to be reconnected. Always cap the distal end of the line using a red combi-stopper.
- Only a small number of IV lines were correctly labelled (see *CPP0222 Labelling of Injectable Medicines & Lines*). All IV lines require a IV line label to be completed and attached.

All *Alaris* Point of Care Units are required to be plugged in at all times (unless transferring patients etc.) when in use & in storage.

Breast Feeding Mother Sticker

The 'breastfeeding mother' alert sticker has been developed to assist with identification of breastfeeding status and to promote breastfeeding friendly prescribing within BHS.
The sticker is to be attached to all medication charts of breastfeeding women, by medical or pharmacy staff. It acts as a prompt for staff to consider the use of medications compatible with breastfeeding.
Where possible a mother's desire to breastfeed should not be compromised by her need to take medications; rather medication choice should be adjusted to enable breastfeeding to continue safely for both mother and infant.
Refer to *CPG0088: Medicines and Breastfeeding* for more information.
Stickers will be supplied to appropriate areas by the lactation consultants.

Patient's Own Medications

A patient was admitted to hospital and her husband visited in the morning. The husband believed that the nursing staff were running a bit late and tried to help them out by administering his wife's morning medications from her *Webster-pak*. What he did not know was that her medications were to be withheld.
Always highlight with the patient and/or carer (as soon as possible in the episode of care) to only take medications administered by a hospital health professional. Importantly, secure any Patient's Own Medications as soon as possible (e.g. bed side drawer, drug room).