Issue 6, May/June 2015

Ballarat Health Services

Medication Safety Newsletter

Medication Safety May

May is Medication Safety Month at Ballarat Health Services. Throughout the month, activities are planned to raise awareness of Medication Safety with both staff and patients. Medication Safety PDP sessions have been scheduled as follows:

Date	Time	Location
Monday 4 May	2.15pm-3pm	QE Seminar Room 1
Tuesday 5 May	2.15pm-3pm	Base Seminar Room 1 &2
Wednesday 6 May	9.30pm—10.30pm	QE Gandarra Conference Room
Wednesday 13 May	9.00pm-10pm	Base Lecture Theatre
Thursday 14 May	2.15pm-3pm	QE Main St Meeting Room
Friday 15 May	2.15pm-3pm	Base Lecture Theatre
Monday 18 May	2.15pm-3pm	Base Lecture Theatre

Attendance at a session will cover nursing/midwifery organisational requirements B1303 (Medication Safety), B1314 (Cold Chain Management) and B1371 (High Risk Medications).

A public presentation, which is open to staff members as well, will be held on Monday 25 May at 6pm in the ERC. Please let your family and friends know about this worthwhile session.

Other activities include;

- Medication Safety month badges. If you are seen wearing one of the 50 Medication Safety badges, you may be awarded a spot prize. Badges will be distributed the week of 11 May.

Medication Safety Badges

- Radio session on VOICE FM on 12 May at 9.15am to share medication safety messages with the community. Tune in!
- Prescriber of the Month nominations, with one nomination receiving a $20 Coles Myer Voucher.
- A Medication Safety quiz. A lucky participant will win a $20 Coles Myer voucher.
- A Medication Safety Humour competition. Share your best humour which will then be used in future Medication Safety education. The best humour will win a $20 Coles Myer voucher.

The Quiz, Humour and Prescriber of the Month entry forms are available from the Pharmacy Department webpage. The quiz questions can also be completed online through the Pharmacy Department webpage.

Medication Safety Humour Entry
Why do females often wrongly have their metformin withheld?

Because health professionals think it is Meant—for—Men!

Domperidone Update

The Therapeutic Goods Administration (TGA) and the manufacturer of domperidone have provided an update for health professionals regarding minimising cardiac risks with this medication. It highlighted that those at greatest risk of serious cardiac events, including sudden death, are those;

- Patients older than 60 years of age
- Taking daily doses of domperidone greater than 30mg
- Taking concomitant medications which prolong the QT interval
- Taking concomitant medications which inhibit CYP3A4.

The correspondence also reinforced that domperidone is indicated **SHORT TERM** for symptoms associated with gastroparesis and intractable nausea and vomiting. Other key points were;

- Domperidone should be used at the lowest effect dose for the shortest duration.
- For adults, the maximum dose of domperidone is 10mg three times a day with a maximum duration of one week for nausea and vomiting or four weeks for other indications.
- Domperidone use is contraindicated in patients with heart failure.

Please report any adverse events associated with domperidone use via Riskman and, where appropriate, to the Therapeutic Goods Administration (TGA) . The link is available through the BHS home page under “useful links”.

Medication Security- Destruction of Drugs of Dependence

CPP0496 Medication Security highlights not only the process of how to destroy drugs of dependence (DD -S8 and S4D), but the documentation required as well. All S4D’s can be destroyed by 2 nurses.
For S8 medications partially used sterile units (e.g. part ampoules) can be destroyed and documented by 2 nurses. All other S8 destructions require a pharmacist or medical officer witness.

If the appropriate staff members are available at the time, the DD may be discarded into the sharps container or for larger volumes down the sink (i.e. partially used infusion bags). The two staff members involved must both sign the DD register in the comments section and record the amount discarded. Alternatively some forms (e.g. Medication Pain Control Regional MR675.01) have a specific location for 2 staff members to sign or the disposal register can be utilised.

If the appropriate staff members are not immediately available the item should be placed in an appropriate bag (e.g. clip lock bag) and sealed, written into the drug disposal register and stored in the safe.
The medication is required to be included in the change of shift drug count until it can be destroyed.
Destruction must be documented in the disposal register with the item placed in the sharps container, returned to pharmacy or for large volumes placed down the sink.

Congratulations

It is with great pride that the Medication Safety Team reports that five **Met with Merits** were achieved for Standard Four: Medication Safety in the recent accreditation.
The team would like to thank all staff who contributed to the increased awareness of medication safety principles throughout the organisation, and reviewed and changed their practices as a result.

RiskMan Reports

Whilst completing a twice daily check of a patient’s buprenorphine patch, it was discovered that the patch had been dislodged. The patch was re-applied before the patient experienced any deterioration in pain control. Thanks to a transdermal patch sticker being applied to the order and the appropriate checks taking place, the dislodged patch was picked up quickly and corrected.
Always confirm that a transdermal patch sticker has been applied to patch orders on the drug chart